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MCHIP QUARTERLY REPORT

REPORTING PERIOD: APRIL - JUNE 2010

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July 30, 2010

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Acronyms and Abbreviations

ADC	Area Development Committee
AIDS	Acquired Immune Deficiency Syndrome
AED	Academy for Educational Development
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CDC	Center for Disease Control
CM	Community Mobilization
CTS	Clinical Training Skills
DEC	District Executive Committee
DFID	Department for International Development (UK)
DIP	District Implementation Plan
DOT	Directly Observed Therapy
EHP	Essential Health Package
EMNC	Essential Maternal and Newborn Care
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
FANC	Focused Antenatal Care
FP	Family Planning
GOM	Government of Malawi
HHCC	Household-to-Hospital Continuum of Care
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IP	Infection Prevention
IMA	Interchurch Medical Assistance
IPTp	Intermittent Presumptive Treatment, Pregnancy
KCN	Kamuzu College of Nursing
KMC	Kangaroo Mother Care
LA	Lumefantrine Artemether
LBW	Low Birth Weight
MCHS	Malawi College of Health Sciences
MDG	Millennium Development Goal
MNH	Maternal and Neonatal Health
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
NMCP	National Malaria Control Program
NMR	Neonatal Mortality Ratio
NMT	Nurse Midwife Technician
OHA	Office of HIV/AIDS
PAC	Post Abortion Care
PMI	President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PPH	Postpartum Hemorrhage
PQI	Performance and Quality Improvement
QIST	Quality Improvement Support Teams

RH	Reproductive Health
RHU	Reproductive Health Unit
SNL	Saving Newborn Lives
SP	Sulfadoxine Pyrimethamine
SSC	Skin-to-skin Care
SRH	Sexual and Reproductive Health
SWAp	Sector Wide Approach
USAID	United States Agency for International Development
WHO	World Health Organization
WRA/M	White Ribbon Alliance/Malawi

Executive Summary

In September 2009, USAID/Malawi bought into the Maternal and Child Health Integration Program (MCHIP), a five-year USAID global flagship award implemented by Jhpiego in partnership with Save the Children, Population Services International (PSI), John Snow Inc., Macro International, Inc., PATH, the Institute for International Program (IIP/JHU), and Broad branch Associates. In Malawi, the primary implementing partners are Jhpiego (as the prime), Save the Children and PSI. MCHIP is supporting the Ministry of Health (MoH) and USAID/Malawi strategy to accelerate the reduction of maternal, neonatal and child mortality towards the achievement of the Millennium Development Goals with a prime programmatic objective to increase utilization of MNCH services and practice of healthy maternal, neonatal and child behaviors.

To achieve this objective, MCHIP will focus on the following results:

Facility

1. Increased access to and availability of quality facility-based essential maternal and newborn care and child and postpartum family planning services

Community

2. Increased adoption of household behaviors that positively impact the health of mothers and newborns and children under 5 years of age
3. Increased availability of community-based MNH services through Health Surveillance Assistants

Enabling Environment

4. Strengthened MNH policies, planning and management in place at the national, zonal and district level
5. Increased commitment of resources for MNH from GoM and other donors
6. Strengthened planning and monitoring of MNH activities at community level

Social Marketing

7. Increased availability and access to low osmolarity ORS among mothers and caregivers of children under 5
8. Increased use of oral and injectable contraceptives among middle income women of reproductive age intending to use FP methods

Social Mobilization

9. Promotion of correct and consistent use of LLINs, correct and prompt use of ACT anti-malarial among caregivers of children under five and promotion of IPT among pregnant women
10. Prompt and effective treatment of malaria among children under five and improved awareness around uptake of IPT among pregnant women
11. Increased community and district action to support use of high impact MNH interventions

Program Outputs

Key program achievements during the April-June 2010 reporting period included the following:

1. In May 2010 MCHIP/Malawi disseminated CMNH model and Performance Quality Improvement (PQI) pilot at health centers results in all four MCHIP focus districts for an audience of community leaders, health center staff, DHMT, District Assembly and local NGOs working in the districts on MNH. The results suggested that the CBMNH model was well adopted at the district level and there is tremendous improvement in utilization of MNH services at the facility level— both for antenatal , delivery and postnatal services. The results of the PQI initiative showed improved quality of health delivery in PQI intervention sites as compared to non-intervention sites. The documentation and dissemination of these results served as a basis for advocating for the scale up of the CMNH and PQI models in the focus districts where MCHIP is currently working as well as other districts. Following the dissemination , the members of the DHMT developed work plans scaling up activities of PQI and CMNH to additional health

centers. The Chairperson of the National Quality Assurance Technical Working Group recommended that scale up be extended to the national level.

2. In April MCHIP/Malawi conducted a Training of Trainers for PQI trainers. Twenty service providers with prior knowledge and experience in PQI were drawn from 20 hospitals implementing PQI in Reproductive Health and were successfully trained as trainers in Performance and Quality Improvement processes including teaching methodologies. . This has increased the national pool of trainers to facilitate scale up and decentralization of the PQI trainings, supervision and coaching.
3. In the reporting quarter, family planning detailers identified 150 facilities that are now part of the private providers' network. These facilities were visited at least once every month and were either restocked with SafePlan oral and injectable contraceptives or assisted technically. The quantities distributed in this quarter were slightly higher than in the previous quarter which shows that **there is potential for the private sector to grow** when there is more communication attached with the sales. In the upcoming quarter, communication materials will be developed and rolled out to help improve sales. Detailing visits will continue in order to provide support to the providers.
4. Of the 320,000 LLINs that were received in the January-March 2010 quarter, 47,100 LLINs were distributed in the Northern zone of Malawi according to the distribution plan provided by the National Malaria Control Program reaching a total of 120 health facilities in the Northern Region and 65,600 LLINs were distributed in the Southern region reaching 271 health facilities. LLINs are provided free of charge at facilities during under 5 clinics and antenatal clinics.

Key Accomplishments by Activity

1. Expansion of Performance and Quality Improvement in Reproductive Health (MCHIP Partner Lead: Jhpiego)

1.1 Activity: Expansion of PQI/RH at Health Center level

Outputs and Outcomes: On 24th - 25th May 2010, MCHIP conducted two district-level dissemination meetings on the PQI model for health centers in Machinga and Nkhotakota and on 26 and 27 May 2010 in Phalombe and Rumphi Districts. The objectives of the dissemination meeting were to inform service providers, the DHMT and district-based NGOs on the PQI IP/RH model for health centers as well as address the findings of the PQI documentation exercise which took place in January 2010 on the difference in the quality of IP/RH service provision at implementing sites and comparison sites. As discussed in the previous January-March 2010 quarterly report, the sites assessed were 4 implementing health centers (Ntaja health center in Machinga, Phalombe health center, Alinafe health center in Nkhotakota and Bolero Rural Hospital in Rumphi) and 2 comparison sites (Nsanama in Machinga and Ngala health center in Nkhotakota). The results showed a significant difference in the quality of IP/RH services, with PQI intervention sites performing significantly better.

Following presentations by the PQI officer on the above details, MCHIP facilitated a working session with members of the DHMT to develop work plans to facilitate budgeting and scale-up of PQI activities to additional health centers in the district. During the session, DHMT committed to scaling up the PQI model at the following health centers:

Rumphi – Lura Health Center, Ng'onga Health Center and Mpompha Health center.

Nkhotakota – Mwansambo and Ngala health Centers.

Machinga – Nyambi Health Center, Nsanama Health Center and Nayuchi Health Center

Phalombe – Nkhwayi health Center, Chetsekesea Health Center and Mwanga health Center.

In addition to the above mentioned district level dissemination meetings, MCHIP also conducted a briefing with the Chairperson of the National Quality Assurance Technical Working Group (NQA TWG). The Chairperson endorsed the evidence that indeed PQI is having an impact on improving quality of care in RH and further recommended that scale up should be advocated for nationally and not only in MCHIP’s four focus districts.

From 26 to 30 April 2010, MCHIP conducted TOT for PQI trainers. These trainers were drawn from 20 Hospitals implementing PQI in Reproductive health. The purpose of the training of Trainers was to increase a pool of trainers and to prepare for decentralization of the PQI Modules 1 to 3 training in the Districts as districts prepare for scaling up of PQI RH activities in their districts. 20 Service Providers with prior knowledge and experience in PQI were successfully trained as trainers in Performance and Quality Improvement processes.

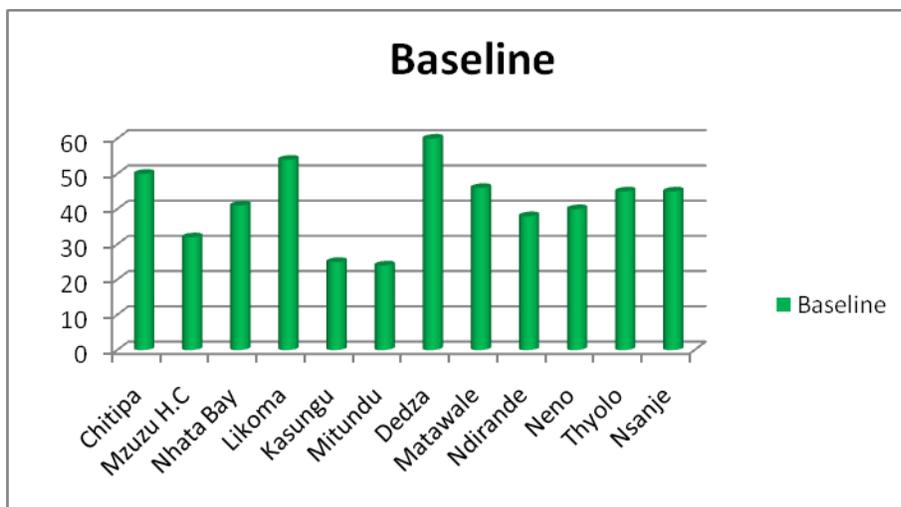
Issues/Challenges: N/A

Next Steps: The dissemination of results from the PQI documentation at the National level will be conducted in the next quarter during RHU’s annual national dissemination meeting. MCHIP will, in addition, follow up with the DHMTs from the 4 districts who are in the midst of incorporating their scale up plans for PQI activities into their DIPs. MCHIP will continue to liaise and engage other stakeholders in the implementation of the scale up plans. The dissemination at National level will aim at sensitizing other stakeholders and policy makers to support the scale up plans of PQI to other health centers in both MCHIP focus districts and other districts. Some of the twenty Service Providers trained as PQI trainers will be involved in the Zonal training for PQI module 3 for QIST members from the 12 new health facilities implementing PQI in RH. The training will be conducted in the next quarter.

