

Community Intermittent Preventive Treatment for Malaria in Pregnancy

Implementation Guide
Version 2



November 2018
Cover photo: Karen Kasmauski



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The Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project is an innovative, community-based approach that aims to dramatically increase the number of pregnant women in malaria-affected countries in sub-Saharan Africa receiving antimalarial treatment, thus saving the lives of thousands of mothers and newborns.

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Contents

Abbreviations	v
Acknowledgments	vi
Introduction to the Community Intermittent Preventive Treatment for Malaria in Pregnancy learning resource package.....	1
Rationale	1
TIPTOP's role	1
Why CDI?.....	2
Introduction to this <i>Implementation Guide</i>.....	4
Whom is the <i>Implementation Guide</i> for?	4
Purpose and objectives of the <i>Implementation Guide</i>	6
How to use the <i>Implementation Guide</i>	9
Roles and responsibilities	12
Who needs to be involved in the partnership for malaria control?	12
Establishing CDIs for malaria control	24
Plan and organize community entry	24
Conduct a community entry meeting	25
Facilitating a CDIOFM.....	28
Conduct community-wide meetings.....	32
Conduct feedback meeting	37
Train community-selected CHWs.....	40
CDI focal persons prepare for CDI.....	43
CHWs carry out interventions.....	43
Appendix A. Checklists for community health workers (CHWs) providing intermittent preventive treatment in pregnancy with sulfadoxine- pyrimethamine (IPTp with SP)	49
Instructions	49
Appendix B. Learning objectives for Community Intermittent Preventive Treatment for Malaria in Pregnancy learning resource package.....	54
Appendix C. Patient education handout.....	60
Appendix D. Job aids for providing intermittent preventive treatment in pregnancy (IPTp) with sulfadoxine-pyrimethamine (SP)	62

Appendix E. Checklist for monthly supportive supervision of community health workers (CHWs)	64
Appendix F. Supportive supervision checklist: Prevention of malaria in pregnancy (MiP) in health facilities.....	66
References	67

Abbreviations

ACT	artemisinin-based combination therapy
ANC	antenatal care
CDI	community-directed intervention
CDIOFM	community-directed intervention orientation and facilitation meeting
CDTI	community-directed treatment with ivermectin
CHW	community health worker
c IPTp	community-directed intermittent preventive treatment in pregnancy
<i>Counseling Flip Chart</i>	<i>Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart</i>
CSM	community self-monitoring
CSO	civil society organization
HCW	health care worker
<i>Implementation Guide</i>	<i>Community Intermittent Preventive Treatment for Malaria in Pregnancy: Implementation Guide</i>
IPTp	intermittent preventive treatment in pregnancy
ITN	insecticide-treated bed net
LLIN	long-lasting insecticidal net
LNMP	last normal menstrual period
M&E	monitoring and evaluation
MiP	malaria in pregnancy
MOH	ministry of health
NGO	nongovernmental organization
PHC	primary health care
RDT	rapid diagnostic test
SP	sulfadoxine-pyrimethamine
SSA	sub-Saharan Africa
TIPTOP	Transforming Intermittent Preventive Treatment for Optimal Pregnancy
TWG	technical working group
WHO	World Health Organization

Acknowledgments

The materials for this Community Intermittent Preventive Treatment for Malaria in Pregnancy learning resource package were adapted from the following sources:

- African Programme for Onchocerciasis Control (APOC), World Health Organization (WHO). 2012. *Curriculum and Training Module on the Community-Directed Intervention (CDI) Strategy for Faculties of Medicine and Health Sciences*. 2nd ed. Ouagadougou, Burkina Faso: APOC, WHO. http://www.who.int/apoc/publications/EN_CDI_Manual_final.pdf?ua=1. Accessed June 29, 2018.
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- Brieger B, Okeibunor O. *Malaria in Pregnancy Project Implementation Manual*. Unpublished document developed by Jhpiego for Nigeria Federal Ministry of Health/National Malaria Elimination Program/World Bank.
- Transforming Intermittent Preventive Treatment for Optimal Pregnancy project briefs

Introduction to the Community Intermittent Preventive Treatment for Malaria in Pregnancy learning resource package

Rationale

In sub-Saharan Africa (SSA), annually over 25 million pregnant women are exposed to infection from malaria (Desai et al. 2007). An estimated 10,000 pregnant women and up to 200,000 newborns die from malaria in pregnancy (MiP), primarily due to the infection from *Plasmodium falciparum* parasites transmitted through mosquito bites (Dellicour et al. 2010). Furthermore, recent data indicate that up to 20% of stillbirths in SSA are attributable to MiP (Lawn et al. 2016).

In 2012, the World Health Organization (WHO) updated its policy to promote initiation of intermittent preventive treatment in pregnancy (IPTp) for malaria with the antimalarial medication sulfadoxine-pyrimethamine (SP) as early as possible in the second trimester, along with the use of insecticide-treated bed nets (ITNs) and effective case management (WHO 2013). The primary indicator for the prevention of MiP was also updated to measure coverage of three doses of IPTp with SP (WHO 2013). In 2015, WHO affirmed the effectiveness of IPTp with SP, even in areas where malaria is resistant to SP (WHO 2015). However, in spite of its proven effectiveness, access to the medication has been limited in many countries with a medium to high prevalence of malaria.

Despite growing parasite resistance to SP in some areas (Flegg et al. 2013), IPTp with SP remains a highly cost-effective, lifesaving strategy to prevent the adverse effects of MiP in the vast majority of pregnant women in SSA. Recent estimates indicate that a full course of IPTp with SP decreases the incidence of low-birthweight babies by 43%, severe maternal anemia by 38%, and perinatal mortality by 27% among women experiencing their first or second pregnancies (Roll Back Malaria Partnership 2014). It is also one of the few health interventions that peer-reviewed evidence has shown reduces neonatal mortality (Menéndez et al. 2010; Sicuri et al. 2010). Delivery of IPTp requires a functioning antenatal care (ANC) platform and access to quality-assured SP.

TIPTOP's role

The Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project aims to significantly reduce incidence of MiP. This 5-year project funded by Unitaid will increase pregnant women's access to lifesaving quality-assured SP at monthly intervals during pregnancy.

The TIPTOP project will drive impact in target countries to help governments increase access to this cost-effective intervention, leading to better maternal and newborn health outcomes.

The TIPTOP project approach is simple and innovative. TIPTOP uses the **community-directed intervention (CDI) approach**—where community members take the lead in delivering an intervention in their own community—to introduce community-level distribution of quality-assured SP and expand ANC attendance. The project, managed and implemented by Jhpiego, will substantially reduce missed opportunities for eligible pregnant women to receive SP by helping to reach those most vulnerable in four African countries: Democratic Republic of the Congo, Madagascar, Mozambique, and Nigeria (Figure 1).

Jhpiego is collaborating to achieve the desired project results with:

- Barcelona Institute for Global Health as research and evaluation lead
- WHO
- Medicines for Malaria Venture

The TIPTOP approach is designed for sustainability: Project success will be realized when countries are able to scale up this community-based model. TIPTOP will support ministries of health (MOHs) and coordinate closely with key stakeholders supporting MiP implementation in each country to create a platform for long-term success.

The 5-year landmark project will:

- Generate evidence to inform change in policy recommendations across SSA for the WHO.
- Introduce and set the stage for scale-up of community distribution of IPTp with quality-assured SP.
- Introduce and increase demand for quality-assured SP.

Why CDI?

To achieve the objectives of the TIPTOP project and ensure wide coverage, as well as community ownership and sustainability of the program, an approach was needed that strengthens the community to participate in the project's implementation. CDI is an ideal mechanism. Hence, the TIPTOP project created this *Community Intermittent Preventive Treatment for Malaria in Pregnancy: Implementation Guide* (the *Implementation Guide*) to fill the need for a reference manual that can guide stakeholders in implementing and managing a CDI for MiP process.

Figure 1.

Transforming Intermittent Preventive Treatment for Optimal Pregnancy project countries: Democratic Republic of the Congo, Madagascar, Mozambique, and Nigeria



For many years, health services and nongovernmental organizations (NGOs) have distributed health commodities to communities—for example, vaccines, vitamin A, ITNs and long-lasting insecticidal nets (LLINs), ivermectin for onchocerciasis, guinea worm filters, condoms, and antiretroviral and tuberculosis drugs. However, hard-to-reach communities have not been able to access these interventions. This situation is particularly evident in malaria control for SSA, where coverage rates have remained poor for low-cost interventions like sleeping inside ITNs/LLINs, prompt and appropriate treatment with artemisinin-based combination therapy (ACT) drugs, and IPTp, and malaria continues to claim lives of many women and children.

Operational studies—sponsored by the UNICEF/United Nations Development Programme/World Bank/WHO Special Programme for Research and Training in Tropical Diseases—on the CDI approach demonstrated that communities can carry out the task of health commodity distribution thoroughly and accurately (Special Programme for Research and Training in Tropical Diseases 2008). The studies revealed that communities are capable of taking charge of commodity distributions if:

- The disease is perceived as an important health problem that affects all sections of the community
- An intervention is available that is relatively simple to implement
- The intervention has a clearly perceived benefit
- Implementation of the intervention is under the full control of community health workers (CHWs; see Figure 2)
- The intervention materials are made adequately accessible to the community

Figure 2.

Gloria Chinwedu, a midwife, prepares to deliver care in her community.



Photo by Gladys Olisaekee, Jhpiego.

The most critical factors, however, are **community empowerment**—to take charge; receive and monitor commodities; provide oversight for the selected CHWs as they identify and counsel pregnant women and distribute commodities to them; and liaise with the MOH and partners to ensure the success of the implementation.

Introduction to this *Implementation Guide*

Whom is the *Implementation Guide* for?

This guide is for programs implementing CDIs to address MiP. The people carrying out this work are referred to collectively as **facilitation teams** (Figure 3). A facilitation team consists of:

- National and subnational MiP technical working groups (TWGs)
- District and community malaria control teams
- Training facilitators and CDI focal persons (see Box 1), who may be:
 - Facility health care workers (HCWs)
 - District CDI team members
- CHWs, as they will be referred to throughout this guide. Depending on the community, CHWs may also be known as:
 - Community implementers
 - Community volunteers
 - Community-directed distributors
 - Commodity distributors
 - Community nominees

The training facilitator (Figure 4) will be responsible for training the HCWs and CHWs. In the anticipated setup, the training facilitator may be the district-level maternal and newborn health coordinator or someone from the district health office in a similar role. Experienced and skilled training facilitators may have to be engaged just to conduct the trainings.

Figure 3.

A meeting of implementers.



Box 1. Selection criteria for focal person for community-directed intervention

- Health care worker trained in intermittent preventive treatment in pregnancy, supportive supervision, and effective training skills
- Works in health facility near the community (preferably in the antenatal care clinic)
- Has interest in community-directed intermittent preventive treatment in pregnancy and agrees to participate in the project

Figure 4.

A training facilitator leads a training of community health workers in Democratic Republic of the Congo.



Photo by Fabrice Witanday, Jhpiego.

Community-level CDI focal persons (preferably, facility-based HCWs responsible for ANC and knowledgeable on the CDI process) will be responsible for:

- Contacting the communities
- Planning, implementing, and monitoring community-directed intermittent preventive treatment in pregnancy (c-IPTp)
- Assisting training facilitators and, often, training CHWs themselves
- Conducting supervision visits as needed

The **CDI focal person is the permanent contact person with the communities** and will lead the monthly supportive supervision meetings of CHWs, during which service delivery records, referrals, and stock status of SP are reviewed.

The **CHWs** visit pregnant women at home, counsel them and their families about MiP, deliver IPTp with SP (where allowed), and refer pregnant women for ANC.

