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Maternal and Child Health Integrated Program

Malawi

Close Out Report for Activities Implemented between October 2009 – February 2012

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ACRONYMS

AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CAC	Community Action Cycle
CAG	Community Action Group
CBD	Community-Based Distribution
CBDA	Community-Based Distribution Agents
CECAP	Cervical Cancer Prevention
CHAM	Christian Health Association of Malawi
CMNH	Community Maternal and Newborn Health
CM	Community Mobilization
DHMT	District Health Management Team
EHP	Essential Health Package
EHAP-IFH	Enhanced HIV/AIDS Prevention and Improved Family Health Program
EmOC	Emergency Obstetric Care
FANC	Focused Antenatal Care
FP	Family Planning
GAIA	Global AIDS Interfaith Alliance
GOM	Government of Malawi
HHCC	Household-to-Hospital Continuum of Care
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IPT	Intermittent Presumptive Treatment
KCN	Kamuzu College of Nursing
KMC	Kangaroo Mother Care
LLIN	Long Lasting Insecticide-treated Nets
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOVE	Models for Optimizing Volume and Efficiency
NMCP	National Malaria Control Programme
ORS	Oral Rehydration Salts
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of Mother to Child Transmission
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PQI	Performance Quality Improvement
RH	Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach

TOC
USAID
VMC

Targeted Outreach Campaign
United States Agency for International Development
Voluntary Medical Male Circumcision

EXECUTIVE SUMMARY

The Maternal and Child Health Integrated Program (MCHIP) is a United States Agency for International Development (USAID) project that aims to assist in scaling up evidence-based, high-impact maternal, newborn and child health (MNCH) interventions and thereby contribute to significant reductions in maternal and child mortality and progress toward Millennium Development Goals 4 and 5.

MCHIP started work in Malawi in 2009, continuing activities begun by two earlier USAID programs: ACCESS and Enhanced HIV/AIDS Prevention and Improved Family Health (EHAP-IFH). Working in four districts (Machinga, Nkhotakota, Phalombe and Rumphu), MCHIP helped Malawi to strengthen the household-to-hospital continuum of care (HHCC).

From October 2009 to February 2012, MCHIP achieved several significant milestones under the twelve Intermediate Result Areas.

Intermediate Result 1: Increased access to and availability of quality essential maternal and newborn and child care services and postpartum services including Family Planning (FP). The key milestones were as follows: Documentation of improved Maternal and Newborn Health (MNH) clinical practices at the health center at Performance and Quality Improvement (PQI) intervention and non-intervention facilities, Scale-up of integrated Reproductive Health-Infection Prevention and Prevention of Mother-to-Child Transmission (RH-IP-PMTCT) performance standards to 16 additional health centers (for a total of 32 health centers), RH recognition achieved at three additional hospitals (Mzuzu Central and Dowa and Machinga District Hospitals), IP recognition achieved at one additional hospital (Machinga District Hospital) and Pilot of electronic PQI data collection system using tablets.

Intermediate Results 2: Increased adoption of household behaviors that positively impact the health of mothers and newborns and children under 5 years of age and

Intermediate Result 3: Increased availability of integrated community-based MNH/FP services through Health Surveillance Assistants; **Intermediate Result 10:** Increased community and district action, through community-based networks and communication programs, to support use of high impact MNH interventions. The key milestones were Scale up of Community Maternal and Newborn Health (CMNH) package and Community Mobilization (CM) to 2,637 villages in 19 traditional authorities (TAs).

Intermediate Result 4: Strengthened MNH policies, planning and management in place at the national, zonal and district level resulted in the following key milestones: Trained 60 additional tutors in Basic Emergency Obstetric and Newborn Care (BEmONC), Provided technical assistance to Global AIDS Interfaith Alliance (GAIA) to train 12 tutors from Kamuzu College of Nursing (KCN) in BEmONC, Trained 158 tutors in Postpartum Family Planning (PPFP), Strengthened skills laboratory at KCN and two clinical practice

sites (Kawale and Area 25), developed and printed 10,000 copies of three types of PFP job aides (flip chart, poster and leaflet) to be distributed countrywide, Developed, printed and distributed 1,500 copies of seven types of Laminated Obstetric Protocols countrywide, Developed and printed 2,000 copies of the revised Reproductive Health Strategy to be distributed countrywide.

Intermediate Result 5: Increased commitment of resources for MNH from Government of Malawi (GOM) and other donors resulted in Adoption and roll out of CMNH package in PMNCH/Catalytic Initiative focused districts and Resource Mobilization by MCHIP and Dock-Dock and distribution of equipment and supplies to 16 health facilities.

Intermediate Result 6: Strengthened planning and monitoring of MNH activities at the community level. Key milestones were: development and roll-out of new Monitoring and Evaluation (M&E) tools to MCHIP focus districts and re-oriented 400 HSAs on new M&E tools for CMNH.

Intermediate Result 7: Increased availability and access to low osmolarity Oral Rehydration Salts (ORS) among mothers and caregivers of children under 5 key milestones were as follows: Procured, cleared and stored 1 million sachets of low osmolarity ORS for eventual distribution countrywide and Distributed 758,820 sachets of ORS and 135,000 bottles of Water Guard through commercial outlets nationally.

Intermediate Result 8: Increased use of oral and injectable contraceptives amongst middle income women of reproductive age intending to use FP methods; Designed and implemented a pilot initiative on social marketing of FP in Machinga district.

Intermediate Result 9: Promotion of correct and consistent use of Long Lasting Insecticide-treated Nets (LLINs), correct and prompt use of ACT anti-malarial among caregivers of children under five, and improved awareness and uptake of IPT among pregnant women had the following key milestones: Launched United Against Malaria (UAM) Initiative which reached a total estimated 2.5 million people through live broadcast, and 19,000 people directly during the launch event, Distributed 234,974 LLINs from October 2009 to September 2010 and 985,633 LLINs in October 2010 to December 2011 to health facilities across the country, targeting pregnant women and children under-five and Developed malaria IEC messages on treatment of malaria according to national guidelines and correct and consistent use of LLINs, reaching an estimated 218,989 people.

Intermediate Result 11: Strengthened integration, provision and access to quality Prevention of Mother to Child Transmission (PMTCT) and Reproductive Health Services resulted in the following key milestones: Trained 359 service providers and data clerks from 10 districts in the new PMTCT guidelines, Developed PQI standards on early infant diagnosis, early infant feeding, integrated FP-HIV, integrated Sexually Transmitted Infection (STI)-HIV, and integrated Cervical Cancer Prevention (CECAP) and HIV services

and Introduced PQI PMTCT integrated standards to 36 facilities and conducted baseline assessments at these facilities; average scores were 38.2%.

Intermediate Result 12: Increase access to Voluntary Medical Male Circumcision (VMMC) had the following key milestones: Supported the first VMMC outreach campaign using MOVE principles which provided Malawi with operational guidance and was a catalyst in implementation of VMMC, Circumcised 4,348 men during the 4 week campaign in Mulanje district and Developed VMMC protocols and guidelines and tools for future use by the MOH and implementing partners to scale up VMMC countrywide.

BACKGROUND

Despite progress over the past decade, Malawi's key health indicators lag far behind course for achieving the Millennium Development Goals (MDGs) 4, 5, and 6 (Table 1).¹ For instance, 98% of pregnant women receive antenatal care (ANC) from a health provider, however only 46% make the four

Table 1: Malawi Health Indicators 2015 MDG Targets

Indicator	Current Status	2015 Target
Maternal mortality ratio	675/100,000 live births	475/100,000
Under-5 mortality rate	112/1,000 live births	58.5/1,000
HIV prevalence	11%	reversal
Delivery with skilled attendant	72%	85%
Contraceptive prevalence rate	42%	60%
HIV test during ANC visit	87%	100%

recommended visits or receive the entire focused antenatal care (FANC) package. Similarly, though 72% of all deliveries take place in health facilities, only 19% of facilities are equipped to provide Emergency Obstetric Care (EmOC).² Neonatal mortality—primarily caused by asphyxia, low birth weight, and prematurity—accounts for more than a quarter of deaths among children under five;³ after that period, children primarily die from malaria, pneumonia, complications from diarrhea malnutrition, and HIV. An HIV prevalence of 11% heightens morbidity and mortality in all age groups.⁴

In addressing the health needs of its citizens, the GOM uses the Sector Wide Approach (SWAp), a vehicle for donor support to the Ministry of Health (MoH) to deliver an Essential Health Package (EHP) of services free-of-charge for all citizens. The MoH operationalizes the SWAp to deliver the EHP through the Program of Work, the Malawi Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality, the Reproductive Health Strategy, and the national plan for Accelerated Child Survival and Development. Together these plans outline the GOM's vision to scale up the EHP through the health system, which delivers services primarily through the MoH (60%) and the Christian Health Association of Malawi (CHAM) (37%), with the balance provided by private-sector institutions and local government. The MOH has embarked in recent years on decentralizing planning and budgeting to District Health Management Teams (DHMT). Vertical programming remains a major challenge, leading to many missed opportunities with clients.

MCHIP began field support activities in Malawi in December 2009. MCHIP/Malawi was designed to support the MoH delivery of the EHP and USAID/Malawi strategy to accelerate the reduction of maternal, neonatal and child mortality towards the achievement of the Millennium Development Goals. MCHIP/Malawi's prime programmatic objective was to increase utilization of MNCH services and practice of healthy maternal, neonatal and child behaviors. The project expanded on the

¹ DHS 2010.

² National EmONC Needs Assessment 2005.

³ MICS 2006.

⁴ DHS 2010.

foundation built by previous USAID investments under the ACCESS Program EHAP-IFH Project.

This report documents MCHIP's achievements during from October 2009 to February 2012.

MCHIP PROGRAM

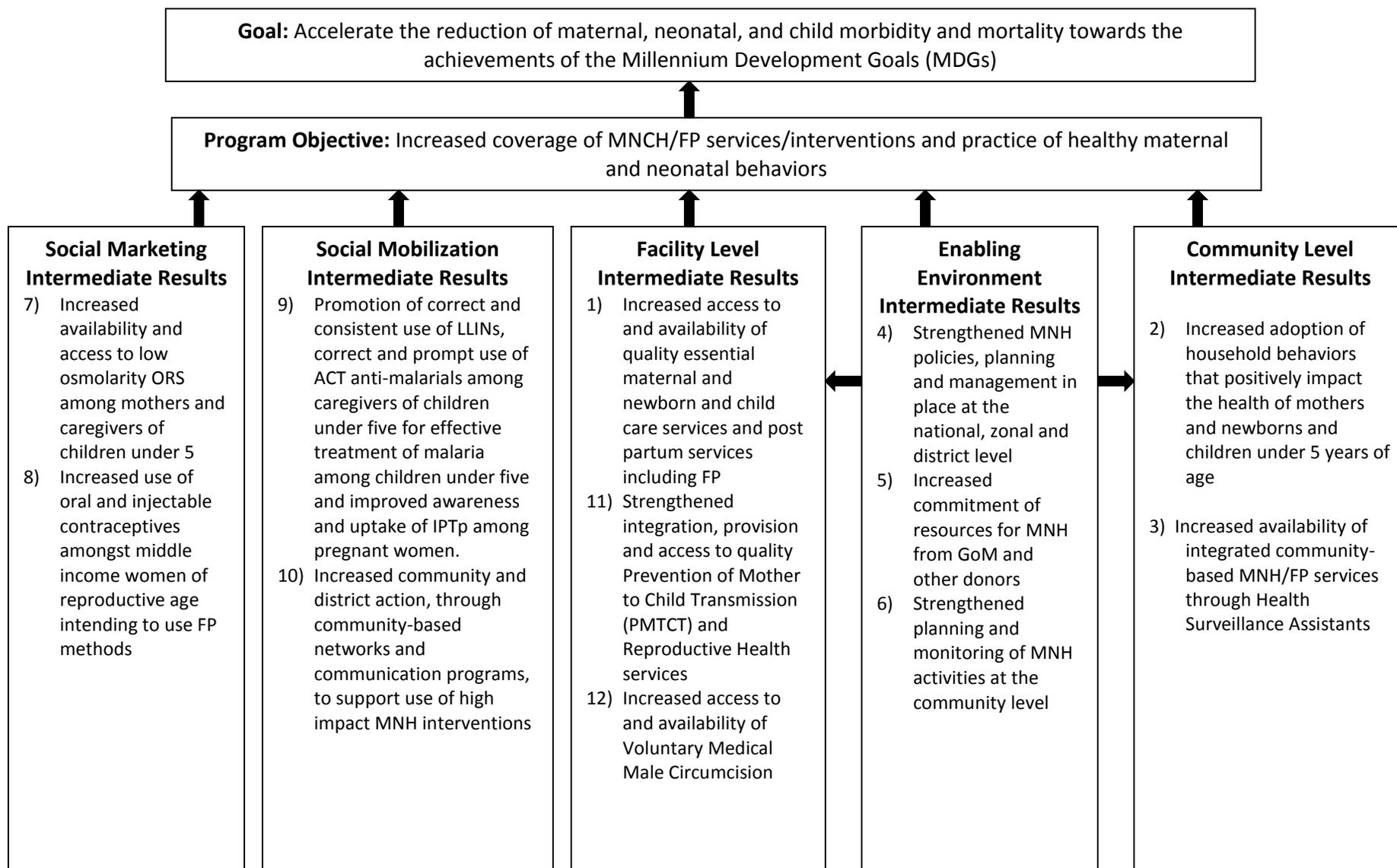
Goals and strategies of MCHIP Global program

MCHIP's focus is to reduce maternal, newborn, and child mortality in 30 priority countries by 25% through increasing the use of a focused set of high impact MNCH interventions that address the major causes of death among mothers, newborns and children under five. Delivery strategies address barriers to access and use of high-impact interventions along an MNCH continuum of care that links communities, first-level facilities, and referral facilities.