1.2 Activity: Expansion of PQI/RH at the Hospital Level

Outputs and Outcomes: From 11th - 24th April 2010, MCHIP facilitated the baseline assessments in the new 12 expansion health facilities (9 hospitals and 3 health centers) for PQI RH. The baseline assessments were conducted by the Quality Improvement Support Team (QIST) members from the new expansion sites which include: Chitipa, Nkhata-Bay, Likoma, Kasungu, Mitundu, Dedza Thyolo, Nsanje and Neno Hospitals ; Mzuzu, Matawale, Ndirandehhealth Centers. All the health facilities except for Dedza scored less than 50% and only Dedza scored 60% on the baseline (see Figure i below).

Figure 1: PQI RH baseline assessment scores, April 2010



Issues/Challenges: The multiple roles of QIST members distracted some of them from participating in the baseline assessments as planned. This resulted in the facilitators and a few QIST members overworking to complete the baseline assessments in the prescribed time.

Next Steps: There is need for DHMT to commit the QIST members to PQI activities so that during the internal assessments, all the QIST members should be available and participate in the internal assessments and dissemination of the results. The DHMT should also intensify the supportive supervision of PQI in RH activities.

1.3 Activity: Update provider BEmONC skills at new PQI/RH sites (both District Hospitals and Health Centers)

Outputs and Outcomes: Not initiated during reporting period.

Issues/Challenges: N/A

Next Steps: MCHIP will develop a concrete plan and timeline for implementing BEmONC updates for in-service providers in the July- September 2010 quarter. MCHIP expects to provide funds directly to the district in order to conduct the on-site BEmONC updates using trained trainers (safe motherhood coordinators) as well as provision of training materials to the 10 districts. Tutors trained in BEmONC under the ACCESS and MCHIP programs will facilitate these on-site BEmONC updates.

2. Expand the capacity of training institutes to provide BEmONC skills training (MCHIP Partner Lead: Jhpiego)

2.1 Activity: Increase knowledge and skills of midwifery tutors in training colleges

Outputs and Outcomes: MCHIP organized 2 BEmONC training sessions for tutors this quarter. During the two training sessions 39 out of the target 40 tutors were trained. The tutors were drawn from all 13 nurse-midwifery training institutions. The two week training sessions were conducted in Blantyre. The topics covered included focused antenatal care, management of labour and use of the modified partograph, management of puerperium, repair of episiotomy, and management of selected complications of labour and delivery, newborn and the post partum period.

The training comprised of 4 days of updating the participants in the evidence based knowledge in managing the conditions listed above. Another 4 days were dedicated to clinical practice in antenatal, labour, post natal and kangaroo mother care. Pelvic models were used by participants to practice skills prior to practice on clients during clinical practice.

Providers also commented on the importance of using the “skills checklist” when assessing students’ competency in the skills laboratory prior to practicing on clients. The skills checklist, provided during the BEmONC training, empowers tutors to use a standardized method of evaluating students’ performance and clinical skills.

Issues/Challenges: MCHIP trained 39 tutors out of the target 40, missing the target for year 1 by 1 due to conflicting dates with the nursing college academic calendar. In year two, MCHIP has planned one more BEmONC training for tutors where MCHIP plans to add the remaining tutor who was missed in this quarter.

Next Steps: The gap of one tutor not trained in year one will be filled in year two BEmONC training.

2.2 Activity: Provide technical assistance to MoH and other partners to conduct BEmONC trainings

Outputs and Outcomes: Not initiated during reporting period. MCHIP has trained 39 tutors in BEmONC (capacity building) thereby increasing the pool of trainers that MOH –RHU, Save the Children and other partners can use at any time.

Issues/Challenges: N/A

Next Steps: In consultation with USAID/Malawi, MCHIP will develop a catalytic strategy to detail MCHIP’s approach for leveraging additional resources and support to scale-up BEmONC.

3. Expand KMC in the four focus districts (MCHIP Partner Lead: Save the Children)

3.1 Activity: Expansion of KMC including Ambulatory and Community KMC in four focus districts

Outputs and Outcomes: MCHIP oriented 15 service providers from Rumphi District on 23rd April and 15 service providers from Nkhotakota on 15th June on Ambulatory and Community KMC. The participants for these trainings included service providers with knowledge on Newborn Health and Kangaroo Mother Care acquired from their previous trainings in either of the following: BEmONC, KMC, and the Integrated Maternal and Newborn Care training package, which at that time did not have a component on Ambulatory and Community KMC. The trained service providers will manage LBW babies and counsel families with premature babies on KMC. Introduction of Ambulatory and Community KMC enables LBW babies to be managed in three different ways (facility based, ambulatory or community-based KMC) depending on the severity of the newborn birth weight (see Table 1).

Table 1: Management criteria for LBW infants

Birth Weight	Management	Definition
<1800 grams	Facility based KMC	To be admitted to a hospital. Babies are discharged after gaining weight on at least 3 consecutive days, Regain birth weight, weighing at least 1500g and ability to go back to a nearest facility for follow up care.
1800 - 1999 grams	Ambulatory based KMC	Have very short hospitalization. Discharged much early. Ability to come for follow up care much more frequently at a facility 2 to 3 times in the first week. HSAs crucial for follow up.
2000 – 2500 grams	Community based KMC	To be managed by HSAs in the community. No need to go for follow up at a facility

In addition, MCHIP trained 40 HSAs, (20 from Rumphi and 20 from Nkhotakota) on Ambulatory and Community KMC. These HSAs were trained under ACCESS and are already providing CBMNH in the catchment area of Bolero and Mwazisi Health Centers in Rumphi; Alinafe, Mtosa, Malowa and Benga Health Centers in Nkhotakota, however the training package did not have a component of Ambulatory/Community KMC.

Additional 50 HSAs from new MCHIP scale up Health Centres (25 from Mhuj and Katowo Health Centers in Rumph and another 25 HSAs from Mpsa, Holy Family and Phalombe Health Centers in Phalombe District) were trained in Ambulatory and Community KMC during the initial CBMNH package using the training manual which has integrated Ambulatory and Community KMC content. In total, 90 HSAs were trained in Ambulatory and Community KMC in this quarter covering a total of 8 facility catchment areas (Bolero, Mwazisi, Mhuj and Katowo in Rumph; Alinafe, Mtosa, Malowa and Benga in Nkhotakota). Please refer to summary table below on the number of HSAs trained to date, under MCHIP, on Ambulatory and Community KMC.

Table 2: HSAs trained to date on ambulatory and community KMC

	# HSAs trained
Total direct KMC training under MCHIP	120
Total direct KMC training under under ACCESS	20
Total integrated KMC- CBMNH Training	100
GRAND TOTAL	240

Next Steps: In July to September 2010 quarter, MCHIP will provide supportive supervision to all KMC sites in all the MCHIP focus districts. MCHIP will also conduct one training session for HSAs in Ambulatory and Community KMC in each of the MCHIP districts; thus training an additional 80 HSAs in Community and Ambulatory KMC.

3.2 Activity: Support DHMTs to plan KMC scale-up at hospitals and health centers

Outputs and Outcomes: MCHIP followed up with the DHMTs regarding DIP planning and finalization during the joint supportive supervision in May 2010. The Districts indicated that they included scale up of KMC interventions at 10 health centers in their DIPs. The 10 scale up health facilities include the following: Mangamba and Nayuchi in Machinga; Bua and Dwambazi in Nkhotakota; Lura, Ng'onga and Mphompha in Rumph and Nkhwayi, Chitekesa and Mwanga in Phalombe. DHMTs selected these sites as scale-up sites for the entire CMNH package and therefore the KMC trainings will be integrated along with CMNH scale-up.

Issues/Challenges: None

Next Steps: MCHIP will follow up with the DHMTs regarding the timeline for scale up of KMC interventions as planned in the identified health facilities and will conduct supportive supervision in all the four focus districts during the July – September 2010 quarter.

4. Strengthening Postpartum Family Planning (MCHIP Partner Lead: Jhpiego)

4.1 Activity: Strengthen knowledge and skills on immediate post partum and post abortion family planning for midwifery tutors and service providers

Outputs and Outcomes: MCHIP funded PFP district-level (on-site) training sessions for service providers from 10 of the 16 targeted districts/sites (Machinga, Thyolo, Nsanje, Phalombe, Dedza, Nkhota kota, Kasungu, Nkhata Bay, Rumph and Chitipa) which included 10 participants from each district were planned for this quarter. Funds were collected by 9 districts and training sessions were conducted in 7 districts. As at the end of this quarter, 70 service providers have been orientated in postpartum and post abortion family planning.

4.2 Activity: Follow-up visits to tutors trained in PFPF and BEmONC

Output and Outcomes: Not initiated during reporting period.

Issues/ Challenges: N/A

Next Steps: Conduct supportive supervision for tutors in selected nursing/midwifery colleges in July-September 2010. During the supportive supervisory visit, MCHIP will monitor the implementation of BEmONC and PFPF as the tutors train students and the impact that the knowledge and skills acquired has on clients that are served by the students. In addition, the course outlines will be checked to verify the inclusion of both BEmONC and PFPF content.

5: Increased availability of community-based MNH services through Health Surveillance Assistants (MCHIP Partner Lead: Save the Children)

5.1 Activity: Document and Disseminate results of the CMNH model as a basis for advocating for its scale up in other districts

Outputs and Outcomes: Following data collection for process documentation that took place in the quarter of January to March 2010, MCHIP develop a draft documentation report in April 2010. MCHIP plans to finalize the documentation report in August 2010 after district and National dissemination meetings which took place in May and June 2010 respectively. MCHIP jointly disseminated results of CMNH model with Performance Quality Improvement (PQI) results at district level in all MCHIP focus districts in May 2010. Participants for dissemination included selected community leaders; representatives from Health center staff; DHMT; District Assembly and NGOs working in the district on MNH activities. The results showed that the CBMNH model was well adopted at the district level and there is tremendous improvement in utilization of MNH services at facility level both for antenatal, delivery and postnatal services. The National level dissemination was postponed from June to July 2010 and MCHIP plan to disseminate the CBMNH model jointly with Save the Children. Refer to graphs 2-4 below for program specific results from the four implementing districts.