Purpose and objectives of the *Implementation Guide*

This guide is meant to supplement Jhpiego's Prevention and Control of Malaria in Pregnancy learning resource package in programs implementing CDIs to address MiP (Jhpiego 2015). Its purposes include the following:

- To support implementers in strengthening communities to be directly involved in the effective delivery of IPTp with SP to all eligible pregnant women in the community
- To build and sustain community demand for ITNs/LLINs, IPTp with SP, ACT, and rapid diagnostic tests (RDTs)
- To support CHWs:
 - In identifying and referring pregnant women to the ANC clinic
 - Where allowed, in providing first or follow-up doses of SP to eligible pregnant women
- To assist implementers of the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project at the different levels of implementation—from national to community—in promoting the involvement and participation of various stakeholders, ownership at all levels of implementation,^{*} and sustainability of the intervention

Primary objective

Help the facilitation team, in partnership with the health service, strengthen communities by:

- Approaching the community
- Training CHWs on procedures for:
 - Delivering intervention commodities (e.g., IPTp, ITNs/LLINs, ACT)
 - Referring pregnant women to ANC
 - Recordkeeping
 - Reporting
- Monitoring and supervising the CHWs

^{*} For simplicity's sake, this document uses the terms national, subnational, district, and community to name the levels. Adapt as needed to the country context.

Specific objectives

Help the facilitation team learn how to:

- Build partnerships between communities (end users of the intervention), frontline health facilities, and civil society organizations (CSOs), including:
 - Donor agencies
 - Community-based organizations
 - Faith-based organizations
 - NGOs
- Inform and educate the community
- Train community-selected CHWs
- Train health staff on effective monitoring and supervision of community delivery of IPTp with SP or any other intervention
- Achieve the desired community commitment to sustaining high coverage of intervention commodities and services (see Table 1 for indicators that the CDI process has been successfully established)
- Use the information and experiences resulting from implementation to improve on delivery of similar interventions (IPTp with SP, ITNs/LLINs, and ACT) to other communities

Table 1. Key indicators to measure successful establishment of the community-directed intervention (CDI) process

Indicator	Definition	Means of verification
Community participation	Level of involvement of different segments of the community (e.g., women, men, various age groups, minorities) in decision-making meetings about project implementation	<ul style="list-style-type: none"> • Attendance lists from community-wide meetings • Minutes of community-wide meetings • Names of CDI subcommittee participants
Community self-monitoring (CSM)	Steps and exercises undertaken by community members to monitor and ensure smooth delivery of an intervention	<ul style="list-style-type: none"> • Verbal/written CSM reports • CSM meeting reports
Coverage level	Proportion of eligible people who received and use intervention commodities, including intermittent preventive treatment in pregnancy, insecticide-treated bed nets and long-lasting insecticidal nets (ITNs/LLINs), artemisinin-based combination therapies, and rapid diagnostic tests, during the period under review	<ul style="list-style-type: none"> • List of registered pregnant women • Community health worker (CHW) register • List of pregnant women who received commodities (e.g., sulfadoxine-pyrimethamine [SP]) from the CHWs

Indicator	Definition	Means of verification
Community support	Contributions made by the community toward the smooth operation of the CHWs' assignment.	<ul style="list-style-type: none"> • Tally of in-kind or cash contributions community members agree to make toward compensating CHWs for their work • Tally of in-kind or cash contributions community members actually make
CHW performance	CHWs' effectiveness in carrying out their assignments of: <ul style="list-style-type: none"> • Collecting and distributing intervention commodities • Delivering services in the community 	<ul style="list-style-type: none"> • List of registered pregnant women reached by the CHWs • List of pregnant women given doses of three SP tablets at home visits • Completeness and correctness of community health systems records • Monthly reports of CHW activities available
CHW morale	CHWs' motivation and zeal to perform their assignment well, including: <ul style="list-style-type: none"> • Conscientiously delivering services and collecting and delivering intervention commodities • Keeping good records 	<ul style="list-style-type: none"> • Tally of in-kind or cash contributions from community members and stakeholders to: <ul style="list-style-type: none"> - Help CHWs with transportation - Defray CHWs' costs for mobile phone airtime • Retention rate of trained CHWs
Partners' performance of their roles	How well implementation roles are performed by the various partners, including: <ul style="list-style-type: none"> • CDI focal persons • Community members • Civil society organizations 	<ul style="list-style-type: none"> • Completed supportive supervision checklists (Appendixes A and D) with suggestions for improvement • Meeting reports
Use of existing channels to manage intervention	Whether implementers tap into existing national and subnational channels to track demand for, request, and deliver intervention commodities (such as quality-assured SP) and services	<ul style="list-style-type: none"> • Imported or locally procured commodities (e.g. SP, ITNs/LLINs) are distributed through existing national supply chain management channels • Updates on malaria in pregnancy (MiP) programming in the country are placed on the agenda and discussed during national or subnational technical working group (TWG) meetings

Indicator	Definition	Means of verification
Policymaker discussion and articulation of malaria's impacts and the benefits of community-directed intermittent preventive treatment in pregnancy (c-IPTp)	Commitment of policymakers to discussing and explaining the social and economic impacts of malaria as well as the benefits of c-IPTp	<ul style="list-style-type: none"> • Minutes of legislative meetings discussing c-IPTp • Policies formed supporting c-IPTp • Existing national antenatal care and MiP guidelines are updated based on latest World Health Organization recommendations
Policymaker commitment and funding for MiP intervention and c-IPTp	Commitment of policymakers to enabling the CDI process for MiP	<ul style="list-style-type: none"> • Budget line item allocating funds to MiP (including c-IPTp) implementation • Logistical support/counterpart funds for MiP activities, including ensuring regular supplies of: <ul style="list-style-type: none"> - Quality-assured SP - ITNs/LLINs - Artemisinin-based combination therapy tablets
Knowledge and application of CDI guidelines	CDI focal persons' ability to facilitate communities in learning, understanding, and applying CDI processes	<ul style="list-style-type: none"> • CDI focal persons' minutes of community-wide meetings including ratified resolutions • Completed maps of available resources in the community, facilitated by CDI focal persons and created by the community
Healthy partnerships to increase/sustain intervention coverage	Efforts to promote healthy partnerships and enhance intervention coverage through: <ul style="list-style-type: none"> • Decentralization of decision-making • Information sharing • Collaboration and regular meetings among facilitation teams 	<ul style="list-style-type: none"> • Formation of functional TWGs at subnational levels • Reports of national and subnational TWG meetings • Minutes/reports from partner meetings • Publication/circulation of jointly made decisions

How to use the *Implementation Guide*

Please read this guide prior to starting project implementation and plan your activities with the tools and suggestions it contains. As you plan, revisit the contents to incorporate its guidance in the work.

Any country or district delivering malaria control interventions can use the *Implementation Guide*, adapting the CDI approach to its existing CHW service delivery platform for sustained high coverage of MiP interventions. The basic CDI processes described in this guide (see Table 2 for overview) can also be adopted for use in other community-level programs for integrated disease control. For sustainability, countries are encouraged to harmonize the principles outlined in this guide to their existing MiP and CHW guidelines.

Table 2. Overview of community-directed intervention (CDI) processes

Step	Who is responsible?	Action	Where can more detailed information be found?
1	National- to community-level CDI facilitation teams	Organize and plan community entry	"Plan and organize community entry" heading in this <i>Community Intermittent Preventive Treatment for Malaria in Pregnancy: Implementation Guide (Implementation Guide)</i>
2	Community-level facilitation teams, including CDI focal persons and, if available, onchocerciasis/CDI coordinators	Conduct a community entry meeting with community leaders to: <ul style="list-style-type: none"> • Explain CDI to community leaders • Get permission to involve the community • Organize a CDI orientation and facilitation meeting (CDIOFM) 	"Conduct a community entry meeting" heading, <i>Implementation Guide</i>
3	Community leaders, CDI focal persons, and district-level facilitation teams	<ul style="list-style-type: none"> • Conduct CDIOFM with community representatives • Discuss results of previous interventions/distributions 	"Facilitating a CDIOFM" heading, <i>Implementation Guide</i>
4	Community representatives and community members	Conduct community-wide meetings to: <ul style="list-style-type: none"> • Discuss resolutions from CDIOFMs • Decide which resolutions community members want to ratify • Introduce the following ideas, form subcommittees, and: <ul style="list-style-type: none"> - Carry out community mapping - Carry out pregnant women registration - Decide on criteria for community health worker (CHW) selection with guidance from the CDI focal person and district health office representative - Plan for community self-monitoring 	"Conduct community-wide meetings" heading, <i>Implementation Guide</i>

Step	Who is responsible?	Action	Where can more detailed information be found?
5	Community representatives and community-level facilitation teams	Conduct feedback meeting so community representatives can report from community-wide meetings, then all: <ul style="list-style-type: none"> • Create action plans (including dates and approach) for CDI implementation • Select CHWs based on agreed-on selection criteria • Plan CHW trainings 	“Conduct feedback meeting” heading, <i>Implementation Guide</i>
6	Training facilitators	Train CHWs	<ul style="list-style-type: none"> • “Train community-selected CHWs” heading, <i>Implementation Guide</i> • <i>Training in Community-Directed Intervention to Address Malaria in Pregnancy: Facilitators’ Guide</i> • Modular PowerPoints
7	CHWs	<ul style="list-style-type: none"> • Collect and distribute intervention commodities • Refer adverse reactions 	<ul style="list-style-type: none"> • “CHWs carry out interventions” heading, <i>Implementation Guide</i> • Appendix A checklists, <i>Implementation Guide</i>
8	CHWs and CDI focal persons	<ul style="list-style-type: none"> • Meet for supportive supervision • Submit treatment records 	“Meet for supportive supervision” heading, <i>Implementation Guide</i>

Roles and responsibilities

This section identifies those to be involved in project implementation, with their roles and responsibilities.

Who needs to be involved in the partnership for malaria control?

The vital partners for the CDI process include the following:

- Communities
- Health facilities
- Facilitation teams
- Relevant CSOs and external donors

In the CDI process, it is essential that all partners:

- Be committed to the empowerment process of the community
- Try not to dominate, but rather contribute according to their roles and responsibilities
- Share a common objective
- Be effectively involved and function harmoniously to make project implementation a success

Partner activities may be coordinated by a national association of CSOs, or CSO coordinating bodies at subnational or district levels, if such exist. Partners should always remember that **in the CDI process, the project belongs to the community and the health service**. Other partners are supporting the key players (community and health service) within a specified time period to establish commodity delivery, monitoring, recording, and reporting systems. The health service and community (Figure 5) should ultimately take over the long-term operation of the activities.

Figure 5.

Civil society organization representatives hold a community awareness meeting in Democratic Republic of the Congo.



Photo by Fabrice Witanday, Jhpiego.

Community roles and responsibilities

- CHWs will execute the intervention
- Community members should collectively:
 - Discuss the health problem from their own perspective, as well as possible interventions, taking into account relevant community knowledge and additional information provided to them
 - Decide whether they want the health intervention (in this case IPTp) to be delivered at the community level and, if so, take the responsibility for its implementation
 - Design the approach to implement the intervention in the community and identify the resources needed within the community, including:
 - Planning how, when, and where to implement the intervention and by whom it will be implemented
 - Supervising
 - Deciding what support to provide to the implementers and how to monitor the process

- Discuss results of community self-monitoring and adjust the implementation strategy accordingly

Health services roles and responsibilities

Health services, includes all health staff in the line of delivering the intervention, right from the national-level malaria control or elimination program down to the HCW at the level of the frontline health facility. They should:

- Identify community leadership structure and sociocultural organization and consider these in all interactions with the community
- Introduce to the community the concept of CDI and technical aspects of preventing and controlling MiP
- Provide and facilitate capacity-building and technical support as required by the interventions
- Provide and support supervision based on procedures and criteria of the interventions that have been agreed upon with the community

CDI facilitation teams roles and responsibilities

NATIONAL MIP TWG

Membership

- National malaria control or elimination program
- Other government divisions such as:
 - Maternal and child health or reproductive health divisions
 - Department of health planning, research, and statistics
 - National agency for food and drugs administration and control
 - National primary health care (PHC) development agency
- Ministry of information and media organizations
- Ministry of education and other agencies concerned with human development
- National and international NGOs involved in malaria control (e.g., President's Malaria Initiative and the Global Fund to Fight AIDS, Tuberculosis and Malaria)
- Multilateral agencies (e.g., WHO, UNICEF)

Responsibilities

1. Identify key CDI stakeholders.
2. Organize a meeting of all national-level stakeholders:
 - a. If community-directed treatment with ivermectin (CDTI) for onchocerciasis has been taking place in the country, ask the national onchocerciasis coordinator to explain CDI, its purpose, and its processes to stakeholders. Otherwise, bring in a facilitator with experience in integrated delivery of an intervention through the CDI approach to explain CDI.
 - b. Discuss the essential malaria services (sleeping inside **ITNs/LLINs**, giving IPTp with SP to eligible women, and prompt diagnosis and **case management**) and gain consensus on the role of the government in participating in delivery of these services.
 - c. As part of the meeting, obtain a commitment to form a core CDI team whose members will organize the following steps.
3. Coordinate collection and analysis of malaria-related program coverage data from all sources and partners. Ensure baseline and follow-up surveys are conducted.
4. Conduct an inventory of health facilities:
 - a. Each country should have an MOH with a public health unit. This unit will serve as the base for organizing CDI activities: mobilization, training, supply management, monitoring and evaluation [M&E], supportive supervision.
 - b. Make an inventory/list of MOH/public health unit staff who can take charge of malaria and CDI activities.
5. Train national or subnational training facilitators who will in turn train district training facilitators to do the following:
 - a. Organize a 1-day review of basic malaria control activities for selected health facility staff.
 - b. Organize a 2-day training for a subgroup of those who participated in the 1-day review. Members of this subgroup will organize and supervise CDI activities in their catchment area. The training may include:
 - i. Mapping a community's resources (see Figure 6).
 - ii. Practice outreach to a real village.

