

Malawi BASICS, Annual Report Project Year 3

1 October 2009 – 30 September 2010

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During a Growth Monitoring Promotion session in Zomba, volunteers teach mothers about complementary feeding



Annual Report Year Three

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Health in Malawi

With over 13.5 million inhabitants, Malawi remains one of the poorest countries on earth. Despite sustained efforts to improve the quality of life for its people, the vast majority of Malawians live in poverty with limited access to basic health services and clean water. The country continues to suffer a severe shortage of health workers and is further burdened by a very weak health infrastructure that is in the process of decentralizing authority to the district level. However, the country has made tremendous advances in child health, having achieved extraordinary reductions in child and infant mortality, and being one of the few African nations to be on track to meet the MDG for child mortality. The MoH has provided significant and progressive leadership to build on these achievements, as evidenced by initiatives like the new Essential Health Package and the National Strategic Plan for Child Survival and Development.

BASICS Project

The United States Agency for International Development (USAID) awarded the Basic Support for Institutionalizing Child Survival (BASICS) project a four year contract (from 2007 to 2011) to assist the national and district level in strengthening delivery and maximizing coverage of essential child health and nutrition interventions. BASICS implements activities in eight target districts (see right). The goal of BASICS is to improve access to and use of quality child health, nutrition and HIV/AIDS services and to increase adoption of household and community behaviors that promote health and prevent illness in vulnerable infants and children under 5 years. To reach this goal, BASICS works to: (1) improve facility-based treatment and preventive care to ensure quality newborn/child health and nutrition (and associated HIV) interventions are delivered in all health centers and district hospitals; (2) expand access to proven newborn and child health interventions through community-based delivery, using the village clinics (HSA's) and community volunteers/networks to reach children and families in under-served and hard-to-reach communities; and (3) generate demand and accountability for child health and nutrition, linking facility and community-based care, but also capturing civil society and local government (District Assemblies) to sustain coverage and results.

BASICS eight target districts



The following four components have guided the implementation of the technical approach and are addressed individually in this report:

1. Improved prevention and management of childhood illness
2. Improved infant and child nutrition
3. Support the efforts of the MoH in Malawi in PMTCT and pediatric HIV through technical support to the PMTCT Advisor and HIV/AIDS Technical Assistance Positions in the MoH
4. Strengthening of community malaria interventions through a small grants program.

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ACKNOWLEDGEMENTS

BASICS implemented an extensive range of activities during Project Year 3. These activities benefited a substantial number of people throughout Malawi. Successful implementation has hinged on participation and support from numerous stakeholders which include the MoH (ARI unit, HIV unit, IMCI unit, NMCP and Nutrition Unit amongst others), DHMT's in districts (Balaka, Chikhwawa, Kasungu, Mangochi, Nkhotakota, Nsanje, Phalombe, Salima and Zomba), numerous community groupings in the districts mentioned above, USAID COTR and activity managers, development partners, NGO's and CBO's, BASICS staff, in-country MSH staff and MSH Home Office staff backstopping the program.

ACRONYMS

ACSD	Accelerated Child Survival and Development Strategy
AFASS	Affordable, Feasible, Accessible, Sustainable and Safe
AIDS	Acquired Immune Deficiency Syndrome
AL	Arthemeter-Lumefantrine
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
CCM	Community Case Management
CDC	Centers for Disease Control
CHAM	Christian Health Association of Malawi
CHSU	Community Health Sciences Unit
CMAM	Community Management of Acute Malnutrition
CPT	Cotrimoxazole Preventive Therapy
CTC	Community Therapeutic Care
DEC	District Executive Committee
DHEO	District Health Education Officer
DHMT	District Health Management Team
DHO	District Health Office
DIP	District Implementation Plan
DOTS	Directly Observed Treatment, Short-course
EHP	Essential Health Package
ENA	Essential Nutrition Actions
ETAT	Emergency Triage Assessment and Treatment
FADUA	Frequency, Amount, Density, Utilization of food by micronutrient and Active feeding
FAST	Friend of AIDS Support Trust
FBO	Faith Based Organization
FP	Family Planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Growth Monitoring and Promotion
GVH	Group Village Head
HCT	HIV Counseling and Testing
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Health Management Team
HSA	Health Surveillance Assistants
IEC	Information, Education and Communication

IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment for Pregnant Women
ITN	Insecticide Treated Nets
IYC	Infant and Young Child
LLIN	Long Lasting Insecticide Treated Nets
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MFSG	Mother Father Support Groups
MIP	Mother Infant Pair
MoH	Ministry of Health
MSH	Management Sciences for Health
MTCT	Mother-to-Child Transmission
NAC	National AIDS Commission
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
NRU	Nutritional Rehabilitation Unit
OPC	Office of the President and Cabinet
ORT	Oral Rehydration Therapy
OTP	Outpatient Therapeutic Program
PHI	Pediatric Hospital Initiative
PiTC	Provider initiated Testing and Counseling
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PY	Project Year
SMS	Short Message Service
SP	Sulphadoxine Pyremethamine
SPS	Strengthening Pharmaceutical Systems
TA	Technical Assistance
TNP	Targeted Nutrition Program
TOT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	United States Government
VH	Village Head
VTC	Voluntary Testing and Counseling
WALA	Wellness and Agriculture for Life Advancement
WAMI	Word Alive Ministries International
WHO	World Health Organization

1. KEY ACHIEVEMENTS

During the past year (Oct. 2009 to Sept. 2010), the United States Agency for International Development's (USAID's) Basic Support for Institutionalizing Child Survival (BASICS) project focused on a significant expansion of activities in a wide range of areas – in particular, improved child survival through the expansion of village clinics, improved hospital and health center level emergency triage assessment and treatment, increased implementation in Growth Monitoring and Promotion (GMP) sessions, increased numbers of women and children accessing antiretroviral therapy (ART) and expansion in the coverage of the second dose of intermittent preventive therapy for pregnant women (IPTp).

Following are some of the key project achievements during the third year of the project (PY3):

1.1 Improved Prevention and Management of Childhood Illnesses

Community case management (CCM): Approximately 500 village clinics brought to scale seeing approximately 283,669 episodes of disease during FY2010. Supportive activities have included the development of HMIS and LMIS packages including village clinic registers and a SMS-based reporting system, the procurement and distribution of ORT equipment and bicycles, and support for the development and implementation of supervision and mentorship approaches for CCM.

Emergency triage assessment and treatment (ETAT) / Pediatric Hospital Initiative (PHI): There has been continued support for the consolidation of ETAT/PHI. Tools and approaches were developed to strengthen the quality of pediatric care provision (peer review audit, death audit and monthly data reporting forms). A new approach of decentralizing ETAT to health centre level has been implemented with the implementation of ETAT at 56 health centers in the 8 BASICS supported districts. Prof Liz Molyneux was appointed as consultant to support the PHI implementation process – she has provided technical assistance to the MoH and has developed a series of in-service training modules for PHI. 100 Oxygen concentrators were procured for distribution to health facilities in Malawi. Based on the experience of implementing and expanding ETAT/PHI the Afghan Ministry of Public Health has requested the Malawi MoH to host a visiting delegation from Afghanistan to learn more about the expansion of the program.

Zinc supplementation: All groundwork required for the implementation of zinc in the management of diarrhea was completed FY2010. This included the development of training materials for health workers, the printing of training manuals, orientation of more than 2200 health workers oriented on the use of zinc, the development of a communication strategy to support introduction and roll out, quantification of zinc needs and the initial processing of an order by the MoH to procure zinc. Unfortunately, at the end of FY2010 zinc had not reached Malawi which has delayed final implementation.

1.2 Strengthen and expand nutrition at the facility and community levels

Community-based ENA: During FY2010 ENA has expanded from the original Mother Father Support Group (MFSG) model operating at limited scale to the implementation of a strengthened growth monitoring promotion (GMP) model operating at scale in Phalombe at approximately 84

outreach sites. Key activities have included the development of a nutrition manual for HSA's and volunteers, counseling cards, a M&E system based on tracking important GMP indicators, and the development of supervision and mentoring approaches for the volunteer components of the GMP program. BASICS participated in preparations and national launch of the Malawi Nutrition Strategy.

Community management of acute malnutrition: BASICS continued to support the implementation of CMAM in Malawi. 6799 Severely malnourished children benefited from outpatient care during FY2010.

1.3 Combating HIV/AIDS

BASICS has continued to contribute to strengthening and expanding HIV service provision in Malawi. More than 100,000 persons including 24,000 pregnant women and 10,000 children benefited from HIV testing conducted by BASICS employed counselors. BASICS supported the MoH with expansion of supervision and mentoring from the national level – a model that was conceptualized by the MoH and BASICS some two years ago and which has now gained wide acceptance by the HIV Unit and other partners engaged in PMTCT activities. BASICS has worked closely with the HIV Unit to strengthen PMTCT data systems – the major contribution being to support the implementation of the new ANC and maternity registers thereby strengthening routine data collection systems. BASICS supported refresher training of ARV provision including the introduction of presumptive therapy of HIV affected children. The introduction of ART for presumed severe HIV diseases increased the number of infants accessing ART by 65% (from 172 pre-intervention to 283 post-intervention) compared with 15% (259 pre-intervention to 300 post-intervention) for the rest of the country. BASICS has contributed substantially to the development of a Mother Infant Pair follow up model – in Phalombe more than 834 women have benefited at the pilot sites in Phalombe whilst the approach has been introduced with the participation of UNICEF and MSF in Chikhwawa and Chiradzulu. BASICS technical assistants working in the MoH have played an especially important role during FY2010 to plan for the introduction of new WHO guidelines for PMTCT band ART.

1.4 Prevention and control of malaria

Small grants: The BASICS small grants program was successfully expanded to cover 26 out of 28 districts in Malawi thereby making a substantial contribution to the provision of malaria messages at community level. Significant support was provided to NGO's and CBO's to expand and strengthen program implementation capacity through support for strengthened financial management and data collection capacity.

Intermittent Preventive Therapy for Pregnant women (IPTp): BASICS supported the NMCP to implement a national level supervision of malaria in pregnancy which was followed by the refresher training of service providers in IPTp – this included the distribution of job aids that were developed by the ACCESS program a few years ago. The IPTp program benefited from the roll out of ANC registers which has facilitated the accurate tracking of SP coverage levels.

Case management: Progress with regards to community case management has been described – however this program has been supported with PMI funding which has made a substantial contribution towards the successful implementation. Malaria case management makes out a little more than half of all episodes of disease seen at village clinics – this highlights the importance of malaria case management in the successful provision of community case management.

2. IMPROVED PREVENTION AND MANAGEMENT OF CHILDHOOD ILLNESSES

2.1 Community Case Management (CCM)

Over the past years, BASICS has continued to *expand access to and use of quality child health interventions through strengthening district and community provision of newborn and child health services*. The project has supported the development of key policies, such as the Accelerated Child Survival and Development Strategy (ACSD). Substantial progress has been made by USAID/BASICS in laying the foundation for ACSD; the IMCI technical working groups (TWG's) have been supported to coordinate child health service provision, District Executive Committees (DEC's) have been oriented on child survival activities, and training of trainers and health workers have taken place for both ACSD and IMCI. Within BASICS' eight districts, a number of key community-IMCI systems were put in place during this past year: a HMIS and LMIS package for CCM was finalized, a supervision and monitoring component used to strengthen the quality of care was incorporated, and essential supplies were provided (i.e., drugs, basics ORT equipment, village clinic registers, and bicycles). The HMIS and LMIS package for CCM was developed in collaboration with key stakeholders, including the IMCI unit, UNICEF, WHO, DELIVER and HTSS. The final LMIS package is comprehensive and includes supply management elements for HIV (test kits), family planning commodities and CCM drugs.

During this past year, USAID/BASICS participated in various key CCM meetings, such as the first annual CCM review meeting, stakeholders' meetings and the PMNCH review meeting. As a result, there has been a growing awareness among stakeholders of the need to coordinate the variety of inputs currently available for the scale up of CCM.

BASICS trained an additional 102 HSA's in 5 districts (Chikhwawa, Zomba, Salima, Kasungu, and Rumphi) in CCM of childhood conditions. Additional supportive activities included: the training of Health Centre In-Charge's (senior HSA's) in aspects of CCM and the orientation of village clinic committees; 200 drug boxes were procured and 500 ORT kits for use at village clinics were assembled and distributed to HSA's providing village clinic services; continued support for the TWG and DEC meetings; implementation of CCM quarterly review meetings for HSA's providing CCM; and 168 HSA supervisors were oriented on appropriate supervisory techniques for CCM, as well as 84 nurses/clinicians were trained as mentors. In addition, SMS reporting began in four districts, whereby district level TOT's were trained and 222 phones were distributed to HSA's managing village clinics in Mangochi, Salima, Nsanje and Zomba. Over time, USAID/BASICS numerous array of CCM activities have rapidly expanded access to community-level care to children under five.

The reporting rate has increased from 39.4% to 74.3% during PY3. While data collection remains a challenge, data drawn from 395 village clinics in 8 districts indicates that 283,669 children accessed care during the past year (Table 1).

Table 1: Number of episodes of disease assessed by diagnosis and district, Oct 2009 - Sep 2010

	Chikwawa	Kasungu	Nsanje	Phalombe	Salima	Mangochi	Zomba	Balaka	Total
Fever	18,089	22,027	8,330	20,150	24,516	29,978	17,271	20,831	161,192
Pneumonia	8,436	10,305	4,669	11,173	14,330	18,950	10,552	14,117	92,532
Diarrhea	3,559	2,605	1,899	3,699	4,642	6,521	3,588	3,432	29,945
Total	30,084	34,937	14,898	35,022	43,488	55,449	31,411	38,380	283,669

2.2 Emergency Triage Assessment and Treatment (ETAT) / Pediatric Hospital Initiative (PHI)

USAID/BASICS has had long-term involvement in the MoH's ETAT/PHI initiative, collaborating with both the MoH and WHO, and such, has *significantly improved the management of childhood illnesses*. During PY3, USAID/BASICS assisted the MoH to implement systems with the aim of strengthening inpatient care pediatric care. These included:

- introduction of peer review and death audit approaches, as well as monthly data reporting forms, to strengthen quality of care;
- providing support for regular hospital level pediatric review sessions;
- development of training materials which can be used on-site;
- development and distribution of job aids in the form of wall charts describing key life-saving interventions

According to Norman Lufesi, ETAT Coordinator at the MoH, "one of the most powerful things about BASICS is that the program is dealing with the system, not just the individual programs".