MCHIP/Malawi Objectives and Interventions

MCHIP/Malawi's prime programmatic objective was to increase utilization of MNCH services and practice of healthy maternal, neonatal and child behaviors. To achieve this objective, MCHIP focused on the results depicted in Figure 1: MCHIP/Malawi Results Framework.

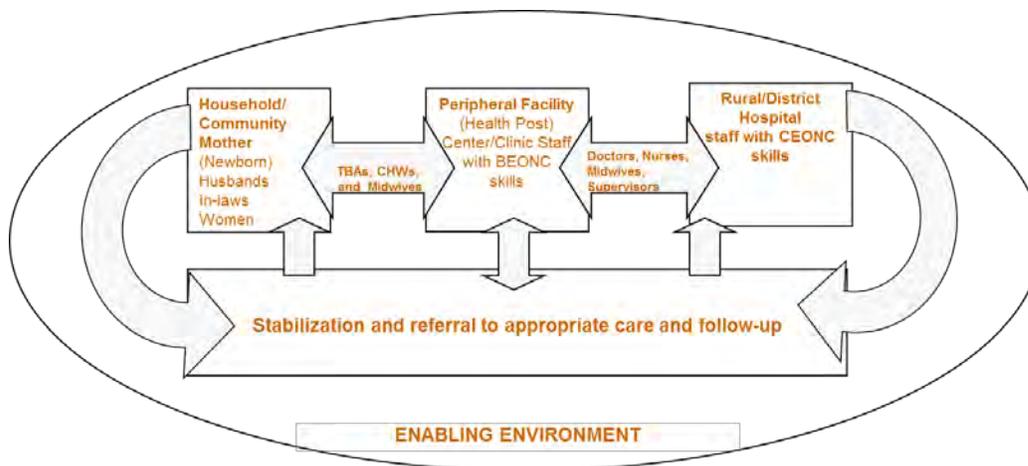
Figure 1: MCHIP Malawi Results Framework



Household to Hospital Continuum of Care

The Household to Hospital Continuum of Care (HHCC) approach, as depicted in Figure 2, simultaneously addresses maternal and newborn issues of the community, facility and within the enabling environment, using evidence-based interventions and best practices (See figure below). Addressing facility-based challenges while neglecting community/social issues - or vice versa - will not lead to the desired effects of reduction in Maternal Mortality Ratio and Newborn Mortality Ratio.⁵ By developing a comprehensive, integrated approach at the community, peripheral and district-level facilities while concurrently strengthening the national-level enabling environment, MCHIP contributed to the MOHs goal to significantly reduce maternal and newborn morbidity and mortality. The HHCC addresses all three delays⁶ associated with maternal and newborn deaths by improving household and care-seeking practices, empowering the community to create and maintain an enabling environment for increased utilization of Essential Maternal and Newborn Care services, whether public or private, and improving the quality of care provided in the community and district.

Figure 2: Household to Hospital Continuum of Care



MCHIP/Malawi's Implementation Strategies

To have impact with these results at a national level, MCHIP employed two primary strategies: a) expanding and adding to the foundation laid by ACCESS and EHAP projects with direct implementation in specific geographic areas and b) leveraging other resources to scale up interventions at the national level.

Building on ACCESS maternal and newborn health activities, MCHIP operationalized the HHCC model in four focus districts: Machinga, Nkhotakota, Phalombe and Rumphu. In Malawi, the HHCC comprises of a set of proven, evidence-based interventions focused

⁵ ACCESS 2005. Household-to-hospital continuum of maternal and newborn care.

⁶ The 3 delays are: 1) delay in recognizing complications; 2) delay in reaching a medical facility; and 3) delay in receiving good quality care at the facility.

on facility and community activities and include improving providers' skills to deliver Basic Emergency Obstetric and Newborn Care (BEmONC), postpartum Family Planning (PPFP), and Prevention of Mother to Child Transmission (PMTCT) services, improving the quality of care in facilities, and establishing Kangaroo Mother-Care (KMC) services; delivering community maternal and newborn health (CMNH) services through Health Surveillance Assistants (HSAs) and facilitating community mobilization (CM) through HSAs. In this project, the traditionally vertical technical interventions of MNH, FP, and PMTCT were integrated as appropriate and feasible to improve access to services and to avoid no missed opportunities during the provider-client interaction. In addition to facility and community interventions, MCHIP worked closely with the DHMTs to improve their capacity to plan, implement and manage their District Implementation Plans and include support to MCHIP/MoH interventions within their planning. Table 2 summarizes the interventions in the focus districts.

MCHIP contributed to strengthening and dissemination of policies supporting service delivery which built on a foundation established by ACCESS at the national level. MCHIP sought to improve pre-service education representing Malawi's 13 pre-service institutions. by updating 100% of the 160 pre-service tutors with the integrated training materials in BEmONC and PPFP. MCHIP also strengthened the clinical skills laboratory at KCN and two clinical/practical training sites for PPFP (Kawale and Area 25 health centers) through the provision of the requisite equipment and supplies to enable training of students in PPFP using humanistic approach in clinical skills laboratory and facilitate their clinical skills through provision of the same materials at the health facilities for continued clinical practice. MCHIP continued supporting Malawi's national PQI initiative by ensuring participation of all 24 district and four central hospitals in Infection Prevention, Reproductive Health and PMTCT. In addition MCHIP supported MoH in scaling up PQI initiative to 32 health centers in the four districts.

The other major predecessor project, EHAP-IFH, provided the foundation for MCHIP's social mobilization and social marketing activities. With malaria as a leading cause of morbidity and mortality in Malawi, MCHIP supported national malaria control efforts in collaboration with the National Malaria Control Program (NMCP) of MoH and other malaria stakeholders. MCHIP coordinated distribution of LLINs in accordance with the national supply chain system. MCHIP conducted national Information, Education, Communication (IEC) campaigns focusing on use of LLIN, uptake of Intermittent Presumptive Treatment (IPT), and prompt care and treatment of malaria using media platforms of radio, TV, and drama groups.

MCHIP used a social marketing approach to promote family planning and diarrheal disease control. Building on MCHIP partner PSI's lengthy experience in promotion of the commercial product Thanzi ORS for the treatment of diarrhea, MCHIP continued the procurement and distribution of the Thanzi ORS product. The product is accompanied by behavior change communication messages, including messages about proper hand washing during key times of the day.

In 2008, a large unmet FP need and a very small private sector market share for FP services led MCHIP partner PSI to introduce low priced contraceptive products through private providers. MCHIP continued social marketing efforts of the branded injectable and oral contraceptive products, through 300 licensed private sector providers (working in 200 outlets) and supported mass media communication and Interpersonal Communication and Counseling activities to help promote access and use of the private sector as an alternative source for accessing FP. In addition MCHIP partner PSI successfully conducted a pilot activity in one Traditional Authority in Machinga district to socially market FP products using Community-based Distribution Agents (CBDAs). The pilot activity sought to gauge the impact of compensating volunteers on contraceptive uptake and motivation among the CBDAs.

MCHIP's efforts at leveraging other resources or catalyzing action took a different approach depending on the intervention and context, such as a district, zonal, regional, or national focus. The fundamental principle, however, was MCHIP's active engagement with MNCH stakeholders to leverage non-MCHIP resources, both human and financial, to scale up the interventions. MCHIP coordinated with UNICEF, UNFPA, GAIA and other partners such as the Catalytic Initiative or Partnership for Maternal Newborn and Child Health (PMNCH), which focus on community-based MNH interventions, in order to expand coverage of the MOH's approved CMNH and CM interventions. As part of the focus district activities, MCHIP worked closely with DHMT to prioritize MNCH in DIPS and include resources to support or expand current facility and community-based interventions.

MCHIP remained flexible to changing USAID priorities as well. In the second program year, MCHIP expanded activities by supporting scale up of PMTCT services in 10 selected districts and establishing and scaling up Malawi's voluntary medical male circumcision (VMMC) program. Using the PQI approach, MCHIP developed PMTCT-specific standards and applied them in 36 targeted facilities and updated providers in those facilities in PMTCT service delivery using the MoH approved training package. MCHIP also integrated mother-infant pair follow up by HSAs to ensure adherence to PMTCT protocols to the HSA's CMNH responsibilities and initiated the roll out process through training HSAs from the selected districts. Building on MCHIP global experience with VMMC, MCHIP worked within the enabling environment to ensure policies and procedures were in place to support a national VMMC program, established a pool of national VMMC trainers, and supported Dedza and Mulanje District Hospitals to improve efficiency of their VMMC services. MCHIP also organized the first major outreach VMMC campaign that coupled demand generation activities with increased supply through establishment of static VMMC sites that practice Models for Optimizing Volume and Efficiency (MOVE) principles for a four week period in 2011. The campaign showed strong numbers and demonstrated an approach that the MOH can replicate to conduct additional VMMC campaigns in order to support meeting their national VMMC targets.

Table 2: Summary of Focus District Interventions

Intervention	Description
Performance and Quality Improvement	Performance and Quality Improvement (PQI) is a national initiative designed to improve quality of service delivery. It provides measurements of key performance indicators and facility-based Quality Improvement Support Teams develops and implements a plan to make improvements to identified gaps. Upon achieving 80% of standards, the facility is recognized in a national event. The integrated standards focus on ANC, Labor and Delivery, Postpartum/Postnatal Care, ENC, FP, STI prevention and management, Cervical Cancer prevention and HIV/AIDS, infection prevention and PMTCT integration. MCHIP targeted 32 out of the 56 health centers in the focus districts.
Provider Clinical Updates	Linked with PQI initiative, providers must have updated skills to deliver services according to standard. MCHIP built the capacity of providers in targeted facilities to provide the following services: FANC, BEmONC, PNC, HBB, KMC, ENC, PFP and PMTCT. This included supportive supervision to mentor providers in the targeted skills.
Kangaroo Mother Care	KMC, also known as skin-to-skin care, has proven as effective as an incubator for temperature control of low birth weight babies at the facility level. ⁷ MCHIP aimed to establish Ambulatory and Community KMC services linked to targeted health centers in focus districts and the establishment of 2 facility based KMC centers in Phalombe District.
Community Maternal and Newborn Health	HSAs deliver preventative MNH services to manage normal care before, during and after childbirth, prevent obstetric problems and seek additional help when necessary. HSAs make three antenatal and three postnatal visits to the home. HSAs counsel pregnant women and their families on birth preparedness/complication readiness, postpartum family planning, PMTCT, and advocate for facility-delivery and post natal care. HSAs are taught to recognize danger signs in mothers or newborns and refer to a health facility as necessary. MCHIP targeted 180 HSAs attached to targeted health centers.
Community Mobilization	HSAs facilitate community mobilization so that communities become active participants in delivery of MNCH services. The process empowers the community to lead, identify, plan, implement and monitor key MNCH interventions within their community and in collaboration with their local health facility.

⁷ Charpak et al, 1997. Kangaroo mother versus traditional care for newborn infants < 2000 grams: a randomized, control trial. Pediatrics 1997; 100: 682-688

MAJOR ACCOMPLISHMENTS

Intermediate Result 1: Increased access to and availability of quality essential maternal and newborn and child care services and postpartum services including FP

Milestones achieved:

- Documentation of improved MNH clinical practices at the health center at PQI intervention and non-intervention facilities
- Scale-up of integrated RH-IP-PMTCT performance standards to 16 additional health centers (for a total of 32 health centers)
- RH recognition achieved at three additional hospitals (Mzuzu Central and Dowa and Machinga District Hospitals)
- IP recognition achieved at one additional hospital (Machinga District Hospital)
- Pilot of electronic PQI data collection system using tablets

PQI at Health Centers

ACCESS initiated the PQI process using the Standards Based Management and Recognition (SBM-R) approach at the health center level in 2008 in 12 health centers and had supported it for one year before start of MCHIP activities. (See Table 2 for description of PQI process). SBM-R uses operational, observable performance standards, which are agreed upon by the health service providers themselves, for on-site individual, peer and health facility assessment of current or prevailing service delivery practices. Improvements in quality of services are tied to a reward/incentive program that uses facility and public recognition of such achievements as a form of motivation to encourage acceptable performance. SBM-R consists of four sequential processes as follows: setting performance standards, implementation of the standards, monitoring performance to measure progress and rewarding the achievements made in order to motivate service providers. Figure 3 describes the SBM-R processes

Figure 3: Standards-Based Management and Recognition

Standards-based Management of Health Service Delivery

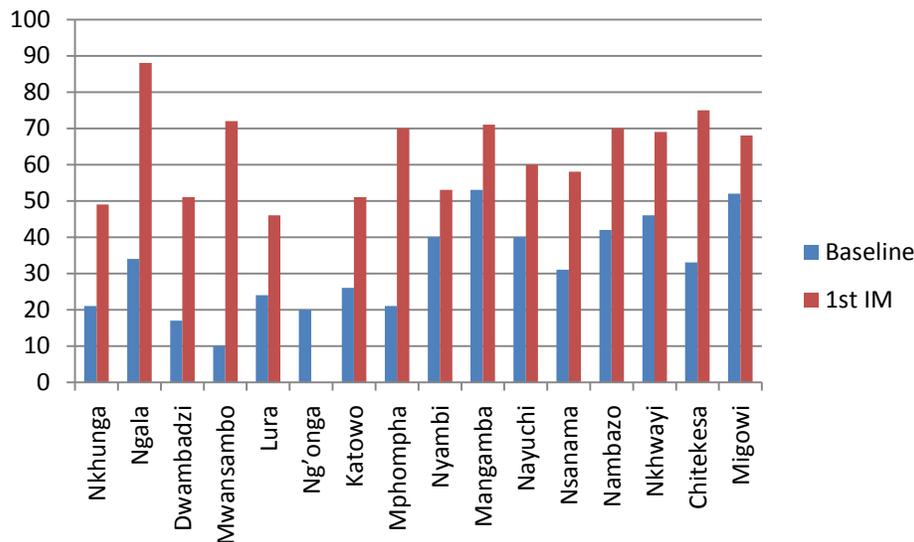
Set Standards 1	Implement Standards 2
Reward Achievements 4	Measure Progress 3

Before extending the PQI initiative to additional health centers, MCHIP conducted an analysis of provider adherence to the integrated RH-IP standards at PQI intervention facilities supported under the ACCESS program. According to the results, intervention sites achieved an average PQI follow-up score of 56.6% (range 33%-65%) in April 2009 compared to 34.3% (range 19-49%) at baseline in 2008. To contribute to the descriptive analysis on PQI improvement at the health center level, in January 2010, Jhpiego and the MoH conducted external assessments at four randomly selected PQI intervention facilities and two non-PQI intervention facilities to determine differences in quality of RH service provision. Interventions sites had an average total score of 47.6% standards met compared to an average total score of 22.3% for the two control sites. All interventions sites were observed to be practicing Active Management of the Third Stage of Labor (AMTSL) to prevent postpartum hemorrhage. Other findings included the following: At PQI sites, integration of PMTCT in RH services were offered routinely in postnatal care and family planning service delivery points; internalization of the performance standards by service providers was achieved when Hospital Management was supportive; presence of essential resources, and mentoring, coaching and regular supportive supervision is critical to successful implementation of the PQI process to improve RH services. These general findings supported the MOH's goal to scale up PQI to additional health centers.