Figure 6.

Trained community health workers draw a community map after a village walkthrough.



Photo by Enobong Ndekhehe, Jhpiego.

6. Conduct a national inventory:

- a. Visit the subnational comprehensive health center and work with facility staff to list the names of communities in the area.
- b. If the subnational area does not already have a map of its catchment/service area, help the facility staff sketch a map.
- c. Plan with the facility staff how they will visit each subnational area to introduce CDI for malaria.
- d. If CDTI for onchocerciasis is already being implemented, determine how many of the subnational areas intended to participate in CDI for MiP have experienced CDTI and how many have not. Discuss with health facility staff how they will introduce CDI in areas with CDTI experience and in areas without such experience.

7. Collaborate with the existing national malaria commodity supply management team to ensure SP availability in project sites.

8. Collaborate with the national malaria records system to ensure appropriate flow of malaria-related data.
9. Support existing supervisory systems from the national health team to subnational health teams.
10. Coordinate all activities related to implementation of c-IPTp, including review of policies and learning resource packages to support implementation.
11. Advocate with policymakers for their support and ownership of the c-IPTp program.
12. Develop, print, and disseminate a national strategy document for c-IPTp implementation.
13. Ensure sustained availability of commodities to subnational areas and districts, monitoring supply and distribution.
14. Assure quality of commodities supplied.
15. Monitor project implementation and adverse reactions to commodities.
16. Collate distribution reports from the subnational areas and submit to the MOH.
17. Collate, review, and use MiP-related data for decision-making at the national level and provide feedback to the subnational and district levels.

SUBNATIONAL MIP TWG

Membership

- Representatives of the subnational MOH (especially malaria unit) and PHC development agency
- Reproductive health or maternal and child health division of the subnational MOH
- Representatives of ministries of
 - Education
 - Information
 - Women's affairs or equivalent
- Government agencies involved in human development activities
- Media organizations
- Subnational CSOs
- Other stakeholders

Responsibilities

1. Identify key CDI stakeholders.
2. Organize a meeting of all subnational-level stakeholders, including all members of the subnational health team:
 - a. If CDTI for onchocerciasis has been taking place in the subnational area, ask the onchocerciasis coordinator to explain CDI, its purpose, and its processes to stakeholders. Otherwise, bring in a facilitator with experience in integrated delivery of an intervention through the CDI approach to explain CDI.
 - b. Discuss the essential malaria services (ITNs/LLINs, case management with ACT, RDTs, and IPTp) and gain consensus on the role of the community in participating in delivery of these services.
 - c. As part of the meeting, obtain a commitment to form a core CDI team whose members will organize the following steps.
3. Coordinate collection and analysis of malaria-related program coverage data from all sources and partners.
4. Conduct an inventory of health facilities:
 - a. Ideally, each subnational area should have at least one central hospital/comprehensive health center. This facility will serve as the base for organizing CDI activities: mobilization, training, supply management, M&E, supportive supervision.
 - b. If a subnational area has more than one comprehensive health center, each should organize CDI with the districts within its catchment/service area.
 - c. If a subnational area has no facility, or is so big that existing facilities cannot reach all residents, identify alternative CDI organizing points (e.g., a school or a private clinic).
 - d. Make an inventory/list of subnational health facility staff who can take charge of malaria and CDI activities.
5. Train national or subnational training facilitators who will in turn train district training facilitators to do the following:
 - a. Organize a 1-day review of basic malaria control activities for selected health facility staff.
 - b. Organize a 2-day training for a subgroup of those who participated in the 1-day review. Members of this subgroup will organize and supervise CDI activities in their catchment areas. The training may include:
 - i. Mapping a community's resources.
 - ii. Practice outreach to a real village.
6. Conduct a subnational inventory:
 - a. Visit each district hospital and work with facility staff to list the names of each district in the facility's catchment/service area.
 - b. If the facility does not already have a map of its catchment/service area, help the staff sketch a map.

- c. Plan with the facility staff how they will visit each district to introduce CDI for malaria.
 - d. If CDTI for onchocerciasis is already being implemented, determine how many of the districts intended to participate in CDI for MiP have experienced CDTI and how many have not. Discuss with facility staff how they will introduce CDI in districts with CDTI experience and in districts without such experience.
- 7. Collaborate with the existing subnational malaria commodity supply management team to ensure SP availability in project sites.
- 8. Collaborate with the subnational malaria records systems to ensure appropriate flow of malaria-related data.
- 9. Support existing supervisory systems from subnational health teams to district health teams.
- 10. Coordinate all activities related to implementation of MiP control, including activities of CSOs in the subnational area.
- 11. Advocate with policymakers for their support and ownership of the c-IPTp program.
- 12. Adapt the national c-IPTp strategy document for implementation at district level.
- 13. Write terms of reference for district-level facilitation teams.
- 14. Disseminate the adapted c-IPTp strategy document to districts and health facilities.
- 15. Ensure sustained availability of commodities to districts and health facilities.
- 16. Monitor CHW training and supply of commodities to CHWs.
- 17. Assure quality of commodities supplied.
- 18. Using the supervisory checklists (Appendix A), conduct quarterly on-the-job supportive supervision of CHWs.
- 19. Monitor implementation and adverse reactions to commodities.
- 20. Report health facility data to district, subnational, and national health authorities, including specific programs (e.g., malaria, maternal and child health), as appropriate.
- 21. Collate distribution reports from the districts and submit to the national core CDI team.

DISTRICT MALARIA CONTROL TEAM

Membership

- District health manager
- District PHC staff
- Staff from district-level education and information departments
- District CSOs

Responsibilities

1. Identify key CDI stakeholders.
2. Organize a meeting of all district-level stakeholders, including all members of the district health team:
 - a. If CDTI for onchocerciasis has been taking place in the district, ask the onchocerciasis coordinator to explain CDI, its purpose, and its processes to stakeholders. Otherwise, bring in a facilitator with experience in integrated delivery of an intervention through the CDI approach to explain CDI.
 - b. Discuss the essential malaria services (ITNs/LLINs, case management, IPTp, RDTs) and gain consensus on the role of the community in participating in delivery of these services.
 - c. As part of the meeting, obtain a commitment to form a core CDI team whose members will organize the following steps.
3. Conduct an inventory of health facilities:
 - a. Ideally, each district should have at least one district hospital. This facility will serve as the base for organizing CDI activities: mobilization, training, supply management, M&E, supportive supervision.
 - b. If a district has more than one facility, each should organize CDI with the communities within its catchment/service area.
 - c. If a district has no facility, or is so big that existing facilities cannot reach all residents, identify alternative CDI organizing points (e.g., a school or a private clinic).
 - d. Make an inventory/list of district health facility staff who can take charge of malaria and CDI activities.
4. Train frontline staff:
 - a. Organize a 1-day review of basic malaria control activities for selected frontline health facility staff.
 - b. Organize a 2-day training for a subgroup of those who participated in the 1-day review. Members of this subgroup will organize and supervise CDI activities in their catchment areas. The training may include:
 - i. Mapping a community's resources.
 - ii. Practice outreach to a real village.
5. Conduct a district inventory:
 - a. Visit each PHC facility and work with facility staff to list the names of each community in the facility's catchment/service area.
 - b. If the facility does not already have a map of its catchment/service area, help the staff sketch a map.
 - c. Plan with the facility staff how they will visit each village/unit to introduce CDI for malaria.

- d. If CDTI for onchocerciasis is already being implemented, determine how many of the community units intended to participate in CDI for MiP have experienced CDTI and how many have not. Discuss with health facility staff how they will introduce CDI in communities with CDTI experience and in communities without such experience.
6. Collaborate with the existing district malaria commodity supply management team to ensure SP availability in project sites.
7. Collaborate with the district malaria records systems to ensure appropriate flow of malaria-related data.
8. Support existing supervisory systems from district health teams to frontline facilities.
9. Coordinate all activities related to implementation of MiP control, including activities of CSOs in the district.
10. Advocate with traditional, political, and religious leaders in the district for their support and ownership of the c-IPTp program.
11. Disseminate the adapted c-IPTp strategy document to community health committees and health facilities.
12. Ensure sustained availability of commodities (especially quality-assured SP) to communities and health facilities.
13. Ensure supplied commodities are properly stored.
14. Monitor CHW training and supply of commodities to CHWs.
15. Using the supervisory checklists (Appendix A), conduct on-the-job supportive supervision of CHWs.
16. Monitor implementation and adverse reactions to commodities.
17. Collate distribution reports from the community level and submit to the subnational core CDI team.
18. Report to the MOH on the implementation of MiP and c-IPTp interventions.

COMMUNITY MALARIA CONTROL TEAM

Membership

- PHC clinic staff
- Teachers, agriculture extension agents, and other stakeholders with an interest in malaria-related work.
- Local CSOs
- Community opinion leaders

Responsibilities

1. Identify key CDI stakeholders.
2. Organize a meeting of all community-level stakeholders, including all members of the community health team:
 - a. If CDTI for onchocerciasis has been taking place in the area, ask the onchocerciasis coordinator to explain CDI, its purpose, and its processes to stakeholders. Otherwise, bring in a facilitator with experience in integrated delivery of an intervention through the CDI approach to explain CDI.
 - b. Discuss the essential malaria services (ITNs/LLINs, case management, and IPTp) and gain consensus on the role of the community in participating in delivery of these services.
 - c. As part of the meeting, obtain a commitment to form a core CDI team whose members will organize the following steps.
3. Conduct an inventory of health facilities:
 - a. Ideally, each community should have at least one health facility. This facility will serve as the base for organizing CDI activities: mobilization, training, supply management, M&E, supportive supervision.
 - b. If a community has more than one facility, each should organize CDI with the subcommunities within its catchment/service area.
 - c. If a community has no facility, or is so big that existing facilities cannot reach all residents, identify alternative CDI organizing points (e.g., a school or a private clinic).
 - d. Make an inventory/list of frontline health facility staff who can take charge of malaria and CDI activities.
4. Train frontline staff:
 - a. Organize a 1-day review of basic malaria control activities for selected frontline health facility staff.
 - b. Organize a 2-day training for a subgroup of those who participated in the 1-day review. Members of this subgroup will organize and supervise CDI activities in their catchment areas. The training may include:
 - i. Mapping a community's resources.
 - ii. Practice outreach to a real village.
5. Conduct a community inventory:
 - a. Visit each health facility and work with facility staff to list the names of each village, kin group, or subcommunity unit in the facility's catchment/service area.
 - b. If the facility does not already have a map of its catchment/service area, help the staff sketch a map.
 - c. Plan with the facility staff how they will visit each village/unit to introduce CDI for malaria.

