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MCHIP Malawi Quarterly Report

FY2013 Q4 (July - September 2013)



Male circumcision in Thyolo District Hospital, maintaining infection prevention practices



Malawi Vice President, Khumbo Kachali helping in administering symbolic rotavirus at the launch of the vaccine in October 2012, Lilongwe

Project Name: MCHIP
Reporting Period: FY 2013 – Quarter 4 : July 1, 2013 – September 30, 2013
Project Duration: October 2011 – September 2013
Evaluation Dates: TBD
Person Responsible for Drafting this Report: George Chiundu, Jennifer Berg and Lolade Oseni
<p>Project Objectives:</p> <p>Immunization</p> <ol style="list-style-type: none"> 1. Successfully introduce rotavirus vaccine in October 2012, support MOH/EPI in monitoring and follow up of PCV and Rota vaccines and assist with the GAVI Alliance application submission process for the measles second dose. 2. Improve the capacity of the MOH/EPI to develop skills and improve the performance of its staff in new vaccine introduction and routine immunization. 3. Strengthen the platform for new vaccines introduction by developing national immunization policy, improving routine immunization monitoring and evaluation, data quality, vaccine and cold chain management at the national, zonal, district and health facility levels. <p>HBB</p> <ol style="list-style-type: none"> 1. Evaluation: Evaluate the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi over time. 2. Pre-service: Establish HBB training methodology in 13 Malawi pre-service institutions implementing ENC (MCHIP core-funded) <p>VMMC</p> <ol style="list-style-type: none"> 1. Support CHAM and MOH to conduct 8,100 MCs by September 2013 through: <ol style="list-style-type: none"> a. Training providers and orienting support staff at Thyolo District Hospital, Malamulo Mission Hospital and Thomas Health Center b. Support quality assurance efforts including development and implementation of a waste management plan c. Strengthen M&E systems

Immunization

I. Overall Progress of the Project for the Quarter

Activities Planned	Activities Accomplished
Provide technical support for training on Reaching Every District (RED) in districts supported by other partners including UNICEF and CHAI	<ul style="list-style-type: none"> MCHIP shared the lessons learnt from Zimbabwe on RED implementation. MCHIP also assisted CHAI on planning for RED Micro planning to be implemented in the interventional study districts of Mangochi, Karonga and Lilongwe from November, 13 to February, 14.
Conduct supportive supervision	<ul style="list-style-type: none"> The role of MCHIP was to be part of the supportive supervision team that included MOH and partners. These visits were not done due to competing priorities for MOH and partners and no date fixed for the next month. MCHIP raised its concerns during partners meetings.
Support preparations for Measles/Polio supplementary immunization activities (SIAs)	<ul style="list-style-type: none"> MCHIP is a member of the national task force, which has met four times so far. MCHIP provided technical support for the development of social mobilization materials from 22nd to 26th August and training of district TOTs in 3 zones; North, central west and South East, from 23rd to 28th September.
Conduct Data Quality Self-assessment (DQS) in the remaining districts	<ul style="list-style-type: none"> The activity is not yet done due to competing priorities but it will be done in the second quarter of next year.
Conduct Rotavirus Vaccine Post Introduction Evaluation (PIE)	<ul style="list-style-type: none"> MCHIP provided both local and external technical support for the Rota PIE which took place from 10th – 18th July. The evaluation was done at the national EPI unit, the 3 zones and 6 districts, which are: Karonga, Nkhatabay, Thyolo, Zomba, Dowa and Kasungu. The key findings of the evaluation include the following: <ul style="list-style-type: none"> Availability of an introduction plan at the national level to guide implementation of activities, however, these plans are not available at the zonal and district levels. The training was well conducted and there were adequate training materials. The HCWs demonstrated good knowledge of Rota

