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MCHIP Malawi End-of-Project Report

October 2011–June 2014



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Submitted by:

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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Country Summary: Malawi



Selected Health and Demographic Data for Malawi

| | |
|---|------------|
| Gross domestic product per capita (USD) | \$309.73 |
| Total population | 15,263,417 |
| Maternal mortality ratio (deaths/100,000 live births) | 675 |
| Skilled birth attendant coverage | 72% |
| Antenatal care, 4+ visits | 45.5% |
| Neonatal mortality rate (deaths/1,000 live births) | 31 |
| Infant mortality rate (deaths/1,000 live births) | 66 |
| Under-five mortality rate (deaths/1,000 live births) | 112 [30]* |
| Treatment for acute respiratory infection | 65.7% |
| Oral rehydration therapy for treatment of diarrhea | 70.1% |
| Diphtheria-pertussis-tetanus vaccine coverage (3 doses) | 93% |
| Modern contraceptive prevalence rate | 42.2% |
| Total fertility rate | 5.7 |
| Total health expenditure per capita (USD) | \$19.07 |

Sources: World Bank, Malawi Demographic and Health Survey 2010, WHO, UNICEF.
 *UNICEF <5 mortality ranking (1=highest mortality rate).

Major Activities by Program

Immunizations

- Supported a series of assessments and trainings for vaccine introduction in order to facilitate the introduction of the pneumococcal vaccine (PCV) and rotavirus vaccine in Malawi
- Provided pre-service and in-service education to strengthen the vaccination coverage

HBB Evaluation

- Conducted an evaluation of the HBB program throughout Malawi to understand both how the program was being implemented and the associated results in terms of health system performance, provider competence, quality of care, and outcomes

VMMC

- Led a successful three-week VMMC mini-campaign and three-month VMMC mass campaign in Thyolo district
- Facilitated the harmonization of national M&E tools in order to strengthen the monitoring and management of VMMC service delivery in Malawi

| | | | | | | |
|--|--|---|-------------------------|----|--------------------------|----|
| Program Dates | October 2011–June 2014 | | | | | |
| Total Mission Funding to Date by Area | \$3,384,550 \$1,000,000 – Immunization; \$200,000 – HBB Evaluation; \$2,184,550 – HIV for VMMC | | | | | |
| Total Core Funding to Date by Area | \$125,000 – OHA \$255,197 – MCH | | | | | |
| Geographic Coverage | No. (%) of provinces | 5 | No. of districts | 28 | No. of facilities | 30 |
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Table of Contents

| | |
|--|------|
| Acronyms and Abbreviations | v |
| Acknowledgments | vi |
| Executive Summary | viii |
| Introduction | 1 |
| Major Accomplishments..... | 3 |
| Cross-Cutting Themes | 20 |
| Recommendations and Way Forward | 23 |
| Annex 1: Indicator Matrix | 1 |
| Annex 2: Success Stories | 6 |
| Annex 3: List of Materials and Tools Developed or Adapted by the Program | 146 |

List of Tables and Figures

| | |
|---|----|
| Figure 1. Immunization Coverage in Malawi | 3 |
| Figure 2. Malawi Routine Immunization Coverage, 2004–2013 | 4 |
| Figure 3. Data Quality Self-Assessment Findings on Quality of Immunization Services, 2012 | 7 |
| Figure 4. Verification graph for Data Quality Self-Assessment, 2012..... | 7 |
| Figure 5. Campaign Administrative Coverage, November 2013..... | 9 |
| Figure 6. Life-of-Project VMMC trainings, Thyolo..... | 11 |
| Figure 7. Cumulative VMMC Achievements over the Life of the Project..... | 12 |
| Figure 8. Declining Adverse Event Rate for Male Circumcision | 12 |
| Figure 9. Increasing Post-Operative Follow-Up Rate | 13 |
| | |
| Table 1. Assessments at Three Facilities | 15 |
| Table 2. External Assessment of Mlale Mission Hospital, January 28–30, 2014 | 15 |
| Table 3. External Assessment of St. Gabriel’s Mission Hospital, March 18–20, 2014..... | 18 |