Additionally, BASICS made the following contributions:

- training of health workers in ETAT;
- procurement of essential equipment such as oxygen concentrators;
- development of policies, such as treatment guidelines and a WHO assessment tool for quality pediatric care; and,
- expansion of ETAT to health centers – a total of 56 in the 8 BASICS supported districts..

Quarterly peer review audits, funded by USAID/BASICS and WHO, were conducted in 8 BASICS districts. These meeting have been useful in identifying challenges and developing appropriate responses for common problem areas:

- Clinicians tend to misclassify a variety of conditions leading to poor management. Monitoring of vital signs is poorly done and very rarely checked even for very sick children.
- Essential lifesaving equipment is often not available in the facilities (oxygen concentrators, glucometers, pulse oximeters, blood pressure machines, thermometers, etc.).
- Standard management protocols are not available in most facilities for common conditions.
- There is limited supervision being done especially for CHAM and private institutions like Illovo clinics.
- Clinicians do not follow standard malaria treatment guidelines as illustrated by the use of Quinine for non-severe cases of malaria.
- The reviews were revealing information which was sometimes new to management which showed that some of the data collected in facilities never gets used at the facility level.

USAID/BASICS, in collaboration with WHO, provided support for the first national meeting for ETAT/PHI. This meeting, which was hosted by the MoH, provided a forum whereby a variety of participants (central MoH, DHMT members and hospital staff) received feedback on findings from the ETAT/PHI assessment conducted in 53 hospitals during 2009.

Data collected through the reporting system is helping the ARI Unit understand important issues such as the range of emergency conditions which children present with (respiratory distress constitutes 41%, convulsions – 36% and coma – 9%). This knowledge assists planning in terms of equipment and supplies procurement and areas where clinicians require further training. Data reviews have demonstrated definitive decreased inpatient mortality rates in the hospitals in Phalombe, Balaka and Chikhwawa. Data analysis is demonstrating the important seasonal variations of admission and death rates – especially the rainy season is very problematic when there are increased admissions of children with malaria, diarrhea and malnutrition – these increased admissions place a high burden on hospital facilities which limits the ability of facilities to cope with a substantial increase in death rates.

2.3 Zinc Supplementation

USAID/BASICS is supporting the MoH's initiative to implement zinc and low osmolarity ORS to manage diarrheal disease. The implementation of treatment with zinc was targeted for 2010 and is a collaborative activity involving the MoH, BASICS, WHO and UNICEF as key stakeholders. Key activities supported by USAID/BASICS include:

- finalization and printing of training manuals for health workers;
- training of trainers (70) followed by training of health workers (1300) in 26 of the 29 districts;
- briefing of District Health Education Officers (DHEOs)^a and their assistants (there were 52 officers from 26 districts who participated);
- assisting the MoH in the development of a National Strategic Communication Plan in preparation for the launch of zinc;
- a variety of other preparations required to support the launching of zinc supplementary therapy.

Unfortunately, the procurement of zinc has remained a major challenge and despite many efforts from both IMCI Unit and partners no supplies of zinc have yet arrived in Malawi. This has as a consequence the delayed implementation of Zinc supplementation for the management of diarrhea.

3. IMPROVED INFANT AND CHILD NUTRITION

3.1 Community-Based Essential Nutrition Actions (ENA)

USAID/BASICS works to *strengthen the promotion of general child nutrition at the community level to advance and increase coverage of nutrition interventions* through the implementation of high impact ENA. The project focuses on community-based key activities, such as growth monitoring and promotion (GMP), mother and father support groups (MFSG's), providing support to the MoH's Child Health Days, and Mother Infant Pairs (MIPs) follow up as a means to implement the seven components of ENA within communities:

3.1.1 Strengthening GMP

Throughout the year, BASICS focused on the scale up of the GMP program through outreach clinics and health centers throughout the entire Phalombe District and in the catchment area of Bimbi Health Centre in Zomba. A number of key activities took place:

- Draft community-based GMP kits, which included reference training materials on GMP interpretation and the use of information for growth promotion, registers for under IYC under 2 years, and counseling cards focusing on ENA and GMP were finalized, translated into Chichewa, and shared with stakeholders;
- 750 GMP kits consisting of training books, counseling cards and under 2 registers (Chichewa version) were distributed to Phalombe and Zomba ENA project districts.
- Salter weighing scales were distributed to 72 villages: 19 to Phalombe and 53 to Zomba, in which 12 villages are MFSG villages and 41 were covered as part of GMP outreach expansion catchments villages and also distributed all GMP outreach sites (89 for Phalombe covering the whole district; 13 for Zomba 's 53 villages).
- Children's health passports were provided to those who do not have one.
- Complementary feeding demonstration utensils (MOH standard cup, teaspoon and tablespoon including jugs and pails) are distributed for infants who reach 6 months for introduction to complementary feeding.
- IEC material t-shirts/bags with complementary feeding demonstration cups, spoons and jugs for demonstration on hand washing has been provided to all MFSG volunteers.
- Around 270 (198 for Phalombe and 72 for Zomba) MFSG facilitators were mentored in GMP, as per ENA review recommendations. Also, 604 (489 for Phalombe and 115 for Zomba) volunteers along with the HSA's and health workers working in the GMP outreach sites have been trained for the scale up of GMP in improved GMP service provision. Volunteers were trained on basic improved GMP practices (i.e., weighing of the child, assessing the child's health and nutrition status, teaching caregivers how to read and interpret the growth chart, and counseling them on GMP). All volunteers were provided with a set of counseling cards to facilitate the provision of nutrition information. Group village Heads (GVH) and Village Heads (VH) have also been trained in ENA and GMP and are part of the front line supervision team to ensure that GMP activities are going on well. As shown by pre and post-test assessments from the trainings, significant gains in knowledge have been made. For example. pre and post-tests from one of the TOT's in July 2010 (which had 25 participants) showed knowledge gained from an average of 35% during pre-training to an average of 79% post-training.

- Counseling corners have been introduced at outreach sites to provide focused counseling according to child's age, health status and maternal reproductive health. Counseling corners include: 0-6 months for key competencies on sustained exclusive breastfeeding, 6 -24 months for complementary feeding, sick child corner, FP, HIV/PMTCT, and ANC. At the end of a weighing, the volunteers who weigh the child inform the mother or care giver on which counseling corner to visit first.
- An M&E system and relevant GMP tools (including tools to conduct a baseline) were developed; and a comprehensive survey in which MOH took a leading role was conducted to prepare for the rollout of GMP for Phalombe and Zomba districts.

Additionally the following key points are worth noting

- The MOH held a National stakeholders' meeting on January 22nd, 2010 to disseminate the ENA Program Review Results and recommendations which included strengthening community-based GMP, introducing the register for children under 2 years of age, and improved counseling on IYCN, including HIV exposed children.
- BASICS was involved in the planning meetings for the National launch of the nutrition policy and the strategic plan. On January 29th, 2010, BASICS participated in the launch of the National Nutrition Plan. For this event, BASICS provided financial contributions to the Office of the President and Cabinet (OPC).

GMP records are beginning to flow in. Data is shown in Table 3 for Phalombe and Zomba. The data is small, but shows a positive start to community GMP commitment.

Table 3: GMP data from Phalombe and Zomba

Indicator	Phalombe <i>GMP data from 16 MFSG villages, Aug. 2010</i>	Zomba <i>GMP data from 53 villages, Sept. 2010</i>
Total # of under 2 children enrolled in the GMP register	798	2,049
Total # of under 2 children weighed	466 (58% of those registered)	1,796 (88% of those registered)
Total # of under 2 children with weight gain	380 (82% of those weighed)	1,592 (89% of those weighed)
Total # of under 2 children who did <i>not</i> gain weight	59 (13% of those weighed)	160 (9% of those weighed)
Total # of under 2 children who did <i>not</i> gain weight this month and last month	32 (4% of those weighed)	144 (8% of those weighed)

In addition to targeting children, GMP sessions have been successful in engaging pregnant women. As seen in Table 4, around 242 pregnant women are registered in Zomba GMP sessions; 50 of the women registered during the month of September, 2010.

Table 4: GMP data from Zomba, showing the participation of pregnant women in GMP sessions

Indicator	Zomba <i>GMP data from 53 villages, Sept. 2010</i>
Total # of pregnant women in the register from last month	192
Total # of pregnant women registered this month	50
Total # of pregnant women in the register at the end of the month	242
Total # of pregnant women who expected to deliver this month	91
Total # of pregnant women who have delivered	87
Total # of live births	87

3.1.2 Development and Mentoring of MFSG's

In order to improve nutrition through community-level interventions, BASICS works to *expand MFSG's for the promotion of exclusive breastfeeding and support of transition to exclusive replacement feeding*. MFSG's provide an opportunity to promote ENA activities, such as exclusive breastfeeding and supporting proper transition to exclusive replacement feeding in communities with high HIV/AIDS prevalence. In addition, MFSG's emphasize male involvement and teach men how to support proper feeding and prepare safe foods for infants and children.

MFSG's were established in two districts, Phalombe and Zomba, both of which have high MMR, IMR, HIV and malnutrition rates. After consensus with the MoH, DHO and TA's, mapping and selection of community MFSG members was established. Training curricula and ENA IEC materials were developed and translated into Chichwea. Once the training materials were finalized, TOT (using HSA's) and training of volunteers was conducted. MFSG volunteers were trained in ENA activities and are responsible for:

1. Conducting regular practical sessions in:
 - Breastfeeding management
 - Complementary feeding
 - Growth monitoring promotion including simple clinical screening of mother-infant pair for all mothers regardless of HIV status
 - Referral of children and women who need further help to the HSAs and or next level of care
 - Motivate mothers, fathers and men to practice FP and know their HIV status during the practical session
2. Conducting home visits to families that need extra support such as pregnant mothers, post natal mothers with their newborns, convalescing infants and young children including children in CTC program, HIV infected mothers with their exposed children
3. Conducting FGDs on MCH/FP, HIV, nutrition and home hygiene for multi mix and special groups of mothers/fathers men and grand parents
4. Implementing MIP follow-up for all households regardless of HIV status from pregnancy till born infant is 2 years of age
5. Keeping simple records on GMP and morbidity of IYC

Following ENA program review which took place in June 2009, BASICS focused to address the recommendations made strengthen MFSG ENA components and to roll out GMP as the major

activity to reach the majority of children under 2 years of age for improved IYCN through GMP outreach sites.

Mentoring of MFSGs:

In PY3, volunteers trained through the MFSG activity were incorporated into the larger GMP activity to ensure that the skills and knowledge they have gained in ENA continue to be used to promote infant and young child nutrition. The training package for mentoring of facilitators was completed and is currently in use; TOTs for mentors was completed in both districts. The mentorship focused on provider refresher trainings for facilitators, especially for GMP. Facilitators were given insight into how they could help set up effective counseling at outreach clinics held for GMP and immunizations.

In order to improve nutrition for IYC (regardless of HIV status) at the community level, BASICS works to *expand MFSG's scope and skills to reduce the risk of HIV infection through breastfeeding for HIV exposed IYC*. MFSG's provide an opportunity to reduce stigma associated with MTCT, support HIV infected mothers in sustaining exclusive breastfeeding, prepare them for timely introduction to complementary feeding and support proper transition to exclusive replacement feeding *when nutritionally adequate complementary foods are Affordable, Feasible, Accessible, Sustainable and Safe (AFASS) is met any time between 6 – 12 months of infant's age* in communities with high HIV/AIDS prevalence.

In addition, MFSG's emphasize male involvement. They discuss the issues with fellow men and provide information on the importance of knowing ones HIV status, attending ANC/PNC, and safe labor and delivery practices. In addition, MFSG's teach men how to support optimal breastfeeding practices, how to prepare safe complementary foods and taking part in feeding of IYC, and how to reduce the work load for wives during pregnancy and breastfeeding.

Coverage of MFSG's:

To date, 31 villages are covered by MFSG's (19 in Phalombe and 12 in Zomba); 296 (192 for Phalombe and 72 for Zomba) MFSG volunteers exist, and over 1,600 IYC under 2 have been reached. All MFSG's have registered their household catchment allocations of 18-20 per facilitator and have initiated follow-up activities. MFSG's regularly follow up on home deliveries, MIP's and other families to ensure proper breast feeding, prevention of harmful traditions, identify IYC under two years of age who are not growing well, and provide referral for those in need. Record keeping is being conducted within each household and MIP's are being followed from pregnancy until the child is two years of age. In addition, focus groups are being conducted for various nutrition and reproductive health activities to motivate community members for early health seeking behaviors. According to the village headmen, as a result of these activities, ANC attendance and facility-based deliveries are rising, maternal and neonatal deaths are decreasing, child health disease prevalence has lessened, and breast feeding/complementary feeding practices have been improved.

3.1.3 PMTCT MIP Follow-Up Continuum of Care for HIV Exposed IYC

BASICS initiated to pilot test a health facility based a model of MIP follow-up of HIV exposed IYC in three health facilities: the Holy Family Hospital, Phalombe Health Center and Mpsa Health Center. Key competencies for MIP include simple clinical assessment, GMP, sustaining exclusive breastfeeding and complementary feeding principle competencies, timely breastfeeding cessation process when AFASS is met between 6 -12 months and PMTCT psychosocial counseling

competencies. The Goal for the MIP program is to ensure that 90% of HIV-exposed IYC in the MIP cohort are HIV free with optimal nutrition status.