Activities Planned	Activities Accomplished
	<p>vaccine.</p> <ul style="list-style-type: none"> • Advocacy and sensitization meetings were held at all levels. Different types of posters and flyers were distributed throughout the country and different print and electronic media were used to disseminate information in order to increase awareness and community acceptance of Rota vaccine. The major weakness was late distribution of IEC materials. • To assure comprehensive Rotavirus immunization reporting, the national EPI database and district reporting tools were updated to include Rota vaccine prior to introduction. There is good coverage of Rota vaccine at national level, 85% from January to May, 2013. • Overall there is adequate cold chain capacity & well-functioning refrigerators at all levels. Temperature monitoring charts were routinely recorded and up to date. Generally there is good cold chain management in the sampled districts. No expired vaccines or vaccines with late-stage VVMs were observed. However, no monitoring of temperature is done during transportation of vaccines. • There were no stock outs of Rota in all districts except one, Karonga. Good vaccination techniques were observed during vaccination sessions. All health facilities use safe injection equipment, AD syringes and safety boxes, for immunization. However, there is improper disposal of injection waste in some facilities, especially in Kasungu district. • Rota sentinel surveillance has been established in the country at Queen Elizabeth Central Hospital in Blantyre. The site is performing well and there are 4 sites established to monitor intussusception. • Government fully finances procurement of traditional vaccines and also co-finances new vaccines. The evaluation recommendations will be implemented by the programme and partners.
<p>Work with the EPI program to develop a work plan for adoption and introduction in schools of the revised EPI prototype curricula.</p>	<ul style="list-style-type: none"> • The implementation plan was developed together with the EPI programme. The activities have been included in both the cMYP and POA for 2014.

Activities Planned	Activities Accomplished
	MCHIP will support implementation of some activities i.e. adaptation of the curriculum and orientation of lecturers/tutors.
Support GAVI proposal writing for Measles-Rubella vaccine	<ul style="list-style-type: none"> Malawi submitted a proposal to GAVI for the introduction of measles second dose and after the approval, MCHIP will support MOH in the introduction process including training of health workers and communication to the communities..
DVD MT/SMT training	<ul style="list-style-type: none"> The MCHIP immunization Advisor attended the training in DVDMT/SMT, which took place from 5th – 9th August, 13. The training participants were district and zonal EPI coordinators. Districts will be using this database for all vaccine data and monitoring of performance and stocks.
USAID financial management training	<ul style="list-style-type: none"> The MCHIP Advisor attended the financial management course which was organized by the mission in Blantyre from 12th – 16th August, 13. This course covered all aspects of finances, travel and procurement within USAID which should be followed by USAID grantees and sub grantees.

II. Challenges, Solutions and Actions taken

Challenge	Action taken
Due to competing priorities, MCHIP was not able to implement the DQS in the remaining districts and the national supportive supervision at zonal and district levels.	MCHIP is planning to implement these activities next year.

III. Lessons, Best Practices and Recommendations

The best practice we have done in this quarter is to help other EPI partners; UNICEF and CHAI, in RED implementation although MCHIP has not been able to implement its RED training due to reallocation of funds.

IV. Success Stories

In collaboration with MOH and other partners, MCHIP conducted the Rotavirus vaccine Post Introduction Evaluation (PIE) in three zones in six districts. Overall, the Rotavirus vaccine introduction was successful with no serious issues encountered. The PIE found that Rotavirus vaccine coverage is mostly equal to Penta and PCV coverage. Age restriction did not affect Rotavirus vaccine coverage and the introduction of Rotavirus vaccine did not affect the routine

immunization system. There were no stock outs of Rotavirus vaccine in most districts, and good vaccination techniques were observed during vaccination sessions. All health facilities used safe injection equipment, AD syringes and safety boxes. The findings and recommendations of the Rotavirus Vaccine PIE were presented to the MOH and also incorporated into the work plans.

V. Management Issues

The work plan and PMP were developed for the PY6. The activities are up to June 2014. These are pending USAID approval.

VI. Update of the PMP

The table below summarizes progress toward key indicators.