- d. If CDTI for onchocerciasis is already being implemented, determine how many of the community units intended to participate in CDI for MiP have experienced CDTI and how many have not. Discuss with health facility staff how they will introduce CDI in communities with CDTI experience and in communities without such experience.
6. Collaborate with the existing community malaria commodity supply management team to ensure SP availability in project sites.
7. Collaborate with the community malaria records systems to ensure appropriate flow of malaria-related data.
8. Support existing supervisory systems from the frontline health facility teams to CHWs.
9. Encourage community ownership of MiP interventions.
10. Design social and behavior change communication materials (or adapt existing materials) with the input of community members.
11. Create awareness by sensitizing communities to the rationale and process for implementing the adapted c-IPTp strategy.
12. Participate in establishing and facilitating community-based committees for health development/CHW support.
13. Ensure that CHWs carry out c-IPTp in accordance with national guidelines.
14. Network with other CSOs in the community or district to strengthen implementation of the national MiP strategy and adapted c-IPTp strategy.
15. Monitor implementation and adverse reactions to commodities.
16. Identify barriers to the implementation of c-IPTp and share them with the community to elicit solutions.
17. Ensure that CHWs prepare good-quality data with approved data capture tools and submit the data to the CDI focal person.
18. Collate distribution reports from the frontline health facilities and submit to the district core CDI team.

Establishing CDIs for malaria control

This chapter provides facilitation teams with advice and guidance on the best ways to establish a successful and sustainable CDI for malaria control. It describes in detail how to carry out and monitor the various processes involved in the overall approach.

Plan and organize community entry

Identify intervention communities and plan timing

- Identify the communities that will be facilitated. A maximum of five communities per facilitator is recommended for effectiveness.
- Establish contact with the relevant authority at the district council:
 - Get them involved.
 - They are stakeholders and should be represented.
 - They can also facilitate entry into the community.
- Assess community logistics:
 - Number of communities involved
 - Accessibility
 - Transportation
 - Usual timing for delivery of malaria control commodities
- Based on communities' commodity delivery schedules, prepare a schedule for community sensitization.

Approach the health service

- The main goal of this component of the CDI process is to **build a partnership between the community members and HCWs** in the facility nearest to the community. CDI benefits the health system by reducing HCW workload when communities take responsibility for an intervention. Increased contact between community members and HCWs improves human relations and increases utilization of health services.

- Train all HCWs in the district and communities where the intervention is implemented on all aspects of malaria control using the CDI process. Use the *Training in Community-Directed Intervention to Address Malaria in Pregnancy: Facilitators' Guide* and 14 modules aimed at HCWs (see Appendix B). Choose and assign CDI focal persons to facilitate CDI rollout within their respective catchment communities.
- Enumerate the roles of CDI focal persons in CDI processes for malaria control, including:
 - Mapping facility catchment areas
 - Ensuring that all communities in the facility's catchment area participate in CDIs for MiP
 - Reaching out to **community leaders**
 - Organizing meetings to mobilize support and commitment for CDI
 - Facilitating community census and mapping exercises
 - Reviewing census and mapping results to estimate needed commodities and supplies
 - Coordinating:
 - CDI training: Training community-selected CHWs and providing retraining as needed to refresh CHWs and replace dropouts
 - Supervision: Conducting supportive supervisory visits at the facilities and in the community
 - Supply chains: Commodity storage and maintaining stock of basic health commodities for CDI
 - Recordkeeping: Ensuring communities and CHWs collect and submit data in a timely manner and incorporating community data with facility data for onward transmission

Conduct a community entry meeting

CDI focal persons are trained to undertake this task. Hold informal meetings or otherwise make contact with leaders and health personnel to gather some basic and unbiased knowledge of the community and its characteristics and to seek advice on how to succeed. If necessary, seek the assistance of a respected community leader based at the district headquarters to get to know the community's terrain and its members' outlook.

Approach community leaders to orient them, explain CDI, and gain support

- Visit the communities or send a message through the community's local health facility and/or CDI focal person:
 - Inform them of your intention to visit.

- Send word that you would like to meet with leaders to introduce the program.
- Let the town crier and other information agents be involved to create awareness.
- Mention those who should be present at the initial meeting (see Box 2). This meeting may have four or five key leaders whose support is needed to proceed.
- The CDI focal person should discuss with community leaders and choose a convenient day and time to secure a suitable appointment.

Box 2. Possible community leaders to approach for entry

- Village chief/head
- Community health workers and healers
- Leaders of civil society organizations
- Community secretary
- Teachers, school heads
- Religious and opinion leaders
- Other gatekeepers

MEET WITH THE COMMUNITY LEADERS

The CDI focal person should lead the discussion on CDI, the process of carrying out the CDI orientation and facilitation meeting (CDIOFM), and any other issues community leaders may want to include.

- Make sure that the invited community leaders are in attendance.
- Greet and thank them for honoring the appointment despite their tight schedule.
- Commend them for the great effort to get rid of malaria in their community.
- Be conscious of the politics of development/problems of the community:
 - Do not get involved but try to enlighten where necessary.
 - Respect the sensitivities and culture of the people.
- Explain to the leaders CDI and your mission to the community:
 - Inform them about available services.
 - Jointly define the problem.
 - Present the advantages of using the CDI approach to address pressing health and developmental problems, such as the scourge of malaria.
 - Identify the roles and responsibilities in using the CDI approach, including:
 - Community roles in accessing the available services
 - Why the community needs to take the lead in the campaign
 - Leaders' responsibilities
 - Contributions of other partners
 - Answer leaders' questions.

Organize a CDIOFM

- Get permission to assemble community representatives for a CDIOFM:
 - Mention that it is necessary to find a way for all those involved in the campaign to talk freely with each other for better understanding and program success.
 - Explain that an avenue to facilitate communication among the partners is to hold a CDIOFM (“**big malaria meeting**”) that would include all the partners involved in malaria control programs:
 - A good representation of the community’s social structure
 - Health service
 - Policymakers
 - CSOs
 - Educational institutions
 - Religious leaders
- Enumerate the benefits that would accrue to all the partners including the community when a successful meeting is organized.
- Highlight the decisions leaders need to make in organizing the CDIOFM:
 - Whether to have a separate CDIOFM or share a CDIOFM with two or three other communities with close social and cultural affinities. Suggest to them the other communities and the benefits of having a shared meeting.
 - Number of community representatives to the meeting and their representation of the community social structure
 - Venue
 - Logistics
 - Entertainment
- Obtain a clear sense of commitment from the leaders.
- Assist the community leaders to draw up an agenda. The agenda does not necessarily have to be written on paper. Listen, advise, and accept their decisions—the meeting is theirs.
Example agenda items:
 - Community member introduces the reason for the meeting.
 - Community member introduces the CDI focal person and any other people that have come from the district health office.
 - Community leader leads the discussion of key issues, such as community health priorities to be discussed.
 - Any other issues they may want to include.

- At the end of the community entry meeting, decisions should have been reached on the following:
 - The date of the CDIOFM (taking into consideration the status of TIPTOP project implementation)
 - Venue of the CDIOFM
 - Whether the CDIOFM will include multiple communities
 - Who should attend the CDIOFM, including representatives of the sociocultural dynamics of the communities, such as:
 - Community leaders
 - Health facility in-charges
 - District health office representatives
 - CSO representatives
 - Association of market women
 - Sociocultural groups
 - Religious leaders
 - Other partners expected at the CDIOFM (e.g., the health service personnel, community representative to the local government council, food supplier if any)
 - Agenda (should be flexible to reflect main issues affecting malaria control in the community)

Facilitating a CDIOFM

This section provides CDI focal persons advice and guidance on best practices for conducting CDIOFMs. The goals of this meeting are to build partnership with community members and ensure stakeholder participation in malaria control activities. It may not be possible to do everything at one meeting.

- Reach out to the **entire community through representatives**. Leaders should invite representatives for all villagers: men, women, youth, and even “visitors” like farm laborers.
- Let community members select who is to preside or get a knowledgeable and respected community member to do so. The community should be in charge. Do not interfere with any of the arrangements.
- The meeting atmosphere should be democratic. Participants should be encouraged to speak their minds and to be frank in their contributions.
- Language of communication should be mutually agreed upon.
- Arrive early on the agreed-on day.
- Remain at the background during the meeting:
 - Dress simply and neatly to show respect to the community members.

- Wait for facilitators to call you to speak.
- Make contributions but do not impose ideas.
- Be very frank and objective.
- Do not promise what you cannot provide and do not comment on any issues you do not have full knowledge of.
- Praise them where necessary and further encourage them.
- Ensure that there is someone in the community to take notes of the discussion:
 - The community should take its own notes.
 - You also take notes as they discuss.
 - Members of the relevant community, health service, and other partners are expected to create a report on the outcome of the CDIOFM and share it to all levels.
- **Preferably**, have a community member:
 - Introduce the reasons, topic, and agenda for the meeting.
 - Introduce and usher in members of the high table.
 - Introduce other participants, including the CDI focal person, any additional facilitators from the health service, other partners.
 - Conduct prayers.
- When you are given the opportunity to talk, please note the following:
 - Concept of CDI: community ownership and sustainability
 - Responsibility of the community
 - Duration of the new program you represent and long-term benefits
 - Contribution of other partners to malaria control by your assessment of the community (refer to partners' strengths and highlight the aspects that still require greater commitment by them)
 - Encourage participants to agree on measures to improve malaria control in their community.

Conduct the meeting

- Greet the community leaders and representatives.
- Briefly commend them for their effort to get rid of the health problem in the area and their support for the intervention activities.
- Mention that it is necessary to understand how satisfactory the last intervention period was.
- Discuss:
 - Awareness of the program

- Need to assess the performance of the community
- Community responsibility to ensure individual and community compliance
- Booster program to improve health of everyone in the community
- Explain that it is not necessary for you, the CDI focal person, or anyone outside the village to come and find out these things before community members do so themselves. They can collect information that will help them find out how well they did in the last distribution of malaria control commodities and how they can improve future rounds.

DISCUSS RESULTS OF PREVIOUS INTERVENTIONS/DISTRIBUTIONS

- Greet and commend community leaders and representatives for the effort to wipe out malaria from their community.
- Explain the need to learn about past efforts at community development and why these succeeded or not:
 - The only way to assess how well things are done is to review the distribution of intervention commodities themselves.
 - The community needs to meet to:
 - Decide on methods to assess previous performance
 - Discuss the previous commodity delivery
 - Prepare for the next intervention
- Collect information on the status, strengths, and weaknesses of malaria control activities in the community.
- Remind them that it is not enough that an individual has received the intervention commodity. It is also important to ensure that one's family members and neighbors do so.
- Obtain information about the performance of the community in a previous distribution exercise:
 - Number of people in the village
 - Number of people in the village that received the intervention commodities
 - Number of people in the village that were absent during the distribution of the intervention commodities or refused
 - Number of CHWs and community support

PLAN FOR CDI

- Allow meeting participants to discuss and decide the indicators of interest to them. Ask if there are other indicators besides the ones they mention. If they do not mention the following indicators, prompt by asking them whether they should also know:
 - How many people are in the village including children, young people, and women. Everyone should be counted.

- How many people received malaria control commodities and services.
- How many people refused the commodities or were absent during mass distribution.
- Jointly define the problem.
- Inform the community about available services.
- Identify community roles in accessing the available services.
- Request community representatives meet with all community members to:
 - Ensure participation of all segments of the community
 - Discuss community implementation plan (CHW selection, census, distribution of commodities)
- At the end of the plenary, encourage meeting participants to form small working groups to deliberate on the major issues highlighted in the presentations/discussions. Allow them to brainstorm on the issues raised; you should contribute information about:
 - The roles of the health service
 - Any other partner involved
 - Other issues which might require further clarification from you
- Representatives should share with their respective stakeholders the resolutions reached
- Evaluate how well the CDIOFM was done.

Report on the CDIOFM

- Members of the relevant community, health service, and other partners are expected to create a report on the outcome of the CDIOFM and share it to all levels.
- The following information is expected in the report:
 - Introduction
 - Methodology
 - Agenda
 - Experiences of implementation by partners (strengths and weaknesses)
 - Major issues discussed
 - Resolutions
 - List of participants

Conduct community-wide meetings

After the CDIOFM, community representatives are required to hold community-wide meetings with all members of their respective constituencies. These follow-up meetings are intended to engage everyone in the CDI process. It may not be possible to do everything at one meeting.