Monthly follow-up key activities along with support from family members for each MIP include:

- Simple clinical assessment for and infant on HIV related infections including HIV status of infants and Young Children
- Growth pattern and nutrition assessment of infants and Young Children including immunization status
- Counseling for growth promotion according infant’s age, growth pattern, health and HIV status
- Infant feeding demonstrations – Key competencies to sustain exclusive breastfeeding in the first 6 months of life and complementary feeding principle for IYC above 6 months of age
- Psychosocial supportive counseling
- Referral to HIV related services and family planning

Results:

1. Phalombe has enrolled 834 HIV positive pregnant from May 2009 to September 2010 as shown below the table:

District	MIP enrolled	Samples collected for HTC PCR	Infants tested	Negative	Positive	Waiting for results
Phalombe	834	365	280	258	22	85

2. There is improved breastfeeding and complementary feeding practices for HIV exposed IYC. This is observed from the growth patterns showing improved weight gain monthly.
3. Support family involvement helps mothers implement prescribe PMTCT intervention and reduce stigma and discrimination associated with HIV infection.
4. Mothers look forward to MIP sessions because they get new skills and knowledge for every visit.
5. All mothers are on effective contraceptives.
6. There is good linkages with other HIV related services and community support.

Early this year, UNICEF expressed interest in the Phalombe MIP experience and requested BASICS to replicate MIP in Chikwawa District. Currently MOH HIV unit has scheduled packaging of MIP training materials using BASICS’ Phalombe and Chikwawa training notes as basis for packaging.

With support from USAID/BASICS, the MoH’s Child Health Days distributed Vitamin A to 1,239,974 children in the eight districts during this past year.

3.2 Community Management of Acute Malnutrition (CMAM)

To improve curative nutrition interventions at the national level, USAID/BASICS participated in regular national nutrition policy review and strategy development sessions. BASICS also continued to take a central role in CMAM Technical Working Group meetings which provided guidance to MoH. At the district level, USAID/BASIC works to *expand and improve the quality of treatment of severe acute malnutrition through CTC/CMAM*. BASICS has been a large advocate of promoting nutrition activities through capacity building efforts, such as enhancing communication, providing

on-going trainings to health providers, HSAs and volunteers, and encouraging supportive supervision.

Through CMAM activities, USAID/BASICS supported Ministry of Health to expand coverage and improve the quality of treatment for severe malnutrition. PY3 supported a growing capacity in districts manage CMAM through trainings, district nutrition coordination and supervision. Key activities included the orientation of CMAM providers on M&E of CMAM; with the aim to enhance data management for decision making at all levels. 83 DHO staff were trained in M&E aspects of CTC; Following a review of performance indicators for NRU's, it was noted that there were gaps in the management of severe acute malnutrition. As a result, refresher trainings were given to 197 clinicians, nurses and supervisors in the management of severe nutrition in NRU's. These trainings were held in all eight BASICS partner districts. During the year 6799 severely malnourished children benefited from CMAM services in the BASICS supported districts.

The MoH has been conducting regular national-level Targeted Nutrition Program (TNP) meetings, bringing together nutrition implementers from across the country to discuss key issues, policies, guidelines and approaches. The TNP Committee was formed in 2001 as a subcommittee of the national Food Security Technical Committee that provided quick technical response to the then nationwide food security crisis. The TNP forum has continued to grow qualitatively, as demonstrated by an increasing number of various nutrition policy and implementation documents that have been produced in the few years that the forum has functioned. Inclusion of partners from various organizations has helped to keep the forum active through technical and financial support. But these achievements are largely registered at national level.

While the national TNP meetings are functioning quite well, the weakness is that the structure is not replicated at the district and community levels; thus closing out key players and causing a gap between policy and implementation. BASICS has recognized this deficiency and during the last three years, six districts have received technical and financial support to build nutrition coordinating structures along the lines of the national TNP forum, enabling key nutrition players at the district level to interact and discuss methods for targeting resource-poor families to in order to improve impact. The primary goal of TNP meetings is to coordinate selective feeding for malnourished people, including targeted supplementary feeding and therapeutic feeding (i.e., through Nutrition Rehabilitation Units [NRUs] and Outpatient Therapeutic Programs [OTPs]). The roles and outcomes of the meetings vary, depending on the districts' needs and interests. In general, participants may discuss a range of the following:

- a. Assessment of current nutrition status situation , interventions, implementing partners including lessons learnt from other implementing organizations
- b. Targeting Mechanism (explore different ways of targeting nutritional support)
- c. Develop action plan for implementation of the TNP basing on the current situation
- d. Develop and review National guidelines for supplementary and therapeutic feeding activities
- e. Develop and review indicators for monitoring and evaluation of TNP
- f. NGO and private sector involvement
- g. Establish mechanism for linkage, collaboration, networking and information sharing
- h. Identify resource requirements
- i. Resource mobilization

So far, BASICS districts are the only ones who have instituted coordination mechanisms for initiatives at the district level. During PY3, twelve district level TNP meetings have been held in 6 districts. At the end of PY3, BASICS engaged a local consultant to assess impact of this district level

nutrition coordination. Results will be shared with MoH and other stakeholders at a national forum.

4. SUPPORT THE EFFORTS OF THE MOH IN MALAWI IN COMBATING HIV

4.1 Prevention of Mother-To-Child Transmission (PMTCT) of HIV:

USAID/BASICS expanded PMTCT services in the eight districts and increased referral of infants in need of HIV care and treatment services through the establishment of functional referral networks from PMTCT, community, IMCI, OVC and ART programs, and immunization sites. One of the greatest accomplishments of the year was the development and roll-out of new ANC and maternity registers. The new registers were implemented in Dec. 2009, and in one month, over 3,000 health workers were trained in all districts of Malawi. These new registers encourage follow-up and enable tracking of accurate maternal and child health indicators, such as PMCTC. In addition, the new register allows one to link ANC visits to IPTp uptake – something which was not previously possible.

According to Michael Eliya, PMTCT Coordinator within the MoH, the BASICS project has made a 'strong contribution to the beneficiaries on the ground'.

New WHO guidelines on PMTCT and ART were released this year; BASICS participated in a national level meeting to review the implications on PMTCT and ARV treatment. BASICS staff have also been incorporated into a Task Force working on implementation of the national guidelines. BASICS focused as well on strengthening the monthly PMTCT reporting system. Due to the new ANC/maternity registers, as well as through quarterly district review meetings, the reporting rate has improved to almost 80% in the 8 BASICS districts.

BASICS continued to support the HIV Unit with supervision and mentoring activities during FY2010. The HIV Unit was able to conduct two rounds of national supervision which was complemented by zonal level mentoring activities for district level PMTCT coordinators. Items discussed at mentoring meetings included logistics management of HIV supplies such as test kits and nevirapine and in-service training for coordinators on PMTCT data management. This support reflects an important systems strengthening component of BASICS and USG support to the MoH.

There has been an *increase in follow-up of mother infant pairs seen through PMTCT programs*. Introduction and strengthening of Mother Infant Pair (MIP) follow up strategies provided ongoing support for the PMTCT mentoring program initiated during FY2009. See detailed write up in Section 4.1.3 *PMTCT MIP Follow-Up Continuum of Care for HIV Exposed IYC*.

BASICS is exploring the use of routine testing at immunization clinics to monitor PMTCT transmission rates and strengthening community-support for PMTCT. A concept paper and proposed budget was developed and discussed with USAID and Centers for Disease Control (CDC). We are currently in the midst of discussing the proposed activity with other stakeholders with the aim of finalizing the research proposal within the next two to three months.

Strengthening the transport of CD4 and PCR specimens has had limited success this year. Initially, a transport assessment tool was developed in collaboration with the MoH laboratory coordinator – implementation was however delayed due to pressing demands on the laboratory coordinator and the assessment was never conducted. The HIV Officer for BASICS visited Machinga district to see

transport systems set up by the Clinton Hunter AIDS Initiative – BASICS will work towards implementing similar approaches in BASICS districts during PY4.

4.2 Pediatric HIV

Activities implemented during PY2 aimed at increasing the uptake of HTC in children have had limited impact; therefore a new set of approaches were implemented during PY3. These included the implementation of Provider initiated Testing and Counseling (PiTC), a partnership with Baylor Pediatric Initiative to capitalize on their experience in strengthening pediatric ART and using innovative approaches to implement HTC at outreach clinics at community level. Delays in the finalization of the sub-contract with Baylor delayed implementation of the program substantially with substantial implementation commencing in October 2010.

During the past year, *there has been an increase in the number of clinically qualified children under five on ART*. BASICS continued to support the implementation of CPT prophylaxis at hospitals and health centers and in collaboration with the MoH, access to ART for children was expanded. Around 400 clinicians were trained on new ART guidelines and districts were supported to initiate ART supervision and outreach throughout the district whilst district level quarterly review meetings were initiated in a number of districts. Presumptive therapy for HIV affected children was included in the training – this led to a 64% increase in the number of children accessing ARV's in the BASICS supported districts (from 172 children initiating treatment during Jan-Sept 2009 to 283 children accessing treatment between October 2009 till June 2010). This was achieved by more than doubling the number of children accessing presumptive ART – thereby indicating the feasibility of the approach especially when the number of children being diagnosed through EID appears to be declining. However – it is clear that substantial work needs to be done to ensure access for all children who are HIV affected.

4.3 HIV Testing and Counseling (HCT)

HTC is ongoing with 83,960 people tested in district hospitals during PY3. The village to village HTC continues to gain popularity and expanded in Salima when 100 community leaders were orientated on the concept. After initial focus groups and a larger sensitization campaign were conducted, a total of 46 villages were reached instead of the targeted 40 villages (representing 115% of the target reached).

Over a period of 11 months, 4,328 individuals (2,488 females [57%] and 1,840 males [42%]) were tested and counseled for HIV during village to village testing in the 46 Villages (March 2009 to May 2010) (Table 7). Overall, 36 individuals tested positive [0.8%]; 18 of those were started on ARV due to this program.

Table 7: Individuals tested by age

Testes by age	Number
17 months	21
18 months – 14 yrs	522
15 yrs – 24 yrs	2,713
24 yrs and above	1,072
Total	4,328

Additionally, the pilot NGO grant program, whereby counselors employed through NGO's are deployed to health facilities to conduct HTC, began this year. Two NGO's, Word Alive Ministries International (WAMI) and Friend of AIDS Support Trust (FAST), are now providing HTC services in 12 facilities in Phalombe and Nsanje. Since their inception, 24,891 tests have been conducted, 15,819 in Phalombe and 9,072 in Nsanje. Supervision of grantees has continued throughout this

period. During one of the supervisory visits, it was noted that one of the grantees had 7 out of 10 counselors who were not accredited to provide HTC; the NGO was requested to discontinue employment of these counselors and have currently recruited new set of counselors. This is a valuable lesson-learnt from the pilot phase.

4.4 National Level Technical Assistance to the MoH HIV Unit:

USAID/BASICS provides much needed support to the MoH's HIV unit, such as: 1) strengthening capacity, policies and guidelines in HIV and PMTCT at the Ministry level, including improved overall coordination of HIV/AIDS services and capacity development; and 2) providing technical assistance to the MOH to scale up HIV programs including PMTCT.

Main achievements:

- A new policy for PMTCT and ART was developed. This policy is based on new WHO guidelines (2009) and proposes to 'test and treat' all pregnant HIV infected women irrespective of clinical stage or CD4 count. This policy was successfully proposed to the senior management in the MoH, the Malawi partnership forum and the CCM. Once this policy is implemented the MTCT rate is expected to decrease drastically.
- USAID/BASICS provided support to the development of the application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in round 10. This application will provide the funds to implement the new PMTCT and ART policy together with funds that will become available through reprogramming of the existing Global Fund grant.
- The program facilitated the move of the HIV and AIDS department from the MoH headquarters to new refurbished offices at CHSU in Lilongwe.

BASICS Technical assistants provided support to the HIV Unit during FY2010 as indicated below.

Development of policies, guidelines and strategic plans:

- Development of draft TB/HIV Guidelines (PMTCT)
- Development of Four-Year Pediatric HIV Care Acceleration Plan, 2009 – 2013 which is an addendum to the Five-Year PMTCT Scale Up Plan, 2008 - 2013 (PMTCT –MoH)
- ANC Pre-test and Post-test Counseling Tools (PMTCT)
- Development of paediatric ART guidelines
- Development of draft guidelines for viral load monitoring of persons on ART
- Development of draft for new supply management system for HIV program commodities ((MoH –HIV)

Technical and administrative support for HIV Unit:

- Organization of the national Integrated HIV and STI meeting for DHOs, 8 and 9 October 2009.
- Organization of HIV and AIDS Technical Working group meeting (MoH-HIV)
- Preparation of international TB/HIV conference in Lilongwe
- Contribution to the NSA appeal write up (MoH –HIV)
- Preparation of disbursement request for HIV commodities to GFATM (MoH-HIV)
- Preparation of procurement plans and submission of budgets and disbursement requests for National AIDS Committee (NAC) and CDC grants

- Preparation of ART distribution plan (MoH –HIV)
- Initiation of a review of supply management system for commodities for the HIV and AIDS program.
- Support for the implementation of new WHO guidelines through a variety of activities
 - a. preparation and organization of TWG subgroup meeting to discuss new WHO guidelines followed by a HIV symposium and other meetings for the development of plans for the implementation of the new approach to ART and PMTCT.
 - b. development of the scale up plan,
 - c. development of guidelines,
 - d. costing of implementation of new guidelines including forecasting of requirements for new treatment regimens
 - e. presentations to MoH senior management, GFATM Country Coordinating Mechanism, Malawi Partnership Forum, and at the NAC biannual meeting

Support for program supervision, mentoring and training:

- Supported the training and roll out of HW's in revised ANC and Maternity Registers and Woman Health Passport in all districts of Malawi.
- Supported national level PMTCT supervision and mentoring activities.
- Supported ART supervision

5. STRENGTHENING OF COMMUNITY MALARIA INTERVENTIONS

5.1 Small Grants Program

With PMI funding, USAID/BASICS established a malaria small grants program in Malawi. The grants program awards grants to NGOs to support malaria activities in Malawi over a period of four years; four cycles of grants exist and each one is for one year. There are three objectives of the small grants program:

1. Increase correct and consistent use of ITNs and number of households that re-treat and care for their ITNs, particularly for children under 5, pregnant women, and people living with HIV/AIDS.
2. Strengthen the effectiveness of community networks to communicate and convince households about the necessity of preventing malaria (i.e., through year-round ITN use).
3. Increase the number of children under 5 that are given the full recommended course of treatment with coartem and increase the number of private drug distributors trained on the new malaria policy.