Indicator	FY 2013 Target	FY 2013 Achievement to date	Notes
<i>Indicator 1.1.1:</i> Number of new vaccines introduced	2	1	Rota was introduced in October 2012. The country has decided to introduce Measles Second dose in 2015 and GAVI proposal was written and submitted
<i>Indicator 1.1.2:</i> Percentage of children less than 12 months of age who received PCV3	95%	91%	This is a cumulative coverage up to August. September data is yet to be published by MOH.
<i>Indicator 1.1.3:</i> Percentage of children less than 12 months of age who received first dose of Rotavirus vaccine	94%	87%	This is a cumulative coverage up to August. September data is yet to be published by MOH.
<i>Indicator 1.1.4:</i> Percentage of children less than 12 months of age who received penta3 through USG supported programs	95%	90%	This is a cumulative coverage up to August. September data is yet to be published by MOH.
<i>Indicator 1.1.5:</i> Number of supportive supervision visits conducted with MCHIP assistance	4	0	Supervision was not done by MOH/EPI and partners during the 4 th quarter. Due to SIA preparatory activities within the reporting period, the team was unable to conduct the planned supervision. To take place in the 2 nd QTR.
<i>Indicator 1.1.6:</i> Post Introduction Evaluation conducted	1	1	Rota PIE was conducted in July 2013.
<i>Indicator 1.1.8:</i> Percentage of children less than 12 months of age who received Measles vaccine	95%	87%	This is a cumulative coverage up to August. September data is yet to be published by MOH.
<i>Indicator 1.9</i> Number of EPI management tools revised/developed	9	9	The tools have been revised and are ready for printing. MCHIP estimates printing will be done during the 1 st Quarter of yr 14.
<i>Indicator 2.2.3</i> Number of health workers trained as IIP TOTs	88	88	Target accomplished during 2 nd quarter.
<i>Indicator 2.2.4</i> Number of health workers trained in IIP	1,548	1,406	The number of health workers trained was reduced due to the reduction in the funds due to appreciation of the Malawi Kwacha.
<i>Indicator 2.1.2:</i> Routine Immunization field guide revised	1	1	Activity accomplished.
<i>Indicator 3.1.2:</i> Number of districts reporting negative dropout rate	0	3	This is the overall dropout rate up to August. September data is yet to be published by MOH.
<i>Indicator 3.1.4:</i> EVM assessment conducted	1	1	This activity was implemented during the 1 st quarter.
<i>Indicator 3.1.5:</i> EVM improvement plan developed	1	1	Developed during the 2 nd quarter.

Note: The achievements are cumulative for the year.

VII. Planned Activities for Next Quarter: October to December, 2013

- Supporting integrated Measles supplemental immunization activities (SIA), MCHIP will be supporting the SIAs both technically and financially in preparatory activities i.e. materials development, trainings, follow up and supervision during the actual days.
- MCHIP will support coverage survey which will be done in November for both the SIAs and routine immunization. MCHIP will be involved in all the steps of the survey.
- Supporting the workshop on adaptation of revised EPI prototype curricula which will be introduced in all the colleges.
- Training of tutors/lecturers in the revised EPI curricula
- Printing and distribution of EPI management tools

Helping Babies Breathe

I. Overall Progress of the Project for the Quarter

Activities Planned	Activities Accomplished
Preparation for Round-2 data collection – Training of Data Collectors	<p>The IRB renewal procedures for both JHSPH and COMREC were finalized in the quarter and renewal certificate received.</p> <p>The training took place from 26th to 31st August, 2013. A total of 33 data collectors were trained (10 Males;23 Females). All data collectors were MoH employees trained in HBB/IMNH with extensive experience working in the maternity ward. Facilitators came from MOH-(Departments of Reproductive Health and Clinical Services), Jhpiego, Kamuzu College of Nursing and JHSPH. Methods of instruction included Lecture, Role play, Simulations, Question and Answer and Practical sessions. Data collectors were taken through all the tools used in data collection during the training.</p>
Round 2 Data collection	<p>Data collection was done in 27 districts in 90 Health facilities from September 2 - 28, 2013. Same facilities were included in the survey in both round one and round two of the evaluation data collection. Quantitative data were collected using Labor and Delivery Observations, Health Worker Interviews, Simulation Case Studies, Document Reviews, and Health Facility Assessment while Qualitative data were collected through Key Informant Interviews. In addition to health facilities in-charges, National level professionals from MoH and partners (UNICEF, USAID, Kamuzu College of Nursing, Association of Malawi Midwives and others) were interviewed as key informants. Since there has been scale up of HBB to several other districts, data analysis will use dose –response analysis as compared to intervention - control analysis which was done in Round 1. As compared to round 1, there were about 600 more deliveries in second round.</p>

II. Challenges, Solutions and Actions taken

Challenge	Action taken
A large number of students from academic institutions on internship reduced the probability of observers observing large number of deliveries.	The Observers maximized the time when there were fewer students in the ward e.g., evening shifts and weekends.

III. Lessons, Best Practices and Recommendations

- During the data collection exercise, increasing the number of data collectors used as observers as compared to mobile interviewers led to the increase in observations made and did not have negative effect on the sample in the non-observation facilities.
- Minimum number of observations to be made per facility should not be uniform but should depend on the facility caseload, i.e. Facility level sample size should depend on total number of deliveries conducted per month.