Discuss resolutions from CDIOFMs

All CDIOFM participants should debrief their constituency members on the deliberations, resolutions, and outcomes of the CDIOFM.

Decide which resolutions community members want to ratify

- The wider community should meet to decide which ideas from the CDIOFM it wants to ratify.
- Brainstorm and ratify the resolutions of the CDIOFM.
- If the community decides an idea from the CDIOFM will not promote or sustain CDI, it can reject the idea.

Introduce community actions and form subcommittees

Discuss with community members their roles in CDI, get commitment, and carry out the following activities.

COMMUNITY MAPPING

Value of community mapping

- Mapping is a very important component of almost all practical situation assessments.
- All programs need to have a sense of:
 - Where do people live?
 - Where are the problem areas?
 - Where are the community resources?
 - Where are others carrying out similar interventions?
- Mapping is not just about locations. It is a joint activity with the community where all can learn more.

- When community members are involved in mapping, they learn more about the problems and resources in their community (Figure 7).
- They can more clearly see service quality issues like access and equity.

How to map a community

- Map health and development resources:
 - Ask people to mention and describe the location of key health and development resources that the community values, such as:
 - Healers
 - Opinion leaders
 - Medicine shops
 - Local CSOs
 - Ask people about major subdivisions of the community such as wards and clans.
 - Ask the group to mention key persons and organizations in the community that can help promote the program.
 - Identify any possible opposing people or roadblocks.
- Map resources (people and organizations) that women, especially pregnant women, go to for advice and help (Figure 8):
 - Where do they get advice?
 - Are there women who regularly deliver babies?
 - Where do they get medicines?
 - From whom do they get financial, emotional, and other support?
 - Identify women's associations and support groups.
- Take notes of the mapping activities and chart the results (see Table 3).
- If there is time, help the community draw an actual map to be kept in the community (Figure 9).

Figure 7.

Completed community map showing geographic features, gathering places, and community resources in a village in Nigeria.

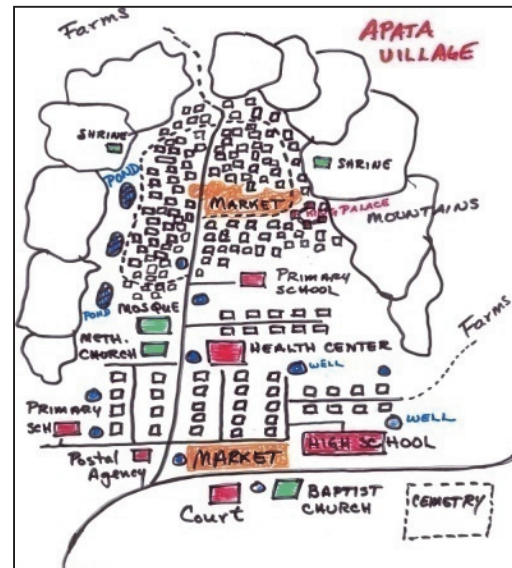


Figure 8.

Women gathered at an antenatal clinic listen to a health talk.



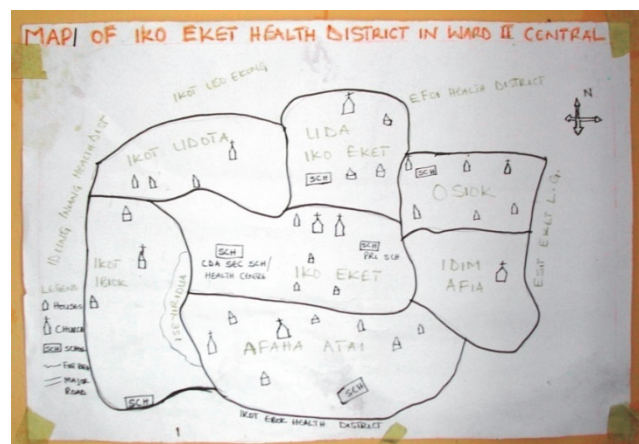
Photo by William Brieger, Johns Hopkins University/Jhpiego.

Table 3. Template chart of mapping results

Community resource	Specific examples
Names of women leaders	
Names of community subsections (e.g., wards)	
Names and locations of health resources—public, private, indigenous	
Names of key women's social groups	
Other special resources for pregnant women	

Figure 9.

Sample of community map



PREGNANT WOMEN REGISTRATION

- Conduct community census to aid in estimating commodity needs.
- Develop and help maintain village register of pregnant women.

DECIDING CRITERIA FOR CHW SELECTION

- Community members decide on criteria for CHW selection with guidance from CDI focal persons and district health office representatives (see Box 3).
- Advise community members to use the information generated from community mapping to help develop the criteria of types of people best suited to serve as CHWs for MiP programming.
- Identify subcommunities (wards, clans, families, neighborhoods) from which CHWs could be selected.

PLAN FOR COMMUNITY SELF-MONITORING (CSM)

Find out if the community members know why CSM is necessary.

What is CSM?

- The CSM process empowers a community to oversee and monitor the performance of a program (in this case, malaria control activities) and ensure that it is being implemented according to plan. CSM enhances CDI by encouraging the community to take full control. On the basis of feedback from the reports of the community-appointed monitors, community members can take appropriate steps to remedy problems and perpetuate best practices.
- The **objective is to enhance community participation in malaria control** using the CDI approach by empowering the community members to take on the responsibility of assessing the malaria control basic package in their communities (see Figure 10).

Box 3. Selection criteria for community health workers (CHWs)

Required

- Resident in the study community
- Nominated by study community's leaders
- Agrees to participate
- Accepts nonmonetary incentives
- Literate enough to:
 - Complete CHW register, antenatal care card, and referral form
 - Use *Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart*

Preferred

- Previous training as a CHW

Figure 10.

Maguimba Health Committee members in Nhamatanda District in Mozambique.



Photo by Emmanuel Otolorin, Jhpiego.

- The CSM process requires regular interaction between CDI focal persons and the community. This interaction provides the opportunity for the CDI focal person to support the community in providing solutions to unforeseen problems as soon as they arise. CSM includes an **ongoing dialogue between the CDI focal person and the community**: The CDI focal person should inquire into reasons behind implementation problems and the community should help explain, then all should work together to form action plans to address the problems.
- Good monitoring practices involve the submission of all reports on time. All persons involved in the monitoring process should be encouraged to keep adequate reports. To illustrate this to community members, show an image of villagers with writing materials in front of a home talking. The discussion they could be having: “Your wife did not go for her second dose of malaria medicine?” **or** “Now that you have a net, how many members of your household sleep inside it?”
- Review other programs with CDI: An example would be projects in other sectors such as onchocerciasis, fertilizer distribution, or HIV/AIDS saying to an HCW, “Can we borrow that guide, please? We would like to use it too for our new project.”

Minimum requirements for CSM

Who should be the monitor?

The community may select anyone provided that:

- There are at least four monitors per community of 500 people and more.
- There are equal numbers of male and female monitors.

Which indicators should be included in CSM?

Important indicators to include are those decided upon by the community at the CDIOFM meeting as part of the discussion on results of previous interventions/distributions.

When should CSM be done?

- A community monitoring exercise should be held every 3 months during an ongoing intervention to ensure community members recall the delivery of the intervention.
- Evaluation of the monitoring exercise, which is based on the monitor's report and its analysis, is the key to understanding what needs to be done to improve malaria control activities. To effectively monitor the implementation process, community monitors and CDI focal persons should frequently interact with the community. At every available opportunity, they should provide feedback on the program's progress and allow community members to express opinions and suggest improvements.

Must there be a meeting after the monitors have collected the information?

Yes, there must be a meeting of the community, monitors, and CDI focal person. The meeting's purposes are to:

- Discuss the information collected by the monitors.
- Give feedback to the community on what the monitors found.
- Provide feedback by discussing the findings of the monitoring exercise. For example, the CDI focal person can ask the community: "Now what do you intend to do since the CHWs are overwhelmed with the workload?"

Must there be a report?

- There must be a written report from the monitors to the district health office after each meeting between the monitors, community members, and CDI focal person.
- The report may be in the local language. Do not insist on it being typed.

Conduct feedback meeting

- Community representatives should report back from the community-wide meetings.
- CDI focal persons and facilitation team members should:
 - Reiterate the importance of community members playing their roles
 - Follow up on any action delegated to the health service as resolved by the CDIOFM and ratified in the community-wide meetings

Create action plans for CDI implementation

- The community and the health service personnel should follow up by turning ideas into action plans, including deciding on convenient days, times, and means for distribution of health commodities:
 - For community-directed intermittent preventive treatment in pregnancy (c-IPTp), the CHW could go from house to house or hold a distribution in a central place for all identified pregnant women.
 - Alternatively, pregnant women could seek these services when needed, and go to the CHW's house to receive the commodities.
- Document the community action plan.
- The CDI focal person should follow up with communities to:
 - Make sure action plans are being implemented
 - Resolve any conflicts or problems that may have arisen
 - Agree on interventions to address challenges identified
 - Discuss any challenges and success stories

Select CHWs based on agreed-on selection criteria

Make a list of selected CHWs. Check with selected CHWs to make sure they are interested in participating and willing to accept nonmonetary incentives.

Plan CHW trainings

Support and sponsor CHWs to attend c-IPTp training. Such support may include reimbursement of their transportation expenses to the training venue and any lodging expenses where necessary, allowances for meals and incidental expenses, and provision of free training materials.

MAKE A TRAINING PLAN FOR CHWS (SEE TABLE 4 FOR TEMPLATE)

- Select venue:
 - Accessible location within the community, not in a classroom (see Figure 11)
 - Large enough for CHWs and other interested persons to attend
 - Accessible toilet facilities
- Choose times that are convenient for the trainees and training facilitators, as all have work and family responsibilities.
- Involve community leaders in the training (e.g., in opening or closing ceremonies for training sessions).

- Identify training requirements and materials, including sources for commodities (e.g., quality-assured sulfadoxine-pyrimethamine [SP]) for demonstration.
- Gather relevant information, education, and communication materials including SP packaging and inserts.
- Plan for refreshment (tea/coffee breaks).
- Create a friendly learning environment.
- Make training lively, interactive, and supportive (review Module 10 PowerPoint on effective teaching skills).
- Give information on the training (timing, venue, requirements) to CHWs and training facilitators.

Table 4. Training plan template

[illegible]

Figure 11.

Holding a training session in the community, Nhamatanda District, Mozambique.



Photo by Samuel Mabunda, Jhpiego.

Train community-selected CHWs

- See *Training in Community-Directed Intervention to Address Malaria in Pregnancy: Facilitators' Guide* for training contents.
- Emphasize importance of keeping within CHW scope of work.
- Use adult learning approaches.
- Make sessions interactive, starting with CHWs' knowledge of MiP (prompt for issues not mentioned):
 - Start with general discussion on participants' experience with malaria.
 - Build on existing community knowledge.
 - Discuss experience with severe malaria in the community.

- Discuss the management of malaria in the community. Note the different modes of management, for example:
 - Prevention by sleeping inside insecticide-treated bed nets (ITNs) or long-lasting insecticidal nets (LLINs)
 - Provision of a minimum of three doses of SP to all pregnant women
 - Early detection of clinical malaria and treatment with appropriate antimalarial drugs in accordance with national guidelines.
- Target all segments of community separately (including men).
- Discuss drug availability within the community.
- Skills training for CHWs will include:
 - Identifying eligible pregnant women and administering intermittent preventive treatment in pregnancy (IPTp)
 - Health education on ITNs/LLINs, IPTp, and case management
 - Provision of commodities
 - Referral

Health education on ITNs/LLINs

It is not enough to give people an ITN/LLIN. We also need to:

- Teach them how to effectively set up the nets in their homes.
- Remind them to sleep inside the nets regularly so that they will benefit from the nets' protection.
- Remind them that nets are the only safe protection they can use against mosquitoes.

Health education on IPTp

The CHW should:

- Collect commodity from agreed-on point (usually the designated health facility).
- Inform the community leader of drug availability.
- Give health education on IPTp to the pregnant woman.
- Issue drug to eligible pregnant woman and ensure she swallows full dose.
- Record the information about giving IPTp in CHW register.
- Refer pregnant woman to antenatal care (ANC) clinic for:
 - Comprehensive ANC
 - Follow-up doses

- ITN/LLIN if she has not already received one
- Review malaria treatment drugs available as well as treatment modes, regimen, requirements, possible adverse reactions, and reaction management.
- Review role of ITNs/LLINs.