Figure 2: Malaria Grant Program - District coverage map



To date, there are 21 grantees who have implemented IEC programs in 27 of Malawi's 28 districts (see Fig. 2). The main focus of the grantees is to provide community-based BCC messages, which they implement through activities such as: radio listening clubs; trainings for HSAs and volunteers; community mobilization activities, outreach meetings, and interface meetings; door to door meetings by volunteers; and village meetings. Collaboration between the MoH, BASICS, local NGO's and the community (i.e., community members and leaders, as well as volunteers) has been vital in reaching the objectives.

In PY3, BASICS extended Cycle 1 and 2 grantees, and expanded the grants program to a further 16 districts through the appointment of Cycle 3 and 4 grantees (which consisted of 11 new grantees). A challenge existed in terms of aligning the period required by grantees to generate an impact (18 - 24 months) with the remaining 24 months of the child health program with an expected end date of September 30, 2011. To deal effectively with this challenge, some of the grantees in Cycle 3 were contracted to undertake project implementation in two districts rather than the usual one district.

Figure 2 Key	
	Cycle 1 & Extension
	Cycle 2 & Extension
	Cycle 3
	Cycle 4
	Not Covered

It is expected that by the end of PY4, BASICS would have implemented small grants activities in a total of 26 districts through four different cycles. Annex 3 provides a list of the grantees, including their operating district and cycle number. In addition, the BASICS M&E team rolled out new M&E tools to the 11 NGO's and installed the Malaria database for 10 of the 11 grantees^b to improve their data collection systems. In addition,

^b One of the grantees' computer was not working and was therefore unable to download the new Malaria database.

around 680,000 sets of IEC materials (case management, LLIN's and IPTp) were procured and are being distributed to grantees; visual teaching aids were finalized, pre-tested and made ready for printing.

Capacity building activities with grantees:

The program has undertaken a number of activities with the aim of building the capacity of participating grantees and the District Health Management Teams (DHMT). Key activities in this respect have been quarterly meetings, supervisions, trainings and orientations. Quarterly meetings have allowed grantees and DHMTs to debate and adopt best practice for their respective projects, enhanced peer learning and has assisted to forge cordial and symbiotic relationships between grantee and DHMT. Supervisory efforts undertaken by BASICS team has assisted grantees on the spot with technical backstopping, facilitated the imparting of project and financial management skills. Lastly, BASICS has carried out a series of trainings and orientations for the grantees. Some of the key trainings include proposal development training which have culminated into grantees developing meaningful proposals and budgets; and, accountants orientations which have dwelt on imparting basic accounting and reporting skills for grantee accountants.

5.2 Intermittent Preventive Treatment for Pregnant Women (IPTp)

In collaboration with the NMCP, USAID/BASICS is currently implementing numerous activities geared towards strengthening IPTp, based on three common objectives:

- 1. Access to IPTp materials for health facilities increased*
- 2. Improved and increased supportive supervision to health facilities providing malaria in pregnancy services*
- 3. Improved quality of IPTp*

USAID/BASICS provides much needed support to the NMCP through activities such as:

- Supporting capacity building through training district malaria coordinators.
- Provision of equipment to support implementation of DOTS for IPTp
- Providing funds for the development of supervision tools.
- Financial support to NMCP for an M&E manager.

According to Mr. E. Kaunda, Malaria Officer responsible for IPTp, NMCP, the greatest help BASICS has provided has been in the areas of training and supervision. This past year, BASICS collaborated with NMCP and SPS to extend the number of facilities visited during quarterly supervisions on malaria in pregnancy, jointly conducted by NMCP and SPS. The objectives of the supportive supervision are to:

- assess level of implementation regarding malaria activities in relation to malaria in pregnancy in the country
- provide assistance in deficient areas noted for improvement
- assess the strengths and gaps for program improvement

Malawi has a total of 615 health facilities, of which, a total of 571 provide ANC services; supportive supervision was conducted in all facilities that provide ANC services. NMCP and BASICS collaborated in developing an integrated malaria supervision tool that was used by district level malaria coordinators to conduct quarterly supervision and obtain relevant information. The

supervision focused on six key areas: service provision, health worker training, intermittent preventive treatment, LLIN's, data management, and IEC.

During the third quarter of PY3, IPTp supervision was conducted by Malaria Coordinators in 571 facilities providing ANC services in all districts using the newly developed supervision check list. The findings were disseminated at the malaria and safe motherhood coordinators meeting, and also during a malaria TWG meeting in Blantyre. The supervision report made a substantial contribution to the IPTp component of the Malaria Program Review.

Additionally, BASICS funded the NMCP to conduct orientation for health workers on the materials developed by ACCESS (maternity wheel and IPTp job aids). These orientations took place at the district level in the form of one day orientation meetings.

5.3 Other support to the NMCP

BASICS supported the NMCP to conduct a WHO initiated review of the malaria control program – both through the provision of technical assistance in sub groups (communication, malaria in pregnancy) and through funding support for a consultant to help document the review process). BASICS employed an M&E Officer who has been seconded to the NMCP to support the development of institutional M&E capacity.

6. STRENGTHENING INFORMATION SYSTEMS

6.1 Monitoring and Evaluation (M&E)

During PY3, BASICS conducted activities to improve information systems in a number of program areas. This forms part of systems strengthening perspective that BASICS applies to program implementation.

IMCI and ETAT/PHI:

BASICS worked with the IMCI Unit to develop an M & E system for village clinics. Once the system was defined, BASICS supported scale up to all 8 BASICS supported districts. This included training of 588 HW's in data management with an emphasis on collecting utilization data and data required for supply management from village clinics in close collaboration with USAID DELIVER Project and MoH. BASICS printed 3000 village clinic registers which has been distributed nationally by the IMCI Unit.

BASICS engaged Frontline SMS Medic, a NGO dedicated to finding mHealth solutions for communications between communities and health facilities in developing nations. The SMS technology facilitates rapid reporting of supply needs and facilitates collection of utilization data – a challenge when data in the past had to be collected by hand from hard to reach sites. The system has been piloted in 4 districts – 238 HSA's were trained and provided with a cell phone and solar charger. This has eased the process of data collection from the hard to reach areas where village clinics are operated to the DHO where data is collated and shared with stakeholders. BASICS in collaboration with the CFPHS project are continuously assessing the performance of the SMS – based system to ensure that it remains functional and able to produce consistent data. A number of bugs have been identified which have been resolved in collaboration with Frontline SMS Medic.

BASICS has worked to strengthen data collection from facilities implementing ETAT/PHI. Support has included the development of the basic data collection and reporting system. Review of the data collected through this system is enabling a greater understanding of the epidemiology of emergency care needs within pediatric care and utilization trends. This understanding will facilitate the development of improved management systems at hospitals and health centres.

Nutrition:

BASICS has developed and implemented a model for monitoring GMP activities at outreach sites and for GMP services provided through volunteers at community level. Support has come through the development of indicators, and new register for IYC and training providers on data collection. The system is relatively new and there will be ongoing support for this activity during PY 4.

BASICS trained 83 DHO staff as trainers and supervisors in Nutrition data management. These in turn conducted a series of cluster based data management trainings for CTC service providers in their respective districts. A total of 433 facility based staff have been trained in 6 districts excluding Salima and Nsanje where Concern Worldwide and COOPI respectively provide financial and technical support in Nutrition programming. These trainings have improved recordkeeping capacity of CTC staff as demonstrated through completeness and accuracy of records observed during CTC program supervision by MoH Nutrition Unit Staff

HIV/AIDS:

BASICS contributed to the strengthening of PMTCT data through a variety of mechanisms. These included support for the roll out of the ANC and maternity registers, support for the PMTCT Unit to conduct supervision and mentorship which included in-service training on PMTCT data collection, quarterly meetings with PMTCT providers to strengthen their understanding and capacity to complete monthly PMTCT reports and support for assistants statisticians to visit health centres to collect monthly PMTCT reports. This package has contributed towards enabling the PMTCT Unit in the MoH to collect a continuously improving PMTCT data set. In addition BASICS, continues to work with the HIV Unit and other stakeholders to conceptualize and test a model for the monitoring of mother infant pair follow up at health facilities and in communities

Malaria:

BASICS supported data collection M&E activities both for the small grants program as well as for IPTp. The Malaria Grants Data management and reporting system was reviewed. New tools were developed and introduced to 11 grantees for ease of data collection and reporting. A database for consolidating data at district level was developed and rolled out to all except one grantee.

The roll out of new ANC registers has brought substantial benefits to tracking IPTp coverage. BASICS together with the NMCP incorporated aspects of data management into the recent series of IPTp refresher training whilst joint supervisions between BASICS and the NMCP continues to strengthen overall data collection and use.

Strengthening M&E at a national level:

BASICS deployed a M&E Officer to the NMCP to support the development of M&E capacity within the NMCP. The officer has been intensively involved in the recent Malaria Indicator Survey conducted during 2010 as well as in the development of the next 5 year Strategic Plan. BASICS staff have participated in the M&E TWG and have made contributions towards developing the M&E components of SWAP II.

Internal monitoring of project activities:

During FY2010 substantial efforts were made to strengthen data quality within the BASICS program. BASICS added two assistant-statisticians to support the current M&E Officer to ensure that quality data is captured and is effectively utilized and shared. BASICS M&E staff have taken a pro-active approach to reach out directly to districts to facilitate the collection of quality data. This done by regular visits to districts to review the quality of data and on a quarterly basis the assistant-statisticians travel to each district to provide hands on assistance during the collection of quarterly data. This has facilitated the process of ensuring a high coverage of data collected for village clinics (75% during last quarter) and PMTCT (up from 53% in quarter 1 of FY2010 to about 80% for quarter 4). The hands on approach ensure that errors are corrected in the district prior to submission to the central level.

Data quality assessments were performed in four districts namely Chikwawa, Balaka, Kasungu and Salima. These assessments were done jointly with the Central Monitoring and Evaluation Division (CMERD) of the Ministry of Health. The benefit of this exercise is to identify and data management gaps and suggest ways of addressing them so that management decisions are made on valid data.

BASICS conducted a baseline study on ENA program implemented in Zomba and Phalombe using a 30 cluster sample design. In total, 60 villages in Phalombe and Zomba were visited where survey teams comprising of BASICS staff, MoH staff and external enumerators and supervisor conducted interviews with 680 pregnant women fathers and mothers of under 2 children to assess mother

and infant feeding practices. The results of the study (not yet released) will form a basis for comparison when evaluating the impact of the program after one year of implementation.

7. CHALLENGES, SOLUTIONS AND ACTIONS TAKEN

Despite BASICS successes in implementing these key child survival activities, a number of challenges (both external and internal) occurred during the past year. These are highlighted below:

CCM: The co-implementation of CCM in Zomba by PSI and BASICS created problems. BASICS emphasized the MoH approach to implement CCM in hard to reach areas whilst PSI has followed a different approach to train high numbers of HSA's in CCM which includes areas outside hard to reach areas. This created problems and the DHMT temporarily ceased all training activities. The large scale implementation of CCM may lead to drug supply problems in future once the CIDA funded projects come to an end with the high number of service delivery points. Following discussions with PSI, the IMCI Unit and USAID, an agreement was reached that it is appropriate for BASICS to limit further support to CCM in Zomba district and to expand implementation of CCM to districts where CCM has not been adequately implemented – this includes Nkhata Bay, Rumphu and Chitipa.

Zinc: The implementation of the zinc program has been severely hampered by the challenges of accessing zinc through the Central Medical Stores. Despite numerous statements indicating that zinc would be arriving in-country this unfortunately never materialized and final program implementation was never possible.

Nutrition:

During FY 2010 there was a need to strengthen coordination between BASICS, the Office of the President and Cabinet (OPC) and other nutrition stakeholders. BASICS took a number of steps such as the harmonization of BASICS activities with MoH and OPC plans, submission of quarterly reports to both the MoH and OPC and to ensure that MoH staff are regularly invited to activities initiated through BASICS. Unfortunately, it was not possible to involve MoH staff very effectively from the national level to support field activities due to many competing demands. However, it can be reported that the effort to link BASICS staff more closely to the MoH and OPC nutrition units has worked and there is a greater participation by BASICS staff in national level MoH and OPC nutrition activities. At the district level there is good collaboration between BASICS staff and MoH staff. A further challenge related to ENA is the existence of competing sets of counseling materials without consistent messaging. There is a need to develop a set of materials which all programs can use when working in the field of infant and young child nutrition.

Malaria: The small grants program lagged in terms of meeting expected targets for FY2010. This was especially noted for persons reached through IEC/BCC activities. There were two main reasons for this problem: the transition of the BASICS program to MSH caused bureaucratic delays as the contacting requirements for grantees had to be changed to meet MSH standards which caused substantial delays; secondly, BASICS staff made use of estimates to set targets which is more problematic at the start of a new program. There has been a misalignment of cycles between the USAID reporting cycle and the implementation cycle of grantees which has further complicated

effective tracking. The positive news is that individual grantees have been effective in meeting their targets as set out at the start of the grants cycle. The team managing the small grants now have the benefit of the experience of managing three cycles of grants and less problems can be expected for FY11.

HIV: BASICS has faced two major challenges during the course of PY3. Firstly, there were delays in the implementation of the Baylor sub-contract which delayed the start of the activity. Important components of the activity such as strengthening of ART service delivery in Kasungu and Phalombe and strengthening linkages between HIV testing of children and enhanced access to HIV services were only implemented early in October 2010. Secondly, the shortage of HIV test kits impacted on service delivery during the course of the year.

Transport and fuel shortages: Lack of fuel in the country, combined with bad roads causes numerous problems for transportation and implementation of key activities. BASICS staff have had to spend large amounts of time whilst search for and queing for fuel. As a solution, BASICS will be stocking up on fuel in preparation for future fuel shortages.