IV. Success stories

- The sample size for second round of data collection was met. Unlike in the first round where the shortfall was about 600 deliveries, second round managed to observe about 2100 deliveries against a sample size of 2084. This was achieved because minimum number of observations per facility depended on the facility caseload/volume. While in the first round all facilities contributed equally to the sample size, in the second round the contribution of each facility to the sample size was relative to the number of cases normally seen in the facility.

V. Management Issues

- None

VI. Planned Activities for Next Quarter: October - December, 2013

- Data entry training for data entry clerks
- Data entry for second round HBB Evaluation data
- Data cleaning for second round of HBB Evaluation data
- Drafting second round HBB Evaluation Report

Voluntary Medical Male Circumcision

I. Overall Progress of the Project for the Quarter

Activities Planned	Activities Accomplished
<p>Conduct male circumcisions using different service delivery models such as static, outreach and campaign in Thyolo and Malamulo.</p>	<ul style="list-style-type: none"> • 8,798 male circumcisions were conducted in the quarter: July – September 2013, bringing the total circumcisions for the FY to 13,499. This was mainly achieved through a national VMMC campaign which was conducted from July 22 to September 7, 2013. • This campaign followed a successful mini-campaign that was conducted in March 2013, which yielded 3,416 circumcisions in three weeks, exceeding the campaign target of 1,500. • The mass campaign was part of the National VMMC campaign whereby MCHIP targeted 15,000 circumcisions to contribute to the national target of 60,000. MCHIP reached 8,790 male circumcisions representing 58.6% of the set MCHIP target for the campaign. The national campaign yielded a total of 39,886 Male Circumcisions (i.e. 66.5% of the set target), and MCHIP contributed 22% of this total.
<p>Orientation on VMMC package to 40 HTC counselors from Thyolo District.</p>	<ul style="list-style-type: none"> • 30 HTC counselors from Thyolo District were oriented on VMMC package bringing total trained counselors to 51. • The number of counselors was increased from the targeted 40 in order to ease the district's pressure of VMMC trained counselors during participation in the national mass campaign.
<p>Planning for VMMC campaign in July/August at Thyolo District</p>	<ul style="list-style-type: none"> • Planning of the mass campaign conducted in July to September 2013 had been ongoing through National level coordination meetings, Thyolo District specific planning meetings, development and review of plans. • The campaign was a national level campaign involving Thyolo, Mulanje, Phalombe, Blantyre, Nkhhotakota and Lilongwe districts, and implementing partners included MCHIP, I-TECH, PSI, CHAM and Banja La Mtsogolo (BLM). The target for the campaign was 60,000 circumcisions, where MCHIP planned to contribute a target of 15,000 for Thyolo district. • MCHIP supported MoH to coordinate the campaign at national level for all partners and districts involved. However, each partner was responsible for its catchment area and MCHIP was responsible for Thyolo district.

Activities Planned	Activities Accomplished
	<ul style="list-style-type: none"> • MCHIP was a lead partner in coordination and was part of the national steering committee, which was responsible for planning, supervision at national level and decision making on the campaign. MCHIP was central in managing data collection and reporting to the committee including assisting partners with reporting templates and mentoring where necessary.
Continued support to the development of national strategy on VMMC	<ul style="list-style-type: none"> • The meeting, which was scheduled for this quarter (July – September 2013) was postponed to next reporting period as most partners including MoH focused on the campaign which demanded full attention during its planning and implementing phases. • This meeting will be a follow up to the first meeting conducted in April 2013 through MoH (HIV/AIDS Unit) coordination and included main VMMC players including USAID, National AIDS Commission (NAC). • During the first meeting, a draft strategy was developed and is currently pending review and finalization by the stakeholders during the next meeting.
Coordinate harmonization of National M&E tools including VMMC database	<ul style="list-style-type: none"> • MCHIP has been involved throughout the year with the review of the national VMMC tools including providing input for the revised tools. • MCHIP played a lead role in harmonizing the national mass campaign reporting structure, demonstrating the possibility of harmonized tools and M&E structure • MCHIP supported the MOH in developing the VMMC reporting form in DHIS2 data management platform. The use of DHIS2 in reporting national VMMC data will be fully implemented in FY 14. •
Consolidation of the final VMMC waste management plan which will be shared to other VMMC partners.	<ul style="list-style-type: none"> • Site specific waste management plans were developed for Malamulo and Thyolo District hospitals in Quarter 2. • A meeting with MoH QA team to review and solicit comments to finalize the plan was postponed further and will be rescheduled to the next reporting period as the MOH HIV/AIDS Unit could not manage to host the meeting in the reporting period due to other competing and equally important activities e.g. planning and participation in the national VMMC mass Campaign. • However, the tool has been used in its draft form during the mass campaign. Revisions and sharing