Acronyms and Abbreviations

| | |
|----------------------|--|
| CBO | Community-Based Organization |
| CHAM | Christian Health Association of Malawi |
| DHO | District Health Officer |
| DQS | Data Quality Self-Assessment |
| EPI | Expanded Program on Immunization |
| HBB | Helping Babies Breathe |
| IIP | Immunization in Practice |
| IPC | Infection Prevention and Control |
| M&E | Monitoring and Evaluation |
| MCHIP | Maternal and Child Health Integrated Program |
| MOH | Ministry of Health |
| MOVE | Models for Optimizing Volume and Efficiency |
| PCV | Pneumococcal Vaccine |
| PEPFAR | President's Emergency Plan for Aids Relief |
| PPE | Personal Protective Equipment |
| PQI | Performance and Quality Improvement |
| QIST | Quality Improvement Support Team |
| SBM-R® | Standards-Based Management and Recognition® |
| SIAs | Supplemental Immunization Activities |
| SSDI-Services | Support for Service Delivery Integration-Services |
| TNA | Training Needs Assessment |
| USAID | United States Agency for International Development |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organization |

Acknowledgments

The Maternal and Child Health Integrated Program (MCHIP) gratefully acknowledges the Ministry of Health of Malawi and USAID/Malawi, which has provided financial support and guidance to MCHIP in the implementation of this program.

The immunization team would like to thank the World Health Organization, UNICEF, and the Clinton Health Access Initiative for their collaboration and assistance with MCHIP initiatives.

The Helping Babies Breathe team, first and foremost, would like to thank the Malawi Ministry of Health. We would also like to thank the maternity clients who agreed to allow our study teams to observe their care and the care of their newborns, even under emergency circumstances. Without their participation, the study would not have been possible. In addition, we extend our thanks to all the health facility directors and medical personnel in the health facilities assessed for their participation. We understand that they are extremely busy, and we very much appreciate the time they devoted to our evaluation.

The VMMC team would like to thank the HIV Unit of the Malawi Ministry of Health and the entire national VMMC technical working group for their continued commitment to rapidly scaling up VMMC services throughout Malawi. We would also like to thank our partners—Project Concern International and the Christian Health Association of Malawi—for their support in Malawi Defense Force site and Thyolo district, respectively.

The infection prevention team would like to thank the Malawi Ministry of Health District Health Office, Quality Assurance Desk Officer and the entire team as well as the National Assessors for their technical support. In addition, we extend our gratitude to the service providers and the management of the three institutions in Lilongwe district. Without their commitment we would not have achieved what we have so far.

Without the talent and dedication of the following MCHIP staff members in Malawi, success would not have been possible:

| NAME | TITLE | SERVICE |
|----------------------|--|-------------------|
| Naomi Kalemba | Communications and Knowledge Management Specialist | 2 months |
| Abubakari Mwinyi | MC Technical Advisor | 1 year, 6 months |
| Angella Mtimuni | M&E and HBB Coordinator | 1 year, 8 months |
| Maynard Mtemang'ombe | Logistics Officer | 1 year, 6 months |
| Madalo Kasamba | Procurement and Logistics Officer | 2 years |
| Tabeni Kumwenda | Administrative Officer | 2 years |
| Mbumba Kosana | Front Desk Officer | 2 years |
| Edda Okafor | HR Officer | 2 years, 9 months |
| George Chiundu | M&E Specialist, VMMC | 1 year, months |
| Hannah Hausi | Immunization Technical Officer | 2 years |
| David Amoruso | Program Management Officer | 6 months |
| Lolade Oseni | Sr. Monitoring and Evaluation Advisor | 2 years, 3 months |
| Owen Chitete | Finance Officer | 2 years |
| Frank Mndala | Finance and Administration Manager | 2 years, 9 months |
| Leopold Buhendwa | Chief of Party | 7 months |

| NAME | TITLE | SERVICE |
|--------------------|-------------------------------|-------------------|
| Tambudzai Rashidi | Country Director | 2 years, 9 months |
| Precious Lupeska | Finance Officer | 1 year, 9 months |
| Abigail Bonongwe | Zonal Manager | 2 years |
| Elizabeth Mpunga | Zonal Technical Specialist | 1 year, 5 months |
| Jane Banda | District Team Leader | 2 years, 9 month |
| John Gondwe | District Clinical Coordinator | 2 years |
| Charlene Chisema | District Clinical Coordinator | 2 years, 9 months |
| Nitta Aofi | District M&E Coordinator | 1 year, 3 months |
| Mike Butao | Data Management Coordinator | 2 years, 9 months |
| Brian Jumbo | Zonal M&E Specialist | Resigned |
| Welcome Pengapenga | Driver | 2 years, 9 months |
| Rodney Mkwinda | Driver | 1 year, 5 months |
| Elias Kumwenda | Driver | 1 year, 8 months |
| Fredrick Liwewe | Driver | 1 year, 8 months |
| Naomi Njolomole | Program Assistant | 2 years, 9 months |
| Felix Gulumba | Office Assistant | 1 year, 11 months |

Executive Summary



The Principal Secretary, Dr. Charles Mwansambo, giving a symbolic dose of rotavirus vaccine with the Minister of Health, Honorable Khumbo Kachale, holding the baby.