8. LESSONS LEARNT, BEST PRACTICES AND RECOMMENDATIONS

Roll out of national activities: BASICS supported the national level implementation of programs in a number of areas. The roll out of the ANC and Maternity Registers demonstrated how an important activity may be quickly rolled out when more than 3000 HW's were introduced to new tools over a period of 1 month. This was complemented by the support provided to the PMTCT Unit for national level supervision and mentorship activities when in-service training on the tools was provided to district level PMTCT coordinators. IPTp activities were conducted at a national level – components included facility level supervision and large scale in-service training when almost 1000 HW's were oriented on tools developed through the ACCESS program. Finally – large scale support was provided to the IMCI Unit for implementation of zinc supplementation at national scale. Activities included support for development of materials required for the orientation of HW's on the use of zinc, training of HW's and provision of support to the Health Education Unit to conduct communication activities in support of zinc implementation. These activities demonstrate how development partners are effectively able to support important MoH initiatives and facilitate implementation.

Comprehensive support for programs: The preparation for the roll out of the LMIS and M&E components of village clinics is a good example of effective and comprehensive program support. A variety of organizations collaborated to support the MoH initiative (IMCI Unit, HMIU and pharmaceutical services from the MoH, BASICS, DELIVER, UNICEF and WHO), a series of tools were developed which will be used by all partners supporting IMCI and a well-defined process of roll out to the districts was defined. The roll out extended beyond a training activity only – included in the comprehensive package was the provision of LA, LMIS and M&E tools, ORT equipment and bicycles. HSA's working at village clinics were thus comprehensively supported to continue the implementation of community case management.

Use of innovative technology: The implementation of the Frontline SMS Medic program has progressed relatively smoothly. Important lessons have been learnt through the process. HSA's have accepted the technology and have found it relatively easy to use. This is in contrast to CBDA's who have experienced problems when entering data into the phones. Problems occurred during the period when the solar chargers had not arrived. Cell phone batteries were swapped for poor quality batteries at charge centers in the rural areas when HSA's took their cell phones to be charged. Problems arose with the software used for transmitting data – this required ongoing problem solving to eliminate software problems. Despite the challenges, there is a sense that the most problems have been resolved and that the technology has great potential for the future.

Innovative solutions for the expansion of HTC service provision: The Village to Village HTC program as well as the small grants program whereby NGO's deploy counselors to health centers have been identified by the HTC Unit in the MoH as best practices. The Village to Village HTC approach has demonstrated how HTC can be effectively pushed to the community level thereby increasing access to HTC and generating community participation. The initiative is described in a success story titled *Village to Village HTC in Salima: Village to Village HTC brings services to rural communities*. The small grants program facilitated the deployment of counselors to 10 health centres in 2 districts in a cost-effective manner. The activity has supported the introduction of uninterrupted HTC service provision at health centers whilst freeing up HSA's to continue their community level work. The initiative is described in a success story titled *Promoting Voluntary Counseling and testing; Local NGO's increase voluntary HIV testing and counseling through radio*

advertis. These activities have proven to be successful in task-shifting / reducing the workload of HSA's, and reaching a large number of people in hard to reach areas with HTC

Linking between program areas to strengthen service delivery: BASICS has been able to work with different programs to strengthen integration of services and improve effectiveness of resource utilization. In districts where the Community Family Planning and HIV Services program has been operating a number of HSA's have been trained to provide both family planning services (DMPA) and CCM – this represents an example of effective integration of two different but complementary programs which decrease infant and young child mortality in a complementary fashion.

The implementation of ETAT at the health centre level shows considerable promise in terms of strengthening one of the weaknesses of IMCI – poor referral practices. The ETAT experience at hospital facilities has demonstrated the programs capacity to reduce childhood mortality in a very practical fashion through the teaching of hands on emergency care skills to health workers. The practical skills have the ability to strengthen referral practices of IMCI providers at health centres and to complement the current IMCI program where weaknesses exist in terms of preparing children for referral to hospital. BASICS will continue to explore how the relationship between IMCI and ETAT may be strengthened during the course of PY3.

The implementation of new ANC and Maternity registers demonstrates how a single activity may benefit two or more programs. Roll out of these tools very concretely benefited the PMTCT program in terms of accessing important information to monitor program implementation whilst the IPTp program benefited through the introduction of tools which enable the tracking of IPTp coverage. Other program areas will benefit as well – the Reproductive Health Unit will benefit from data collected through the revised tools.

Finally, a series of CCM activities were supported through funding from the Child Survival pot and the PMI pot. Child Survival funds were used to support the training of HW's in CCM (HSA's trained in CCM, medical assistants trained as mentors, senior HSA's as supervisors) whilst PMI funds were used to support the development of the logistics management and information systems component for CCM. This level of integration demonstrates how program funding from different sources can be harmonized to strengthen program implementation.

Renewing interest in Growth Monitoring and Promotion: The re-introduction of an emphasis on GMP creates possibilities to strengthen a important component of ENA services. Anecdotally, it appears that growth monitoring has had little interest for a number of years in Malawi. During the course of PY3, BASICS has been able to develop a series of tools (GMP manual, counseling cards and M&E tools) and to work with the DHMT's of Phalombe (entire district) and Zomba (Bimbi catchment area) to strengthen GMP activities. The activity was supported by a baseline nutrition survey which will become the basis for a repeat survey during June 2010 to determine the impact of the program. Whilst the activity is in its relative infancy some benefits and lessons are becoming clearer: tools which have been developed are able to complement current MoH activities whilst it has been clearly shown from the Phalombe experience that implementation can proceed relatively smoothly and quickly and that the model has potential for national level replication.

9. MANAGEMENT ISSUES

There was a significant expansion of BASICS activities at the end of PY2 due to a contract amendment at the end of PY2. BASICS as a program transitioned from management through the BASICS Project to MSH. These two aspects created a number of challenges for local project management in Malawi.

A substantial number of staff needed to be recruited at the start of PY3. These included two District Coordinators (Balaka and Zomba), three Community Liaison Officers (Kasungu, Mangochi and Phalombe), a Malaria Assistant, a HIV Assistant, two Assistant Statisticians and a Grants Administrative Assistant. These staff were required to support implementation of the expanded set of activities. During Quarter 2, the recruitment of the malaria M&E Technical Advisor, who has been seconded to the NMCP, was finalized.

The transition of the local BASICS project to MSH management brought a set of challenges. Administratively, the approach to managing small grants changed which impacted on both the malaria and HIV small grant programs and brought about delays as grant manuals had to be changed and adapted to MSH requirements. A new support team had to be built for the BASICS project within MSH and this took substantial time and effort. Financial management and reporting systems changed which required additional effort from program staff to manage the change process.

Finally, within the MoH there has been a changing perspective on the role of TA's in the MoH. During PY3 two TA's were transitioned from the MoH. Dr Peggy Chibuye completed her contract in February 2010 and returned to Zambia. Dr Erik Schouten left the MoH at the end of September 2010 and transitioned to the BASICS program. A number of lessons were learned during the transition process for both TA's – the MoH is re-looking the roles of TA's within the ministry and the provision of TA needs to be re-engineered to reflect these changes and considerable communication is required between organizations providing TA and the MoH to ensure effective performance of TA's. Considerable time was required by the BASICS COP to facilitate the management of the transition of both TA's.

10. PLANNED ACTIVITIES FOR PY4

The table below represents the key focus activities to be implemented during PY4 of the BASICS program.

Program Area	Activities
Child Survival	<ul style="list-style-type: none"> • Consolidation of current CCM activities – management the supply and distribution of drugs is a priority • Expansion of CCM to select districts – Rumphu, Nkhata Bay and Chitipa • Support the implementation of new components of CCM – newborn sepsis and care; development of job aids • Support the IMCI Unit in strengthening IMCI service provision – training of supervisors; refresher training for providers • Consolidation of ETAT/PHI activities – especially quality performance initiatives and strengthening of data collection. • Documentation of program inputs and outcomes
Zinc	<ul style="list-style-type: none"> • Provision of support to facilitate final implementation – this may include some training, supervision during implementation, and technical assistance.
HIV/AIDS	<ul style="list-style-type: none"> • Support for the implementation of new WHO PMTCT and ART guidelines • The implementation of the PMTCT Effectiveness Survey • Support for the MoH to strengthen specimen transport systems • Increasing the number of children who access HTC and ART – the Baylor Pediatric Initiative will play a key role in this • Documentation of program inputs and outcomes
Nutrition	<ul style="list-style-type: none"> • Consolidation of the GMP and MFSG activities • Support the Nutrition Unit of the MoH to implement new WHO growth standards • Documentation of program inputs and outcomes
Malaria	<ul style="list-style-type: none"> • PY4 focus will dwell on monitoring and supporting the grantees to ensure we meet planned program targets. • Continued support for increased IPTp coverage • Support the NMCP to develop program manual for malaria coordinators at district level • Documentation of program inputs and outcomes
Other	<ul style="list-style-type: none"> • Support MoH in the definition and development of SWAp II through participation in Technical Working Groups and other areas where help required

ANNEXES

Annex 1: Progress towards achieving annual targets

Annex 2: Work plan progress for the period October 2009 to September 2010

Annex 3: Malaria Grants Program Grantees and Operating Districts

Annex 4: BASICS Quarterly Work plan, PY4 (October – December 2010)

Annex 1. Progress towards achieving annual targets

Indicator	2010 Target	Achievement				2010 Achievement
		Q1	Q2	Q3	Q4	
1. # HSA's trained in CCM	160	78	20	228 ^c 87 ^d 84 ^e	14	340 ^e 87 ^d 84 ^e
2. # Health Centers where ETAT is implemented	70	0	0	0 ^f	56	56
3. # of babies aged 0-28 days treated with cotrimoxazole or other antibiotics by doctors, nurses, clinical officers, medical assistants and HSAs	1,600	867	458	574	422	2,321
4. # of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	14,000	2,647	1,806	1,580	7,032	13,065
5. # of people trained in child health and nutrition through USG-supported health area programs (Child Survival and Nutrition) ^g	2,382	264	990	1,563	2727	5544 M= 3,571 F= 1,973
6. # of pregnant women with known HIV status (includes women who were tested for HIV and received their results) MSH Counselors	24,000	6,725	4,749	6,208	6,380	24,062
7. # of pregnant women with known HIV status (includes women who were tested for HIV and received their results) Indirect results	96,178	18,736	24,545	29,183	27,051	99,515
8. # of HIV-positive pregnant women assessed for ART eligibility through CD4 testing at USG-supported sites	4,326	987	314	1,217	1,157	3,675
9. # of HIV-positive pregnant women who received ARV's to reduce risk of mother-to-child transmission	12,258	2,461	2,474	2,042	2,972	9,949
a. By prophylactic regimen: single dose nevirapine only	6,576	1,539	1,539	1,229	1,316	5,623

^c HSAs mentored at nearest facility for a period of 1 week

^d HSA supervisors trained as mentors

^e Nurses and clinicians trained as mentors

^f Awaiting equipment

^g Trainings include PHI/ETAT, CCM Supervisors, LMIS & Drug Management, Mentorship for HSAs, Mentorship for Supervisors, Clinicians and nurses training in CTC and ENA for Community Facilitators Training

b. By prophylactic regimen: 2 ARVs	4,384	790	603	414	864	2,671
c. By prophylactic regimen: HAART	1,297	132	332	399	369	1,232
10. # of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (MSH employed counselors)	46,000	14,592	16,182	14,505	14,619	59,898
11. # of individuals who received T&C services for HIV and received their test results (Grants program)	70,000	0	2,269	9,945	12,677	24,891
12. # of individuals who received T&C services for HIV and received their test results (PiTC)	13,000	2,259	2,658	2,047	1,081	8,045
13. # of HIV-positive persons receiving cotrimoxazole prophylaxis (pregnant women)	9,000	2,840	2,749	2,455	2,263	10,307
14. # of HIV-positive persons receiving cotrimoxazole prophylaxis (children under 15)	6000	2,034	2603	2,979	2,635	10,251
15. # of children with advanced HIV infection <u>newly</u> enrolled on ART	3000	768	620	654	Est 680 Data not available for Q4 from MoH - av of last 3 quarters	2723
16. # of health care workers who successfully completed an in-service training program (HIV only)	2180	2579 ^h	169 ⁱ	362	173	3,283
17. Known positives at entry	3,600	385	1,003	1,555	1,431	4,374
a. # of new positives identified	20,400	1,687	2,494	3,175	3,032	10,388
18. # of children reached by USG-supported nutrition	5,300	1,703	1,830	1,992	1,274	6,799
19. # of children who received Vitamin A	1,200,000	636,366	0	603,608	0	1,239,974
20. # of people reached through community outreach activities that promote the correct and consistent use of ITNs (OP indicator)	5,400,000	60,853	376,181	1,088,000	2,038,103	3,563,137 M = 1,387,502 F = 2,175,635
21. # of people reached through community outreach that promote treatment of malaria according to national guide lines	5,400,000	60,853	376,181	1,088,000	2,038,103	3,563,137 M = 1,387,502 F = 2,175,635

^h Included 2002 trained in new ANC register

ⁱ Correctly posted ANC register training in quarter 1

(OP and task order indicator)						
22. # of people trained in malaria treatment or prevention with USG funds (OP and task order indicator)	20,800	2,109	1,674 938M 736 F	4,055 2,351 M 1,704 F	10,282	18,120
23. # children under 5 treated for fever at village clinics	22,400	12,179	45,658	56,323	45,814	159,974
24. Train TOTs on the use of materials adopted from the previous ACCESS project	56	0	0	0	0	0
25. # of health personnel trained in IPTp	1,230	0	54 ^j	0	992	1,046
28. % of pregnant women attending ANC who receive a first dose of IPT1 under direct observation	90%	0	0 ^k	78.9%	0	78.9%
29. % of pregnant women attending antenatal care who receive a second dose on IPT2 under direct observation	80%	0	0 ^l	58.2%	0	58.2%
30. # staff trained on new ANC register	1,000	0	1,000	0	0	1,000