Health education on case management

- Even with efforts to protect people, some may be exposed to mosquitoes and come down with malaria.
- As soon as a person is starting to feel sick with fever, they should immediately go to the health facility for treatment with the correct drug.
- Stress the importance of taking all doses of the antimalarial drug to ensure that it removes all the disease from the person.

Provision of commodities:

- Malaria diagnosis tools (e.g., rapid diagnostic test [RDT]kits)
- Malaria prevention drugs including drugs for IPTp
- ITNs/LLINs: There are two possible modes of distribution:
 - CHWs collect nets from nearest facility and distribute for free directly to households:
 - Start with small supply.
 - If CHW is found capable, increase supply.
 - CHWs collect ITN/LLIN coupons from the health service and give to pregnant women in the community to redeem at dedicated health facilities:
 - CHW maintains village register of pregnant women.
 - CHW records delivery of ITN/LLIN or coupon for each woman who received one.

Referral

- Conditions for referral
- Referral facilities
- Use of appointment cards and referral forms

CDI focal persons prepare for CDI

- Conduct advocacy visits to health facilities and district medical stores to ensure adequate and timely supplies of ITNs/LLINs, SP, and artemisinin-based combination therapy (ACT).
- Quality-assured SP and other commodities (e.g., RDTs) are transported from the subnational or national medical stores to the health facility.
- Provide drug box so CHWs can keep commodities safely.
- Buy supplementary medicines (e.g., analgesics) for the community.

CHWs carry out interventions

Collect and distribute intervention commodities

STEP 1: PREPARE FOR HOME VISIT

- Request a meeting with the community leader. Announce your readiness to commence c-IPTp distribution and request the leader notify community members.
- Review village register of pregnant women:
 - Update as needed by adding names and addresses of newly identified pregnant women and crossing out names of those who have already delivered.
 - Select pregnant women to visit.
- Meet with the CDI focal person in the health facility:
 - Review your plan to commence c-IPTp implementation in your community.
 - Collect intervention materials and, on receipt, sign an inventory register at health facility confirming collection:
 - ANC cards, appointment cards, CHW register, and referral forms
 - *Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart* and patient education materials (if not given at time of training)
 - Lockable SP storage box (if not provided during training)
 - ITNs/LLINs (where available): Give ITNs/LLINs to all households in the community. If only one ITN/LLIN is available per household, give to pregnant woman and her children.
 - Stock of quality-assured SP commodities based on estimates of pregnant women in your community
- Assemble contents of the project bag (see Appendix A).
- Maintain commodities safely; keep quality-assured SP locked in a safe place.

STEP 2: VISIT PREGNANT WOMAN'S HOME

Introduction

On arrival at the home of the pregnant woman:

- Introduce yourself.
- Ask to see the head of the family or the head's representative and brief him/her on the purpose of the visit.
- Ask for permission to talk briefly with family members about the health challenges posed by malaria, especially in children and pregnant women.

Counseling on MiP

- If the head of the family agrees, use the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) *Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart* to educate the pregnant woman and her family members about the effects of MiP.
- Give patient education handouts on MiP (see Appendix C) to pregnant woman and her family.
- Counsel about the benefits of ANC for all women.
- All pregnant women, irrespective of gestational age (age of pregnancy), should be referred to the health facility for comprehensive ANC. Ideally, every pregnant woman should visit the health facility in the first trimester (i.e., before 13 weeks gestation) for early care.

Provision of ITNs/LLINs

- If only one ITN/LLIN is available per household, give to pregnant woman and her children.
- Educate the household members on how to set up and maintain a net according to type of sleeping arrangement pregnant woman and/or other household members have (bed, mat, other).
- Help the pregnant woman to hang her own net and advise her to sleep inside the net every night.
- Plan to visit the woman again in 4 weeks to check whether she has been sleeping inside the net each night.

Provision of IPTp with SP (see IPTp job aids in Appendix D)

- Determine the eligibility of the pregnant woman to receive c-IPTp (using the following inclusion criteria):
 - Woman is **13 or more weeks** pregnant:
 - Ask about the date of the first day of the last normal menstrual period (LNMP) and use a pregnancy wheel to determine the gestational age.
 - If woman is unsure of LNMP or gestational age, ask if **quickening** has occurred (i.e., the baby has started to move in the womb), which suggests a pregnancy of 16 or more weeks.

- Woman has not taken a sulfa-containing drug in the last 4 weeks, for example:
 - SP
 - Septrin
 - Bactrim
 - Fansidar
 - Co-trimoxazole
- Woman:
 - Has no allergies to sulfa-containing drugs
 - Has not had an adverse reaction to any sulfa-containing drugs
 - Has not had a severe adverse reaction to any previous medication
- Review woman for any **exclusion criteria** such as:
 - Woman is less than 13 weeks pregnant: If LNMP is unknown, has not yet felt the baby moving in the womb (quickening). This occurs from 16 weeks of pregnancy.
 - Woman received a sulfa-containing drug (including SP or co-trimoxazole) in the last 4 weeks.
 - Woman has an allergy to sulfa-containing drugs, has experienced an adverse reaction to a sulfa-containing drug, or has experienced a severe adverse reaction to any previous medication.
- **If you determine the pregnant woman is eligible** for the first dose of quality-assured SP and the national policy allows community distribution of the first dose of IPTp with SP by CHWs, as in Democratic Republic of the Congo and Nigeria, then:
 - Have a cup of clean water available.
 - Give a dose of SP (three tablets) as IPTp.
 - Watch woman swallow the three tablets (directly observed therapy; see Figure 12).

Figure 12.

A community health worker directly observes a pregnant woman taking her sulfadoxine-pyrimethamine dose.



Photo by Enobong Ndekhedehe, Jhpiego.

- Keep the used SP blister packs for record purposes and future restocking.
- Remind woman to go to the nearest health facility to get her second dose in 4 weeks' time.
- Document and refer:
 - Complete an ANC appointment card for the pregnant woman and refer her to the nearest health facility for comprehensive ANC.
 - Fill in the CHW register with the name of the woman, ANC card number, and the medication given, if any.
 - Also **refer woman to health facility** if she reported a previous adverse reaction to a sulfa-containing drug.
- Plan to visit the woman again in 4 weeks to follow up on her health-seeking behavior: Did she go to the health facility for ANC and IPTp? If your national policy allows you to provide follow-up doses, provide next IPTp dose if necessary.

Home management of malaria

- Educate community members on need to promptly report to the health facility if they experience fever.
- If someone reports fever, ask about signs and symptoms to ensure person has malaria and not another illness with fever.
- If the country policy does not allow the CHW to identify and manage uncomplicated malaria, the CHW should **immediately refer** a person with suspected malaria to the nearest health facility.
- If the country's policy allows CHWs to perform these tasks, then:
 - Use RDTs to diagnose malaria:
 - This can be done before referral to a health facility.
 - If an RDT performed on a pregnant woman with fever is negative, the woman should be referred to the health facility for detection and treatment of other causes of fever.
 - Identify and manage uncomplicated malaria:
 - Select correct drug packet for person's age.
 - Watch person swallow first dose.
 - Remind person to take remaining doses.
 - Explain drug will not cure unless all doses are taken.

Meet for supportive supervision

There will be three occasions for supportive supervision:

1. The CDI focal person will facilitate the monthly meetings with CHWs at the health facilities (see Appendix E for checklist).
2. The CDI focal person will be visited by CHW supervisors from the district health office to review the project (see Appendix F for checklist). Afterward, they will jointly visit the CHWs in the community.
3. The CHW supervisors from the district health office will embark on a quarterly supportive supervision visit to all CHWs in a community.

MEET WITH CDI FOCAL PERSON MONTHLY

- Contact the health facility to find out the day and time for the monthly CHW c-IPTp supportive supervision meeting.
- Prepare for the meeting by assembling the following:
 - Stock card for quality-assured SP
 - Blister packs of consumed quality-assured SP
 - CHW register
- Record and report c-IPTp treatment:
 - Each TIPTOP implementation country has developed standard operating procedures to describe recording and reporting practices for c-IPTp to track SP doses, ANC referrals, ANC contacts, and SP stock and stock-outs. Please refer to country-specific standard operating procedures to review descriptions of:
 - Data recording and monthly reporting tools used by CHWs
 - Data recording and monthly reporting tools used by ANC providers
 - Monthly review of ANC and CHW data by facility staff
 - Data quality checks for ANC and CHW data
 - Data use poster by health facility (see Figure 13)
 - Monthly reporting schedule
 - Both the health facility and the CHW will maintain records related to SP provision.
 - The CHW:
 - Maintains SP distribution records and summarizes these in a monthly report to the health facility
 - Shares the CHW register data with the CDI focal person and compares it with the health facility's data on referrals and IPTp

- Collects the list of pregnant women in the community who missed their ANC visits and makes a plan to visit them at home to encourage them to go to the ANC clinic and, where appropriate, to assess them for eligibility to receive the next dose of IPTp.
- Replenish stock of quality-assured SP and other commodities used in the previous month.

Figure 13.

A health care worker facilitates a training in Mozambique on the data use poster, which is used to visualize performance trends.



Photo by Samuel Mabunda, Jhpiego.

Appendix A. Checklists for community health workers (CHWs) providing intermittent preventive treatment in pregnancy with sulfadoxine-pyrimethamine (IPTp with SP)

Instructions

These checklists can be used:

- To help CHWs remember the steps they are to take during home visits
- As observation checklists:
 - For classroom practice during training
 - During supportive supervision in the field

If using as observation checklists, place a “Y” in the case column if the step is **performed satisfactorily**, an “N” if it is **not performed satisfactorily**, or an “N/O” if it is **not observed**.

- **Satisfactory:** Performs the step according to the standard procedure or guidelines
- **Unsatisfactory:** Performs the step but does not meet standard procedure or guidelines
- **Not observed:** Step not performed by participant during observation

Checklist 1: For CHW interaction with pregnant women to give first IPTp dose

Step	Cases				
Prepare for home visit					
1. Review community map and register of pregnant women.					
2. Check contents of project bag for completeness: <ul style="list-style-type: none">• <i>Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart [Counseling Flip Chart]</i>• Patient education handouts• Blister packs of quality-assured SP tablets• CHW register• Antenatal care (ANC) cards, appointment cards, and referral forms• Pregnancy wheel• Notebook and pen• Optional: sachets of drinkable water and paper cups					
3. Review record of previous visits to the area (where applicable).					
4. Put on branded attire of the Transforming Intermittent Preventive Treatment for Optimal Pregnancy project (T-shirt, cap, etc.).					
Visit pregnant woman at home					
5. Knock on the door of selected household.					
6. Greet the household member respectfully and kindly.					
7. Introduce yourself and ask for the head of the household.					
8. Ask to confirm that there is a pregnant woman in the household.					
9. Ask head of household for permission to discuss the burden of malaria in pregnancy (MiP) with the pregnant woman and her family.					
Use the <i>Counseling Flip Chart</i> to counsel on MiP					
10. Ask to sit in a convenient spot where all household members can see the <i>Counseling Flip Chart</i> .					
11. Present the content of the <i>Counseling Flip Chart</i> , including: <ul style="list-style-type: none">• Effects of malaria on pregnant women and unborn children• Importance of ANC attendance as early as possible before 13 weeks (3 months) of pregnancy• Benefits of comprehensive ANC (nutritional supplements, early detection and management of pre-existing problems, early detection and management of complications of pregnancy, etc.)• Interventions for the prevention and control of MiP:<ul style="list-style-type: none">- Sleeping inside an insecticide-treated bed net or long-lasting insecticidal net- Taking a minimum of three doses of IPTp with SP- Prompt diagnosis and treatment of women with symptoms and signs of MiP					
12. Encourage listeners to ask questions and provide answers.					