Figure 2: Percentage women counseled on FP and developed a birth plan

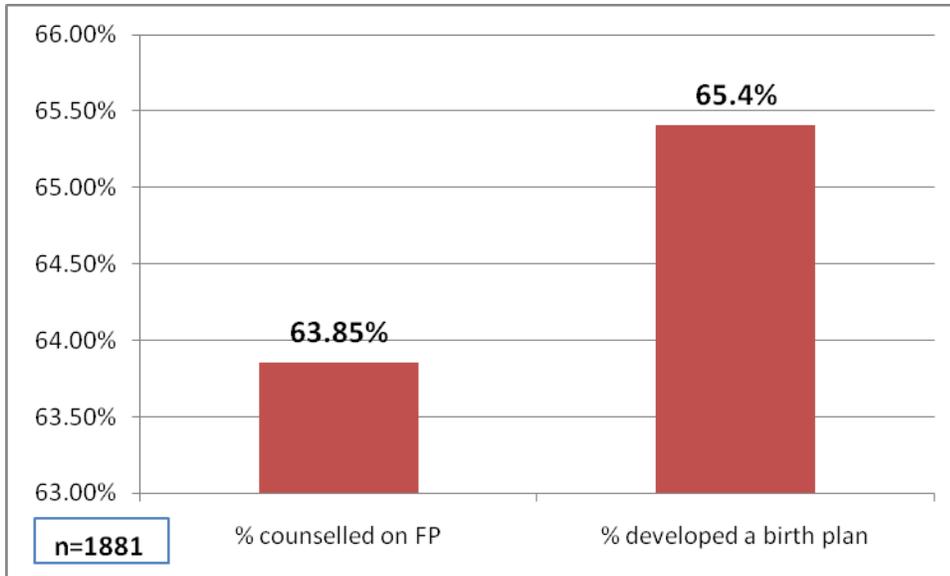


Figure 3: Percentage of mother and newborns identified with a danger sign

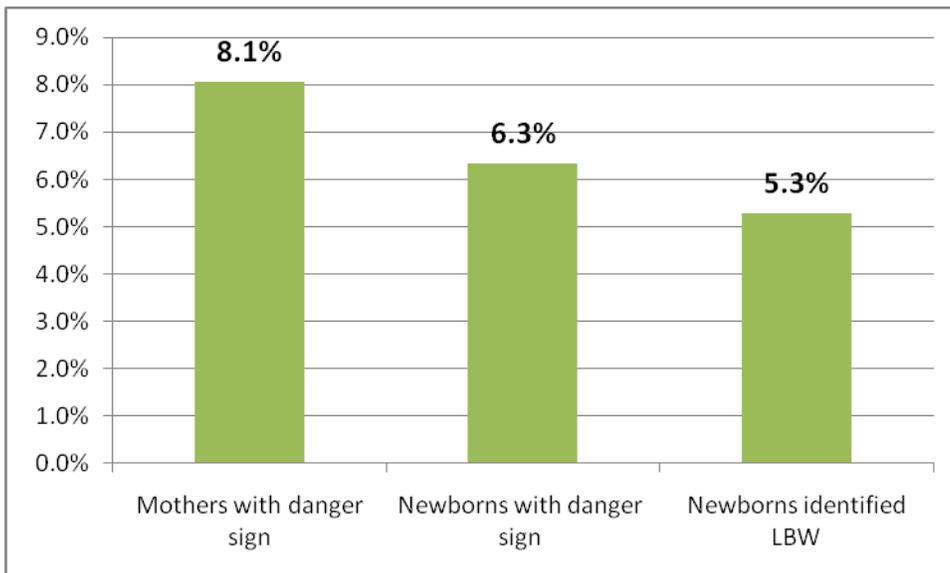
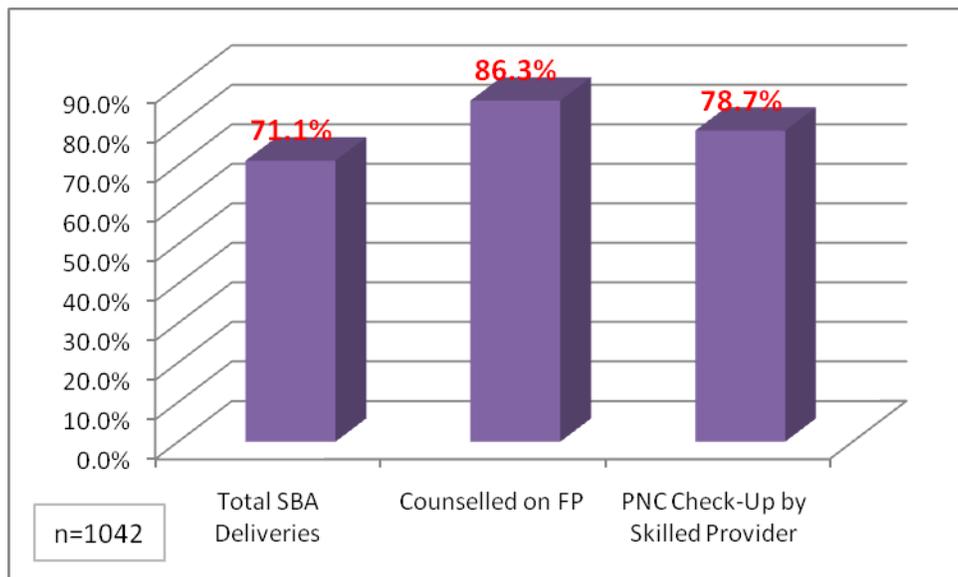


Figure 4: Percentage of deliveries with a SBA, mothers counseled on FP and postnatal checkups



Issues/Challenges: None

Next Steps: MCHIP will disseminate CBMNH results jointly with Save the Children (SNL program) at the RH National Dissemination meeting scheduled for July 2010 and finalize the documentation report by August 2010

5.2 Activity: Support DHMTs to saturate coverage of the district with the CMNH model in the existing districts

Outputs and Outcomes: MCHIP continued conducting HSA trainings in the CBMNH package and trained 50 HSAs; 25 from the new scale up health centres in Rumphi (Mhuju and Katowo) and finished training the remaining 25 HSAs in the previous Health Centres initiated under ACCESS in Phalombe district (Mpsa and Phalombe Health Centres and Holy Family CHAM Hospital). The trainings were facilitated by district trainers trained under the ACCESS program and MCHIP provided technical support during the training. MCHIP further conducted two knowledge sharing sessions with 40 HSAs previously trained under the ACCESS program (20 each from Rumphi and Nkhotakota). The aim of the sessions was to review and update HSAs’ knowledge and skills in Community MNH and Community Mobilization. HSAs reported some problems in completing the CBMNH HSA reporting form and shared a number of interesting experiences and challenges in community mobilization. One HSA from Machinga for example shared on how one Community Action Group mobilizes the community to support less privileged women with new wrappers (chitenje) as encouragement to deliver at the health facility (women fail to access health care when they don’t have a new wrapper, they fear ridicule from fellow women and sometimes nurses).

MCHIP also assisted DHMTs of the four focus districts to develop implementation plans for scaling up the CBMNH Model in their districts. The districts identified the following health centres for scale up: Mangamba and Nayuchi in Machinga; Bua and Dwambazi in Nkhotakota; Lura, Ng’onga and Mphompha in Rumphi and Nkhwayi, Chitekesa and Mwanga in Phalombe. The scale-up work plans have been developed by the DHMT and the districts are expected to solicit funds to support implementation of the scale up work plan through their DIPs. Their criteria for choosing these additional health centers is delay in seeking health care which result in morbidity and mortality, these factors improve with CBMNH as demonstrated in current implementation sites.

Joint supportive supervision was conducted by MCHIP, RHU and District staff in the following facilities: Nkhotakota District Hospital: Alinafe, Mwansambo and Malowa health centres; Rumphi District Hospital: Mwazisi and Bolero health centres; Phalombe and Mpsa; Machinga District Hospital and Chikwewo HC in May 2010. It was noted that CBMNH interventions are showing some progress. Vibrant community action groups are empowered to find solutions for the identified problems and seek outside support for interventions which they lack capacity and resources for example Malowa CAG in Nkhotakota, invited the DHMT and District Assembly Representatives to discuss the possibility of funding the construction of a maternity wing which they identified as one major problem in the area; all the CAGs visited in Machinga, Nkhotakota and Rumphi keep records of who is pregnant in the community, follow up women after delivery and encourage each other to deliver at a health facility. In addition, HSAs are still conducting antenatal and postnatal home visits. However, some HSAs had problems with documentation of home visiting information and the problems were rectified during the supervision visit. Supervision to the remaining facilities will be conducted next quarter.

MCHIP held meetings with Save the Children to review the HSA Data collection form. The initial form is lengthy and has a lot of variables which generate information that is not used. As part of the review process, MCHIP and Save the Children went on a field trip in Nkhotakota to discuss with HSAs some difficulties they encounter while using the data collection forms and how they use the information which they collect to benefit the health centre. Problem areas were identified and information will be used to improve the reviewed data collection form.

MCHIP facilitated a meeting with RHU and Save the Children to discuss development of guidelines for Community MNH National scale up to ensure that the future scale-up districts are given clear guidance on how to initiate the CBMNH model. Draft guidelines were developed, circulated to partners and will be disseminated together with the CBMNH model at the National RH Dissemination meeting in July 2010.

Issues/Challenges: N/A

Next Steps: The CBMNH Model comprises CBMNH package and Community Mobilization. MCHIP has finished the planned HSA training in CBMNH package and plans to conduct Community mobilization trainings for 100 HSAs in 4 sessions in July – September 2010 quarter. MCHIP will also continue working with Save the Children to finalize the HSA reporting form

5.3 Activity: Identify platforms for Scaling up the Community MNH model in other districts

Outputs and Outcomes: The MCHIP work plan proposed a plan to meet with potential partners to provide an overview of the MCHIP program and identify key areas of overlap with regards to community activities. After learning that similar NGOs would be participating in RHU's national dissemination meeting, MCHIP decided to utilize the RH dissemination meeting as a platform for informing stakeholders of MCHIP's household to hospital continuum of care and disseminating results of the CBMNH model (as well as PQI). Initially, the meeting was supposed to take place in June however it was postponed to 7th July 2010. The partners that have been invited to the RHU dissemination meeting include: UNFPA, UNICEF, WHO, Save the Children, CHAM, WALA, FHI, FPAM, MSH, World Vision International, DHOs and DNOs from all 28 districts in Malawi; College of Medicine; BASICS,. RHU formally indorsed CBMNH model as the national package.

MCHIP gave a Poster Presentation at a Global Health Council's Annual Conference in Washington DC, on improving MNH in Malawi Communities based on the work of the ACCESS program. The poster has a powerful message on what is being achieved with community MNH and many participants visited the podium.

Issues/Challenges: N/A

Next Steps: MCHIP has prepared to share CBMNH results at the RH dissemination meeting that has been organized by RHU on 7th July 2010. MCHIP will continue identifying potential partners to provide an overview of the MCHIP program and identify key areas of overlap with regards to community activities.