In Year 2, MCHIP expanded the integrated PQI in infection prevention, reproductive health and PMTCT to 16 additional health centers within the four districts. According to the performance results, all sites measured significant improvements in adherence to PQI standards averaging a performance score of 60% at 1st internal assessment compared to a

32% performance score at baseline except for three health centers of Lura in Rumpfi, Nyambi in Machinga and Nkhunga in Nkhotakota (see Figure 4 below for complete results). During MCHIP's final meetings with stakeholders DHMT's indicated that they would facilitate QIST in conducting further internal assessments and addressing the gaps. Ngonga was unable to conduct internal assessment because the only nurse-midwife who was working at this health center requested for transfer due to conflicts with some members of the community. MCHIP lobbied with DHMT to post another midwife, however this was not successful because midwives were fearful of the community and the issue was handed over to the DEC to resolve.

Figure 4: PQI Scores for 16 expansion health centers



PQI at District and Central Hospitals

ACCESS introduced PQI in IP and RH in 16 district hospitals and four central hospitals by 2008, MCHIP supported these hospitals through intensive supportive supervision and external validation. In addition MCHIP scaled up PQI IP and RH to the remaining 12 districts thereby achieving 100% national coverage of district and central hospitals. In 2009 Mchinji district hospital was the first hospital to be recognized as a center of excellence in RH under the ACCESS program.

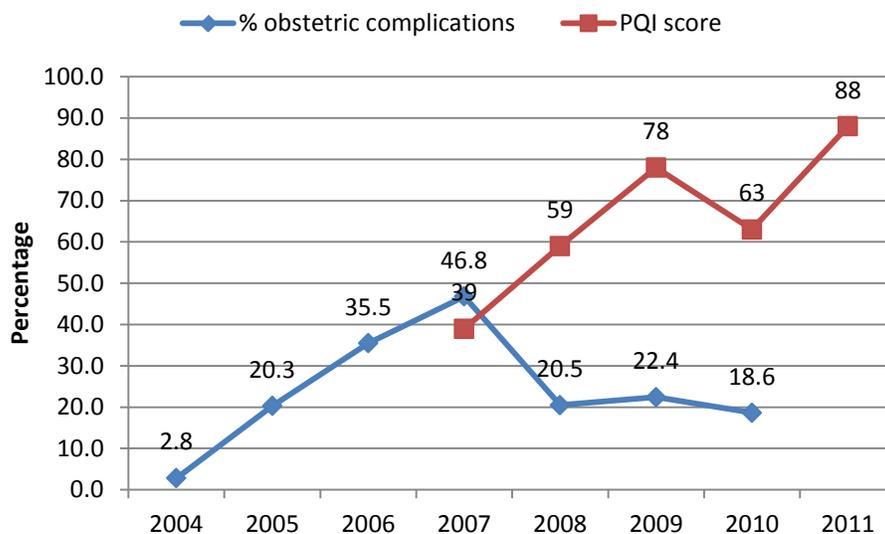
In 2010, two hospitals qualified as centers of excellence in the provision of RH services by achieving 80% of standards during an external verification assessment by Ministry of Health: Mzuzu Central Hospital and Dowa District Hospital. In Mzuzu Central Hospital, between 2004 and 2009, there was a 36% decline in maternal deaths as a result of direct obstetric complications. Similarly, at Dowa district hospital, the incidence of women who developed obstetric complications following delivery dropped from 23.2% in 2008 (pre-intervention) to 16% in 2010. By following PQI RH standards for managing complications during delivery, these facilities improved early diagnosis and correct

management of eclampsia and postpartum hemorrhage which are among the five direct causes of maternal deaths in Malawi.

In 2011, Machinga District Hospital was recognized in both infection prevention and control practices and reproductive health service delivery and recognized as a center of excellence in IP and RH. “The quality improvement initiative in RH [implemented at this facility] is a great example of interventions to address maternal mortality as stipulated in President Obama’s Global Health Initiative,” said Deputy Chief of Mission from the US Embassy, Craig Anderson. Service statistics gathered by the hospital revealed impressive gains in the reduction of maternal and newborn morbidity, including:

- Reduction in the number of direct obstetric deaths from 5.6% in 2005 to 2.7% in 2010;
- Improvement in the management of women with bleeding after delivery and of pregnant women who develop serious conditions related to high blood pressure caused by pregnancy; and
- Reduction in the number of women who developed obstetric complications following delivery from 46.9% in 2007 to a record low of 18.6% in 2010 (nearing the UN recommended level of 15%) (Figure 5 below).

Figure 5: Decline in obstetric complications, Machinga District Hospital



Pilot of electronic PQI data collection system

The current PQI scoring system uses a paper-based data collection system. MCHIP made efforts to transition this system to an electronic system using durable computer tablets. Data collected from facility assessments will be captured on a durable, tablet computer and uploaded to an off-site system that will produce performance dashboards

using the data. The dashboards will allow district and other MOH staff to quickly analyze performances of individual facilities. MCHIP successfully pilot tested the tablet in selected health centers and the district hospital in Nkhotakota and will provide follow on USAID projects with necessary details to roll out the electronic data collection process.

PQI Sustainability

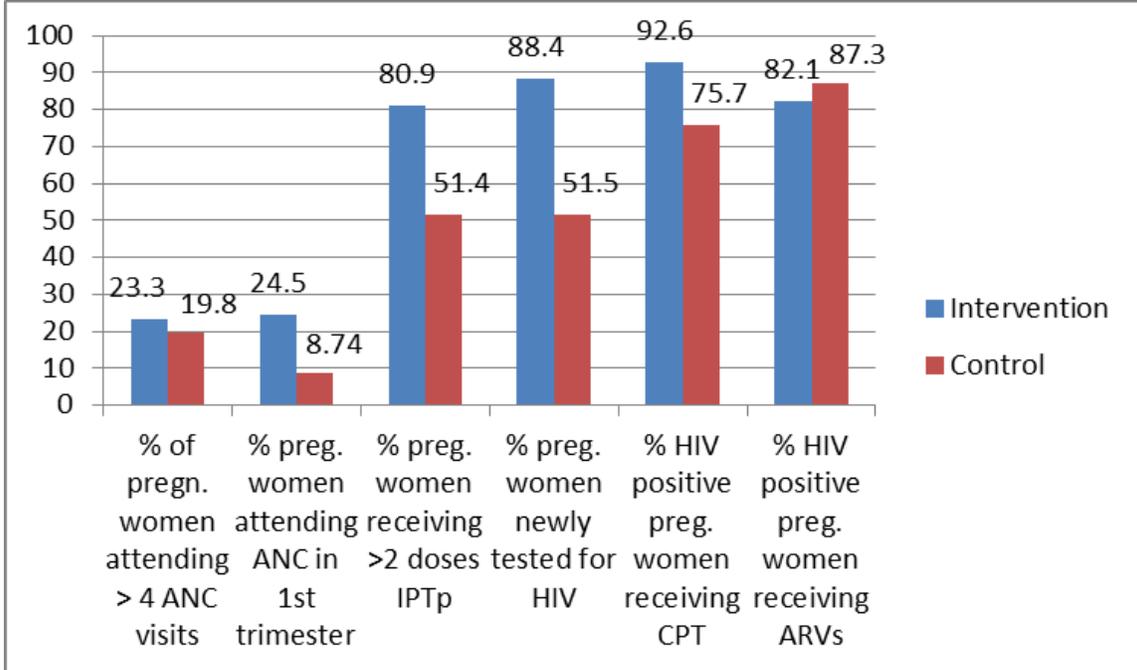
The PQI Initiative is housed within the MoH and MCHIP contributed to strengthening the Initiative as a whole including building capacity of staff of Quality Assurance Secretariat. The MoH led with MCHIP support activities at all levels of the PQI process from initial assessments, supportive supervision and the recognition process. One of MCHIP's legacies is developing the capacity of the MoH to lead this ambitious quality improvement process.

Pilot PMTCT-MNCH integration in Phalombe District

In 2009 in Phalombe District, MCHIP and BASICS, USAID's child health project, implemented a joint, integrated MNCH-PMTCT approach to community-based services that required different interventions from HSAs. Determining integrated program strategies across the continuum of care took time however initial service delivery data comparing intervention and non-intervention facilities showed promising results (see Figure 6 below).

Review of service statistics data was done for the period January-September 2010, however only complete data was available for Phalombe for the period July –September 2010. Data was analyzed for all three intervention facilities and nine non-intervention facilities, representing all facilities in Phalombe district. In Antenatal care, results indicated that in general the intervention facilities were achieving better coverage of MNH and HIV-related service delivery indicators compared to non-intervention facilities an indication of the value of integration of services.

Figure 6: ANC service statistics in integration and non-integration sites, Phalombe



In maternity, the results are similar across intervention and non-intervention sites (Figure 7). Observationally, we have noted that there continues to be challenges with testing in maternity due to the lack of human resources and the high workload.

Figure 7: PMTCT counseling and testing in maternity, Phalombe

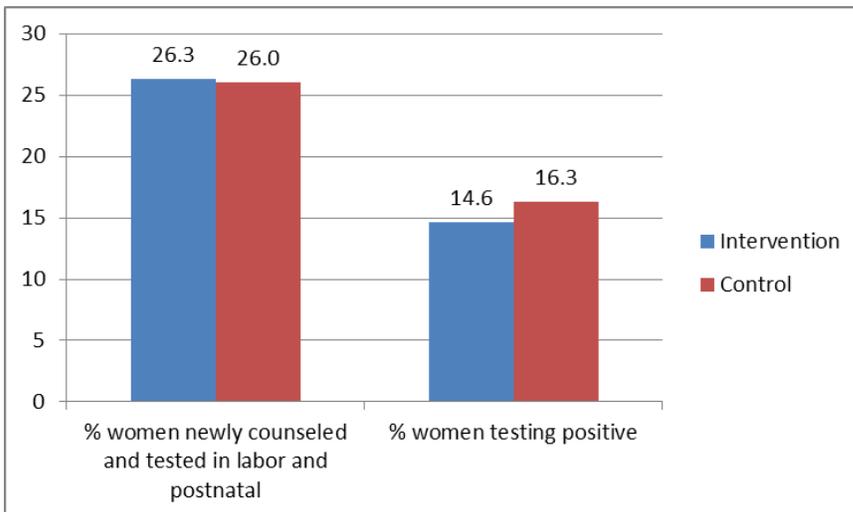
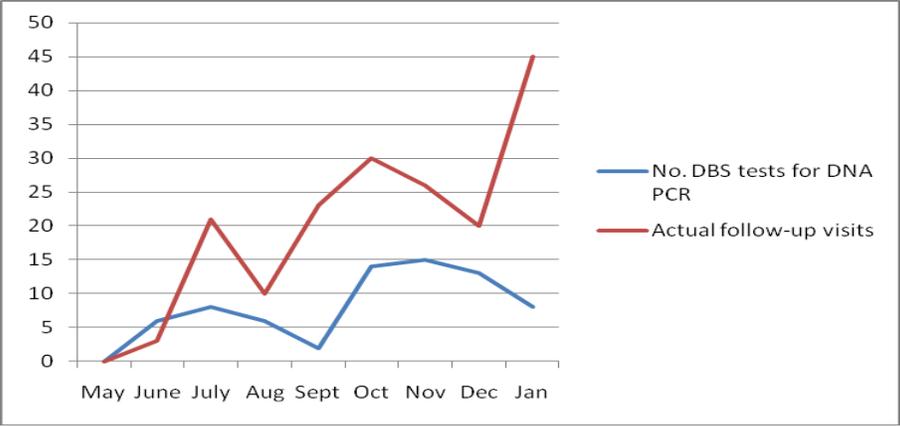


Figure 8: Trends in DBS testing and follow-up following introduction in Phalombe



SPOTLIGHT: HELPING BABIES BREATHE

Major causes of neonatal mortality in Malawi include neonatal sepsis (29%), prematurity (27%) and asphyxia (23%) (DHS 2008). Efforts to prevent asphyxia related deaths in Malawi have been constrained by the lack of resuscitation skills among health workers (HW) present at the time of birth. Traditionally, resuscitation skills have been difficult to improve and sustain as asphyxia is a rare event, making it very difficult to have enough cases to provide adequate initial training to HWs and to sustain those skills.