Step	Cases				
Assess pregnant woman for eligibility to receive the first dose of IPTp with SP (in countries where CHWs are allowed to give medicines)					
13. Ask the pregnant woman about the date of the first day of her last normal menstrual period .					
14. Use a pregnancy wheel to determine gestational age (age of pregnancy) if trained to do so. If the woman is 13 weeks pregnant or more, she is eligible for SP.					
15. If woman is unsure of her last normal menstrual period, ask if quickening has occurred (i.e., the baby has started to move in the womb) which suggests a pregnancy of 16 or more weeks. If YES, the pregnant woman is eligible for SP.					
16. Ask if the pregnant woman has received SP or any other sulfa-containing drugs (e.g., Septrin, Bactrim, Fansidar) in the last 4 weeks. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 27 (ANC card).					
17. Ask if the pregnant woman is taking co-trimoxazole medicine. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 27 (ANC card).					
18. Ask if the pregnant woman has had any severe adverse reaction to a medication taken, especially a sulfa-containing medicine. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 27 (ANC card).					
19. Based on the history taking outlined in Steps 13–18, determine whether woman is eligible for SP at this home visit (≥13 weeks pregnant, no history of allergy or adverse reaction to sulfa-containing drugs including SP or co-trimoxazole, has not taken sulfa-containing drugs in last 4 weeks). If so, provide SP.					
Provide first dose of IPTp with SP to an eligible pregnant woman (in countries where this is allowed)					
20. Inform the pregnant woman that she has a right to refuse any medication. Request her verbal consent to give her SP medicine.					
21. If pregnant woman agrees, ask her to get a cup of clean drinkable water.					
22. Give woman three tablets of SP to swallow.					
23. Observe woman swallowing the SP with water (directly observed therapy).					
24. Keep the blister packs of consumed SP in a safe place in your bag.					
Provide post-IPTp counseling					
25. Advise the woman not to take folic acid for 7 days to avoid its interaction with SP. She can resume taking her folic acid after 1 week.					
26. Remind woman to get her second dose of SP in 4 weeks' time at the nearest health facility. Inform her of the date when she should get the next dose.					
Carry out documentation					
27. Complete an ANC card for the woman indicating first dose of IPTp was given if so. Give the pregnant woman an appointment card to go to the ANC clinic to receive other benefits of comprehensive ANC.					

Step	Cases				
28. Complete the CHW register to indicate first dose of IPTp given (if so), ANC card and appointment card given, and referral form completed and given (if so) to the woman.					
29. Ask woman if she has any questions and provide answers. If unable to provide an answer, tell woman to ask the health care worker when she gets to the ANC clinic.					
30. Thank the woman and her family for their time and wish the woman an uneventful pregnancy and safe delivery in a health facility.					
31. Invite the pregnant woman and her family to any upcoming community activity on MiP (e.g., village drama or talks).					
32. Depart from the home.					

Checklist 2: For CHW to conduct a follow-up visit with a registered pregnant woman

Step	Cases				
Prepare for follow-up home visit					
1. Review community map and register of pregnant women.					
2. Check contents of project bag for completeness: <ul style="list-style-type: none">• <i>Interpersonal Communication for Prevention and Control of Malaria in Pregnancy: Community Health Workers' Counseling Flip Chart [Counseling Flip Chart]</i>• Patient education handouts• Blister packs of quality-assured SP tablets• CHW register• Antenatal care (ANC) cards, appointment cards, and referral forms• Pregnancy wheel• Notebook and pen• Optional: sachets of drinkable water and paper cups					
3. Review record of previous visits to the area.					
4. Put on branded attire of the Transforming Intermittent Preventive Treatment for Optimal Pregnancy project (T-shirt, cap, etc.).					
Visit pregnant woman at home					
5. Knock on the door of selected household.					
6. Greet the household member respectfully and kindly.					
7. Introduce yourself and ask for the head of the household.					
8. Ask to confirm that the registered pregnant woman is at home.					
9. Ask head of household for permission to follow up with the pregnant woman.					
Assess pregnant woman for eligibility to receive a follow-up dose of IPTp with SP					
10. Ask to see the ANC card of the pregnant woman.					
11. Review the ANC card to confirm the number of doses of IPTp with SP the woman has received.					

Step	Cases				
12. Ask if the pregnant woman has received SP or any other sulfa-containing drugs (e.g., Septrin, Bactrim, Fansidar) in the last 4 weeks. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 25 (answer questions).					
13. Ask if the pregnant woman is taking co-trimoxazole medicine. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 25 (answer questions).					
14. Ask if the pregnant woman has had any severe adverse reaction to a medication taken, especially a sulfa-containing medicine. If the answer is YES, she is not eligible for SP at this time. Refer her to ANC and continue this checklist at Step 25 (answer questions).					
15. Based on the history taking outlined in Steps 10–14, determine whether the woman is eligible for SP at this home visit (≥13 weeks pregnant, previously received SP dose, no history of allergy or adverse reaction to sulfa-containing drugs including SP or co-trimoxazole, has not taken sulfa-containing drugs in last 4 weeks). If so, provide SP.					
Provide follow-up dose of IPTp with SP to an eligible pregnant woman					
16. Inform the pregnant woman that she has a right to refuse any medication. Request her verbal consent to give her SP medicine.					
17. If pregnant woman agrees, ask her to get a cup of clean drinkable water.					
18. Give woman three tablets of SP to swallow.					
19. Observe woman swallowing the SP with water (directly observed therapy).					
20. Keep the blister packs of consumed SP in a safe place in your bag.					
Provide post-IPTp counseling					
21. Advise the woman not to take folic acid for 7 days to avoid its interaction with SP. She can resume taking her folic acid after 1 week.					
22. Remind woman to get her next dose of SP in 4 weeks' time at the nearest health facility. Inform her of the date when she should get the next dose.					
23. Update the ANC card for the woman to indicate IPTp with SP dose given.					
24. Update the CHW register to indicate IPTp with SP dose given.					
25. Ask woman if she has any questions and provide answers. If unable to provide an answer, tell woman to ask the health care worker at the ANC clinic.					
26. Thank the woman and her family for their time and wish the woman an uneventful pregnancy and safe delivery in a health facility.					
27. Invite the pregnant woman and her family to any upcoming community activity on MiP (e.g., village drama or talks).					
28. Depart from the home.					

Appendix B. Learning objectives for Community Intermittent Preventive Treatment for Malaria in Pregnancy learning resource package

Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
0. (Introductory module)	Get an overview of the Community-Directed Intermittent Treatment in Pregnancy Workshop	Get to know each other	X	X
		List the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project's goal and the workshop learning objectives	X	X
		Discuss the course schedule and learning materials	X	X
		List expected outcomes of the workshop	X	X
		Identify skills participants wish to share with others	X	X
		Decide on the workshop norms	X	X
1.	Outline the global recommendations for antenatal care (ANC) for a positive pregnancy experience	Recognize pregnant women in the community	X	X
		Assess gestational age in pregnant women		X
		Educate pregnant women about the benefits of ANC	X	X
		Describe recommended timings for ANC visits	X	X
		Enumerate the nutritional recommendations for quality ANC	X	X
		List recommended approaches for maternal and fetal assessment in pregnancy		X
		Describe recommended preventive measures for best pregnancy outcome	X	X

Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
		List interventions for common physiological symptoms in pregnancy		X
		Describe health system interventions to improve ANC utilization and quality		X
2.	Discuss why it is important to prevent malaria in pregnancy (MiP)	Describe the global burden of MiP	X	X
		Enumerate the adverse effects of MiP	X	X
		List the recommended approaches to prevent MiP	X	X
		Counsel pregnant women about MiP	X	X
3.	Describe the community-directed intervention (CDI) process	Define the CDI approach	X	X
		Describe program coverage benefits of using CDI	X	X
		Explain the role of the health facility in the CDI process	X	X
		Outline the steps to establish a CDI program	X	X
		List key approaches in gaining community commitment for a CDI program	X	X
		Describe the steps in selecting and training CHWs	X	X
		Explain how CDI can be adapted for use in controlling MiP	X	X
4.	Describe the role of the CDI focal person	Define who may be a CDI focal person	X	X
		Describe the roles of the CDI focal person	X	X
		Explain how the health facility as a whole supports the CDI focal person and CDI activities	X	X
5.	Map community structures, networks, and organizations	Define the term “community” in the context of “community-directed interventions (CDIs)”	X	X
		Describe the purpose of community mapping in building support and solving problems	X	X
		Explain the value of involving community members in mapping their own community	X	X
		List the steps and activities needed to map the organizations and resources in a community	X	X
		Facilitate a community census	X	X

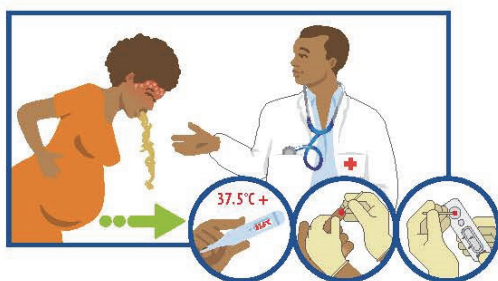
Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
		Use and update the village register of pregnant women	X	X
6.	Use the CDI process to deliver intermittent preventive treatment in pregnancy (IPTp) with sulfadoxine-pyrimethamine (SP)	Describe their country's specific malaria data	X	X
		Identify special IPTp target groups	X	X
		Describe the basis for IPTp and the use of SP for IPTp	X	X
		State the difference between chemoprophylaxis and IPTp	X	X
		Identify who should be given IPTp	X	X
		Identify who should not be given IPTp	X	X
		Describe when and how to give IPTp	X	X
		Describe the benefits of IPTp	X	X
7.	Apply the CDI process to distribute insecticide-treated bed nets and long-lasting insecticidal nets (ITNs/LLINs)	Explain how to obtain and safely maintain stocks of ITNs/LLINs	X	X
		Estimate ITN/LLIN needs based on community census	X	X
		Discuss the need to educate community members on the importance of sleeping inside ITNs/LLINs every night (especially for children and pregnant women)	X	X
		Discuss the need to encourage pregnant women to collect and use ITNs/LLINs as soon as they realize they are pregnant	X	X
		Outline the process of teaching community members how to use the nets	X	X
		Outline follow-up procedures for facility staff and CHWs to encourage continued ITN/LLIN use	X	X
		Discuss the importance of making sure that all women of reproductive age have and use an ITN/LLIN so that they will be protected at the beginning of their next pregnancy	X	X

Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
8.	Describe the importance of recordkeeping, monitoring, evaluation, and community health management information systems	Define “community-based information system” and state why such a system is important	X	X
		Describe the importance of recordkeeping	X	X
		Define basic monitoring and evaluation concepts and state the differences between monitoring and evaluation		X
		State why M&E is important in programming	X	X
		Differentiate between data and information	X	X
		Describe the qualities of good data	X	X
		Identify sources of data (facility and community)	X	X
		Demonstrate how to fill out the CHW register and the referral form	X	X
9.	Get an overview of the TIPTOP project	Describe Unitaid and what it does	X	X
		Describe the TIPTOP project	X	X
10.	Use effective teaching skills to build the capacity of CHWs	List principles and approaches of adult education to be used in training CHWs		X
		Describe a conducive learning environment that enables active skills practice and learning		X
		Identify locally appropriate learning aids		X
		Provide examples of interactive training methods and experiences		X
		Explain the need to monitor, evaluate, and revise training		X
11.	Use supportive supervision skills to monitor performance of trained CHWs	Differentiate between traditional and supportive supervision		X
		Define supervision		X
		Describe who may be a supervisor and the supervisor’s responsibilities		X
		Describe the skills and personal characteristics expected of a supervisor		X
		Define desired performance		X
		Assess current level of performance		X

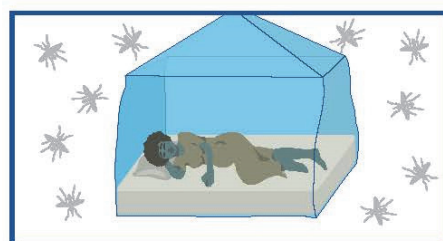
Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
		State the relationship between training and supervision		X
		Describe the use of checklists during supervision and assessment for quality improvement		X
		Describe the process of root cause analysis and selection of problem-solving interventions		X
		Develop action plans to address root causes of gaps in performance		X
12.	Describe supply chain management for CDI	Describe the processes of procuring and storing antimalarial drugs		X
		Explain how to estimate the community's commodity needs	X	X
		Outline the stock recording method and reporting format	X	X
		Describe the distribution process for antimalarial medicines and other malaria commodities (e.g., ITNs/LLINs, rapid diagnostic tests [RDTs])		X
		State how to monitor and report adverse drug reactions	X	X
		Discuss the role of patent medicine vendors in malaria commodity management		X
13.	Describe the roles of the district CDI team members	Describe district core CDI team members and their roles		X
		Explain the division of labor among various core CDI team members		X
		Define a program coordinator and a facilitator—who they are and what they do		X
		Describe components of a work plan and its development process		X

Module #	General objective	Specific objectives	Target audience	
			Community health workers (CHWs)	Health care workers
14.	Describe the use of social and behavior change communication (SBCC)	Identify reasons why people change or do not change behavior easily		X
		Define SBCC		X
		Differentiate between SBCC and information, education, and communication		X
		Discuss: <ul style="list-style-type: none"> • Basic SBCC concepts and methods • Key messages related to community-directed intermittent preventive treatment in pregnancy that can be promoted through SBCC • Ways to use SBCC to promote acceptance of community-directed intermittent preventive treatment in pregnancy among target audiences 		X

Appendix C. Patient education handout



If you get fever or signs of malaria, seek diagnosis immediately and, if tested positive for malaria, take effective treatment.