^j Coordinators oriented on supervision checklist

^k Data not yet captured

^l Data not yet captured

Annex 2: Work plan progress for the period October 2009 to September 2010

Output	Activities	Expected Outcomes	Achievements
Child Health			
1	1. Improved Prevention and Management of Childhood Illness		
1.1	Strengthen Implementation of ACSD		
1.1a	Support ACSD TWG (district level) to meet twice per annum	Capacity of TWGs to support ACSD implementation strengthened	Two DTWG meetings involving key district level stakeholders were supported in each of the districts; Chikwawa, Kasungu and Phalombe and the following had one meeting each; Balaka, Nsanje, Salima, Mangochi and Zomba
1.1b	Train 160 HSAs in CCM of childhood conditions (Chikwawa, Mangochi, Salima, Zomba)	HSAs prepared to implement ACSD - CCM	112 HSAs Trained in CCM in 5 districts; Chikwawa(19), Salima (27), Zomba(20) Kasungu(22) and Rumphi (24)
1.1c	Conduct annual meeting with DEC's to discuss child health and nutrition issues	40 DEC members/district updated on child health and nutrition issues	Done in Kasungu, Mangochi, Balaka and Salima.
1.1d	Orient 160 H/centre in charges where new village clinics set up	Health Centre in Charges understand rationale for ACSD as well as support they need to provide for implementation	168 health centre in-charges and supervisors were orientated on village clinic and drug logistics in all the districts including Nkhatabay. (Kasungu 11, Salima 17, Mangochi 19, Nsanje 17, Chikwawa 17, Phalombe 18, Zomba 43, Balaka 16 and Nkhata-bay 10)
1.1e	Orient 160 H/Centre village clinic committees	Village Clinic Committees understand rationale for the Village clinic and provide necessary support	Oriented 224 Village health committees on Community IMCI in Mangochi (52), Zomba (20), Salima (43), Chikwawa (56), Phalombe (6) and Balaka (73).
1.1h	Conduct quarterly CCM review meetings with HSAs	HSAs will be able to identify and learn lessons from counterparts	Conducted CCM quarterly review meetings in all districts.
1.1i	Train cohort of supervisors and mentors on CCM.	Core group of supervisors (32) trained in each district to support ACSD implementation	86 CCM supervisors and 86 mentors from BASICS supported districts and 10 from Nkhatabay were trained. 84 nurses and clinicians from BASICS supported districts and 4 from other districts were also mentored.
1.1j	Train 340 HC staff and HSA's on drug management at village clinics	Capacity of MOH to use IMCI checklist strengthened	588 health staff, HSA's and DHMT members trained in LMIS & Drug management. (Kasungu 112, Salima 52, Mangochi 44,

Output	Activities	Expected Outcomes	Achievements
			Chikwawa 58, Phalombe 50, Zomba 91, Nsanje 123 and Balaka 58)
1.1k	Implement week long mentorship program for HSAs providing CCM at their nearest Health Centers	HSAs increase skill level in CCM	Mentorship of 326 HSAs done.(Zomba 15, Phalombe 40, Chikwawa 78, Nsanje 25, Salima 54 and Kasungu 54)
1.1l	Printing and distribution of Chart Booklets for Facility IMCI Trainings	Chart Booklets for Clinical IMCI printed and Distributed	1500 copies printed and sent to IMCI Unit
1.2	Strengthen coordination of ACSD implementation at zonal and national levels		
1.2a	Provide support for one Annual CCM review - implemented by IMCI Unit	Provide an opportunity for experience sharing on CCM at national level, review performance in past year and map the best way forward	Patronized a national annual CCM review meeting in Mangochi
1.2b	Procurement of communication system / equipment for SMS project	Communication between Village clinics, District IMCI Coordinators and national IMCI office improved on data as well as LMIS and referral	8 computers, 500 mobile phones and 500 solar charges procured. 237 phones distributed.
1.2c	Support MoH to conduct follow up and supervision of staff trained in facility- based IMCI. Make sure that the IMCI supervisory tool is used and capture data.	2 rounds of IMCI supervision conducted in each district using standard IMCI checklist	IMCI supervision was conducted in Balaka, Nsanje, Chikwawa, Salima and Kasungu, Zomba and Mangochi.
1.2d	Participate in National IMCI Secretariat/TWG activities in collaboration with other partners	TA provided to MoH and other stakeholders	Attended 1 meeting in Salima
1.2e	Conduct analysis of DIP's for 8 districts supported by BASICS with intention of determining range of child health budgets and funding allocated to child health activities	Analysis describes distribution of activities and funding in support of child health	Done with support of consultant and a report is been produced. Findings to be disseminated to all concerned districts.
1.3	M&E System Strengthened for ACSD		
1.3a	Provide technical support for the implementation of CCM M&E system used to track ACSD activities	Ongoing support provided to IMCI Unit to support implementation of CCM	Done alongside LMIS (588) health staff trained in Mangochi, Chikwawa, Balaka, Kasungu, Nsanje, Salima and Phalombe
1.3b	Print and distribute of village clinic registers	Accurate data recorded for M&E system	Printed 3000 copies
1.3c	Train 340 HSAs (20/district) to capture ACSD data	HSAs develop appropriate skills in recording and sending data for M&E	Done alongside LMIS (588 HSAs) ; 303 HSAs trained in SMS Frontline in Nsanje, Salima, Zomba, Balaka and Mangochi

Output	Activities	Expected Outcomes	Achievements
		purposes	
1.4	Strengthen referrals between village clinics and health centers		
1.4a	Print and distribute (ACSD) job aids to village clinics	Job aids printed and distributed to village clinics	Discussing. Not yet done- working on reviewing the materials with the IMCI Unit Still pending
1.5	Expansion of pediatric hospital initiative		
1.5a	Support development of ETAT/PHI Modules.	WHO Handbook converted into a series of modules for in-service training purposes	Bulk of work completed by Prof. Liz Molyneux
1.5b	Define and develop Peer Review Audit, Death Audit and data collection process	Peer review audit and Death Audit guidelines developed and ready for use	Completed
1.5c	Conduct quarterly Peer Review Audits	2 monthly - 108 audits per year in 18 facilities	Done once per quarter in 22 facilities in the 8 districts
1.5d	Train district teams to conduct Death Audits	Staff in all the 18 health facilities capable of conducting Death Audits	Over 200 staff trained in all 9 districts including Nkhotakota.
1.5e	Support district level ETAT review meetings	Provide an opportunity for districts to share experiences and challenges faced during ETAT implementation	Conducted ETAT review meetings in all BASICS supported districts and Nkhotakota.
1.5f	Print ETAT charts	Health facilities provided with essential job aids	Printed and distributed 250 sets
1.5g	Procure and distribute essential child health equipment to 18 facilities	Facilities provided with essential equipment such as Oxygen concentrators, baumonometers, etc	100 Oxygen concentrators with nasal prongs and oxygen analyzers procured
1.5h	Support National Level meetings for the dissemination of ETAT baseline assessment	ETAT Baseline Assessment findings disseminated	Completed
1.6	Health Center ETAT Initiative Implemented		
1.6a	Define emergency care package and develop training package for health centers	PI tools finalized and field-tested	This idea was dropped and instead current ETAT approach to be used.
1.6b	Adapt ETAT training manual - workshop 5 days, 15 people - national	ETAT training manual adapted and ready for use during ETAT trainings for health centre level staff	Decision made to use current ETAT curriculum
1.6c	Develop and procure relevant job aids/ wall charts	Job aids printed and distributed for ETAT services	Done and distributed in all hospitals.
1.6d	Conduct ETAT training	ETAT implemented at health centers	319 facility staff trained from all 8 districts and Nkhatabay. Mangochi trained 90, Nsanje 25, Chikwawa 79, Kasungu 29,

Output	Activities	Expected Outcomes	Achievements
			Phalombe 22, Salima 12, Zomba 25, Balaka 24 and Nkhatabay 13.
1.6e	Procure and distribute emergency child health equipment	ETAT implemented at health centers	In progress –Procurement list to be sent to USAID for approval

Output	Activities	Expected Outcomes	Achievements
ZINC			
Support introduction of new diarrheal treatment using low osmolarity ORS and ZINC			
1	Strengthen coordination of implementation of the new diarrheal treatment		
1.1a	Support Zinc TWG quarterly meetings	TWG collaboration strengthened	Done in Q4, to be done again in the next quarter
1.1b	Support a nalidixic acid study for diarrhea	CMS guided on use/procurement of nalidixic acid	Not done, to be done by MoH
1.1c	Recruit pharmaceutical TA to help manage the zinc procurement process	BASICS will obtain necessary TA through SPS	Done, supported by SPS
2	Develop a communication plan on the new diarrheal treatment		
2.1a	Support development of a trainer's guide to the health workers training manual on new diarrheal treatment using zinc	Trainer's guide developed	Done
2.1b	Pretest the orientation manual and the IEC materials	Orientation manual and IEC materials made user friendly	Done
2.1c	Print health workers orientation manual and trainers' guide on the new diarrheal treatment	Orientation manual and trainer's guide available for use by the service providers	Done, tools available
2.1d	Print communication tools	Communication tools available for use	Done, tools available
2.1e	Distribute communication materials	Communication tools available for use at the lowest level	Not done, pending procurement of zinc
2.1f	Press release on the new diarrheal treatment	People sensitized on the new diarrheal treatment	Not done, pending procurement of zinc
2.1g	Support the Ministers launch of the new diarrheal treatment	People sensitized on the new diarrheal treatment	Not done, pending procurement of zinc
2.1h	Support district IEC campaigns on the new diarrheal treatment	Communities sensitized on new diarrheal treatment	Not done, pending procurement of zinc
3	Orient health workers on the new diarrheal treatment		

Output	Activities	Expected Outcomes	Achievements
3.1a	Support orientation of DHMT on new diarrheal treatment	DHMT members aware of the new diarrheal treatment	Completed
3.1b	Conduct a master trainers' orientation	Trainers prepared to conduct TOTs	Done
3.1c	Support training of trainers 2 per district	District trainers prepared to train health workers	Done in Q4
3.1d	Support training of health workers at district level	Health workers equipped to use the new diarrheal treatment	Done
4	Support M&E for the new diarrheal treatment		
4.1a	Conduct national quarterly supervision	Implementation of the new diarrheal treatment monitored for improvement	Not done. Zinc not yet available in the country
4.1b	Review program implementation at district level (sample reports from 3 health facilities per district)	National program implementation reviewed	Pending
4.1c	Support Zinc quantification review	Use of zinc reviewed for direction on quantities to be procured	Pending

Output	Activities	Expected Outcomes	Achievements
HIV/AIDS			
Strengthen the Ministry of Health of Malawi's capacity in HIV/AIDS and PMTCT Technical Areas			
1	Budget Code 01 - MTCT		
1.1	Strengthen PMTCT including Mother Infant Pair (MIP) follow up		
1.1a	Orient health facility staff on MIP follow up and infant feeding counseling	Health care providers oriented	Conducted in Phalombe Q1 and Chikwawa Q2
1.1b	Conduct biannual PMTCT review meetings to promote PMTCT and MIP follow up	Biannual review meetings conducted	Done in all districts, activity spread over the entire year
1.1c	Introduce mother infant pair follow up register in health facilities	Health care providers able to fill MIP registers	Pending since Q2; waiting for final guidance from HIV Unit
1.1d	Print and distribute MIP registers	MIP registers printed and distributed	Pending since Q2; waiting for final guidance from HIV Unit
1.1e	Print and distribute Mother Infant Pair (MIP) master cards	MIP mater cards printed and distributed	Not done
1.1f	Train 160 health care providers in EID, combination regimen and new ANC registers	HW's able to implement EID and combination regimen therapy	Not done - resources diverted for implementation of ANC and maternity registers.

Output	Activities	Expected Outcomes	Achievements
	(to complement activity initiated by the MoH and UNICEF)		
1.1g	Support district hospitals in transportation of blood samples for CD4 count	Blood sample transportation system in place and functional	Not done, awaiting final guidance from MoH
1.1h	Identify and orient blood sample transporters	Blood sample transporter orientation conducted	Not done, awaiting final guidance from MoH
1.1i	Procure small cooler boxes and specimen container for easy transportation of specimen	Cooler boxes and specimen containers procured	Not done, awaiting final guidance from MoH
1.1j	Procure small boxes to slot in CD4 lab results for respective health centers	Boxes procured	Not done, awaiting final guidance from MoH
1.1k	Procure hard cover registers for documentation of delivery and collection of specimen and results	Hardcover registered procured	Not done, awaiting final guidance from MoH
1.2	Strengthen capacity of MFSG to provide PMTCT counseling		
1.2a	Develop community-level capacity for PMTCT counseling through training of core group of 60 MFSG facilitators	MFSG facilitators build capacity to counsel HIV affected mothers and families on PMTCT and related issues	Done in Zomba and Phalombe
1.3	Strengthen zonal level PMTCT mentorship program		
1.3a	Conduct quarterly zonal level PMTCT mentorship and supervision activities (in collaboration with MoH, EGPAF, Dignitas and others)	District PMTCT coordinators meet quarterly to review PMTCT implementation ; supervision activities conducted	Zonal meetings conducted in all the three regions by PMTCT officers from MoH HIV department
1.4	Explore PMTCT effectiveness estimation		
1.4a	Design intervention approach and develop protocols	Document will outline approach and implementation steps	Process started in Q4, concept paper was developed
1.4b	Conduct feasibility study at select number of pilot sites	Feasibility study will define major issues and problems in preparation for implementation	Pending since Q2; implementation due PY4
2	Budget Code 12 - HVTC		
2.1	Expand HTC services		
2.1a	Conduct HTC outreach in Under fives mobile clinics	Outreach visits conducted once per month in Phalombe	This is an ongoing activity, done in all BASICS districts
2.1b	Conduct meetings with BASICS HTC service providers and MOH HTC coordinators	Meetings conducted	Done in Q2
2.1c	Conduct bi-annual HTC Counselors meetings	Counselors at district level updated on	Done in all 8 districts in Q2