Helping Babies Breathe (HBB) is an educational program to teach neonatal resuscitation techniques to health workers in resource-limited areas. The objective of HBB is to train health workers in limited resource countries in the essential skills of newborn resuscitation, with the goal of having at least one person who is skilled in neonatal resuscitation at the birth of every baby.

With support from USAID/MCHIP, Johnson & Johnson, and other development partners, HBB is being rolled out in 10 districts supported by MCHIP (Nkhotakota, Kasungu, Lilongwe, Machinga, Zomba, Nsanje, Phalombe, Mwanza, Nkhata Bay, Rumpfi); 2 districts supported by Johnson and Johnson (Dowa and Mzimba North) and 2 districts supported by SC Italy (Chitipa and Thyolo). Beginning in April 2011, MCHIP trained five master trainers from the MoH, KCN and Jhpiego; 36 national HBB trainers (50% of all trainers nationally), and 337 providers from 10 districts in HBB (70% of all providers trained nationally). Through Save the Children Italy, Johnson and Johnson and MCHIP's contribution, Malawi as of December 2011 had 72 HBB trainers and 481 providers trained nationally, which created a pool sufficient to fast track the Ministry of Health roll out plan on HBB which was developed in March 2011 by MoH and stakeholders. The HBB trainings and ongoing mentorship will improve newborn resuscitation skills of providers in rural health centers and district hospitals.

Initial results are promising. Review of labor registers during initial supervisory visits to Zomba, Mwanza and Nkhotakota in October and November 2011 revealed that 33 newborn lives were saved through the practice of HBB skills. There was one case of death and one newborn was referred for advanced care. With the roll-out of HBB registers, supported by MCHIP, more robust data is expected to be collected by the MOH and follow-on projects to support increased evidence on the effectiveness of HBB.

From 2011-2013, MCHIP will support a national program evaluation on HBB with a specific objective to measure the quality, coverage, and impact of the Helping Babies Breathe newborn resuscitation intervention at the facility level in Malawi. The evaluation will provide guidance and recommendations for further implementation of the scale up of HBB in Malawi.

Intermediate Results 2: Increased adoption of household behaviors that positively impact the health of mothers and newborns and children under 5 years of age.

Intermediate Result 3: Increased availability of integrated community-based MNH/FP services through Health Surveillance Assistants

Intermediate Result 10: Increased community and district action, through community-based networks and communication programs, to support use of high impact MNH interventions

Milestones achieved:

- Scale up of CMNH package to 19 traditional authorities (TAs); In Nkhotakota 5 T/As (Mwadzama, Kafuzila, Kanyenda, Mphonde, Mwansambo); In Rumphi 6 (Katumbi, Chikulamayembe, Mwankhunikila, Mwahenga, Mwalweni and Sub T/A Chisovya); In Machinga 7 (Chikweo, Ngokwe, Kawinga, Nsanama, Liwonde, Nyambi and Sub T/A Mpola); In Phalombe TA Nkhumba.
- Scale up of CM package to 19 traditional authorities

ACCESS trained 161 HSAs and 25 HSA supervisors from the catchment area of 9 health centers in Machinga, Nkhotakota, Rumphi in community CMNH, and 121 HSAs and 17 supervisors in community mobilization; these HSAs provided CMNH services in 844 communities. To saturate the CMNH model in the four MCHIP focus districts (Machinga, Nkhotakota, Rumphi, Phalombe), there was need to train an additional 883 HSAs.

Malawi CMNH package	
Community ANC visits	Community PNC visits
1 visit per trimester	Visits on day 1, 3, and 8
Birth preparedness counseling	Screen for danger signs
Encourage facility deliveries	Counseling on newborn care, breastfeeding, etc.
Referral for danger signs	Referral for danger signs
FP counseling	Mother-infant pair follow-up
Develop birth plan	
PMTCT counseling	

Building on an existing platform that brings basic MNH services closer to families and raises awareness and demand for high-quality, facility-based MNH services, MCHIP supported scale up of the MoH's nationally approved CMNH-CM model to additional communities and provided ongoing supportive supervision. MCHIP trained 458 Health Surveillance Assistants (HSAs) in CMNH. MCHIP facilitated the development of Community Mobilization training manual and job aids; and trained 400 HSAs in Community Mobilization. MCHIP worked with HSAs assigned to targeted health centers to deliver essential MNH messages and enhance preventive care before, during, and after childbirth, and to promote the use of health care as depicted in the figure above. The HSAs were trained to deliver CMNH messages at home and facilitate community mobilization to engage community members in defining and addressing local MNH challenges in partnership with the health center team. MCHIP documented the lesson learned in this process and disseminated at district level and national forum where RHU

strongly advocated for nationwide scale up by district health management teams and other health partners. In addition MCHIP developed partnerships at community level through establishment of 258 Community Action Groups (CAG) in Rumphi, Nkhotakota, Machinga and Phalombe; the CAG's continue to raise awareness in their community on MNH and also mobilize resources to advance MNH at community level. Malowa CAG in Nkhotakota received a grant of MK3.6 Million (US\$23,000) from the District Assembly for construction of a maternity unit in their area; this is a great testimony on the power of community mobilization following the capacity building on CMNH and CM by MCHIP.

Since 2008, 12,592 home visits to pregnant women and 5,193 home visits to postnatal women have been conducted by HSAs. According to the community MNH monitoring system, rates of skilled birth attendance increased in catchment areas where HSAs conduct antenatal home visits in Machinga, Nkhotakota and Rumphi districts between 2008 and 2011. See Table 3 for details

Table 3: Rates of Skilled Birth Attendance

District	Skilled Birth Attendance Rate 2008	Skilled Birth Attendance Rate 2011
Machinga	54.9%	89.3%
Nkhotakota	61.7%	71.1%
Rumphi	70.3%	84.4%

An analysis of behaviors related to maternal and newborn best practices indicates an increasing trend in adoption of healthy behaviors. Note that 2011 data was excluded from the analysis as data was incomplete due to the introduction of the revised community-based monitoring and surveillance MNH system.

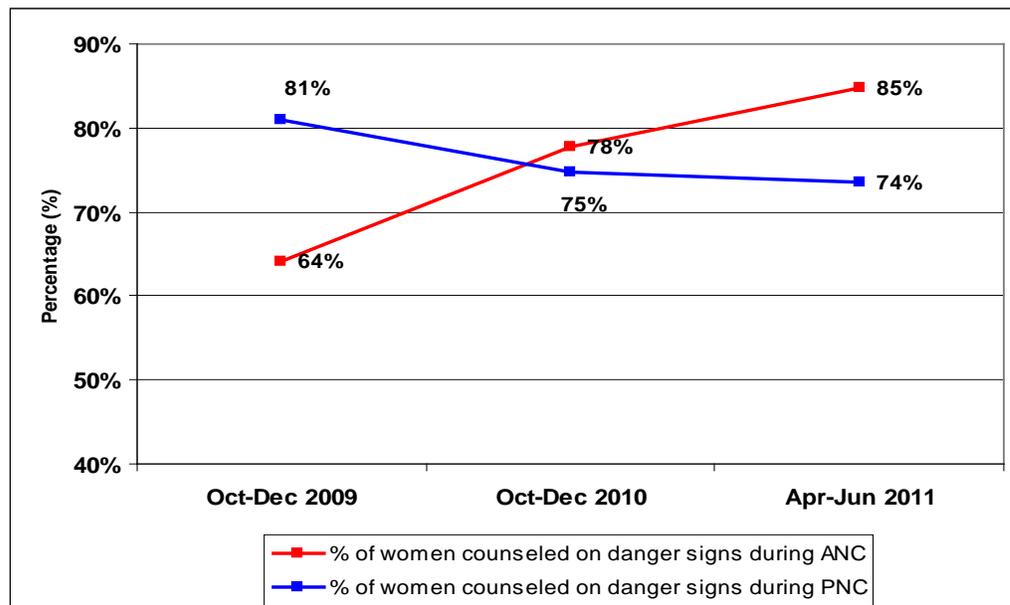
Table 4: Highlights HSAs Visits

Indicator	2008	2009	2010
Number of new ANC HSA visits	753	2925	5778
Number of pregnant women who developed a birth plan	14%	22%	40%
Number of newborns breastfed within 1 hour after delivery	82%	88%	92%

Despite improvements in rates of skilled birth attendance and ANC-related services, postnatal care services delivered by HSAs did not show similar improvements. For example in the Figure 9 below, the percent of women counseled on danger signs during the post-partum period declined while women counseled on danger signs during the ANC period improved. Analysis of the situation shows that PNC visits were low because HSAs do not reside in their catchment area. They rely on family member to deliver a message to the Health Center informing them of a birth. Without this notification, HSAs are not prompted to visit that woman and newborn and will only discover the birth during the next scheduled visit to the area. The majority of PNC visits conducted by HSAs within the one week time frame are to women and newborns within walking distance where the communication with the Health Center was easy. Inadequate

transport (insufficient bicycles) provided by MoH to HSAs negatively contributes to mobility of HSAs.

Figure 9: Percent of Women Counselored on Danger Signs ANC and PNC



As with PQI, the CMNH activities are led by the MoH and MCHIP supported MoH to institutionalize this initiative. For example, MCHIP supported development of a new monitoring and evaluation system linked to the CMNH service delivery components. The system is housed with the MoH.

Table 5: Focus district coverage by intervention area

FOCUS DISTRICT	INTERVENTIONS	ACCESS/MCHIP PRESENCE IN SEPTEMBER 2010	% COVERAGE IN SEPTEMBER 2010	MCHIP PRESENCE IN SEPTEMBER 2011	% COVERAGE IN SEPTEMBER 2011
Machinga No of Health Facilities with Maternity Units: 14 No. of villages: 897	PQI	4 of 14 facilities	28%	8 of 14 facilities	57%
	Community MNH	383 of 897 villages	43%	591 of 897 villages	65.9%
	Community Mobilization	283 of 897 villages	32%	591 Or 897 villages	65.9%
	Kangaroo Mother Care	7 of 14 facilities	50%	7 of 14 facilities	50%
Nkhotakota No of Health Facilities with maternity Units: 13 No. of	PQI	5 of 13 facilities	38%	9 of 13 facilities	69%
	Community MNH	357 of 1693 villages	21.1%	1106 of 1693 villages	65.3
	Community Mobilization	237 of 1693 villages	13.9%	1106 of 1693 villages	65.3

FOCUS DISTRICT	INTERVENTIONS	ACCESS/MCHIP PRESENCE IN SEPTEMBER 2010	% COVERAGE IN SEPTEMBER 2010	MCHIP PRESENCE IN SEPTEMBER 2011	% COVERAGE IN SEPTEMBER 2011
villages: 594	Kangaroo Mother Care	7 of 13 facilities	53%	7 of 13 facilities	54%
Phalombe No of Health Facilities with Maternity Units: 12 No. of villages: 476	PQI	3 of 12 facilities	25%	7 of 12 facilities	58%
	Community MNH	151 of 476 villages	32%	227 of 476 villages	47.6
	Community Mobilization	71/476 villages	15%	227 of 476 villages	47.6
	Kangaroo Mother Care	5 of 12 facilities	42%	5 of 12 facilities	42%
Rumphi No of Health Facilities with Maternity Units: 17 No. of villages: 510	PQI	4 of 17 facilities:	24%	8 of 17 facilities	47%
	Community MNH	299 of 1224 villages	24%	713 of 1224 villages	58%
	Community Mobilization	155 of 1224 villages	12%	713 of 1224 villages	58%
	Kangaroo Mother Care	5 of 17 health facilities	29%	5 of 17 health facilities	29%

Intermediate Result 4: Strengthened MNH policies, planning and management in place at the national, zonal and district level

Milestones achieved:

- Trained 60 additional tutors in BEmONC
- Provided technical assistance to GAIA to train 12 tutors from KCN in BEmONC
- Trained 158 tutors in PFP
- Strengthened skills laboratory at KCN and two clinical practice sites
- Developed and printed PFP job aides to be distributed countrywide
- Developed, printed and distributed Obstetric Protocols countrywide
- Developed and printed revised Reproductive Health Strategy to be distributed countrywide

BEmONC and PFP

At the start of ACCESS in 2007, Malawi had 160 midwifery tutors deployed to all 13 training institutions. The ACCESS program supported strengthening BEmONC skills of 31 midwifery tutors and 27 preceptors representing all 13 of Malawi's nurse-midwifery training institutions to improve their clinical BEmONC skills and improve their clinical training skills. Building on past achievements of ACCESS, MCHIP trained 60 additional tutors in BEmONC and provided technical assistance to the Global AIDS Interfaith Alliance to train 12 additional tutors from KCN in BEmONC. To date 103 out of 160

(68%) of midwifery tutors have updated BEmONC skills and are key players in promoting transfer of learning among midwifery graduates countrywide.

In order to address the unmet needs of spacing births within the postpartum and post abortion period, MCHIP in collaboration with RHU and Nurses and Midwives Counsel of Malawi utilized MCHIP core funds to develop a module on postpartum family planning content as part of the national midwifery training. Further to this MCHIP also updated 158 of the 160 tutors (99%) with PFP skills. The knowledge and skills gained will enable tutors to integrate PFP into their pre-service FP modules for students and ensure that both comprehensive BEmONC and the spectrum of FP counseling include PFP. MCHIP provided basic FP equipment and supplies to Kamuzu College of Nursing to help strengthen their skills laboratory. Additional equipment and supplies were also provided to 2 health centers (Kawale Health Center and Area 25 Health Center) and Bwaila hospital where nursing students are posted as part of their clinical rotation and where FP services are generally in high demand. With these achievements, students graduating from the pre-service training institutions will learn from tutors and preceptors with updated skills and will be able to deliver appropriate care when deployed to their first community post.