Activities Planned	Activities Accomplished
	with all partners will be done in the next reporting period.

II. Challenges, Solutions and Actions taken

Challenge	Action taken
<ul style="list-style-type: none"> After campaign activities, the static sites are usually not active, giving impression that VMMC services are only offered during campaigns. 	<ul style="list-style-type: none"> In order to address this practice, MCHIP routinely holds discussions with the DHMT members and site coordinators towards the end of the campaign or soon after campaign to ensure continuity of VMMC services as routine, where 2 days/week are dedicated to the VMMC service provision. Supplies and other resources were also discussed and adequately supplied to the static sites for routine service use.
<ul style="list-style-type: none"> Most post –op adverse events cases reported during campaign period arose from failure to take good care of the wound at home. Sometimes people of influence within the communities give clients incorrect information or advice on wound care, e.g. application of traditional herbs or medicines on the wound. 	<ul style="list-style-type: none"> VMMC post-op Counseling was conducted which emphasized good medical care of the VMMC wound and follow up visits to the clinic for further care and counseling. Traditional leaders have also been engaged and oriented on the VMMC procedures including home-based post – operative care. This was done in order for the traditional leaders to relay the message to these “home doctors”. It is also hoped that continuous community mobilization activities through different channels will also help to reduce these cases.
<ul style="list-style-type: none"> Some traditional circumcisers (Ngalibas) stop or discourage clients from utilizing VMMC services because they perceive the VMMC project as a competition for them, especially when campaigns take place during traditional circumcision period, as was the case with the July Mass campaign. 	<ul style="list-style-type: none"> To minimize this perception, MCHIP therefore engages the traditional circumcisers during campaigns to mobilize the clients for medical circumcisions at the facility, after which the clients return to the traditional circumcisers for the other non-surgical parts of the tradition (such as speeches, dances, etc). MCHIP also engages the traditional circumcisers to encourage the MC clients to

return to the facilities for post-up care. As such, the traditional circumcisers still see themselves having a role in MC in the community

III. Lessons, Best Practices and Recommendations

- Engagement of traditional leaders to enlighten them on the VMMC procedures including post-operative care at home which helped relay the message to “home doctors”
- MCHIP learned the importance of engaging traditional circumcisers while conducting a mass campaign

IV. Success stories

Traditional Authorities (TA) on the frontline of VMMC demand creation: TA Ngolongoliwa leads by example

Voluntary Medical Male Circumcision (VMMC) hugely depends on community sensitization and mobilization, and acceptance of medical circumcision by the community as HIV prevention intervention. Most areas are either culturally un-circumcising, not ready for it or are circumcising but believe in their cultural practices where circumcision is part of initiation into manhood. In the latter case, they believe it is the responsibility of the traditional circumciser (Ngaliba) and counselor (Nankungwi) to conduct the rituals including circumcision. In both cases, there is resistance to accept medical circumcision, let alone to understand how it is an HIV prevention intervention.

In Thyolo however, Traditional Authorities have been highly engaged and involved in sensitization and mobilization of the community. They are part of the district planning team especially on strategizing where to conduct VMMCs. They use their status to influence positive behaviours and decisions among their subordinates. During the last National VMMC Campaign, the TAs met the DHMT to be sensitized and briefed on VMMC and to help the VMMC team strategize their campaign. They in turn engaged their subordinate chiefs; group village headmen and headmen to assist in telling their people the importance of medical circumcision. They influenced their Areal Development Committees (ADC), Village Development Committees (VDC) and Community Based Organizations (CBO) to be involved in mobilizing the people for VMMC services. The TAs were also participating in some of the demand creation activities, like during VMMC campaign district launch and awareness, and football bonanzas.