6. Advocacy Strategy for Maternal and Newborn Care (MCHIP Partner Lead: Jhpiego, Save the Children, PSI)

6.1 Activity: Participate in key working group meetings

Outputs and Outcomes: From April-June 2010, MCHIP participated in a number of key MNH stakeholder meetings and technical working group meetings. MCHIP's participation in these national level meetings allows MCHIP to continue advocacy of MNH issues and ensure that the mission and vision of MCHIP as a USG partner is well represented in MoH activities. The following key meetings were represented by MCHIP:

1. Malaria Operational Plan (MOP) stakeholders meeting took place on 28th April to discuss progress and plans for upcoming year. MCHIP presented on the challenges faced with the new policy/plan for distribution LLINs and PMI will continue to facilitate discussions between MCHIP and the Ministry of Health.
2. A Presidential Malaria Initiative (PMI) partner's meeting was held on June 1st. Strengthening Pharmaceutical Systems (SPS) presented on the use of smart phones for supervision, which proved to be very user-friendly, enabled rapid feedback of results, and aided with data collection, data entry and analysis. Partner's provided updates on their programs.
3. USAID synergy meeting on June 4th was attended by MCHIP in Blantyre.

Issues/Challenges: None

Next Steps: MCHIP will continue to participate in key national level meetings in the next quarter.

7. Quick Wins to Accelerate Mortality Reduction within Existing Capacity (MCHIP Partner Lead: Jhpiego, Save the Children, PSI)

7.1 Activity: Lead efforts to develop operational plan for the National Roadmap for Accelerating Reduction in Maternal and Newborn Mortality

Outputs and Outcomes: From April-May 2010, MCHIP participated in a taskforce to plan the 2010 follow-up EmOC assessment, the objective of which is to determine progress towards addressing key EmOC indicators following the 2005 National EmOC Needs Assessment. The results of the follow-up assessment, currently underway, will help to inform the development of an operational plan for the National Roadmap. It is anticipated that the results of the EmOC assessment will be presented by September 2010, and once the results have been disseminated, MCHIP will participate in the development of a Roadmap Operational Plan that builds on the results and lessons learned from the national assessment.

Issues/Challenges: None

Next Steps: As previously anticipated and reported in the last MCHIP quarterly report, the results of the roadmap will be available in September 2010 therefore MCHIP will plan to participate in the consultations once they occur, hopefully in early October.

7.2 Activity: Planning for universal coverage of high impact interventions in priority districts

Outputs and Outcomes: MCHIP has begun discussions internally to utilize the list to identify several key MNH high impact interventions that can be rapidly brought to scale in primarily MCHIP's four focus districts and, secondarily, in the 10 PMNCH-CI focus districts. In order to utilize the LiST for analysis at the district level, MCHIP is collecting and consolidating key district-level input data such as demographic and RH

indicators. MCHIP is currently trying to determine if enough district-level data is available in order to use the LiST at the district level.

Issues/Challenges: A key challenge is whether it is worth conducting the LiST exercise for MNH interventions as many “LiST experts” believe that the maternal and newborn health modules are not been adequately validated. Many experts feel that it is too early to use the LiST for calculating maternal lives saved since the interventions listed in the LiST tool have not yet been vetted through the Child Health Epidemiology Reference Group (CHERG) and other international groups.

Additionally, the maternal health modules do not include country specific causes of death but rather have “built in” the regional causes of death. Since the maternal causes of death in Malawi are not entirely aligned to the regional causes of death, any analysis that is produced in Malawi may not be completely accurate.

Next Steps: Based on the above issues with using the LiST for approximating MNH high impact interventions, MCHIP will continue to explore and conduct “test” analyses on whether it will be feasible and/or whether the analysis will add value to current scale-up of evidence based MNH interventions.

8. Update National Reproductive Health Strategy (MCHIP Partner Lead: Jhpiego, Save the Children)

8.1 Activity: Update National Reproductive Health Strategy

Outputs and Outcomes: The activity to review and update the current National Reproductive Health Strategy (2006-2010) took place from 23rd - 24th June 2010 at Hotel Victoria in Blantyre. The review process was lead by RHU and all key RH stakeholders including the following: Director of SWAp, Director of Nursing Services, Deputy Director of Reproductive health, Representatives from the HIV/AIDS Unit of the MoH, Representative from the Director of Clinical Services, UNFPA, WHO, UNICEF, Malawi College of Health Sciences, Kamuzu College of Nursing, Medical Council of Malawi, Nurses and Midwifery Council of Malawi, Representative of the DHO for Salima Hospital, Mai Khanda, Save the Children, MSH, BLM and representatives from MCHIP. The aim of this working session was to review the current RH strategy; identify achievements, gaps, opportunities, threats and incorporate new international and national evidence based trends in RH to respond to RH needs in Malawi in line with the revised RH policy. .

Issues/Challenges: N/A.

Next Steps: Stakeholders agreed that MCHIP will consolidate the notes from the groups and send the first draft of RH Strategy 2010-2015 to stakeholders for their comments and additional input by the end of July 2010.

9. Support Misoprostol pilot in Malawi (MCHIP Partner Lead: Jhpiego, Save the Children, PSI)

9.1 Activity: Support the pilot of Misoprostol in selected districts

Outputs and Outcomes: From April-June 2010, MCHIP worked with Ministry of Health (RHU) and VSI to develop, refine and finalize a study protocol for the pilot of Misoprostol in selected districts. Given the importance and impact of such a study, MCHIP expanded the scope of the study to evaluate the feasibility and effectiveness of prevention postpartum hemorrhage including the provision of Active Management of the Third Stage of Labor (AMTSL) as a “gold standard” approach, and distribution of Misoprostol in the event of home deliveries. The study, entitled, ***A Pilot Study to Determine the Feasibility and Effectiveness of***

Strengthening Active Management of the Third Stage of Labor and Distributing Misoprostol at Antenatal Care to Prevent Postpartum Hemorrhage in Three Districts of Malawi, will be submitted to the College of Medicine's Research and Ethics Committee (COMREC) on July 1st, 2010. A summary of the approach is described below.

MCHIP will use an approach approved by the RHU for introducing misoprostol for management of PPH at home birth. Misoprostol counseling messages will be added to messages delivered during ANC visits and to HSA home visits through the CMNH package in 21 out of the target 62 facilities in three districts. The misoprostol tablet will be distributed at health centers by a nurse/midwife or medical assistant during the third trimester. Providers will follow-up with all women returning to the clinic for a well-baby visit to record information on delivery, misoprostol use, and referral. In addition, 20% of the study participants will be randomly selected for "active follow-up", meaning that a community member trained by the project will visit them within the first two weeks after delivery and conduct a brief interview about their delivery, including misoprostol use and referral. Ongoing MCHIP activities will provide the foundation for the pilot's implementation.

To assess the feasibility and effectiveness of the program, data will be collected from client records, logbooks, follow-up forms, observation checklists, and provider surveys. Various indicators such as the number of births protected from PPH with a uterotonic drug, the number of PPH referrals, the number of women receiving AMTSL at health facilities, and the number of women who correctly used misoprostol at home births will be examined.

Findings from the study will be disseminated to key stakeholders in Malawi such as the Safe Motherhood Subcommittee and the Sexual and Reproductive Technical Working Group. These findings are expected to generate evidence to inform future policy on the importance of a comprehensive PPH prevention strategy that includes strengthening AMTSL in facilities and distribution of misoprostol for use at home deliveries to help prevent PPH.

Issues/Challenges: None

Next Steps: It is expected that a response from COMREC on the approval of the study protocol will be received by the end of August 2010. Once approval by COMREC and USAID/Malawi is received, full implementation will commence by September 2010.

10. Results-Based Financing (MCHIP Partner Lead: Jhpiego, Save the Children, Broad Branch Associates)

10.1 Activity: Introduce Performance Based Financing

Outputs and Outcomes: In June 2010, MCHIP's partner, Rena Eichler from Broadbranch Associates, conducted a TA visit to Malawi aligned with a visit from Norad/KFW consultants to review the design of the RBF pilot. The purpose of the visit was to develop a work plan for USAID support through MCHIP to the planned Norad/KFW supported Results Based Financing pilot aimed at improving maternal health that complements and collaborates with support provided by these donors. Rena Eichler was invited by Germany and Norway to overlap with the final days of their assessment mission to identify areas of collaboration with MCHIP/USAID. This provided the opportunity to meet with USAID, Norway and Germany, to provide an overview of Results Based Financing to the MCHIP team based in Malawi, to consult directly with USAID, and to develop options to incorporate into the MCHIP work plan for the coming year.

The proposed pilot will function in the following districts: Dowa, Kasungu, Nkhhotakota, Ntchisi and Salima. The approach will incorporate both demand and supply side incentives. *Demand side incentives* will include payments to pregnant women for transport to health facilities for deliveries and additional funds to cover food and cooking fuel to enable women and their guardian to come to the facility in advance of the due date and stay in the maternity waiting home/guardian shelter. *Supply side incentives* will provide financial

rewards to health facilities for achieving 2 preset targets: the first is a quantity measure: proportion of pregnant women who deliver in health facilities and the second is a predetermined target of improvement in the PQI score. Weights associated with each measure have not been finalized but the team concluded that a slightly higher weight would be placed on the PQI score than on the quantity target (60%, 40%). Before implementing results based financing, facilities need to be upgraded to have BEmONC capabilities. Support will be provided to enhance BEmONC capacity in facilities in these districts that the MOH has deemed ready or almost ready, equating to roughly 50 out of 104 facilities in the 5 districts. Supply side incentives would be implemented first because there is recognition that it would be irresponsible to stimulate demand without first having the supply side ready to provide quality deliveries. Many of the implementation arrangements have not yet been worked out.

MCHIP has proposed the following role to USAID/Malawi and is awaiting feedback especially on bullet number 3:

1. *Training and scale up of PQI in the 5 pilot districts:* MCHIP will contribute the technical expertise to train trainers to introduce the PQI approach in the health centers in these districts. This will involve conducting a training of trainers workshop and then working along with these trainers to support facility team training, baseline assessments and routine quality self assessments. The baseline assessments will be used to establish targets for improvement in the pilots. Norway/Germany will cover training and participant costs (per diems, transport, etc) for all non-MCHIP staff.
2. *Develop and manage streamlined data collection approach related to PQI:* MCHIP will procure, design, pilot and implement PQI using a handheld device that will enable timely reporting, determine attainment of quality score targets to link to payment of performance awards, analysis of trends, and feed into “performance dashboards” that will summarize high and low performing facilities and high and low performing quality elements for the district and zonal health teams. These dashboards will provide a snapshot of how the districts are performing and help district and zonal teams identify where they should concentrate their technical support.
3. *Contribute to global learning about how to incorporate quality improvement in results based financing systems and how elements of quality respond:* In addition, MCHIP will analyze the data to identify which areas of quality improve quickly and which areas lag under a results based financing system. The data set will be a rich source of information that will contribute to learning in Malawi and globally.