In addition MCHIP trained 340 service providers from fifteen districts (Likoma hospital, Mitundu Community Hospital in Lilongwe, Ndirande Health Centre in Blantyre, Mapale and Matawale Health Centres in Zomba, Dedza, Neno, Nsanje, Nkhatabay, Chitipa, Thyolo, Kasungu Phalombe, Rumphi, Machinga and Nkhotakota district hospitals), this capacity building will reduce missed opportunities to family planning.

PFP job aids were developed, pretested, finalized and translated into Chichewa. The job aids will support service providers and HSAs to provide adequate FP information and facilitate the provision of PFP services and contribute to consistent quality and efficiency of those services. The following PFP job aids were printed and are being distributed country-wide (10,000 Chichewa flip chart, 10,000 Chichewa LAM leaflet, 10,000 laminated copies of PFP options Poster for use by providers).

Facility Refurbishments to Enhance FP Service Provision

MCHIP planned to support minor renovations to facilitate integration of FP in ANC, Maternity and Postnatal clinics at six health facilities. Due to the ongoing delays with approval processes, it was evident that in the event that the actual work started in January 2012; there were so many extenuating circumstances/confounding factors which were out of the projects control (fuel scarcity, availability of materials, the upcoming rainy season) which would negatively affect the renovations. MCHIP in discussion with the Deputy Director of Reproductive Health Unit of MoH and USAID recommended use of the resources planned for renovations towards refurbishing the 6 facilities (table and chairs for staff, lockable cabinets for drugs, portable hand washing facilities, benches for patients). Upon the approval, MCHIP worked with the DHMT of

the four districts to get consensus on their needs as outlined in the Needs Assessment Report.

MCHIP supported six high volume FP sites (Chiringa, Katimbira, Phalombe, Ntaja, Ngala, Bolero) from the four focus districts to enhance FP service delivery through the provision of basic supplies including examination couches, chairs for providers, benches for clients, portable hand washing facilities and drug cabinets.

Policy Support

In response to the needs of MoH and USAID, MCHIP facilitated the review and revision of the National Sexual and Reproductive Health and Rights Strategy 2011-2016; currently in print, 2,000 copies are anticipated to be distributed country wide by August 2012. MCHIP also facilitated the review and revision of Obstetric Protocols (Malaria in Pregnancy, Anemia in Pregnancy, Postpartum Hemorrhage, Abnormal Deliveries, Preeclampsia/Eclampsia, Sepsis, Post natal care); 500 copies of hospital and 1,000 copies of health center protocols of the seven protocols have been printed and distributed country wide as of August 2012.

Intermediate Result 5: Increased commitment of resources for MNH from GoM and other donors

Milestones achieved

- Adoption and roll out of CMNH package in PMNCH/Catalytic Initiative focused districts
- Resource Mobilization by MCHIP and Dock-Dock and distribution of equipment and supplies to 16 health facilities

Catalytic Efforts

As a result of MCHIP and RHU discussions, WHO and PMNCH agreed to use the MoH's CMNH packages and PMNCH has since rolled out the CMNH package in 10 districts of Karonga, Mzimba, Kasungu, Lilongwe, Ntcheu, Dedza, Balaka, Chiradzulu, and Nsanje districts raising the total districts implementing CMNH to 13, or 46% of Malawi nationally. PMNCH also implemented CMNH in non-MCHIP sites in Phalombe district. MCHIP also negotiated with Global AIDS Interface Alliance to support BEmONC training for pre-service tutors.

In partnership with Doc2Dock, a US-based NGO, MCHIP donated assorted medical equipment and supplies valued at Mk 7 million (USD 202,780) to 16 needy maternity units identified by the Ministry of Health (Bolero, Nthalire, Nalunga, Kansonga, Mkanda, Chitowo, Kambenje, Ntaja, Kunenekude and Ndamera health centers; Rumphu, Mchinji, Salima, Machinga, Nsanje and Holy Family hospitals). The equipment and supplies contributed to improving the working environment and enabling health professionals at those facilities to provide quality maternal and newborn health services.

Intermediate Result 6: Strengthened planning and monitoring of MNH activities at the community level

Milestones achieved:

- Development and roll-out of new M&E tools to MCHIP focus districts
- Re-oriented 400 HSAs on new M&E tools for CMNH

As a pilot program, the initial CMNH monitoring tools were designed less as tools to collect routine community-based service delivery data and more as programmatic checklists. This was done to help remind HSAs of key questions to ask and information to collect regarding community level behaviors and practices. As a result, the CMNH documentation and data entry system at the district level was lengthy and burdensome for district staff.

In 2010, following several years of successful implementation of the CMNH program a decision was made by the MOH, MCHIP and Save the Children to establish clear community MNH indicators and redesign the data collection system to support a structured reporting system of those indicators.

The Community MNH indicators were identified during a national workshop of key stakeholders and draft registers and reporting formats were subsequently developed. MCHIP supported the pretesting, revision, and eventual roll-out of the registers—including an orientation of 400 HSAs—in MCHIP’s focus districts. As of the close of MCHIP, 60% of HSAs in three of MCHIP’s focus districts had fully moved over to the new M&E system.

Intermediate Result 7: Increased availability and access to low osmolarity ORS among mothers and caregivers of children under 5

Milestones Achieved:

- Procured, cleared and stored 1 million sachets of low osmolarity ORS for eventual distribution countrywide
- Distributed 758,820 sachets of ORS and 135,000 bottles of Water Guard through commercial outlets nationally

Diarrheal disease is the second leading cause of under-five morbidity and mortality in Malawi. MCHIP supported the procurement, clearing and warehousing of 1million sachets of low osmolarity Thanzi ORS for the treatment of dehydration caused by diarrhea and 135,000 bottles of Water Guard for point of use water treatment. A total of 758,820 sachets of Thanzi ORS and 135,000 bottles of Water Guard were distributed through the commercial outlets across the country. To make sure that mothers and caregivers use Thanzi ORS and Water Guard correctly and consistently, 200 community education sessions were conducted reaching an estimated audience of 17,300 people.

Intermediate Result 8: Increased use of oral and injectable contraceptives amongst middle income women of reproductive age intending to use FP methods

Milestones achieved:

- Designed and implemented a pilot initiative on social marketing of FP in Machinga district (see Spotlight)

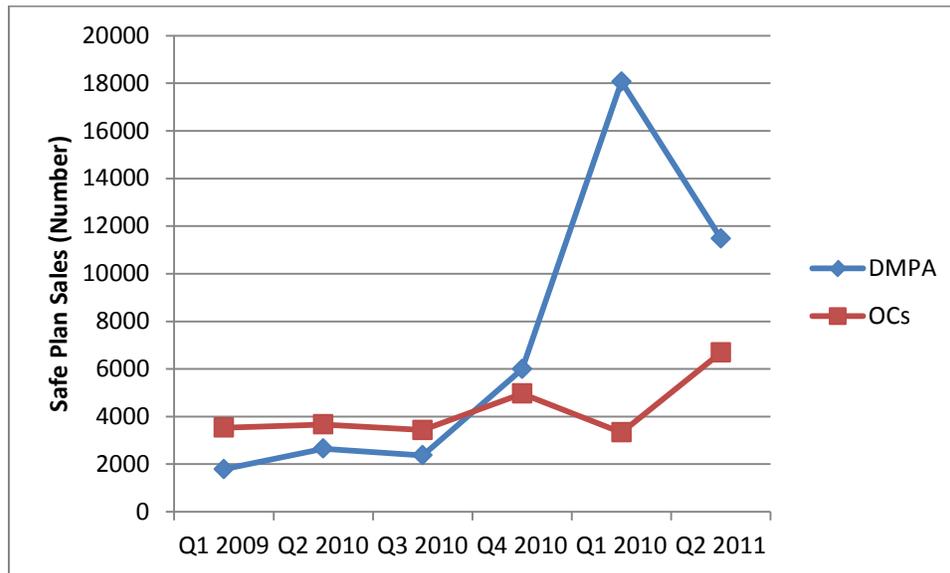
Strengthening FP in Private Sector

The 2010 MDHS indicated that among currently married women, 42% use a modern method of contraception and 4% use traditional methods. With respect to specific modern contraceptive methods, the report showed that injectables (26%), female sterilization (10%), pills (3%), and male condoms (2%) are the most widely used methods. Furthermore the 2004 MDHS highlighted that 28% of married women in Malawi have unmet need for family planning services and only half (55%) of the total demand is satisfied. One way to support the expansion of family planning is to increase the type and number of places where people can get access to contraceptive products.

From 2009-2010, MCHIP trained providers from 206 private clinics across the country to provide oral and injectable contraceptives (Safe Plan). In addition, MCHIP produced communication materials to promote and increase awareness on the use of the private sector as a source of contraceptives.

Continued routine analysis of Safe Plan at the 206 targeted clinics provided strong evidence on the continued uptake of FP commodities in the private sector, largely attributable to frequent stock-outs of FP commodities in the public sector and the continued high demand for FP services. Results indicated a significant increase in uptake of Safe Plan through the private sector. Findings showed that 75,834 vials of injectable contraceptives and 42,520 cycles of oral contraceptives were distributed through the private sector, providing 21,793 couples-years protection. Demand for contraceptives through the private clinics has remained consistently high due to frequent stock outs in the public sector. Distribution of these contraceptives ensures adequate supply for women seeking FP methods offers an alternative service delivery point and increases the contraceptive use in Malawi (see Figure 10 below).

Figure 10: Safe Plan Sales, 2009-2011



In 2011, MCHIP conducted a household survey among women of reproductive age (15-49) in the catchment areas where SafePlan was made available. The goal of the study was to identify key behavioral determinants and population characteristics that are significantly correlated with use of modern contraceptive methods accessed through the private sector; and to inform future program intervention and communication activities. According to the results, 24% of the women interviewed indicated that they obtained any contraceptives from the private sector, 28% of the women obtained their **oral** contraceptives from the private sector while 7.3% obtained **injectables** from the private sector. There is potential for the private sector to be a strong player in family planning service provision considering that 74% of women have an unmet need for contraceptives.

Intermediate Result 9: Promotion of correct and consistent use of LLINs, correct and prompt use of ACT anti-malarial among caregivers of children under five, and improved awareness and uptake of IPT among pregnant women

Milestones Achieved:

- Launch of United Against Malaria (UAM) Initiative which reached a total estimated 2.5 million people through live broadcast, and 19,000 people directly during the launch event
- Distributed 234,974 LLINs from October 2009 to September 2010 and 985,633 LLINs in October 2010 to December 2011 to health facilities across the country, targeting pregnant women and children under-five
- Developed malaria IEC messages on treatment of malaria according to national guidelines and correct and consistent use of LLINs, reaching an estimated 218,989 people

SPOTLIGHT: PILOT INITIATIVE ON SOCIAL MARKETING CONTRACEPTIVES

With 54% of the rural population without access to family planning services within a 5km radius, community based distribution (CBD) has become a successful alternative to bringing the products to the people. Evidence has shown that an effective CBD program is one that has integrated service delivery, is effectively managed, incurs low training costs by keeping the trainings brief while not compromising quality, and allowing the community distribution agents keep all or part of the profits made when they distribute contraceptives at subsidized costs. MCHIP conducted a feasibility study on community based distribution of social marketed contraceptive products in urban/peri-urban areas and for the introduction of Social Franchising Network activities. The study highlighted frequent stock outs and an inadequate number of community-based distribution agents (CBDAs) as primary challenges. The research participants felt that introducing contraceptives through a different channel, (selling versus free distribution), may offer an alternative solution to the frequent stock outs experienced with free commodities, and may aide in retaining the CBDAs that are available. When CBDAs who dropped out were asked for an explanation for their actions, the common reason was that they needed to find a source of income. They also agreed that by selling subsidized contraceptives they would receive some income which could motivate them to continue providing the services.

With this in mind, MCHIP launched a small scale pilot in two Traditional Authorities in Machinga district with support from the Ministry and the district teams. The pilot was conducted in two TAs of Chikweo and Liwonde in Machinga. The target group was defined as low-income women of reproductive age (WRA). These TAs were selected as there are few health centers within their boundaries that offer FP services hence women have to travel long distances to get services. Fifty new CBDAs were identified and trained on family planning counseling and community mobilization. In order to explore the efficacy and role of subsidized delivery, these CBDAs:

Distribute subsidized oral contraceptives and male and female condoms in their communities and keep a portion of the profit. (MK10 for a cycle of pills, MK7 -12 for condoms)
Refer clients requesting other methods to the closest facilities or providers offering these services.
Conduct community sensitization meetings in their catchment areas to promote general contraceptive use and the new initiative.

During this six-month pilot, new clients for oral contraceptives were generally high. Community sensitization events were increased which resulted in more demand created for contraceptives. Findings of the CBDA visits included: there was a significant proportion of people who would pay for contraceptives; perception of roles of CBDAs did not change since inception of social marketing of FP products; the most cited reason for not buying FP products was negative attitude towards FP by some community members; and CBDA profit margin may be too low to result in sustainable motivation. During the life of the pilot, the CBDAs distributed 1,305 pills, 1,201 male condoms and 349 female condoms. The CBDAs counseled 9,969 clients on FP through door-to-door counseling and referred 2,240 clients for other methods including, injectables and implants. The conclusion from this pilot is that social marketing is a window of opportunity to increase service delivery points for FP; a significant proportion of women was able and willing to pay for contraceptives and social marketing can provide a sustainable option to help retain volunteers especially when a range of products are on offer.

MCHIP launched the United Against Malaria initiative in Malawi locally branded as Malungo Zii! (Silence malaria). The objective of the campaign was to increase awareness and empower Malawians in the fight against Malaria.