One TA stood tall, who after being sensitized on VMMC, went ahead to be circumcised. TA Ngolongoliwa is now a champion having gone through the process and is ‘preaching’ VMMC to his people and fellow TAs “the pain during medical circumcision is highly controlled by anaesthetic drugs. You lie down on a bed and within minutes you are told to get up, the procedure is finished, as simple as ABC” he happily shared his experience of the circumcision procedure with the audience in a campaign strategic meeting between the TAs and a team of district campaign supervisors.

STA Ngolongoliwa advising his subordinate chiefs on the importance of VMMC



Although not fully recovered and still within the 6 weeks healing period at that time, he told everyone how differently he was feeling especially on cleanliness and hygiene. He spread the VMMC word like gospel to his people, who in turn registered in numbers, and a site was opened in his area in the middle of the campaign. 439 males were circumcised at this site in Ngolongoliwa, an area that had earlier on shown great resistance towards VMMC.

V. Management Issues

None

VI. Update of the PMP

The table below summarizes progress toward key indicators.

Indicator	FY 2013 Target	FY 2013 Achievement To date	Notes
1. Number of health workers trained in VMMC	53	54	22 providers trained in Oct – Dec 2012 quarter, 18 in the Jan – Mar 2013 quarter and 14 in the quarter April – June 2013, bringing the total number of trained providers to 54, against a year’s target of 53
1b. Number of health workers trained in VMMC TOT	10	10	100% achieved (Training of Trainers). The trainers were identified and trained in the first quarter to assist in the series of district trainings that were planned.
1c. Number of HTC Counselors trained in VMMC package	40	51	21 trained in third quarter and 30 trained early in the fourth quarter. More were trained than targeted to take care of mass campaign needs
2. Number of Males circumcised as part of a minimum package of MC for HIV prevention services	8,100	Neonate – 0 < 15 – 6,058 15 to 24 – 6,120 25 to 49 – 1,258 50plus – 63 Total – 13,499	This is a revised target covering the FY (i.e. Oct 2012 to Sep. 2013). 560 were circumcised in first quarter, 3,190 in second quarter, 951 in third quarter and 8,798 in fourth quarter. Use of campaigns in second and fourth quarters helped the program to reach more males.
3. Number of individuals who received testing and counseling services for HIV as part of MC	90%	13267 (98%)	The remaining 223 clients had recent HIV test results or known HIV+ and 9 had opted out of HIV testing.
4. Number of Adverse events during the procedure	<2%	60 (0.4%)	No moderate or severe adverse event occurred in the April – June 2013 quarter.
5. Number of Adverse events within 48 hours	<2%	117 (1.5%)	The denominator is the number of circumcised males who came for follow up care, and this is for all follow up care

Indicator	FY 2013 Target	FY 2013 Achievement To date	Notes
6. Number of Adverse events within 7 days	<2%	0	Most clients came once within the 48 hours or a bit late (1 – 4 days after circumcision)
7. Number of clients returned at 48 hours post op	N/A	7,422 (55%)	<p>During campaigns most people come back for follow up care at least once.</p> <p>The follow up is still low. There are anecdotal reports from the district that some clients are accessing follow up outside VMMC sites, or from other services within the district hospital such as casualty department and are lost in the system.</p> <p>The counseling is emphasizing the need to visit the VMMC site again for proper counseling and reviews to improve client follow ups</p>
8. Number of clients returned at 1 week post op	N/A	2,040 (15.1%)	Follow up at 7 days is extremely low. Clients do not come because they feel they are ok and do not need medical review, and are missing out on counseling. Counseling at immediate post op and on 2 day follow up visit emphasized on the importance of coming again for further follow up and counseling, and there was an improvement during the mass campaign in July – September 2013 (from 0.4% to 15.1%).
9. Number of health facilities with waste management plan	3	2	The third facility, Thomas Health Center, does not fit the profile of static site which needs to have a proper waste management plan developed. This facility does not have the required number of clinical staff to qualify as a static site, thus it is only used during outreaches and campaigns.
10. Number of facilities reporting complete monthly/quarterly VMMC data	3	2	Thomas Health Centre is an outreach site of Thyolo District Hospital.

VII. Planned Activities for Next Quarter October – December 2013

- MCHIP Leader VMMC close-out activities which will include administrative closeout of all MCHIP leader VMMC activities and development of MCHIP closeout report
- Transition to MCHIP Associate Award: SANKHANI