Issues/Challenges: None

Next Steps: Following receipt of the MCHIP Year 2 program description from the mission, MCHIP will develop a clear workplan that incorporates the elements of results based financing most of interest to the mission, the Ministry of Health, and the global learning agenda.

10.2 Activity: Pilot Performance-Based Financing linked to PQI/RH in MCHIP Focus Districts in Malawi

Outputs and Outcomes: Not initiated this reporting period.

Issues/Challenges: N/A

Next Steps: This activity is dependent on Activity 10.1 above and the RBF modalities that are agreed on by the Malawi government.

11. Social Marketing of Thanzi ORS (MCHIP Partner Lead: PSI)

11.1 Activity: Procurement planning and control of low-osmolarity ORS (Thanzi) stocks

Outputs and Outcomes: Monthly warehouse stocks of ORS Thanzi were monitored and the procurement plan was updated to account for the April-June 2010 stock levels. According to the stock cards, MCHIP/PSI had enough stocks in the warehouse and did not experience any product stock outs during this reporting period.

Table 1: ORS Stock levels

	Jan10	Feb 10	March 10	April 10	May 10	June 10
ORS stock levels	1,231,560	1,171,296	983,184	928,512	841,080	737,637
Procurement plan						1,100,000

Issues/Challenges: N/A

Next Steps: Continue monitoring of product stock levels in the warehouse through updating of the monthly product procurement plan.

11.2 Activity: Procurement of 1.0 million sachets of Thanzi ORS annually.

Outputs and Outcomes: MCHIP followed up on the approval for the waiver and the co-branding of Thanzi ORS following initial delays at the HQ level. It was necessary to apply for the waiver so as to procure Thanzi ORS from the non approved USAID supplier for Thanzi ORS as this supplier is the only one registered in Malawi by the Pharmacies Poisons and Medicines Board. The co-branding of Thanzi ORS including PSI logo was important for PSI to track the product in the market and would also benefit the customers to know where to take the product if it expires in stock or if it has any quality issues to be sorted out. An approval was granted and all Thanzi ORS packaging (carton, dispenser and sachet) were updated with the MCHIP, USAID and PSI logos. The artworks were sent to USAID Malawi office for review and approval. An internal purchase order for 1.1 million sachets of Thanzi ORS was raised, approved and sent to the PSI Washington procurement team.

Issues/Challenges: No challenges.

Next Steps: MCHIP will follow up on the order and shipment. The expected timeline for receipt of the order is December 2010.

12. Family Planning Social Marketing in the Private Sector (MCHIP Partner Lead: PSI)

12.1 Activity: Social marketing of OCs and ICs

Outputs and Outcomes: In the reporting quarter, the detailers identified 150 facilities that are now part of the providers' network. These facilities were visited at least once every month. During the visits, the outlets were either restocked or assisted technically. 3,990 cycles of SafePlan™ Microlette™ and 2,930 vials of SafePlan™ Injectolette™ were distributed through the private sector. The quantities distributed in this

quarter were slightly higher than in the previous quarter which shows that there is **potential for the private sector to grow** when there is more IEC messaging attached with the sales.

In the reporting period, the PSI team met to develop the marketing and communication strategy for SafePlan products. This process was essential to try and streamline appropriate communication objectives that would help improve use of the private sector as a source of contraceptives. From the meeting, it was agreed that for the remaining project life, communication activities will be centered on 3 main areas which are:

- a. Increase brand awareness of the SafePlan brand. It was highlighted through the trainings and detailing visits that most of the women were not familiar with the SafePlan brand. The SafePlan brand was described as a friendly and safe brand that one could equate to a trusted friend or confidante. Messages will be developed to portray this image. This will help clients feel confident in using contraceptives and thereby increase use of the private sector as a source of contraceptives.
- b. Increase awareness on the outlets stocking the products. It also came out strongly during the trainings and the detailing visits that most women were not aware that affordable contraceptives were now available through the private sector. By developing messages indicating the place where one can get contraceptives, women can choose a place closer to them where they can access contraceptives.
- c. Build capacity of Providers to counsel on side effects and other health concerns: As fear of side effects was cited as the main reason for discontinuing contraceptive use, providers will be trained to offer better counseling on side effects and leaflets will be produced for the clients.

Issues/Challenges: N/A.

Next Steps: In the coming quarter, communication materials will be developed and rolled out to help improve with sales. Detailing visits will continue, giving support to the providers.

12.2 Activity: Training of private medical providers on family planning

Outputs and Outcomes: In the reporting quarter, 117 private medical providers were trained in effective counseling. Participants were drawn from the outlets that had been identified to form the provider network. From the trainings, it was realized that a lot of the providers are in great need for updated information. From the trainings, the providers felt they were equipped to offer quality family planning services. Those trained will be followed up during detailing and supervision visits, to see how they are performing and to offer technical support. The 56 providers trained in the previous quarter were also followed up and most of them were practicing well.

Issues/Challenges: The main challenges being faced by the providers were that most of them were receiving very few clients. For some, they were reporting an improvement in client visits but the figures were still quite low.

Next Steps: In the next quarter, there is need to step up communication activities which will inform the public that private clinics are now offering family planning services. This will be done through Activity 12.1 above. Additional trainings for service providers will be scheduled to reach the target 300 private medical practitioners trained in FP.

12.3 Activity: Conduct feasibility studies and prepare concept notes for the piloting of community based distribution of social marketed contraceptive products in urban/peri-urban areas and for the introduction of Social Franchising Network activities.

Outputs and Outcomes: During the reporting period, data was collected on the feasibility of social marketing by CBDAs. From the study the main problems highlighted were the frequent stock outs and inadequate number of CBDAs. The research participants felt that by introducing contraceptives through a different channel, like selling, there would be more alternatives in the event of stock outs and it can be a way of retaining the few CBDAs that are available. When CBDAs who had dropped out were asked for some of the reasons contributing towards their dropping out, the common reason was to find a source of income. They also agreed that by selling contraceptives, they would get some income which could motivate them to continue providing the services.

Issues/Challenges:N/A

Next Steps: The report will be shared with the RHU in July 2010, and they will provide guidance on the way forward.

12.3 Activity: Conduct baseline Family Planning TRaC survey

Outputs and Outcomes: This activity did not take place in the reporting period.

Issues/Challenges: This activity has been moved to year 2 of the program. This decision was made after taking into consideration the following issues:

1. The DHS is being done this year and captures the indicators from the logframe. Going ahead with the TRaC will be a duplication of activities. Having an end of project TRaC will help in assessing whether there was an improvement in the indicators.
2. Considering that the first phase of the trainings is just being finished, having a TRaC this year and another end of project TRaC will not show significant changes in the indicators since there will be less than a year of implementation of activities.
3. Having an end of project TRaC will give a benchmark for the next phase of implementation and give guidance on marketing activities for expansion of the program in the future.

Next Steps: Start preparing the study design for submission to the IRB for approval.

13. Public Sector Support to Provide and Promote Malaria Control (MCHIP Partner Lead: PSI)

13.1 Activity: Participate in effective and accurate LLIN procurement planning with key stakeholders.

Outputs and Outcomes: One planning meeting was held at National Malaria Control Program office and in attendance was MCHIP and Mulli Brothers who are the two LLIN distributors in the country. The purpose was to discuss a long term plan for net distribution since the current model is adhoc. It was agreed that the current net distribution plan is demand driven hence the quantity of LLINS needed per clinic is submitted by the DHOs. However the two distributors were advised to report any problems faced in the health facilities that would need quick action by the National Malaria Control Program.

Issues/Challenges: Currently NMCP continues to provide MCHIP with a distribution plan on an ad-hoc basis relying on district level requests for nets instead of appropriate forecasting. This is likely to affect efficient and effective distribution of LLINs.

Next Steps: Continue to work with NMCP and other partners on long term distribution plan for LLINs through public sector health facilities; this includes ongoing discussions on costs to be incurred using the adhoc distribution plan versus strategic long term distribution plan.

13.1 Activity: Clearing, Receiving, Warehousing, Control, Monitoring and Distribution of LLINs nationwide in collaboration with the NMCP and its partners.

Outputs and Outcomes: No additional LLINs were received this quarter. Last quarter, as reported, 320,000 LLINs were received, cleared and warehoused at PSI warehouses. This reporting quarter (April-June 2010) 47,100 LLINs were distributed in the Northern zone of Malawi according to the distribution plan provided by the National Malaria Control Program reaching a total of 120 health facilities in the Northern Region and 65,600 LLINs were distributed in the Southern region reaching 271 health facilities. The datum level for each facility (maximum number of nets) was determined by National Malaria Control Program.

Table 2. Mosquito nets distributed in Malawi to date

	Chitetezo	Green	Green	Green	Green	TOTAL
Quarter	Blue ITNs	SWAP ITNs	GTZ ITNs	UNICEF LLINs	PMI LLINs	
Oct-09	20,362				1	
Nov-09	13,512					
Dec-09	11,844					
Qtr1	45,718	0	0	0	1	45,719
Jan-10	17,987					
Feb-10	25,562			10,000	41,201	
Mar-10	19,655				3,000	
Qtr2	63,204	0	0	10,000	44,201	117,405
April-10	14,579	0	0	1	47,421	
May-10	10,524	0	0	0	53,001	
June-10	9,782	0	0	100	13,000	
Qtr 3	34,885	0	0	101	113,422	148,407
TOTAL	143,807	0	0	10,101	157,624	311,531

Issues/Challenges:

- There were no client registers to record beneficiaries in the facilities. Health personnel were using plain papers or hard covers to register clients.
- Some clinics were overstocked with nets while others had low stocks.
- A good number of contact persons who were trained to manage nets at health facility level were no longer in health facilities or had been given other responsibilities.

Next Steps:

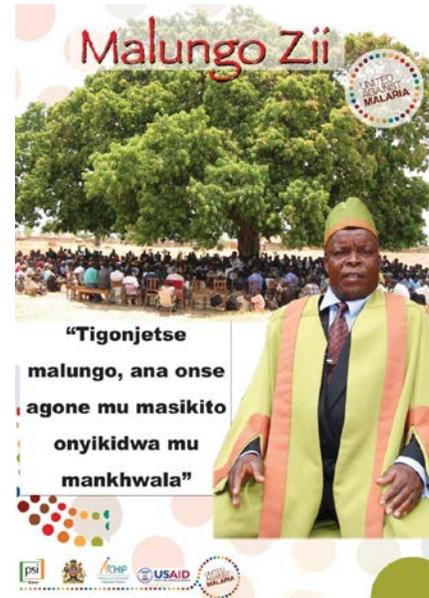
- Work with the NMCP to organize client registers to be delivered to all clinics so that good records of beneficiaries are available at each health facility
- Continue with distribution and monitoring of LLINs through public sector health facilities.
- Follow up with USAID/DELIVER on delivery of the new USAID order of LLINs.