Output	Activities	Expected Outcomes	Achievements
	(240 counselors)	key aspects of HIV	
2.1d	Support Village to Village HTC outreach in Salima (TA Khombedza)	Number of households targeted	Done in Q1 - Q4
2.2	Identify one additional TA for the implementation of village to village HTC		
2.2a	Conduct meeting with community leaders in Salima	Number of community leaders attended the meeting	Done Q2
2.2b	Conduct focus group discussion	Two FGDs conducted	Done in Q2 and Q3
2.2c	Orient local drama and band groups	Local drama and band groups oriented.	Done in Q2 and Q4
2.2d	Conduct sensitization campaign	In four areas in the targeted T/A	Done in Q3 and Q4 in Salima
2.2e	Procure tents, testing tables and chairs	Tents and chairs procured	Done
2.2f	Orientation of data collectors	Data collectors oriented	Done
2.2g	Conduct village to village HTC evaluation	Evaluation conducted and report submitted.	Done
2.2h	Analysis of the evaluation	Analysis conducted	Done
2.2i	Monitor implementation of Village to Village HTC in Salima	Village to Village HTC regularly monitored	Done in Q3, in progress
2.3	Monitor implementation of small grant activity for HTC		
2.3a	Conduct NGO supervisory visits	Supervisory visits conducted	Done in Q2 and Q4
2.3b	Conduct NGO HTC review meetings	Review meetings conducted	Done in Q2 and Q4
3	Budget Code 14 - PDCS		
3.1	Orient HCW's on CPT guidelines		
3.1a	Orient 400 health care workers in CPT guidelines	HCW's oriented to national CPT guidelines	Done Q2 - Q4
3.1b	Print CPT cards	CPT Cards printed	Done, 10,000 cards printed and distributed
3.1c	Print CPT registers	CPT registers produced for use at facility level	Done, 50 registers
4	Budget Code 13 - PDTX		
4.1	Introduce pediatric HIV orientation manual for non-providers at ART sites where pediatric ART is provided		
4.1a	Finalize pediatric HIV Orientation manual for non-ART providers	Pediatric HIV orientation manual reviewed.	Not done, Baylor pediatric HIV has been consulted to finalize
4.1b	Print copies of pediatric HIV orientation manual	Orientation manuals for service providers produced	Not done, awaiting for final copy of manual
4.1c	Train 16 TOT in pediatric HIV	TOTs trained in pediatric HIV orientation manual	Done in Q2
4.1d	Orient 160 health care providers in pediatric	Health care providers oriented in	Not done, pending implementation of Baylor contract;

Output	Activities	Expected Outcomes	Achievements
	HIV	pediatric HIV orientation module	though clinicians and nurses were oriented in Pediatric HTC Guidelines
4.2	Introduce pediatric ART mentorship scheme in collaboration with Baylor		
4.2a	Mentor 140 clinicians and nurses working in pediatric wards, U5 clinic, and NRU in Provider initiated HTC	Clinicians and nurses mentored in PIHTC	Pending; Baylor has started initiating the process in Kasungu and Phalombe during October 2010
4.2b	Support Baylor team to provide TA and mentoring support to Kasungu, Phalombe, Salima, Balaka, Chikwawa	Baylor conducts monthly visits to KA, PE; Quarterly visits to other districts	Done in Q4
4.3	Initiate Provider initiated HIV testing and Counseling in Pediatric wards and under 5 clinics at district hospitals in conjunction with Baylor mentorship scheme		
4.3a	Train Health Care Providers in PiTC	PiTC provided in pediatric wards	Not done
4.3b	Attach health care providers for the mentoring program to ART provider sites	PiTC provided in pediatric wards	Done in Q2 and Q3
4.3c	Recruit and deploy patient experts to motivate clients on the benefits of HTC in children	Patient experts able to motivate clients for HTC	Pushed to next quarter
4.3d	Train patient experts to motivate clients on the benefits of HTC in children	Patient experts able to motivate clients for HTC	Pushed to next quarter
4.3e	Print and distribute Baylor pediatric HIV poster	Pediatric HIV poster printed and distributed	Not done awaiting contract with Baylor
4.4	Support refresher training in ART in collaboration with the MoH		
4.4a	Support the MoH to provide refresher training for 240 HW's in new ART guidelines	HW's implement new guidelines including presumptive therapy for children	Done in Q1

Output	Activities	Expected Outcomes	Achievements
CTC CMAM			
1	Provide ongoing support for community management of acute malnutrition		
1.1	Maintain CTC/CMAM in Balaka, Chikwawa, Kasungu, Mangochi, Phalombe, and Zomba		
1.1a	Train 50 health workers from 3 Chikwawa and 5 Kasungu facilities, to further roll out CTC/CMAM services	Increased access to early treatment of malnutrition in Chikwawa & Kasungu	Done. Training in Kasungu delivered with UNICEF funding as part of partner collaboration
1.1b	Train 200 volunteers to support case community mobilization and case identification in new catchment areas	Communities involved in identifying and monitoring children with malnutrition	Done in Chikwawa and Kasungu. Training in Kasungu delivered with UNICEF funding as part of partner collaboration
1.1c	Train 60 district health staff in Monitoring and Evaluation (team of supervisors who can review M&E at facility level)	Improved data management, data quality assurance, supervision	Done, completed in Q3
1.1d	Train 180 health facility staff in Monitoring and Evaluation	Improved data management and utilization	Done, completed in Q3
1.1e	Support Targeted Nutrition Program (TNP) Committees in building information banks for strategizing linkages and referrals in 7 districts (Balaka, Chikwawa, Kasungu, Mangochi, Phalombe, Salima, Zomba)	Mapping of key food and nutrition interventions implemented through all stakeholders in districts maximizes targeting of nutrition resources	Local Consultant recruited and information on TNP collected from 4 districts and from national nutrition officers
1.1f	Support holding of quarterly meetings for TNP committees in 7 districts (Balaka, Chikwawa, Kasungu, Mangochi, Phalombe, Salima, Zomba)	District linkages in nutrition planning, implementation and referrals enhanced. Local Government nutrition officers actively engaged to support the regularization of TNP meetings.	Done in 5 districts
1.1g	Document District TNP proceedings and disseminate to higher committees	National food security & nutrition committees obtain additional district-specific information	Draft reported initiated for finalization next quarter
1.1h	Support implementation of child health days with inclusion of nutrition displays	Nutrition screening and education given on child health days. Local nutrition situation illustrated	Done in all districts
1.1i	Facilitate monitoring and supervision of the CTC program.	Regular supervision of service sites (OTP) conducted	Done in all districts in Q1, 5 districts in Q2, 3 districts in Q3, 5 districts in Q4

Output	Activities	Expected Outcomes	Achievements
ENA GMP			
1	Strengthen Community Based Growth Monitoring Promotion (GMP) by HSAs and Facilitators at village outreach clinics and home visits		
1.1	Prepare for GMP activity - design of training manual, counseling cards, etc		
1.1a	Half day debriefing meeting of 60 MoH stakeholders on the finding of Community based ENA progress review in 31 villages for Phalombe and Zomba through M/FSGs	Consensus for the way forward built with MoH and other Stakeholders	debriefing with 33 main National stakeholders - OPC, MOH & 31 villages for Zomba & Phalombe held
1.1b	Draft Community Based (CB) Growth Monitoring Promotion (GMP) training manual,	CB GMP manual drafted	Drafted
1.1c	Draft CB Growth Monitoring Promotion Trainers manual	GMP Trainers manual drafted	GPM manual drafted. Inputs made from OPC, MOH ,NGO WALA and USAID
1.1d	Draft GMP counseling cards	GMP counseling cards drafted	Cards drafted and translated in Chichewa and edited as advised by MOH
1.1e	Consolidate finalized drafts of training and trainer's manual and counseling cards	3 sets of training materials consolidated.	Done. Recommendations from MoH incorporated and cards pre-tested in Zomba and Phalombe.
1.1f	One day meeting at central office Lilongwe with key stake holders to share information on CBGMP training, trainer's manuals and counseling card	Consensus built with MoH and other Stakeholders on 3 sets of training materials	Done. Shared with OPC, MOH and WALA & USAID on GMP and counseling cards inputs.
1.1g	Translate Community Based Growth monitoring (CBGMP) training and counseling cards into local language (Chichewa)	Training and Trainers materials translated into Chichewa	Translated and harmonized with counseling cards.
1.1h	Print 1,200 training manuals and counseling cards	1,200 training manuals printed	1,000 manuals printed.
1.1i	Print 200 training of trainer's manuals.	Training materials translated and printed	Same 1000 manuals used as TOT manuals.
1.1j	Print 400 Exclusive breastfeeding counseling cards.	400 breastfeeding cards printed	Edited and printed as a flip for breastfeeding and complementary feeding. 1,000 copies made.
1.1k	Print 400 complementary feeding counseling cards for 6 - 9	400 comp/feeding 6-9 months printed	Edited and printed as a flip for breastfeeding and complementary feeding. 1,000 copies made.
1.1l	Print 400 complementary counseling cards	400 comp/feeding 9 -12 months	1000 copies printed and distributed

Output	Activities	Expected Outcomes	Achievements
	for 9 -12 months	printed	
1.1m	Print 400 counseling cards for sick child	400 counseling cards for sick child printed	Edited and printed as a flip for breastfeeding and complementary feeding. 1,000 copies made.
1.1n	Conduct 5 days training of trainers for 12 health workers involved CBGMP (12 HSAs (8 for Phalombe and 4 for Zomba, 4 DHO professional staff (2 for Phalombe & 2 for Zomba) and 4 MoH National level staff)	20 DHO staff (12 HSAs & 8 professional staff trained as trainers,	4 professional staff and 19 HSAs trained
1.1o	Procure scales, Health passports design job aids, stationery (including 450 hard cover exercise books and 30 chalk boards), bags and umbrellas	scales, Job aids, bags and umbrellas provided to facilitators/facilitators.	Scales, health passports design job aids, stationery, bags and umbrellas procured and distributed in Phalombe and Zomba.
1.1p	Design and implement monitoring system for CBGMP	Routine reporting system developed to track GPM activities	Done and rolled out.
1.1q	Procure and distribute complementary feeding demonstration items and simple materials for renovations of GMP shelters for rainy sessions .	Comp feeding demo items & simple shelters for GMP available	Items procured.
1.1r	Review progress of CBGMP results for the way forward	Findings used for way forward	Done. Agreed actions being taken.
1.2	Implement GMP activity in Phalombe		
1.2a	Phalombe: Conduct half day debriefing meeting on findings of ENA program review briefing on CBGMP for 20 DHMT	20 DHMT members debriefed	Done and 20 DHMT members debriefed.
1.2b	Phalombe: Conduct debriefing meeting on findings of ENA program review for the community in 19 villages (19 village heads, 2 group village heads and 1 traditional authority.	Communities with 22 village Head authorities debriefed	22 village heads briefed
1.2c	Phalombe: Conduct 1 day debriefing meeting on findings of ENA program review for 198 facilitators and plan for the quarter activities on CBGMP for 19 M/FSG villages	198 facilitators debriefed and draft quarterly plans made for CBGMP	198 facilitators debriefed
1.2d	Phalombe: Conduct community mobilization on CBGMP in 19 villages	19 villages sensitized in CBGMP	19 villages sensitized.
1.2e	Phalombe: Conduct 2 days of preparations	20 trainers share responsibilities &	Preparation for GMP with 24 health workers done.

Output	Activities	Expected Outcomes	Achievements
	on CBGMP trainings with 24 trainers/ district	logistics put in place for training	
1.2f	Phalombe: Conduct CBGMP 3 days training for 229 promoters (198 M/FSGFs and 31 HSAs) in 3 teams of 20-22 participants per team	229 promoters (198 M/FSGFs and 31 HSAs for 31 villages trained in CBGMP	198 facilitators and 31 HSAs trained in GMP
1.2g	Phalombe: Conduct CBGMP 5 days training for 204 volunteers in 7 health centers with GMP sites in 3 teams of 20 participants per team	204 GMP volunteer promoters trained in CBGMP	204 volunteers trained
1.2h	Phalombe: 2 days mentorship of 433 Growth promoters (198 facilitators, 31 HSAs and 204 volunteers)	433 growth promoters competently providing GMP as per set standard	Not done. Moved to quarter 1 of year 4.
1.2i	Phalombe: conduct community mobilization on CBGMP in 84 remaining outreach sites in the catchment villages.		Not done.
1.2j	Phalombe: Roll out 5 days training of CBGMP to the remaining 280 volunteers in the remain 84 outreach sites	246 volunteers cover the district with CBGMP activities	246 and 39 additional volunteers (285) trained.
1.3	Implement GMP activity in Zomba		
1.3a	Zomba: Conduct half day debriefing meeting on findings of ENA program review and brief on the CBGMP to 20 DHMT members	20 DHO staff (12 HSAs & 8 professional staff trained as trainers,	20 DHO staff debriefed
1.3b	Zomba: Conduct debriefing meeting on findings of ENA program review for the community in 12 villages (12 village heads, 1 group village heads and 1 traditional authority).	Communities with 14 village Head authorities debriefed	14 village heads -12 village head,1 Group village head and a Traditional Authority debriefed
1.3c	Zomba: Conduct 1 day debriefing meeting on findings of ENA program review for 98 facilitators and plan for the quarter activities on CBGMP in 12 M/FSG villages	98 facilitators debriefed and draft quarterly plans made for CBGMP	98 facilitators debriefed and quarterly plans made
1.3d	Zomba: Conduct community mobilization on CBGMP in 12 M/FSG villages Bimbi catchment area	Communities sensitized on CBGMP	Completed
1.3e	Zomba: Conduct 2 days of preparation for CBGMP training with 12 trainers	12 trainers share responsibilities & logistics put in place for training	12 trainers shared responsibilities and logistics put in place.

Output	Activities	Expected Outcomes	Achievements
1.3f	Zomba: Conduct CBGMP 3 days training for 114 promoters (98 M/FSGFs and 10 HSAs 4 Health center and 2 DHO staff) in 3 teams of 20- participants per team	108 promoters (98 M/FSGFs and 10 HSAs for 12 villages trained in CBGMP	114 (98 facilitators, 10 HSAs and 6 DHO staff) trained.
1.3g	Zomba: Conduct CBGMP 5 days training for 26 volunteers, 10 HSAs, 2 Health center staff and 3 DHO staff in 13 GMP sites in 2 teams of 20 participants per team.	40 participants (26 volunteers and 14 health workers trained in CBGMP	115 instead of 26 volunteers and 6 DHO staff trained in GMP.
1.3f	Zomba. 2 days mentorship of 155 Growth promoters (98 M/FSGFs, facilitators, 20, 10 DHO staff 26 volunteers)	155 volunteers and health staff provide standard GMP services	22 health workers mentored.