The campaign, coinciding with the 2010 World Cup, launched in Lilongwe at Silver Stadium on 12th June 2010. The MoH band and National Team players caravanned throughout Lilongwe providing Malaria awareness messaging and personal experience with Malaria to local Malawians. Partners including MoH officials conducted a “Big Walk’ to Silver Stadium establishing the full partnerships involved in the fight against malaria. Top Super league football teams also competed for the UAM cup supported by targeted messaging throughout the game and a live broadcast throughout Malawi with partner Zodiac radio station. Messages were developed in a collaborative effort between PSI, the NMCP and the Health Education Unit. In addition, current popular band ‘Black Missionaries”, entertained the crowd increasing awareness of the impact of malaria on all aspects of life. It is estimated that 13,000 people were reached with malaria messages at the launch function, 6,000 during the caravan and more than 20,000 during the TOC community mobilization events which were conducted prior to the event. An additional estimated 2.5 million people heard the malaria messages during the live broadcast of the event.

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 Malaria messages in six rural districts with limited access to information but high risk to malaria: Karonga, Nkhata Bay, Salima, Zomba, Blantyre Rural and Nsanje. The activities in the rural districts included Targeted Outreach Communications (TOC) activities prior to the launch, drama, football matches involving local rival teams, traditional dances and speeches by MOH, Ministry of Local Government and traditional chiefs. At night, PSI in partnership with Multichoice beamed the 2010 World Cup games live on big mobile screens in the rural communities thereby creating more excitement with the communities who watched football while listening to malaria messages. Throughout, messaging focused on three malaria interventions: (1) use of LLINs, (2) case management of malaria and (3) IPTp. The outreach events provided the ability to bring people together from varied rural communities to a centralized location to learn and become better educated about malaria prevention and treatment. It is estimated 78,000 people were reached by TOC events prior to the launches, 42,000 during the launch day events and 37,700 during the rural night events.

In addition, several materials such as posters, radio ads and other promotional materials on malaria prevention and treatment were produced, reaching millions of Malawians nationwide. Popular personalities such as the Malawi National Coach, national team players, and traditional chiefs were used to help disseminate IEC materials and participate in outreach activities. During this period 4,000 posters were printed to support the launches and 1,622 radio ads aired on Malawi’s popular radio stations MBC Radio 1, MBC Radio 2, Zodiac and Trans World Radio, reaching an estimated 7 million

people with malaria messages. PSI negotiated with production and media houses to reduce their rates by 50% as part of their in-kind contribution to the UAM partnership. PSI/Malawi also contracted and trained 7 drama groups to carry out community interactive drama performances on malaria prevention and treatment throughout the country. A total of 520 drama performances were conducted reaching 157,970 people.

A total of 234,974 LLINs from October 2009 to September 2010 and 985,633 LLINs in October 2010 to December 2011 were distributed to health facilities across the country, targeting pregnant women and children under-five based on the distribution plan from NMCP. MCHIP conducted a mass distribution campaign for Salima and Nkhosakota districts in collaboration with NMCP and DHMTs of each district to increase universal access to LLINs. Before the actual distribution of the LLINs MCHIP briefed DHMTs, local leaders, HSAs and volunteers, conducted household registration, supervised HSAs during the registration exercise, and verified the registered beneficiaries by HSA supervisors. 387,400 LLINs were distributed (190,000 LLINs for Salima through 128 distribution sites and 197,400 LLINs for Nkhosakota through 130 distribution sites). There was strong collaboration among the MCHIP team, DHMTs, NMCP, Peace Corps Volunteers, HSAs and the community which resulted in delivery of an efficient and effective distribution campaign.

In the second year of MCHIP operations, as part of the “Malungo Zii” campaign phase 2, MCHIP led in the development of malaria IEC messages on treatment of malaria according to national guidelines and correct and consistent use of LLINs. Using these messages, MCHIP reached 218,989 people with the following specific outputs:

- 812 LLIN posters placed on walls of health facilities countrywide
- 9,975 Malungo Zii calendars and posters, 4500 brochures promoting use of LLINs and 600 brochures for IPTp distributed to health facilities and malaria partners countrywide
- 7 drama group team leaders oriented on key messages for MNH. 5 Local drama groups at district level identified in preparation to perform in their communities with messages for IMCI, IPTp and promotion for use of LLINs. These drama groups performed 450 shows reaching an estimated audience of 74,576
- Placing 2,375 radio spots on local radio promoting use of LLIN every night to reduce malaria in pregnant women and children under five.

Finally, MCHIP has supported NMCP of MoH in its efforts to develop LLIN materials for outreach efforts; 70,600 posters have been printed and 3 radio spots placed with local radio stations.

Intermediate Result 11: Strengthened integration, provision and access to quality Prevention of Mother to Child Transmission (PMTCT) and Reproductive Health Services

Milestones achieved:

- Trained 359 service providers and data clerks from 10 districts in the new PMTCT guidelines
- Develop PQI standards on early infant diagnosis, early infant feeding, integrated FP-HIV, integrated STI-HIV, and integrated CECAP and HIV services
- Introduced PQI PMTCT integrated standards to 36 facilities and conducted baseline assessments at these facilities; average scores were 38.2%

In 2011 Malawi revised its policies in accordance with the WHO guidelines to provide universal access to lifelong ART for all HIV positive pregnant women after expanding coverage to CD4 tests. Due to limitations in providing CD4 cell counts universally, Malawi initiated implementation of “Option B plus” whereby all HIV positive pregnant women are started on lifelong ART regardless of CD4 cell count or WHO clinical staging.

Following the revision of these policies in June 2011, Malawi revised its PMTCT and ART training curriculum and in July 2011. MCHIP initiated a series of trainings for 359 service providers and data clerks from 10 districts in the Central East zone, Rumphi, Karonga, Chitipa, Mwanza and Likoma Island. In addition, MCHIP developed PQI standards on early infant diagnosis, early infant feeding, integrated FP-HIV, integrated Sexually Transmitted Infections-HIV, integrated Cervical Cancer Prevention-HIV and inclusion of PMTCT in FANC, labor and delivery and postpartum care based on the new policies and guidelines. Following the finalization of these standards, MCHIP trained 74 PMTCT service providers from 36 sites on PQI for PMTCT-RH integration. Baseline assessments at the sites indicate that sites scored an average 38.2% in adherence to the integrated standards, leaving tremendous room for improvement. Since introduction of these activities occurred towards the end of 2011, there was little time for MCHIP to provide supportive supervision to improve scores and no time for internal assessments.

At the community level, MCHIP facilitated the development of a mother-infant pair manual linked to the existing CBMNH training package for HSAs and developed and pretested MIP counseling cards and registers. The counseling card includes information on HIV and will complement the Community Based MNH Counseling cards. HSAs will use both cards for an HIV positive woman. MCHIP trained 10 trainers and 40 HSAs (10 each from Rumphi, Nkhhotakota, Ntchisi and Likoma) on the integrated MIP-CBMNH package. The national training manual for CBMNH has since been revised to incorporate mother infant pair follow up for HIV and is being used by all partners in training HSAs.

Intermediate Result 12: Increase access to Voluntary Medical Male Circumcision

Milestones achieved:

- Supported the first VMMC outreach campaign using MOVE principles
- Circumcised 4,348 men during the 4 week campaign in Mulanje district
- Develop VMMC protocols and guidelines and tools for future use by the MOH and implementing partners to scale up VMMC countrywide

The Malawi Ministry of Health has established 5-year district-level targets to achieve a minimum of 80% coverage for males accessing VMMC services by 2016. In order to reach 80% coverage, Mulanje District, one of MCHIP's assigned VMMC districts, must perform 1,468 MCs per month for five years. However, current rates of MCs through routine services at Mulanje District Hospital are approximately 30 per week or 120 per month, which is far below the monthly target. In response to this and based on lessons learned from Zambia and Tanzania VMMC campaigns, MCHIP conducted a four-week "demonstration" outreach campaign utilizing MOVE principles. Following intensive client mobilization efforts, 4,516 men registered to receive VMMC during the 4 week campaign. Of these, 4,348 (96.3%) men were cleared and MCs performed. The primary reason for men not being cleared for MC was identified STIs that were required to be treated first. HIV testing uptake was high with 4,237 (97.4%) clients agreeing to be tested. Of these, 2.1% (n=88) clients tested HIV positive. Men in the 15-24 age group (59.8%) constituted the greatest proportion of men receiving VMMC. The overall adverse event rate (for moderate to severe adverse events) was less than 1%. The campaign provided valuable lessons learned for outreach exercises that Malawi must begin supporting in order for districts to meet their VMMC targets.

MCHIP also supported the MOH to train providers to conduct VMMC thereby increasing Malawi's human resources to deliver VMCC services and supporting ongoing support to Mulanje and Dedza District hospital's VMMC program. MCHIP's major results included:

- Trained 42 service providers from 9 high HIV prevalence districts in male circumcision clinical skills (Mulanje, Machinga, Mangochi, Thyolo, Salima, Nkhotakota, Dedza, Kasungu and Nkhatabay). Four of the 42 trained providers came from two hospitals operated by the Malawi Defense Forces (MDF); Cobbe Barracks in Salima and Kamuzu Barracks in Lilongwe. During the practicals, a total of 147 MC were conducted (45 in the first training and 102 in the second). All 45 MC clients from the first training received counseling on HIV and no client reported any adverse events following the surgery. Of the 102 clients operated upon during the second training, all of the 102 clients tested for HIV and only 1 client had moderate adverse events (hematoma) reported on the follow up visit.
- Continued to monitor MC services following the clinical skills training for MC providers. A total of 777 routine adult circumcisions and 1 neonatal circumcision have been conducted in the period February-September 2011. HIV testing uptake continues to be high at 86.8% (n=675). 61% of clients returned for a post-

op visit within 48 hours, decreasing to 39% post-op follow-up at 1 week. The rate of moderate to major adverse events as of September 2011 was low at 1.1% (n=9).

LESSONS LEARNED AND CHALLENGES

Program Challenges

- PNC visits by HSAs were routinely low despite ongoing dialogue between program staff and district level implementers on the importance of PNC follow-up. In most cases, HSAs did not reside in their catchment areas and they relied on family members to deliver a message to the Health Center informing them of a birth. Suggestions for improvement include use of mobile phone to relay message on child birth, supplying bicycles to HSAs for more routine travel and change in policy to incentivize HSAs to reside within their catchment area.
- While PQI standards have been institutionalized by the MOH at the national level in terms of establishment of a recognition system for high performing facilities through application of SBM-R as a quality improvement approach, at the district and facility level there is a lack of prioritization to conduct the PQI internal assessment on a routine basis. Although facilities are only required to conduct internal assessments on a quarterly basis, they often complain of the length of the standards and the time it takes (approximately 2 days) to complete the assessment. Potential ways to overcome this perceived burden is to develop an electronic data collection system that would eliminate the time required to tabulate the results and streamline the standards further by identifying 3-4 critical steps that must be followed in order to achieve the results. Future projects should address these areas including linking PQI to PBI in order to incentivize performance tied to achievement of specified indicators.
- Relying on the HMIS for routine monitoring of program data is a great challenge not only because the system is slow requiring many levels of paper-based reporting but also because the integrity of the data is often questionable. Quality record keeping by providers has not been internalized and more effort and resources are needed to strengthen not only the clinical skills of providers but also emphasize documentation and record keeping. Development of M&E standards and incorporation of M&E modules during provider trainings may help alleviate these issues. Additionally, the MOH deployed statistical clerks to every facility in the country; however they were deployed without laptops or computers. Enabling data clerks by providing the technology they need to enter, clean and analyze data at the point of service delivery is essential.
- Review and update of policy documents including RH Strategy, Obstetric Protocols and PFP job aids took longer than anticipated due to competing

priorities in MoH and among the RH stakeholders. This then resulted in finalization, printing and distribution of the materials being done beyond the project timeframe. It was also not possible to assess and document the impact on PFPF service delivery following use of the PFPF job aids.

Other challenges that are systemic to the health system and will require innovative solutions in order to facilitate sustained improvement in the health sector. They include:

- Staff shortages at the Health Center results in task-shifting of facility-based work to the HSAs, resulting in less time spent in the community and transport is often an issue. Formal integration of the program will ideally lead to better planning and management of priority tasks by HSAs
- Rapid turnover of facility-based management staff negatively affecting ability to develop, implement and monitor action plans intended to improve PQI scores
- Inconsistencies in availability of supplies and stock outs of commodities
- Inadequate supportive supervision at facility and community levels

Lessons Learned

The lessons learned from MCHIP present an opportunity for future programming of MNCH, FP, PMTCT of HIV, malaria and HIV prevention interventions. Unique opportunities will arise following the success of the VMMC outreach campaign in Mulanje; the integration efforts in MCH and PMTCT are yet another opportunity to advance efforts to integrate services that meets the needs of the providers and clients; social marketing is an avenue yet to be utilized to the fullest in order to expand access to reproductive health services. Future projects can harness these valuable lessons and scale up the interventions to cover more health centers and communities and achieve greater impact.

The HHCC has demonstrated the power of community involvement in MNH and the benefits of promoting dialogue between the community and the health center. The PQI initiative has shown that by following PQI standards, facilities can improve maternal and neonatal deaths and sepsis can rates. This is overwhelming evidence for Malawi to consider scaling this to all health facilities considering that puerperal sepsis is the second major cause of maternal deaths in Malawi. Malawi is embarking on developing a Performance-Based Incentives (PBI) system that will reward facilities for achieving set performance targets. Linking PBI to quality improvement efforts will strengthen accountability and responsibility of managers and providers to provide quality health services and improve health outcomes.

PERFORMANCE MONITORING FRAMEWORK

The Performance and Monitoring Plan (PMP) for MCHIP was developed to be aligned with its predecessor program (ACCESS) to ensure continuity of activity monitoring. In addition, based on important lessons learned from the ACCESS program, MCHIP was able to make minor but important adjustments to the monitoring approach that laid the foundation for future scale-up of MCHIP programs.