14. Public Sector Support to Provide and Promote Malaria Control (MCHIP Partner Lead: PSI)

Activity: IEC to promote LLIN, IPTp, and Case Management of Malaria

Outputs and Outcomes: MCHIP/PSI conducted a workshop with NMCP, HEU & Malaria IEC technical working group to finalize the development of messages on LLINs, IPTp and case management. Following this design workshop, MCHIP developed 4 poster & radio concepts on LLINs (Involving national football coach, goalkeeper, a traditional chief and a boy), produced 2 radio jingles on Malaria, printed 4,000 posters and placed 133 radio spots on Zodiak & 102 spots on MBC. MCHIP also developed TV/Mobile video materials on malaria, developed and printed physical & visual promotional materials and developed drama scripts and signed contracts with 7 drama groups.

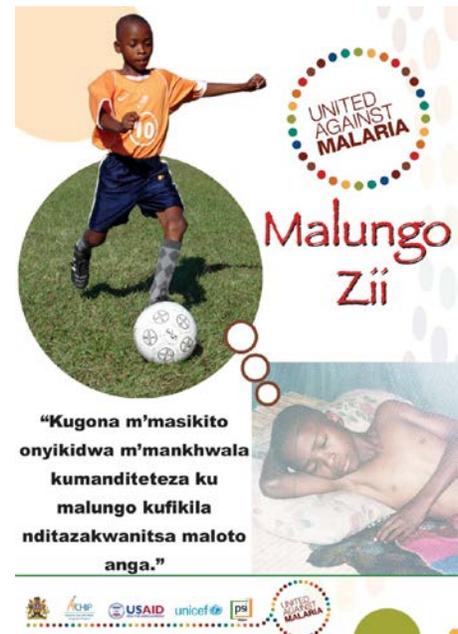
On June 12th, MCHIP launched a national **United Against Malaria Campaign** in Lilongwe with the purpose of creating high visibility awareness at beginning of Malaria campaign and to sustain it throughout world cup. Health Education Band from the Ministry of Health drove around Lilongwe city with the Malawi National team players disseminating the malaria messages to the community and thereafter there was a big walk from Area 15 to Silver stadium led by the PS for Health who officially launched the event at Civo Stadium. The crowd was entertained with music from the famous local band and finally there was a football match between the two super league teams to make a link to the promotional strategy linking it to the World Cup. Following the successful launch of the national United Against Malaria ‘Malungo Zii’ initiative the objective over the span of the World Cup was to deliver the message to six rural districts with limited access to information but high risk to Malaria and two of the six districts (Blantyre Rural and Salima) were reached during the quarter. During the launch, 10,000 people were reached in the stadium, and 6,000 during the drive around the city by Health Education Band and the Malawi National team players. Two of the IEC messages are shown on this page and two more are shown on page 26.



Issues/Challenges: N/A

Next Steps:

- Mini-launches of United Against Malaria Campaign in four districts that are highly prone to Malaria: Karonga, Nkhata-Bay, Nsanje and Zomba districts
- Extend Malungo Zii campaign to increase the correct and consistent use of LLIN to protect pregnant women and children under the age of 5, increase caregivers seeking treatment behavior within 24 hours from the onset of fever, and increase uptake of IPTp among pregnant women at 4 and 7 months pregnancy
- Production and placement of IPTp and case management IEC materials
- Nationwide deployment of the local drama and IPC groups to disseminate messages on LLIN use, IPTp and case management



15. Strengthen Behavior Change and Social Mobilization on MNH issues (MCHIP Partner Lead: Jhpiego, Save the Children, PSI)

15.1 Activity: Strengthening and standardizing behavior change communication messages for MNH

Outputs and Outcomes: At the time of work planning, the original intention of this activity was to disseminate MNH messages developed under ACCESS using existing community-based platforms. However, at the request of the RHU, the printed IEC materials developed under ACCESS were handed over to RHU so that they could be distributed nationally. MCHIP is exploring integration of the same MNH messages into the existing drama groups used by PSI to disseminate messages on Malaria. Further discussions by MCHIP partners will take place in the next quarter (July-September) to see how best to operationalize this idea.

Issues/Challenges:

Next Steps: MCHIP partners (Jhpiego, Save, PSI) to discuss this idea of MNH-Malaria integration using the existing drama groups to disseminate the MNH messages developed under ACCESS.

15.1 Activity: Increase social mobilization around MNH issues at the community level

Outputs and Outcomes: Not initiated during reporting period.

Issues/Challenges: N/A

Next Steps: Beginning July 2010, MCHIP will begin more formal discussions with DHMT and community leaders, including members of the Community Mobilization “Core Groups”, to identify a Safe Motherhood champion in the community who can lead efforts in social mobilization. The Core Groups will take the lead in identifying a key intervention for safe motherhood as well as nominating a representative who has shown dedication to the cause of safe motherhood in the community.

16. Program Management and M&E Activities (MCHIP Partner Lead: Jhpiego, Save the Children, PSI)

16.1 Activity: Monitoring & Evaluation

Outputs and Outcomes: Throughout the quarter, MCHIP continued to monitor program activities through collection of relevant performance and outcome data using existing data collection and reporting systems. Major activities under taken this quarter included the following:

- The M&E Officer continued follow-up with the HMIS and data entry focal persons in each of the four focus districts regarding updates on the Community MNH database, PQI outcome indicator templates, and issues regarding the data entry system and reporting .
- M&E specialist worked closely with Broadbranch Associates to conceptualize the design of the RBF pilot and an M&E system to track the performance indicators. MCHIP is exploring use of handheld technology for monitoring PQI linked to RBF.

Issues/Challenges: Further efforts to institutionalize the process of creating ownership at the district level on data entry and data management needs to be undertaken.

Next Steps: For institutionalization of CMNH indicators and a data management and reporting system, MCHIP will work closely with the Saving Newborn Lives (SNL) team to formalize the data collection and information system currently in place. This will be done in close collaboration with RHU and HMIS to standardize and absorb current practices into the national HMIS system. It is expected that this process will

overlap with Year 2 activities. For monitoring and reporting on key RH outcome indicators, MCHIP will continue to collaborate with RHU and further engage the National Quality Assurance Technical Working Group (NQA TWG) on selecting a few key indicators directly related to PQI (i.e. AMTSL) that can be monitored and tracked as part of an impact assessment on PQI successes.

16.1 Activity: Joint supportive supervision visits for all MCHIP programs at the community and district levels

Outputs and Outcomes: The supportive supervision took place in May 2010 in all four districts at randomly selected health centers. The aim was to assess the progress on PQI/RH/IP, BEmONC, and Community MNH activities along the household to hospital continuum of care model. At the facility level, the primary areas of focus were the antenatal, labour and delivery, postnatal and OPD units. Pharmacy, Laboratory and the dental clinic were also supervised but only at the district hospitals. Some of the major findings of the supervision were that DHMTs have become very supportive of IP/RH and BEmONC activities as evidenced by availability of PPEs in the maternity such as gumboots, screens between delivery beds, hospital linen, and aprons and availability of emergency drugs such as oxytocin and diazepam at all the health facilities. IP/RH/PMTCT activities are progressing well in all the facilities. After the supervision, the DHMT were briefed on the findings and recommendations. The DHMT showed a lot of interest during debriefing and conversant with issues of PQI/RH and IP.

At the community level, HSAs continue to empower communities at both the household and village level by effectively sharing communication messages on safety during pregnancy, birth preparedness/complication readiness, importance of skilled assistance at birth, postnatal care, family planning, and nutrition. Data collected through the HSAs' register indicated improvements in identification of danger signs and access to facility-based services.

Issues/Challenges: Some providers showed inadequate knowledge and several facilities had inadequate equipment on Infection prevention. There is shortage of staff on PQI/IP. The recommendations made were that the DHMT and the QIST should intensify supervision on upholding IP practices and that management should purchase IP equipment.

Next Steps: MCHIP has planned to conduct a comprehensive joint supervision by program staff in the next quarter.

Other Key Activities and Developments

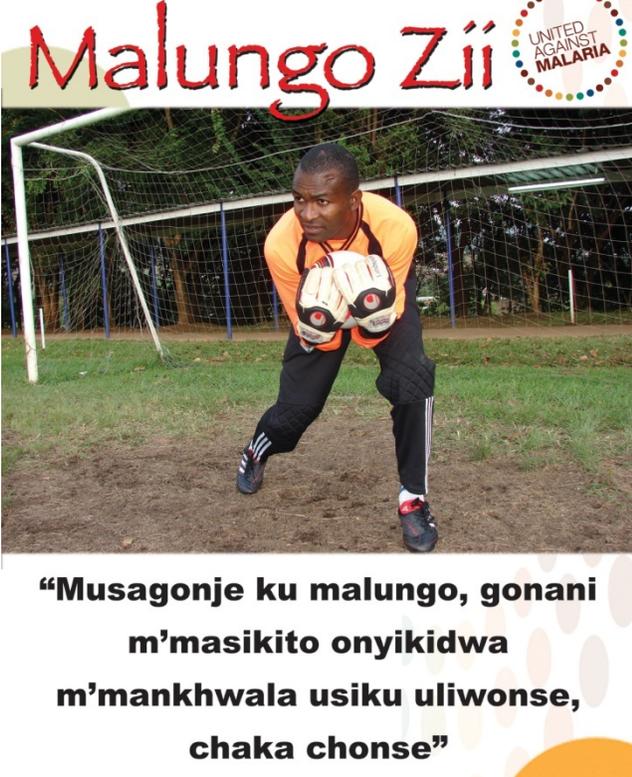
1. On 4-9th May, Dr. Alex Ergo and Dr. Nirali Shah visited Malawi as part of an MCHIP core-funded activity to develop a case study on the lessons learned over a ten year period (since 2000) on health systems and interventions on maternal health. The case study will be one of two case studies and was structured around a common framework that is being developed for MCHIP. The objective of the framework is to allow assessing the effects of health system strengthening initiatives on newborn, child and maternal health results. A first version of the framework was presented to MCHIP in DC in January 2010. The approved framework was used to develop the Malawi case study, and once finalized, the case study will provide an opportunity to refine and validate this new framework.
2. MCHIP Malawi Senior Management Team (Jhpiego, Save the Children, PSI) met on 17th May to discuss the progress to date of all MCHIP activities, discuss major issues or concerns related to implementation and devise solutions to enable positive progress. Of biggest concern is the challenge related to LLIN distribution which relies heavily on distribution planning and schedules. MCHIP will continue to plan with partners and USAID on how best to resolve this bottleneck.