Malawi is a southern African nation of approximately 13.3 million people. In 2009 it had a human development index rank of 160 out of 182. Sixty-eight percent of women and 81% of men are literate. The country has a young population and a total fertility rate of 5.7, the fifteenth highest in the world. The maternal mortality ratio rose 80% from 1990 to 2000, to a rate of 1,120 maternal deaths per 100,000 live births (National Statistical Office and ORC Macro 2001), before declining to 984 (DHS 2005) and then to 675 (DHS 2010).

Family planning use has increased dramatically since 2004, when only 28% of married women were using a modern method. Currently, 42% of women use a modern method, with the increase primarily due to the

continued increase in the use of injectable contraceptives. In Malawi, HIV prevalence is 12.9% for women and 8.1% for men, but HIV testing has increased significantly since the last DHS in 2004. Currently, 72% of women and 51% of men have ever been tested and received their test results. During the last decade, government expenditures on health have increased from 7.3% in 2000 to 17.1% (2006) of total government expenditure. Because Malawi is eligible for funds from the Global Fund, the President's Emergency Plan for Aids Relief (PEPFAR), the President's Malaria Initiative, and other large programs, much of the increase in the use of reproductive health services can be attributed to the increase in donor funding (as a percentage of total health expenditure), from 26.9% to 59.6% of general government expenditures, over the same period.

Against this background of health challenges, the Maternal and Child Health Integrated Program (MCHIP) began in 2009 and had two phases. The first phase, which built on work done by the USAID ACCESS Project, focused on the Household-to-Hospital Continuum of Care model, which simultaneously addressed maternal and newborn health issues at the community and facility level and within the enabling environment, using evidence-based interventions and best practices. The program also concentrated on pre-service education for all 13 of the country's pre-service institutions, including the clinical skills laboratory, so providers could improve their practices and approaches. This first phase of activities, which ran from 2009 to 2011, also included efforts to improve the use of bed nets, social marketing for increasing contraceptive sales and infection prevention practices, as well as laying the groundwork for an expanded effort in voluntary medical male circumcision (VMMC). In 2011, a bilateral USAID Mission-funded program, Support for Service Delivery Integration-Services (SSDI-Services), began implementing a wide range of activities, adding on to some of the MCHIP successes. The full accomplishments of MCHIP's first phase are detailed in the end-of-project report submitted in 2012.

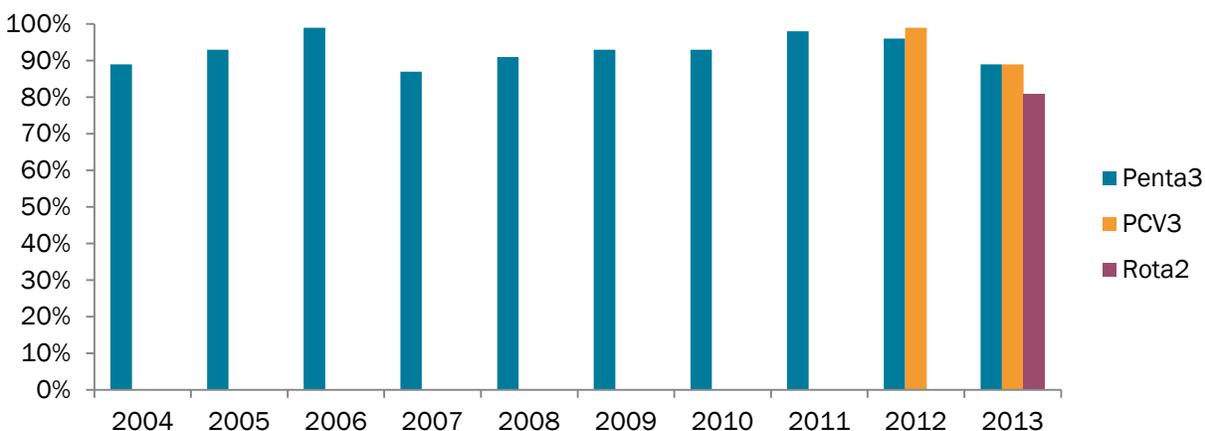
In 2011, the USAID Mission asked MCHIP to move to its second phase of assistance and to concentrate on three specific areas: the introduction of two new vaccines; continuing to expand the VMMC program; strengthening injection safety as an infection prevention intervention; and measuring the quality, coverage, and impact of the Helping Babies Breathe newborn resuscitation intervention at the facility level in Malawi. This phase of assistance was implemented from 2011 to 2014 and is the focus of this end-of-project report.