The PMP was developed with guidance from USAID and MOH to contribute to Malawi’s Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi, the National HIV/AIDS Action Framework and USAID/Malawi’s Operational Plan. In line with the MCHIP Results Framework, MCHIP developed a PMP to track process, output and outcome indicators, linking activities and immediate results to higher-level outcomes. Data quality was always of central concern and as such, MCHIP integrated data quality reviews during supportive supervision visits, included an M&E module during PQI trainings and supported the revision of the CMNH M&E system to account for systemic flaws in the original M&E system.

The following matrix documents MCHIP’s program achievements against the set targets established at the beginning of the project in October 2009. An explanation for each target details reasons for exceeding the target and, in some cases, explanations why targets were not achieved. In almost every case, important lessons learned emerged during the collection and analysis of each performance indicator. And, in each case, the MCHIP team worked internally and with partners (specifically the MOH) to find ways to overcome challenges and document successes.

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
Result 1: Increased access to and availability of quality facility-based essential maternal and newborn care and child and postpartum family planning services								
Number of postpartum / newborn visits within 3 days of birth by trained workers from USG-assisted facilities	70,000	87,755	40,000	38,547	110,000	126,302	Target was exceeded largely due to the community mobilization and CMNH activities implemented at the community level, and improvement in quality of services at the facility level resulting in more women delivering at	

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
							MCHIP's target facilities.	
Number of newborns receiving essential newborn care in selected MCHIP-supported facilities	70,000	80,487	30,000	37,232	100,000	117,719	Coupled with increased number of deliveries at targeted health facilities, and improvement of quality of care as a result of PQI, the number of newborns receiving ENC exceeded the target.	
Number of ANC visits by skilled providers from USG-assisted facilities	154,000	116,078	60,000	73,159	214,000	189,237	Y1 target was not met. This ambitious target was set given the success achieved under the ACCESS program. However, MCHIP start-up activities took longer than expected and inadequate supervision by direct supervisors contributed to decreased momentum between the ACCESS and MCHIP programs.	
Number of people trained in maternal and/or newborn health and nutrition through USG-supported programs	340	581	812	815	1,152	1,396	Savings achieved from conducting on-site trainings instead of group-based, off-site trainings, enabled MCHIP to conduct additional sessions for more	Does not include 139 providers trained in BEmONC with Y1 carryover funds. Overall, MCHIP exceeded its target.

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
							providers.	
Number of HSA visits to pregnant women where counseling and referral was provided for ANC services from 4 focus districts	18,264	5,579	15,000	4,679	33,624	10,258	Competing demands from HSAs at the facility level means less time spent in the community. Inconsistent and incomplete reports contributed to underreporting by HSAs. This will be resolved with the revised M&E system put in place with MCHIP support, reducing the documentation and reporting burden of HSAs.	
Percentage of MCHIP- supported facilities where KMC services are in use	100%	100%	100%	100%	100%	100%	Overall, KMC was readily adopted by districts and providers	Includes 16 new scale-up health centers
Percentage of MCHIP supported facilities where Ambulatory KMC services are in practice	100%	100%	100%	100%	100%	100%	All target facilities implemented ambulatory KMC.	Includes 16 new scale-up health centers
Number of facilities in target districts achieving 80% of standards in RH and IP	3	2	5	2	8	4	(Mzuzu Central Hospital, Dowa District Hospital for RH)	Machinga District Hospital in IP and RH; Thyolo in IP
Number of people trained in FP/RH	560	800	414	559	974	1,359	Savings achieved from conducting on-site trainings instead of group-based, off-site trainings, enabled MCHIP to conduct additional sessions for more	

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
							providers. This was especially true where MCHIP used program savings to conduct BEmONC and PFP trainings for an additional 200 service providers. This includes a training in BEmONC and PQI for providers at Bwaila maternity wing following the opening of the Ethel Mutharika Maternity wing where all previously trained providers from Bwaila were posted.	
Number of USG-assisted service delivery points providing FP counseling or services	330	336	356	362	686	698	An additional 6 private sector outlets were trained and distributing FP commodities.	
Number of women giving birth receiving AMTSL in selected MCHIP-supported facilities	70,000	80,487	30,000	37,232	100,000	117,719	Target setting was based on expected deliveries (54%, MICS 2006) that would occur at the facility-level. However, an analysis of # of deliveries occurring in MCHIP target health centers in FY10 compared to last year (FY09), shows that the # of deliveries has increased by about 20% since FY09. This is largely due to the community mobilization and CMNH work being done at the community level, and improvement in quality of services at the facility level resulting in more women delivering at MCHIP's target facilities.	
Number of counseling visits for	65,000	67,016	30,000	76,650	95,000	143,666	Target was	Target was

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
FP/RH as a result of USG assistance							met.	exceeded following no-cost extension of MCHIP
Number of health facilities rehabilitated or renovated	Indicator not available in Yr1	N/A	4	0	4	0	Not applicable	Due to extenuating circumstances beyond control of the project, minor refurbishments were completed instead of rehabilitation or renovation, which would have significantly delayed closure of the project.
Result 2: Increased adoption of household behaviors that positively impact the health of mothers and newborns and children under 5 years of age								
Result 3: Increased availability of integrated community-based MNH/FP services through Health Surveillance Assistants								
Y1: Percentage of pregnant women and their families in targeted HC catchment areas receive at least 3 home counseling visits from a trained HSA. Y2: Percentage of pregnant women who received at least one antenatal home visit by an HSA in each trimester during	50%	4.0%	50%	3% Machinga 5% Nkhotakota Insufficient data for Phalombe and Rumphi	50%	3% Machinga 5% Nkhotakota Insufficient data for Phalombe and Rumphi	As part of the revision of the CMNH M&E system, MCHIP and partners redefined the CMNH indicators to be more specific and consistent with the critical key interventions. As a result, it was important to include the timing of the three visits for this indicator to be able to document that HSAs were visiting pregnant women	

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
pregnancyPercentage							during each trimester and not just at random times during pregnancy. We see from the result that we are far off from our target. Partly this is due to cultural reasons as women announce their pregnancy late (after the first trimester), most HSAs only conduct 1-2 home visits.	
Y1: Percentage of postnatal women who received at least 3 home counseling visits within one week of delivery from a trained HSA Y2: Percentage of women who received at least two postnatal home visits by a HSA within 8 days of delivery	50%	30%	50%	2% Machinga 11% Nkhotakota Insufficient data for Phalombe and Rumphi	50%	2% Machinga 11% Nkhotakota Insufficient data for Phalombe and Rumphi	This indicator was changed in Y2 following revision of the M&E system, in order to collect information about the timing of HSA visits within the first 8 days after delivery. While the original indicator called for at least 3 visits, it was noted that programmatically, HSAs were only required to conduct three visits if the woman delivered at home. A change in the way this indicator is collected, coupled with better documentation, shows a more realistic picture of HSA performance.	
Percentage of targeted communities that have action plans to support pregnant women and newborns to use MNH services appropriately	80%	80%	80%	80%	80%	80%	Based on program reports	
Result 4: Strengthened MNH policies, planning and management in place at the national, zonal and district level								

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
Number of students graduating from target nursing and midwifery preservice schools with strengthened BEmONC and PFP curricular components	452	440	150	233	602	673	Since 2010 when the BEmONC and PFP curricula were updated and strengthened at all 13 training institutions, 673 NMTs have graduated having received the updated training.	
Number of policies or guidelines developed or changed with USG-assistance to improve access to and use of FP/RH services	1	1	1	1	2	2	Integrated RH-PMTCT PQI Standards at HC level	National RH Strategy; Obstetric Protocols
Number of district-level scale-up plans in place to expand coverage of MCHIP programs	4	4	5	8	9	12	MCHIP 4 focus districts; Scale up plans were developed by DHMTs by identifying facilities and setting aside funds in their DIPs.	PMNCH focus districts. Through concerted advocacy by MCHIP, all PMNCH districts had initiated and begun roll-out of CMNH
Number of policies or guidelines developed or changed with USG-assistance to improve access to and use of Community MNH services	1	1	1	1	2	2	Integrated CMNH-MIP system	Revised CBMNC M&E system
Number of districts demonstrating improved use of data for decision making/priority setting with MCHIP support	4	4	5	4	9	8	In Y1, MCHIP worked closely with DHMTs to institutionalize a service statistics monitoring template for select MNH outcome indicators linked to PQI activities. This monitoring template was used	

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
							subsequently by PQI external assessors during external assessments. In Y2, MCHIP worked with the MOH and Save the Children to revised the CMNH M&E system and this was rolled-out in MCHIP focus districts in the last quarter of Y2.	
Result 5: Increased commitment of resources for MNH from GoM and other donors								
Number of trainings on CMNH, KMC, PQI, BEmONC, FP conducted using leveraged funds by other donors	TBD	0	2	2	2	2	None	BEmONC training (GAIA funded); CMNH trainings (PMNCH funded)
Result 6: Strengthened planning and monitoring of MNH activities at community level								
Number of HSAs documenting and reporting home visits using new community MNH register	N/A	N/A	240	240	240	240	Not applicable	By the end of the year, all HSAs had transitioned to using the new CMNH monitoring and reporting tools
Proportion of facilities reporting Community MNH indicators quarterly to DHMT	N/A	N/A	80%	60.8%	80%	60.8%	Not applicable	Based on 3 districts using the new reporting forms.
Result 7: 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	330,000	0	500,000	500,000	500,000	500,000	Delays in implementation resulted in	Target was fully met.

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
							roll-over of target to Yr 2	
Number of ORS sachets provided through USG-supported programs	1,000,000	0	1,100,000	1,100,000	1,100,000	1,100,000	Branding issues delayed procurement leading to the roll-over of funds/target to Y2.	Target was fully met despite delays in Y1.
Result 8: Increased use of oral and injectable contraceptives amongst middle income women of reproductive age intending to use FP methods								
Number of new clients using oral contraceptives accessed outside of the public	N/A	N/A	150	1,107	150	1,107	Not applicable	Clientele in private sector increased due to stock outs in public facilities. CBDA pilot in Machinga also contributed to increase in uptake of oral contraceptives
Number of repeat clients using oral contraceptives accessed through the private sector	N/A	N/A	600	5,897	600	5897	Not applicable	Clientele in private sector increased due to stock outs in public facilities. CBDA pilot in Machinga also contributed to increase in uptake of oral

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
								contraceptives Same as above
Number of new clients using injectable contraceptives accessed outside of the public sector	N/A	N/A	140	1,875	140	1875	Not applicable	Clientele in private sector increased due to stock outs in public facilities. Same as above
Number of repeat clients using Injectable contraceptives accessed through the private sector	N/A	N/A	700	16,258	700	16,258	Not applicable	Clientele in private sector increased due to stock outs in public facilities.
Percent of 15-49 year olds using oral contraceptives accessed outside of the public	N/A	N/A	Baseline- no target established	28.8%	N/A	28.8%	Not applicable	FP TRaC conducted for first time
Percent of 15-49 year olds using injectable contraceptives accessed outside of the public sector	N/A	N/A	Baseline- no target established	19.8%	N/A	19.8%	Not applicable	FP TRaC conducted for first time
Result 9: Promotion of correct and consistent use of LLINs, correct and prompt use of ACT anti-malarial among caregivers of children under five for effective treatment of malaria among children under five and improved awareness and uptake of IPT among pregnant women.								
Number of ITNs distributed that were purchased or subsidized with USG support	800,000	234,150	934,830	934,830	1,734,830	1,168,980	MOH prioritized distribution of 750,000 government procured ITNs	All remaining nets were distributed despite fuel shortages.

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
Number of people reached through community outreach that promotes the treatment of Malaria according to National Guidelines.	61,250	348,070	170,000	218,989	231,250	567,059	Launch of United Against Malaria campaign contributed to exceeding of target	Continuation of mini-UAM launches in each district
Number of people reached through community outreach that promotes correct and consistent use of LLIN's	57,500	337,370	120,000	259,804	177,500	597,174	Launch of United Against Malaria campaign contributed to exceeding of target	Continuation of mini-UAM launches in each district
Number of pregnant women who are reached by IPT Communications	N/A	N/A	63,600	138,485	63,600	138,485	Overall, this target was well exceeded	
Result 10: 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	2	4	2	0	4	4	MCHIP facilitated the development of district level action plan for universal coverage of high impact interventions, specifically CMNH and PQI for MNH in MCHIP's focus districts	
Number of partnerships with NGOs forged as a mechanism for dissemination of MNH IEC materials	2	2	2	2	4	4	MCHIP forged partnerships with WALA and MSH	MCHIP forged partnerships with IMMPACT and PMNCH
Number of target communities with mechanisms for supporting birth preparedness/complication	2,000 villages	746	2,000 villages	2,132 villages	4,000	2,878	MCHIP achieved slightly more than 50% of this target, with major challenges due to competing	

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
readiness							priorities of HSAs and inability of HSAs to efficiently travel long distances in particularly hard to reach areas. In some villages, lack of supervision also contributed to poor motivation of HSAs.	
Result 11: Strengthened integration, provision and access to quality Prevention of Mother to Child Transmission (PMTCT) and Reproductive Health services								
Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	N/A	N/A	24,939	24,839	24,939	24,839	Not applicable	For July-Sept 2011 quarter only
Number of HIV-positive pregnant women who received anti-retrovirals to reduce risk of mother-to-child-transmission	N/A	N/A	2,993	1,617	2,993	1,617	Not applicable	For July-Sept 2011 quarter only
Percent of HIV-positive pregnant women who received antiretroviral to reduce risk of mother to child transmission	N/A	N/A	80%	73.8%	80%	73.8%	Not applicable	For July-Sept 2011 quarter only
Number of HIV-positive adults and children provided with a minimum one care service	N/A	N/A	2,993	2,503	2,993	2,503	Not applicable	For July-Sept 2011 quarter only
Number of HIV-positive adults and children provided receiving a minimum of one clinical service	N/A	N/A	2,993	2,503	2,993	2,503	Not applicable	For July-Sept 2011 quarter only
Number of HIV-positive persons receiving cotrimoxazole prophylaxis	N/A	N/A	2,394	1,005	2,394	1,005	Not applicable	For July-Sept 2011 quarter only
Number of adults and children with advanced HIV infection	N/A	N/A	2,394	993	2,394	993	Not applicable	For July-Sept 2011 quarter

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
newly enrolled on ART								only
Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing	N/A	N/A	2,993	1,335	2,993	1,335	Not applicable	For July-Sept 2011 quarter only
Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	N/A	N/A	80%	18%	80%	18%	Not applicable	For July-Sept 2011 quarter only
Number of infants who received virological testing in the first 2months	N/A	N/A	1,197	83	1,197	83	Not applicable	For July-Sept 2011 quarter only
Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	N/A	N/A	80%	9%	80%	9%	Not applicable	For July-Sept 2011 quarter only
Number of health workers trained in the provision of PMTCT services according to national or international standards	N/A	N/A	493	512	493	512	Not applicable	For July-Sept 2011 quarter only
Result 12: Increase access to voluntary medical male circumcision								
Number of people trained in medical male circumcision	N/A	N/A	60	42	60	42	Not applicable	MC TOT cancelled due to facilitator per diem negotiations
Number of males circumcised as part of the minimum package of MC for HIV prevention services	N/A	N/A	Routine: 2,064 Campaign: 5,744	Routine: 778 Campaign: 4,348	Routine: 2,064 Campaign: 5,744	Routine: 778 Campaign: 4,348	No intervention in Y1	Difficulty establishing routine services without provision of MC

PERFORMANCE INDICATOR	PY1 TARGET and ACHIEVEMENT		PY2 TARGET and ACHIEVEMENT		Cumulative Target	Cumulative Achievement	COMMENTS	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT			PY1	PY2
								supplies and equipment

SUCCESS STORIES

Why They Do It: Health Surveillance Workers Speak

Dennis Mbulaje never dreamed of being a health surveillance assistant (HSA). In fact, he wanted to be a teacher. But more importantly than that, he wanted to make a difference in his community.