3. USAID/Washington commissioned a video shoot in Malawi to highlight the work on MCHIP to run during the length of the Women Deliver Conference in June. The video shoot was conducted in Machinga on the 20th of May. MCHIP/HQ will send a copy of the video to the Malawi office in the next few weeks which we will then share with the mission.
4. In June, the MCHIP Chief of Party, Tambudzai Rashidi, presented at the Women Deliver Conference in Washington DC on the implementation and scale-up of BEmONC services at health facilities in Malawi. On the same panel, a colleague from Save the Children presented on the CMNH model (including the implementation in MCHIP districts). The panel was moderated by Dr. Chisale Mhango, the Director of the RHU. The Deputy Director of RHU (Fannie Kachale) also presented at the same conference scale up of PQI/RH which is demonstrating improvements in MNH.
5. In June, the MCHIP Deputy Chief of Party and the Community MNH Specialist presented posters at the Global Health Council on two of MCHIP's programs: 1) Strengthening Infection Prevention and Control in Malawi hospitals, and 2) Improving MNH in Communities in Malawi.
6. In June, following the external verification visit to Dowa District Hospital for PQI in RH services where they scored below 80% in three areas of Family Planning starting and follow up and in management of abnormal labour, MCHIP and MoH conducted a re-verification visit to the hospital to verify whether the hospital had made progress towards achievement above 80%. The hospital scored well above 80% (they scored 100% in both Family Planning areas) thereby qualifying them to receive recognition in RH services. The recognition ceremony will be conducted in August 2010.

Below: United Against Malaria Messages launch during World Cup



“Ndafika pano chifukwa ndinatetezedwa ku malungo. Gonani m'masikito onyikidwa m'mankhwalu usiku uliwonse, chaka chonse.”



“Musagonje ku malungo, gonani m'masikito onyikidwa m'mankhwalu usiku uliwonse, chaka chonse”





ANNEX 1: MCHIP MONITORING AND EVALUATION PLAN

*Indicates an "Investing in People" indicator

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARG ET	PROG RESS AS OF 30 JUNE	
Goal: Accelerate the reduction of maternal, neonatal, and child morbidity and mortality towards the achievements of the Millennium Development Goals (MDGs)										
MCHIP Program Objective: Increased coverage of MNCH/FP services/interventions and practice of healthy maternal and neonatal behaviors										
Result 1: Increased access to and availability of quality maternal and newborn care services										
Number of postpartum / newborn visits within 3 days of birth by trained workers from USG-assisted facilities	Number of postpartum/newborn visits at community and facility level within 3 days of their birth, includes skilled deliveries at birth	Maternity register; CMNH register	Documentation of SBA deliveries as they occur in maternity register; HSAs to record dates/times of visit as they occur; Monthly reporting to MCHIP office.	Monthly	HSAs and MCHIP Data Entry Clerk	Quarterly	M&E Specialist, Chief of Party	70,000	71,433	Data on SBA deliveries was collected at all PQI hospitals and MCHIP focus health centers where PNC is incorporated as part of the RH standards.
Number of newborns receiving essential newborn care in selected MCHIP-supported facilities	# of newborns born in selected MCHIP-supported health facilities who receive essential newborn care/ total number of newborns born in selected MCHIP-supported health facilities Essential newborn care consists of: <ul style="list-style-type: none"> • Clean cord care • Thermal care (immediate 	Partograph review, Maternity Register, KMC (LBW) register	Use total number of deliveries at PQI sites as proxy Data collection as AMTSL occurs; Monthly feedback reporting to MCHIP for data review	Monthly	Maternity/Postnatal providers	Quarterly	M&E Specialist, Chief of Party	70,000	71,433	Data on SBA deliveries was collected at all PQI hospitals and MCHIP focus health centers where ENC is incorporated as part of the RH standards.

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	drying and wrapping or KMC) <ul style="list-style-type: none"> • Immediate breastfeeding within 1 hour of birth 									
Number of ANC visits by skilled providers from USG-assisted facilities	Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities. Skilled providers includes: medically trained doctor, nurse, and/or midwife. It does NOT include traditional birth attendants (TBA) or HSAs.	ANC register,	Skilled providers conducting ANC visits will fill a ANC register	As ANC visits occur (facility)	ANC providers	Semi-annually	M&E Specialist, Chief of Party	154,000	113,810	Data was collected from all PQI sites and MCHIP focus health centers where provision of quality ANC services has been incorporated into the RH standards.
Number of people trained in maternal and/or newborn health and nutrition through USG-supported programs	Number of people (health professionals, primary health care workers, community health workers, non-health personnel, volunteers) trained in maternal and/or newborn health and nutrition care through USG-supported programs	TIMS	MNH trainings (including KMC, BEmONC, CMNH/CM, PAC, etc. trainings) as they occur	As trainings occur	Program Officer	Quarterly	M&E Specialist, Chief of Party	340	359	MCHIP managed to train an extra 20 providers in PQI/RH which accounts for why we exceeded the target.
Number of pregnant women referred by HSAs to ANC services from focus districts	Number of pregnant women referred by HSAs for ANC services	CMNH register	HSAs record referrals as they occur; submit copies of	Ongoing, with submission of logs	District Coordinators	Quarterly	M&E Specialist, Chief of Party	18,264	2,300	Data entry is lagging due to the volume of paper

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				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
			logbook to MCHIP on monthly basis	monthly						documentation. MCHIP will conduct a hand count of all logs unentered in the next quarter to verify the exact number of referrals.
Percentage of MCHIP-supported facilities where KMC services are in use	Number of MCHIP-supported facilities which have established KMC room / all MCHIP-supported facilities	KMC (Low-birth weight) Register	Service providers to record clients admitted for KMC	Monthly	Program Officer	Annually	M&E Specialist, Chief of Party	100%	100%	All MCHIP focus health centers have a functional KMC unit
Percentage of MCHIP supported facilities where Ambulatory KMC services are in practice	Number of MCHIP-supported facilities which have established Ambulatory KMC / all MCHIP supported facilities	AKMC Register	HSAs and/or service providers to record AKMC clients	Monthly	Program Officer	Annually	M&E Specialist, Chief of Party	100%	100%	All sites have now been introduced to Ambulatory KMC and have started implementation.
Percentage of facilities in target districts achieving 80% of standards in RH and IP	Number of MCHIP-supported facilities which were able to achieve a total score of 80% or higher, across all standards, on national performance standards / all MCHIP-supported facilities implementing PQI	PQI database	Data collection as assessments occur using a standardized PQI checklist	As assessments occur	External Assessment Team	Semi-annually	M&E Specialist, Chief of Party	3	1 (Mzuzu Central Hospital for RH)	It is expected that 2 additional sites will be recognized in the next quarter.
Number of people trained in FP/RH	Number of people (health professionals,	TIMS	Data collection as trainings	As trainings	Program Officers	Semi-annually	M&E Specialist,	560	436	

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH (including training in service delivery, communication, policy systems, research, etc.)		occur	occur			Chief of Party			
Number of USG-assisted service delivery points providing FP counseling or services	Number of service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated, as appropriate, by type of service: vertical FP/RH; HIV including PMTCT; pre-natal/post-natal or other MCH; sites offering long-acting or permanent methods (IUD, implants, voluntary sterilization).	TIMS, Program Reports	As trainings occur providers indicate the facility they represent.	As trainings occur	Program Officer	Semi-annually	M&E Specialist, Chief of Party	330	330	Consists of 130 service delivery points being strengthened through PQI in the public sector plus an additional 200 service delivery points identified through the private sector receiving SafePlan.
Number of women giving birth receiving AMTSL in selected MCHIP-supported facilities	Number of women who received AMTSL at sampled facilities/Total number of women with vaginal deliveries at sampled	Partograph, Maternity register	Use total number of deliveries at PQI sites as proxy Data collection as AMTSL occurs; Monthly	As deliveries occur	Maternity providers/ MCHIP	Quarterly	M&E Specialist, Chief of Party	70,000	71,433	Data on SBA deliveries was collected at all PQI hospitals and MCHIP focus health centers where

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				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	facilities AMTSL is defined as the following three elements: <ul style="list-style-type: none"> • Use of uterotonic drug within one minute of birth (oxytocin preferred) • controlled cord traction • uterine massage after the delivery of the placenta 		feedback reporting to MCHIP for data review							AMTSL is incorporated as part of the RH standards.
Number of counseling visits for FP/RH as a result of USG assistance	Number of visits that include counseling on FP/RH. Can include clinic visits as well as contact with HSAs and/or CBD agents.	CMNH register, FP register	As counseling visits occur	As counseling visits occur with CMNH register collected monthly	District Coordinator	Quarterly	M&E Specialist, Chief of Party	25,000	20,200	Includes 19,432 facility-based FP counseling visits MCHIP focus districts, and 768 FP counseling visits through HSAs in the community.
Result 2: Increased adoption of household behaviors that positively impact the health of mothers and newborns										
Percentage of pregnant women who develop a birth plan	Number of pregnant women who developed a birth plan / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinators, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of pregnant women who took antimalarials to prevent malaria in pregnancy and folate	Number of pregnant women who took antimalarials and folate / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinators, MNH Advisor, M&E	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010

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				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
tablets					Specialist					
Percentage of women who practiced LAM or other PFP method	Number of postnatal women who accepted PFP method, including LAM / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of women reporting danger signs and seeking immediate medical care	Number of pregnant and postnatal women reporting a danger sign and care sought / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of women who breastfed within 1 hour of birth	Number of postnatal women who report breastfeeding within one hour after birth / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of women who delayed bathing of the newborn for first 24 hours	Number of postnatal mothers who report delaying first bath of newborn for initial 24 hours / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of women who report not taking any traditional herbs to speed labour, to facilitate childbirth, or postnatally	Number of women who report not taking any traditional herbs to speed labour, to facilitate childbirth, or postnatally / Total number surveyed	Lot Quality Assurance Survey (LQAS)	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010
Percentage of women who report practicing Kangaroo Mother Care for low birth weight	Number of women who report practicing KMC for low birth weight babies / Total	Lot Quality Assurance Survey	LQAS survey in focus districts	Annual	District Coordinator s, MNH Advisor,	Year 2 and EOP	M&E Specialist, Chief of Party	TBD		The LQAS is scheduled for September 2010