Output	Activities	Expected Outcomes	Achievements
Malaria Grants			
1	Award grants to NGOs		
1.1a	Extend cycle 1 grants for 12 months (cycle 3 in frequency of awards)	4 NGOs to work in 4 districts are awarded grants-1.2 million people reached with malaria messages	Contracts with the 4 NGOs signed SR, DCT, RC COOPI
1.1b	Solicit expressions of interest from NGOs for cycle 4 grants award	Concept papers received	Awarded 4 Grants
1.1c	Review of concept papers for cycle 4 grants award	Prospective grantees identified for pre-award assessment	Concept papers reviewed. 9 NGOs identified for pre-award assessment Completed
1.1d	Conduct pre-award assessment for cycle 4 grants	5 NGOs selected for grant award	Done. 9 NGOs involved of which 7 who will implement activities in 12 districts were identified as successful
1.1e	Award cycle 4 grants	7 NGOs to work in 12 districts are awarded grants-3 million people reached with malaria messages	Awarded 7 grants to work in seven districts. Message dissemination just started
1.1f	Extend cycle 2 grants for 12 months (cycle 5 in frequency of awards)	4 NGOs to work in 4 districts are awarded grants-1.2 million people reached with malaria messages	Contracts signed in December. Implementation started in Jan
1.1g	Extend cycle 4 grants for 9 months (cycle 6 in frequency of awards)	5 NGOs to work in 10 districts are awarded grants-3 million people reached with malaria messages	Cycle 4 grants just awarded. No extension planned for this cycle due to time limitations

Output	Activities	Expected Outcomes	Achievements
2	Capacity building of grantees		
2.1a	Conduct post-award orientation of extended cycle 1 grantees	4 NGOs equipped with technical and financial skills to effectively carry out project implementation	Done. 4 grantees oriented
2.1b	Conduct proposal development workshop for cycle 4 grants	5 prospective grantee NGOs equipped with technical know-how of proposal development	Done. 5 NGOs oriented
2.1c	Conduct quarterly review meetings	13 grantee NGOs review progress with their DHMTs. NGOs, DHMTs & MSH undergo lessons learning & capacity building	Done once a quarter with all running grantees
2.1d	Conduct supportive supervision to grantees	13 grantees visited for checking/feedback on workplans, quality of work & financial compliance	Done all 18 grantees
2.1e	Conduct capacity building for grantee accountants	First session for 8 grantees from cycle 1 extended & cycle 2. Second session for cycle 4 grantees. Grantees equipped with USG financial & procurement procedures & requirements	Done, integrated with supervision
2.1f	Conduct post-award orientation of cycle 4 grantees	5 NGOs equipped with technical and financial skills to effectively carry out project implementation	Done with 4 grantees. One grantee dropped
2.1g	Conduct proposal development workshop for extended cycle 2 grants (cycle 5 in frequency of awards)	4 NGOs equipped with technical and analytical skills to conduct situation analyses in their districts of operation in readiness for the extension of the projects	Done with 4 grantee
2.1h	Conduct proposal development workshop for extended cycle 4 grants (cycle 6 in frequency of awards)	5 NGOs equipped with technical and analytical skills to conduct situation analyses in their districts of operation in readiness for the extension of the projects	Reviewed plan to recruit cycle 4 grants. No extension for cycle 4 grants due to time limitation
3	Development and provision of IEC materials		
3.1a	Develop, produce and distribute malaria visual aids for community health workers	Reference flipchart developed. 7,500 copies produced and distributed to all grantees	Developed 3000 copies and distributed all of them

Output	Activities	Expected Outcomes	Achievements
3.1b	Produce and distribute malaria IEC materials	60,000 flyers produced and distributed	Mass produced 760, 000 copies. Distribution in progress
4	Program documentation		
4.1a	Document success stories	6 success stories (one per quarter) documented and published	5 Success stories documented. 2 Shared with USAID.

Output	Activities	Expected Outcomes	Achievements
Malaria - IPT			
1	Support malaria supervision activities implemented by SPS		
1.1a	Collaborate with SPS to expand the number of facilities visited during quarterly supervisions	Number of facilities supervised during the routine quarterly supervision program doubled	Not done, NMCP tied up in other activities
1.1b	Collaborate with SPS to conduct quarterly zonal level review meetings	Co-facilitate quarterly review process with NMCP and SPS	Not done, NMCP tied up in other activities
2	Conduct baseline survey on the status of IPTp implementation at facility level		
2.1a	Conduct baseline survey on the status of IPTp at facility level	Survey provides update on status of IPTp implementation in 28 districts	Incorporated in nationwide supervision process
3	Initiate high level discussion on ways to increase coverage of second dose of IPTp		
3.1a	Hold one day seminar to explore ways to increase coverage	Stakeholders review and discuss approaches which may increase coverage	Done during malaria program review.
4	Strengthen capacity of malaria coordinators to conduct integrated malaria supervision		
4.1a	Develop and refine standardized malaria supervision tools	Integrated malaria supervision tool developed	Done, supervision in progress
4.1b	Conduct orientation meeting with malaria coordinators on the use of supervision tools	Malaria coordinators prepared for supervision activities using new tool	Done , supervision in progress
4.1c	Support supervisors to conduct quarterly supervision visits at district level	Facilities are supervised on quarterly basis	Supervision done
5	Orient ANC/Maternity staff to use of ACCESS tools and new ANC materials		
5.1a	Conduct TOT training to orient trainers to ACCESS materials	TOT prepared to conduct	Done. 58 trained
5.1b	Conduct orientation meetings with nurse/midwives on the use of tools	ACCESS tools are actively used by HW's to increase IPTp coverage	Done. 992 Oriented

Output	Activities	Expected Outcomes	Achievements
	developed by ACCESS		
5.1c	Orient staff on ANC and maternity register	Maternity registered provides accurate data required for measurement of IPTp coverage	Concluded in Quarter 1

Annex 3: Malaria Grants Program Grantees and Operating Districts

Operational District	Grantee	Cycle
Balaka	Sue Ryder Foundation International in Malawi	Cycle 2 & 2 extension
Blantyre	Development Aid from People to People	Cycle 3
Blantyre Urban	St John Ambulance	Cycle 1
Chikhwawa	Anglican Diocese of Southern Malawi	Cycle 3
Chiradzulu	Development Communication Trust	Cycle 2 & 2 extension
Chitipa	Church of Central African Presbyterian –Synod of Livingstonia	Cycle 1 & 1 Extension
Dedza	Evangelical Lutheran development Services	Cycle 3
Dowa	Malawi Red Cross Society	Cycle 1 & 1 Extension
Karonga	Evangelical Lutheran development Services	Cycle 3
Kasungu	Malawi Red Cross Society	Cycle 2 & 2 extension
Likoma	Canadian physician Aid and Relief	Cycle 3
Lilongwe	Cooperazione Internazionale	Cycle 3
Machinga	Emmanuel International	Cycle 4
Mangochi	Development Communication Trust	Cycle 4
Mulanje	Project Hope Malawi	Cycle 1 & 1 Extension
Mwanza	Nanzikambe Arts Organization	Cycle 3
Mzimba South	Embangweni Mission Hospital	Cycle 4
Neno	Nanzikambe Arts Organization	Cycle 3
Nkhatabay	Canadian physician Aid and Relief	Cycle 3
Nkhotakota	World Medical Fund	Cycle 1
Nsanje	Anglican Diocese of Southern Malawi	Cycle 3
Ntchisi	Circle for Integrated Community Development	Cycle 3
Phalombe	Project Hope Malawi	Cycle 1
Rumphu	Church of Central African Presbyterian –Synod of Livingstonia	Cycle 4
Salima	Cooperazione Internazionale	Cycle 2 & 2 extension
Thyolo	Development Aid from People to People	Cycle 3
Zomba	Development Aid from People to People	Cycle 1 & 1 Extension

Annex 4: BASICS Quarterly Work plan, PY4 (October – December 2010)

	Program	Component	Activity	Month(tick)		
				Oct	Nov	Dec
1	Child Health	CCM	Improved Prevention and management Of Childhood Illness			
			Strengthen Implementation of ACSD			
			Procurement and distribution of Drug boxes	✓		
			Procurement and distribution of ORT kits		✓	
			RDT testing for CCM		✓	
			Facility IMCI Supervisors training		✓	
			Refresher training for CCM Extension Worker Trainers		✓	
			Health centre in-charges orientation		✓	
			Orientation of Village Clinic Committees		✓	
			CCM Training			
			Strengthen Coordination of ACSD Implementation at Zonal and National Levels			
			Bi-annual Zonal CCM Review meetings			✓
			Train a cohort of CCM Supervisors			✓
			Train a cohort of CCM Mentors		✓	
			M&E System Strengthened for ACSD			
			SMS Equipment procurement		✓	
			Reprinting of Village Clinic Registers		✓	
		Reproduction of Job aids for CCM				
		Facility IMCI Supervision		✓	✓	
		Reproduction of CCM Referral forms		✓		
		CCM Supportive Supervision		✓	✓	
		PHI-ETAT	Expansion of Pediatric Hospital Initiative			
			Procure ETAT Equipment (Training dolls)		✓	
Procure Data Management system equipment			✓			
Bi-annual Pediatric care system Audit			✓			
ETAT Supervision			✓	✓		
Bi-annual Peer reviews				✓		
2	Nutrition - ENA		Support MoH in training health workers on new WHO growth standards		✓	✓
			Support finalization of CTC Guidelines	✓		
			Finalize consultancy report of assessment of district TNP structures. Present results at national TNP meeting	✓	✓	✓
			Support child Health Days		✓	
			Support monitoring and supervision of nutrition activities by MoH nutritionists			✓
3	CMAM -		Support MoH in training health workers on new WHO growth standards		✓	✓
			Support finalization of CTC Guidelines	✓		
			Finalize consultancy report of assessment of district TNP structures. Present results at national TNP meeting	✓	✓	✓
			Support Child Health Days		✓	

	Program	Component	Activity	Month(tick)		
				Oct	Nov	Dec
	NUTRITION		Support monitoring and supervision of nutrition activities by MoH nutritionists			✓
			One day stakeholders' (40) meeting to share, finalized GMP training materials		✓	
			1 day dissemination of GMP baseline survey report for Phalombe & Zomba at District & community level		✓	
			Print 1,500 copies GMP kit (1,500 training materials, 1,500 counseling cards and 1,500 GMP registers)	✓		
			Procure 1,500 each of GMP IEC materials: bags, T-shirts Child's health passport & complementary/ feeding utensils	✓		
			Complete roll out training of remaining of 100 volunteers for Phalombe in remaining 20 outreach sites	✓		
			10 days supervision of 198 M/FSGF in the implementation process of GMP and IYCN	✓	✓	
			30 days supervision to 84 outreach sites in Phalombe for 489 GMP volunteers		✓	✓
			1 day dissemination of GMP baseline survey report for Phalombe at District and community level		✓	✓
			5 days Supervision implementation process of community based GMP for the first 12 villages	✓		
			12 days supervision of 120 volunteers in 41 villages for Bimbi Health Centre catchment area	✓	✓	
			1 day dissemination of GMP baseline survey report for Zomba at District and community level		✓	✓
			Expand GMP to one additional H/C Group village outreach sites		✓	✓
			Repeat supervision of 192 (120 volunteers and 72 M/FSGFs) for Bimbi Health Centre 53 villages			✓
4	Zinc		All partners supporting the Zinc program full aware of the progress in the intervention			✓
			Health workers(Clinicians and Nurses oriented on Managing Diarrhea using Low Osmolarity ORS and Zinc Supplement	✓	✓	✓
			Districts supervised on the implementation of Managing diarrhea using Zinc Supplement and Low Osmolarity ORS	✓	✓	✓
			HSAs oriented on Zinc supplement as part of diarrhea treatment and including such a topic on their day to day IEC activities	✓	✓	✓
5	HIV		Review MIP training package	✓		
			Support MIP training in Chikwawa	✓		

	Program	Component	Activity	Month(tick)		
				Oct	Nov	Dec
			Orient blood sample transporters		✓	
			Procure 20 carrier bags for sample transportation		✓	
			Procure cooler boxes and specimen containers		✓	
			Procure hard cover registers		✓	
			Conduct HTC grants NGO supervision			✓
			Conduct review meeting with NGO grantees			✓
			Support PMTCT review meetings in the districts	✓	✓	✓
			Train health care providers in PITC	✓		
			Train patient experts		✓	
			Conduct coordination meetings with district program coordinators who implement HIV related activities.	✓		
			Conduct MIP TOT training		✓	
6	Malaria Grants		Capacity building of grantees			
			Conduct supportive supervision to grantees		✓	
			Conduct quarterly review meetings			✓
			Conduct capacity building for grantee accountants		✓	
			Monitoring and Evaluation			
			Conduct quarterly data management backstopping to grantees			✓
			Capacity building of monitoring and evaluation function of grantees			✓
			Conduct program mapping with grantees	✓		
			Development and provision of IEC materials			
			Produce and distribute malaria IEC materials			✓
			Grants financial support			
			Reimbursements for cycle 1 extension	✓	✓	✓
			Reimbursements for cycle 2 extension	✓	✓	✓
			Reimbursements for cycle 3	✓	✓	✓
			Reimbursements for cycle 4	✓	✓	✓
			Program documentation			
Document success stories			✓			
7	Malaria IPTp		Conduct district refresher training on IPTp			
			Conduct zonal quarterly review meetings with zonal and districts malaria and safe motherhood coordinators			✓
			Conduct and support supervisors to conduct quarterly supervision visits at district level		✓	
			Conduct operational research on factors affecting uptake of 2 doses of SP at facility level	✓	✓	✓
			Review and Development of IPTp materials	✓	✓	✓