“I like my job and I have done a lot in my area in which I work,” said Dennis. “There were many problems in my community. There was no family planning taking place and so there were more children that we were failing to feed and take care of. Now we are introducing things to make them healthy.”

In Malawi, HSAs are a key component of the household to hospital continuum of care, that building on an existing platform that brings basic maternal and newborn health (MNH) and high-quality, facility-based services closer to families. MCHIP works with HSAs assigned to targeted health centers to deliver essential MNH messages and enhance preventive care before, during, and after childbirth. The HSAs receive training to deliver health messages at homes throughout villages and facilitate community mobilization to engage community members in defining and addressing local MNH challenges in partnership with the health center team.

Dennis is one HSA assigned to Ntaja Health Center. But he is not alone. Idrissa Jackson visits Ntaja regularly as part of her work as an HSA. Idrissa lives far away, like Dennis, but also wanted to do something in the community to make a difference.

“I used to visit some women from home but knew nothing about medicine,” said Idrissa. “Now I not only know what I can do to help, but I also have employment.”

Dennis and Ntaja visit Ntaja to check in and then travel to small villages and visit with

mothers who are expecting or new mothers who have returned home to nurse their babies. They know where these women live either from the health care providers at Ntaja or because they regularly frequent the villages. They then visit these women and counsel them on the need to visit a facility to deliver or how to properly care for their newborn. They work hand in hand with traditional birth attendants and also help coordinate transportation in the event of an emergency due to complications.

They may also provide partner counseling during home visits and work closely with local community action groups, made up of volunteers within the community, so that a mother and child receive the health services they need and have a true support system behind them.

Health messages that are delivered by this essential workforce include encouraging them to visit a facility, what to do should they choose to deliver at home, such as clean cord care, the importance of exclusive breastfeeding and their options with regards to family planning so they can practice healthy spacing and timing.

“When I started, it was interesting and it still is interesting,” said Dennis. “I know I am making a difference and saving lives. That is my reward.”



Community Health Workers from Ntaja with MCHIP staff

It All Starts With a Problem and a Tree



Women and babies were dying in Ntaja, Malawi. The community wanted to do something about it. With the help of MCHIP, the local health center and health surveillance worker assigned to the area, they were able to. How? By coming together as an all-volunteer community action group and starting the task at hand with nothing more than a marker and piece of paper.

Trained in October, a month later they gathered and started by drawing the trunk of a tree- the problem being how to save lives. They next drew roots and identified the major causes of deaths in their community- cultural barriers, lack of education, poverty and starting antenatal care too late. From there they outlined branches of the tree to represent the consequences of these roots if left unchecked. This they called the “problem tree” and it is what they will use as a guide in developing an action plan to make things different.

“This group is helping save lives,” said Edina Mpalume, the village elder. “Before we had women dying as they delivered on their way to the facility and we did not have the necessary health messages to change that.”

Once the Ntaja community action group (CAG) developed their problem tree they were ready for the next step: preparing to mobilize. They mapped out a sequence of

events to include organizing and rallying the community to embrace them and their mission, and exploring ways in which they can start to cut the problem roots away from the tree- and then they could begin to save lives and make a difference.

One barrier that they identified was the high cost of transportation to the local facility. The group came together and purchased a bicycle and fastened it into a makeshift ambulance so that a woman would not have to walk miles on dirt roads. 15 villages use it so the group does a lot of coordinating to make sure it is with women who will be in need. Knowing that is not always feasible, they also encourage women to stay at the facility waiting room before they are ready to deliver so that they are on site should an emergency complication occur. It was important that the CAG realize the importance of midwives, elders and grandmothers and embrace them as part of the process. Grandmothers, typically resistant to change involving women not delivering at home, have not only embraced the group but joined themselves as members.

“We are happy that a woman delivers a baby and that she comes home with a live baby,” said one grandmother. “A live baby and a live mother is what we want.”



Proud Members of the Ntaja Community Action Group

Malawi Facility First to Achieve Dual Recognition Status as Center of Excellence

On April 1st, Machinga District Hospital in Malawi received two certificates and shields from the Minister of Health, making it the first in the country to achieve dual Center of Excellence status. The certificates—in infection prevention (IP) and reproductive health (RH)—were awarded in a ceremony presided over by The Minister, Professor David Mphande, and the Acting Deputy Chief of Mission from the Malawi embassy, Craig Anderson.

“The quality improvement initiative in RH [implemented at this facility] is a great example of interventions to address maternal mortality as stipulated in President Obama’s Global Health Initiative,” Anderson said.

Machinga District Hospital is one of 24 government hospitals implementing the Performance and Quality Improvement (PQI) process to strengthen its RH practices and service delivery, and one of the 40 hospitals implementing IP practices.



Prof. David Mphande, Minister of Health, and Craig Anderson, Acting Deputy Chief of Mission, show the shield to the crowd

During the colorful ceremony, Anderson proudly cited the Machinga facility’s improvements, including reducing the number of deaths related to childbirth by half in a five year period, and reducing the number of women who develop such complications following delivery from 46.85% in 2007 to a record low of 18.6% in 2010.

Minister Mphande applauded MCHIP for their technical support to the Ministry and USAID for its financial support. He also extended his congratulations to Machinga Hospital, noting that they are a role model to be emulated.

In June 2011, an external assessment team visited the facility to assess IP practices, resulting in a score of 91% and qualifying the facility for recognition as a Center of Excellence in IP. Inspired by these results and realizing that IP and control practices are the basis for a sound health care system, Machinga invited the external assessors to return again in July to conduct an external assessment for RH services.

The resulting score was an impressive 88%. In closing his speech, Anderson emphasized the need to see these numbers as lives saved

The Story of Ntano Village: When Communities are Empowered

About 10 Kms from Ntaja Health Centre sits Ntano Village. There, Margaret Matewere is a health surveillance assistant working to improve maternal and child health. Under her leadership, the community formed a Community Action Group comprised of 10 women and 4 men. All volunteers, they would regularly come together and knew that something had to be done so that no woman would die giving birth. So they started identifying why women and children in their village were dying and identified transport as one of the priority problems that had to be resolved.

But how?

They did not have the funds to purchase a vehicle nor to buy a ride to the facility. They knew they needed to bring this problem to the larger community so that as a whole community it could be addressed- and that is what they did.

The village convened one day and the CAG presented the problem to them. They agreed it was an emergency situation and that something needed to be done. Together they decided to contribute some funds to buy wood and nails so that they could construct an emergency stretcher for carrying women experiencing emergency complications from the village to the health facility. A carpenter from the community volunteered to lead construction of the stretcher and the work began. Now this stretcher is shared amongst other villages with women in need who now have a better chance of delivering in a facility than they did before.

Said one member of the CAG, "better to do something than nothing."

And yet it doesn't stop there. While they work on getting a better mode of transportation, this all volunteer force and others within the community have felt empowered that they can truly make a difference. They are holding regular community meetings where they discuss health messages, visit women and families in their homes before and after their pregnancies, coordinate their transportation to the facility and encourage them to visit the Ntaja Waiting Home so they can be there with a skilled provider should an emergency arise.



Malowa Health Center's new maternity wing

This is what happens when a community feels empowered. It is more than the story of Margaret. It is the story of Ntano Village.

Malawi Launches Voluntary Male Medical Circumcision Campaign to Reduce New HIV Infections

A thrill of excitement was in the air as the Government of Malawi prepared to open a new chapter in the history of the country's HIV prevention efforts. Crowds of men, women and children lined the football field cheering and clapping on October 8th as Malawi's Deputy Minister of Health, the Honorable Ralph Jooma, MP, officially launched the country's Voluntary Male Medical Circumcision (VMMC) campaign in Mulanje district. The campaign, which will take place in three health facilities,¹ aims to reach 5,700 men aged 14-49 years.



To the large crowd gathered at Suwazi football grounds, the message was clear: the Deputy Minister was urging all eligible males to receive the free services. "The provision of [VMMC] services will be done within the broader provision of reproductive health services and be comprised of a minimum [VMMC] minimum package," he said. This package includes HIV testing and counselling and referral for antiretroviral therapy, sexually transmitted infection screening and treatment, risk reduction counselling, surgery, and condom programming.

Before arriving at the launch venue, a delegation of senior Ministry of Health (MOH) officials joined USAID Mission Director Douglas Arbuckle in visiting the VMMC outreach site at Muloza Health Center. Located on the border with Mozambique, the health center is small with limited infrastructure. As such, it is typical of the types of facilities that provide the majority of services to 80% of Malawians. Three large tents were erected strategically around the site to enhance the provision of dedicated VMMC service delivery. The tents were used for group education, individual VMMC counseling, HIV testing and counseling, client screening, and recovery.



Mr. Arbuckle praised the MOH and MCHIP Program, saying: "The United States Government extends a message of gratitude to the MOH and MCHIP for this milestone, which has come along due to the leadership of MOH (HIV unit and Health Education Unit) and the great collaboration with partners (PSI, BRIDGE, BLM, Pakachere)."



He spoke of the expected impact of the

campaign, scaling up VMMC services to reach 80% of adult males in Malawi by 2015. As a result, he said, these efforts will:

- Avert more than 265,000 adult HIV infections cumulatively between 2009 and 2025;
- Yield total net savings of US\$1.2 billion between 2009 and 2025; and
- Require more than 2 million VMMCs, with 1.1 million VMMCs being done in 2012 alone.

“To do this will require rapid scale-up of high-intensity services such as the use of a time-limited campaign model which we are launching today,” he said. “We cannot rely on routine service delivery alone to reach the 80% target and achieve greater impact.”

To reduce the country’s number of new HIV infections, currently at 70,000 annually, the MOH has adopted VMMC as a complementary strategy to the country’s existing HIV prevention approaches. Since October 2009, MCHIP with support from USAID has been supporting the MOH to implement such interventions—as well as improvements to maternal, newborn and child health, family planning, malaria, and water and hygiene—across the country, including:

- Capacity building of service providers in nine high HIV prevalence districts² in the provision of VMMC services;
- Facilitating the development of the Malawi Standard Operating Guidelines for VMMC, and training 38 service providers from nine districts, and 4 providers from the Malawi Defense Force on its use;
- Strengthening the two MOH VMMC model sites (Dedza and Mulanje district hospitals);
- Capacity building to 36 prevention of mother-to-child transmission of HIV (PMTCT) sites in nine districts³ and 42 PMTCT sites in Chitipa, Karonga, Mwanza; and
- Implementing a system of mother-infant pair follow-up at the community level to improve PMTCT continuum of care services in four districts.⁴

With MCHIP support, the MOH decided to launch the campaign when routine VMMC services at Mulanje District Hospital were only reaching 8% of the target in a given month. The campaign aims to maximize the efficiency of service delivery so that there is greater impact with the intervention. Other countries in the region have made headway in the provision of MC services through such outreach campaigns. Malawi’s will run six days a week for four weeks, from 10 October – 5 November.

In his final remarks, the Deputy Minister added his thanks, saying: “The MOH and Government of Malawi, through the leadership of His Excellency Ngwazi Professor Bingu Wa Mutharika, extend its appreciation to the United States Government for the continuous support it provides to the health sector.”

[Photo captions: 1. Crowd at launch grounds watching football match. 2. USAID Mission Director giving speech. 3. Deputy Minister of Health, Principle Secretary inside screening/VMMC counseling room with Ms. Gedesi Banda, lead circumciser at Mulanje district and the District Health officer, Dr. Charles Chimpamphano.]

1 Chonde health center, Mulanje district hospital, and Muloza health center

2 Mulanje, Machinga, Mangochi, Thyolo, Salima, Nkhotakota, Dedza, Kasungu and Nkhatabay

3 Salima, Nkhota kota, Dowa, Ntchisi, Kasungu, Rumphu and Likoma Island
4 Rumphu, Nkhotakota, Ntchisi and Likoma