Protect yourself - and later also your newborn - from malaria by sleeping under a bednet each night.



Take iron and folic acid each day to prevent anaemia.



Usually SP is very well tolerated. If, however, you feel adverse drug reactions, consult your health worker.

IMPORTANT FOR PREGNANT WOMAN

Regularly take SP to protect yourself and your baby from malaria.

- From the 2nd trimester, have regular antenatal care contacts.
- Take a full 3-tablet dose of SP to prevent a malaria infection, starting as early as possible in the second trimester, and at least three times during your pregnancy with individual doses given at least one month apart.



Months	1	2	3	4	5	6	7	8	9
Number of SP tablets per month									
Next appointment dates	<div> <div>Months</div> <div> <div>MTWTFSS</div> <div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> </div> </div> </div>								



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Appendix D. Job aids for providing intermittent preventive treatment in pregnancy (IPTp) with sulfadoxine-pyrimethamine (SP)



Regularly give SP to pregnant women to protect them and their babies from malaria




This treatment can be safely administered until the time of delivery. Give a full 3-tablet dose of SP to prevent malaria, starting as early as possible in the second trimester, and at least three times during pregnancy, with individual doses given one month apart.

Months	1	2	3	4	5	6	7	8	9
Number of SP tablets per month									



If the pregnant woman presents with fever or signs of malaria, test for malaria...



...and if she is positive, administer effective treatment.



Ask if the pregnant woman has ever reacted to any medication. If yes and the medication contains sulphur, consult the healthcare worker.



Cotrimoxazole + Sulfadoxine/Pyrimethamine
Women receiving cotrimoxazole should not take SP due to a higher risk of adverse events.



Do not administer SP before week 13 of pregnancy (3 months).



Make sure the pregnant woman has not received SP in the past 4 weeks (individual doses must be given at least one month apart).



Provide the pregnant woman with a glass of clean drinking water and observe her swallowing the 3 SP tablets.



Indicate the date which the pregnant woman took the required dose on the register and the patient card.



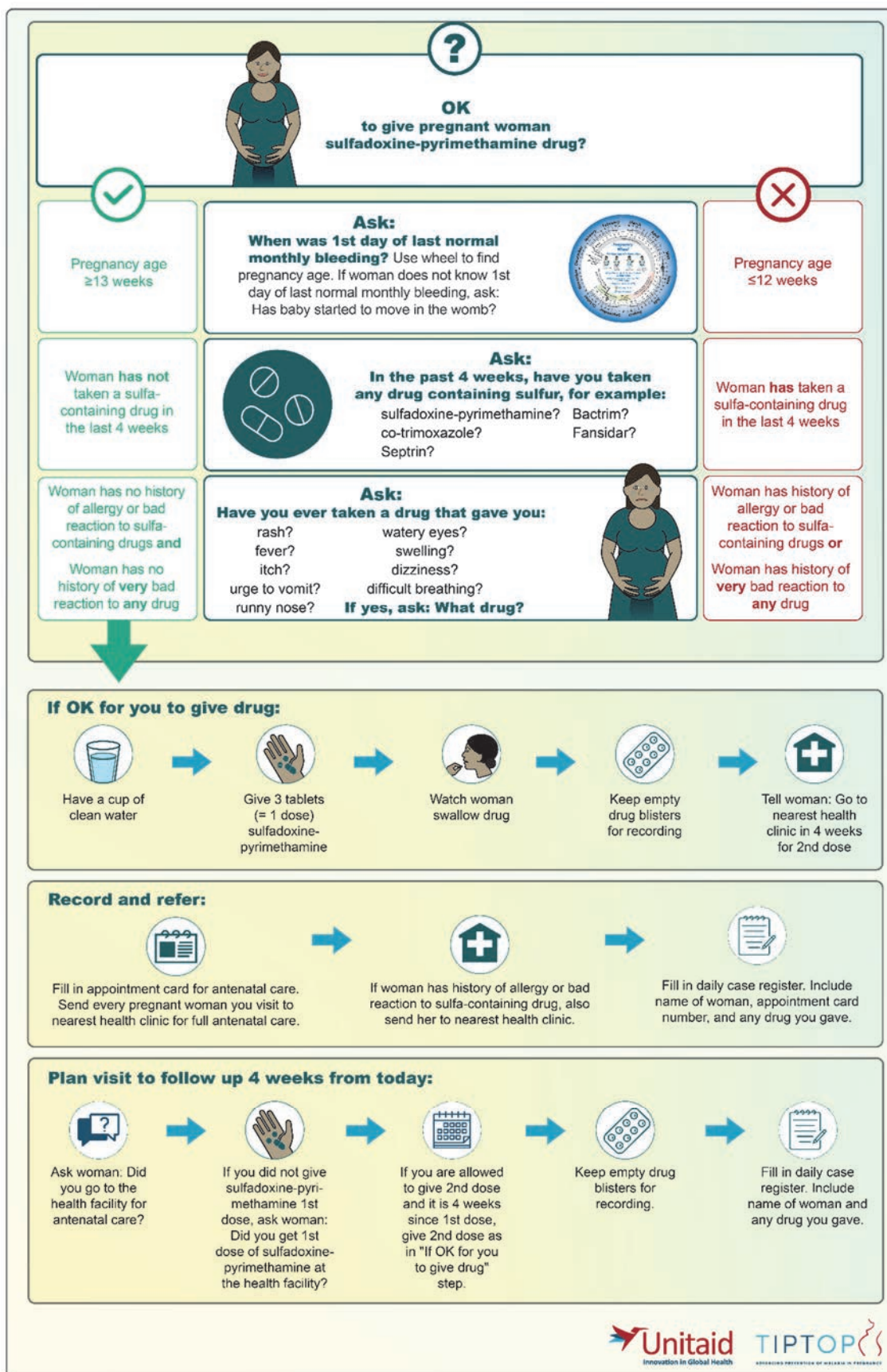
Pregnant women should be given iron and folic acid each day to prevent anaemia.



Set a date for the next required dose and write it down on the patient card.



Explain the importance of returning for a subsequent dose in one month.



Appendix E. Checklist for monthly supportive supervision of community health workers (CHWs)

This checklist is to be completed during supportive supervisory visits and after a review of CHWs' registers and forms. The focal person for community-directed intervention should have the CHWs participate in completing the checklist. Do not complete the checklist without first checking your country's supportive supervision guidelines. The checklist consists of a list of close-ended items (yes and no questions) meant to systematically observe the CHWs' activities. Provide feedback to the CHWs after administering the checklist.

Name of community: _____ District: _____ Date: _____

Names of focal persons for community-directed intervention and CHWs:

	Issues/activities	Yes	No	Comments
1	Are CHWs organized into a group?			
2	Do the CHWs attend monthly meetings with health facility workers?			
3	Are CHWs organizing with each other to conduct community outreach and mobilization activities?			
4	Do CHWs have copies of the pregnant women register and community mapping results?			
5	Do the CHWs lead the community in undertaking periodic mapping/census/registration updates?			
6	Have the required number of CHWs been trained?			
7	Are all trained CHWs working/active on the project?			
8	Are CHWs collecting commodities from an agreed-on point?			
9	Do CHWs have the required recordkeeping registers?			
10	Do CHWs have the required reporting forms?			
11	Are CHWs skillful in completing the registers?			
12	Are CHWs skillful in completing the monthly summary form?			

	Issues/activities	Yes	No	Comments
13	Do CHWs have an adequate stock of quality-assured sulfadoxine-pyrimethamine (SP)?			
14	Do CHWs have an adequate stock of insecticide-treated bed nets or long-lasting insecticidal nets?			
15	Do CHWs have an adequate stock of artemisinin-based combination antimalarial drugs?			
16	Has the community made a decision on mode of distribution?			
17	Has the community made a decision on period of distribution?			
18	Are the knowledge and skills of CHWs on dosing of SP for IPTp adequate?			
19	Do CHWs follow up with pregnant women who are absent for intended home visit? Households that refuse to participate?			
20	Do the CHWs refer pregnant women to the health facility?			
21	Do CHWs refer women who have adverse reactions to SP?			

Appendix F. Supportive supervision checklist: Prevention of malaria in pregnancy (MiP) in health facilities

Name of facility: _____ Type of facility: _____ District: _____ Subnational area: _____ Name of assessor: _____ Date: ____/____/____ Name of client observed: _____ ID number: _____	
Health facility infrastructure and supplies (complete this column once per facility)	Interpersonal communication (complete this column for each health care provider observed)
<p>Check availability of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A copy of national MiP guidelines in antenatal care (ANC) clinic <input type="checkbox"/> MiP posters and job aids in ANC clinic <input type="checkbox"/> ANC and/or MiP counseling flip chart <input type="checkbox"/> Pregnancy wheel to calculate gestational age <input type="checkbox"/> Tape measure to check symphysio-fundal height <input type="checkbox"/> Source of drinkable water <input type="checkbox"/> Suitable cups for patient use <input type="checkbox"/> Prenatal drugs (iron, folic acid) <input type="checkbox"/> Quality-assured sulfadoxine-pyrimethamine (SP) in stock in pharmacy and/or ANC clinic <input type="checkbox"/> ANC register <p>Observe whether the facility provides the following services:</p> <ul style="list-style-type: none"> <input type="checkbox"/> ANC services <ul style="list-style-type: none"> <input type="checkbox"/> If yes, how frequently? Daily [], weekly [], other [] <input type="checkbox"/> Intermittent preventive treatment in pregnancy (IPTp) with SP is provided routinely <input type="checkbox"/> Long-lasting insecticidal nets (LLINs) or insecticide-treated bed nets (ITNs) are provided routinely 	<p>Observe whether the health care worker:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Greets the client respectfully <input type="checkbox"/> Introduces self and tells the pregnant woman what he/she is about to do <input type="checkbox"/> Asks woman about her current pregnancy (gestational age, fetal movements, any problems) <input type="checkbox"/> Asks whether woman is sleeping inside an ITN/LLIN <input type="checkbox"/> Asks whether woman has received any dose of SP <input type="checkbox"/> Checks whether woman is eligible for SP dose (≥ 13 weeks pregnant or feels baby moving; no sulfa-containing drugs in last 4 weeks; no history of allergy to sulfa drugs; not on co-trimoxazole) <input type="checkbox"/> If woman is eligible, checks expiry date of available SP <input type="checkbox"/> Provides drinkable water in a cup <input type="checkbox"/> Gives the three tablets of SP to woman <input type="checkbox"/> Observes woman swallow tablets with water (directly observed therapy) <input type="checkbox"/> Records IPTp dosing in woman's card and case notes <input type="checkbox"/> Gives woman appointment for next dose of IPTp with SP <input type="checkbox"/> Asks whether woman has had any of the known symptoms and signs of malaria <ul style="list-style-type: none"> <input type="checkbox"/> If yes, refers her for rapid diagnostic testing and treatment with nationally recommended antimalarials
A. Total observed (14) =	B. Total observed (14) =
Total percentage score = $(A+B) / 28 \times 100 =$	

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