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARG ET	PROG RESS AS OF 30 JUNE	
babies	number surveyed	(LQAS)			M&E Specialist					
Result 3: Increased availability of community-based MNH services through Health Surveillance Assistants										
Percentage of pregnant women and their families in targeted HC catchment areas receive at least 3 home counseling visits from a trained HSA.	Number of pregnant women and their families receiving at least 3 home counseling visits from trained HSAs / Number of expected pregnancies	CMNH database	As counseling visits occur	Year 2 and EOP	Program Officer, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	50%	Will report end of Y1	
Percentage of postnatal women who received at least 3 home counseling visits within one week of delivery from a trained HSA	Number of postnatal women and their newborns receiving at least 3 home counseling visits from trained HSAs / Number of expected pregnancies	CMNH database	As counseling visits occur	Year 2 and EOP	Program Officer, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	50%	Will report end of Y1	
Percentage of targeted communities that have action plans to support pregnant women and newborns to use MNH services appropriately	Number of target communities that have action plans to support pregnant women and newborn to use MNH services appropriately/ Number of target communities	Program Reports	Review of program reports supplemented by informant interviews during field visits	Year 2 and EOP	Program Officer, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	80%	Will report end of Y1	
Result 4: Strong MNH policies, planning and management in place at the national, zonal, and district and community levels.										
Number of students graduating from target nursing and midwifery preservice schools with strengthened BEmONC and PFP curricular components	Number of students graduating from target nursing and midwifery preservice schools	School records	Aggregate number of graduating students reported to MCHIP by target schools	Annually	Program Officer	Annually	M&E Specialist, Chief of Party	TBD	Will report end of Y1	

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARG ET	PROG RESS AS OF 30 JUNE	
Number of policies or guidelines developed or changed with USG-assistance to improve access to and use of FP/RH services	Number of policies or guidelines developed or changed to improve access to and use of FP/RH services. Includes: Preservice FP Syllabus, National RH strategy update, RBF guidelines, Misoprostol guidelines, etc.	Program Reports	Program officer will detail developments in FP/RH policies or guidelines	As program milestones occur	Program Officer	Annually	M&E Specialist, Chief of Party	1	1	In June, MCHIP facilitated the review and revision of the RH strategy. It will be finalized in the next quarter.
Number of district-level scale-up plans in place to expand coverage of MCHIP programs	Number of scale-up plans developed by districts to expand coverage of MCHIP activities, including community model, PQI IP/RH at health centers, and KMC.	Program Reports	Program officers	As scale-up plans are developed	Program Officer/DH MT	Annually	M&E Specialist, Chief of Party	4	4	MCHIP facilitated a workshop to enable districts to develop scale-up plans. Refer to Activity 1.1.
Number of policies or guidelines developed or changed with USG-assistance to improve access to and use of Community MNH services	Number of policies or guidelines developed or changed to improve access to and use of Community MNH services.	Program Reports	Program officer will detail developments in CMNH policies or guidelines	As program milestones occur	Program Officer	Annually	M&E Specialist, Chief of Party	1	1	CMNH activities were integrated into the revised RH Strategy. In addition, next quarter a workplan for MCHIP's contribution to performance based financing will be developed and contribute to strengthening and scale up of

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
										CMNH.
Number of districts demonstrating improved use of data for decision making/priority setting with MCHIP support	For example, this includes the use of the LiST to inform national or sub-national program planning. This may also include improved use of HMIS, community HMIS, supervision or quality assurance data for decision making.	Meeting minutes, policy documents, program records	Part of PQI internal assessments	As internal assessments occur	HMIS Officer	Quarterly	M&E Specialist/ COP	4	4	Districts utilized the CMNH and PQI results to develop scale-up workplans in their districts. MoH staff continue to enter data at the district-level.
Result 5: Increased commitment of resources for MNH from GoM and other donors										
Number of trainings on CMNH, KMC, PQL, BEmONC, FP conducted using leveraged funds by other donors	Number of MCHIP program trainings conducted using resources/funds from other donors	Training reports	Program Officers	As trainings occur	Program Officer/ GoM	Quarterly	M&E Specialist, Chief of Party	TBD	0	
Result 6: Increased availability and access to low osmolarity ORS among mothers and caregivers of children under 5										
Number of cases of child diarrhea treated through USG-supported programs	Number of cases of child diarrhea treated through USG-supported programs with: a) oral rehydration therapy (ORT), b) zinc supplements	PSI/Malawi source documents (sales documents/ receipts/ invoices)	National level survey using trained data collectors from PSI	Weekly	PSI/Malawi Sales Representatives	Monthly	PSI / MCHIP	330,000	Will report end of Y1	
Number of ORS sachets provided through USG-supported programs	Number of low osmolarity ORS sachets provided through USG-supported programs through community	PSI/Wash and PSI/Malawi source documents (procurement)	National level survey using trained data collectors from PSI	Weekly	PSI/Wash Procurement Specialist for East Africa and PSI/Malawi Warehouse	Quarterly	PSI / MCHIP	1,000,000	0	MCHIP received the waiver on branding in June. This will be reported on in the next quarter.

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	based distribution	contracts, sampling and testing results, warehouse reports/forms)			Manager					
Result 7: Increased use of oral and injectable contraceptives amongst middle income women of reproductive age intending to use FP methods										
Percent of 15-49 year olds using oral contraceptives accessed outside of the public	Number of 15-49 year olds using oral contraceptives accessed outside of the public sector / Number of 15-49 year olds using any FP method accessed outside of the public sector	Tracking Results Continuously (TRaC) Survey; Measuring Access and Performance (MAP) survey	National level survey using trained data collectors from PSI	TRaC: Year 2 MAP: Annually	PSI Research Team	Year 1 and EOP	PSI/MCHIP	TBD		Since the TRaC is being postponed to Y2, MCHIP will introduce an FP register to all the SDPs to collect this data
Percent of 15-49 year olds using injectable contraceptives accessed outside of the public sector	Number of 15-49 year olds using injectable contraceptives accessed outside of the public sector / Number of 15-49 year olds using any FP method accessed outside of the public sector	Tracking Results Continuously (TRaC) Survey; Measuring Access and Performance (MAP) survey	National level survey using trained data collectors from PSI	TRaC: Year 2 MAP: Annually	PSI Research Team	Year 1 and EOP	PSI/MCHIP	TBD		Since the TRaC is being postponed to Y2, MCHIP will introduce an FP register to all the SDPs to collect this data
Number of private sector medical service providers trained in family planning	Number of private medical service providers attending PSI/Malawi family planning training	PSI/Malawi training participant lists and	Training attendance recordkeeping and report preparation	Per training schedule	PSI/Malawi Medical Detailer/Trainer	Year 1 and EOP	PSI/MCHIP	300	173	

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				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	sessions on new topics	reports								
Result 8: Increased ownership and correct and consistent use of LLIN's among mothers and caregivers of children under five										
Number of ITNs distributed that were purchased or subsidized with USG support	Number of PMI-funded LLINs distributed via antenatal clinics and/or mass campaigns; measured in nets.	PSI/Malawi source documents (warehouse requisition s/ delivery documents/ receipts)	Daily Completion of sale document at point of sale	Weekly	PSI/Malawi LLIN/ITN Representatives	Monthly	PSI / MCHIP	800,000	157,624	PMI nets distributed.
Percent of mothers and caregivers of children under 5 years of age who report that their households own at least one mosquito net	Number of mothers and caregivers of children under 5 years reporting that their household own at least one mosquito net / Number of households with children under 5	Tracking Results Continuously (TRaC) Survey; Measuring Access and Performance (MAP) survey	National level survey using trained data collectors from PSI	TRaC: Year 2 MAP: Annually	PSI Research Team	Year 2 and EOP	PSI/MCHIP	TBD		A survey will be conducted in the July-September quarter
Percent of mothers and caregivers of children under 5 years of age who report that their children under 5 years of age slept under an ITN the previous night	Number of mothers and caregivers of children under 5 years reporting that their children under 5 years of age slept under and ITN the	Tracking Results Continuously (TRaC) Survey; Measuring	National level survey using trained data collectors from PSI	TRaC: Year 2 MAP: Annually	PSI Research Team	Year 2 and EOP	PSI/MCHIP	TBD		A survey will be conducted in the July-September quarter

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	SOURCE OF DATA	METHOD OF DATA COLLECTION	DATA COLLECTION		REPORTING		PY1 TARGET AND PROGRESS		COMMENTS
				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	previous night/ Number of household with children under 5	Access and Performance (MAP) survey								
Result 9: Increased community and district action, through community-based networks and communication programs, to support use of high impact MNH interventions										
Number of districts which develop plan for universal coverage of high impact interventions	Number of districts which have developed a plan to roll out coverage of selected “quick-wins” across the district	Program Reports; Roll-out plan	DHMT and MCHIP officers to report as planning meetings occur and plans are developed	Quarterly	DHMT/MCHIP	Annually	M&E Specialist, Chief of Party	2	4	MCHIP’s four focus districts have developed a workplan to scale up the household to hospital continuum of care model including PQI and CMNH package.
Number of partnerships with NGOs forged as a mechanism for dissemination of MNH IEC materials	Number of NGOs partnering with MCHIP to disseminate IEC materials on MNH through their existing platforms	Program Reports	Interviews with key personnel from partners	Quarterly	MCHIP	Annually	M&E Specialist, Chief of Party	2	0	This will be done in the July-September quarter
Number of target communities with mechanisms for supporting birth preparedness/complication readiness	Communities include Village Executive Committees which have developed mechanisms for supporting birth preparedness and complication readiness for community members	Program Records, key informant interviews	Review of program reports supplemented by informant interviews during field visits	Year 2 and EOP	Program Officer, M&E Specialist	Year 2 and EOP	M&E Specialist, Chief of Party	2,000 villages	Will report end of Y1	

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				Schedule	Responsible	Schedule	Responsible	PY1 TARGET	PROGRESS AS OF 30 JUNE	
	Examples include community financial schemes, emergency transport systems or community education schemes									
Result 10: Prompt and effective treatment of malaria among children under five and improved awareness around uptake of IPT among pregnant women and HIV positive mothers										
Proportion of pregnant women who are reached IPT Communications	Number of pregnant women who have seen or heard a USG supported IPT communications	Tracking Results Continuously (TRaC) Survey;	National level survey using trained data collectors from PSI	TRaC: Year 2	PSI Research Team	Year 2 and EOP	PSI/MCHIP	TBD		Messages currently being developed
Proportion of children under five years old with fever in the last two weeks who received treatment with ACTs.	Number of children under 5 years with fever who received ACT treatment within 24 hours of onset / Number of children under five	Tracking Results Continuously (TRaC) Survey;	National level survey using trained data collectors from PSI	TRaC: Year 2	PSI Research Team	Year 2 and EOP	PSI/MCHIP	TBD		A survey will be conducted in the July-September quarter.