Malawi’s immunization program reflects the inherent difficulty of implementing a complex public health approach. On one hand, it had adequate to high coverage rates for basic vaccines, but on the other hand, its vaccine cold chain management and staff skills in running routine immunization programs were subpar. Thus, MCHIP had three objectives for its immunization programming:

- Successfully introduce, nationwide, two new lifesaving vaccines—the pneumococcal vaccine (PCV) in November 2011 and the rotavirus vaccine in October 2012—and assist with the application process for the Global Alliance for Vaccines and Immunization for the measles second dose vaccine.
- Improve the capacity of the Ministry of Health (MOH) and the Expanded Program on Immunization (EPI) in skills development and improve the performance of staff in new vaccine introduction and routine immunization.
- Strengthen the platform for new vaccine introduction by improving routine immunization monitoring and evaluation, data quality, and vaccine cold chain management at the national, zonal, district, and health facility levels.

MCHIP used cascade training to prepare providers for the new vaccine program, ensured that the social mobilization materials were updated and disseminated, and contributed to ensuring that all the tools used to record and monitor vaccinations reflected the two new vaccines. A post-introduction evaluation revealed that the introduction of both vaccines was smooth and successful, the vaccines were well accepted by professionals at all levels and by the community, and both vaccines had been fully integrated into the national immunization program. National coverage is equivalent to that for the other antigens administered at the same time, including the pentavalent and polio vaccines. At the end of 2013 national coverage of PCV3 was 89% and coverage of rota2 was 81%; this is equivalent to the pentavalent3 coverage of 89%.

Malawi Routine Immunization Coverage, 2004–2013



To improve the performance of immunization staff, MCHIP first conducted an assessment to understand the scope of the problem. Among the findings were the following: storage capacity was inadequate at the regional and district levels; distribution of vaccines was a challenge at the district level; and stock management was poor at the district and health facility levels. The team developed recommendations to address these deficiencies. One strategy that MCHIP implemented was producing 750 vaccine and injection material stock books for health facilities to help improve stock management and reduce vaccine wastage. MCHIP also trained more than 1,800 providers in improved immunization practices. At the end of the Immunization in Practice

(IIP) training, there were three trained health workers in every health facility providing immunization services, and the quality of service delivery improved significantly in all health facilities providing immunization.

Because of MCHIP's role in improving immunization practices, the Ministry also drew on the program's technical assistance in the supplementary polio campaign, which was integrated with nutrition services. MCHIP supported the national launch of the integrated campaign through the training of more than 1,600 health workers and orientation of more than 650 district officials. In addition, the project supported social mobilization activities for the campaign, which included 140 drama performances, briefings of 28 major media houses, and construction of two floats that stopped at all trading centers on the way from Mulanje and Mwanza to Blantyre, where the national launch was conducted. This activity also provided global evidence on the successful integration of nutrition interventions and immunizations.

VMMC has been very successful in Malawi and is an essential approach in combatting the increase in HIV prevalence, as well as cervical cancer. Current HIV prevalence rates are 12.9% for women and 8.1% for men, and the Malawi MOH has established an ambitious district-level target of a minimum of 80% coverage for males accessing VMMC services by 2016. Globally, MCHIP is one of the most successful PEPFAR partners in introducing VMMC, and it has continued this success in Malawi. MCHIP organized major outreach VMMC campaigns that coupled demand-generation activities with increased supply through the establishment of static VMMC sites that practice the principles of Models for Optimizing Volume and Efficiency (MOVE). Campaigns showed strong numbers: for example, in Thyolo, a total of 3,416 male circumcisions were conducted during a 17-day campaign. This is 228% greater than the initial campaign target of 1,500 circumcisions. The national campaign from July to September 2013 yielded 8,798 male circumcisions by MCHIP, bringing the total circumcisions for the fiscal year to 13,499. Overall, MCHIP contributed 22% to the total of 39,886 male circumcisions performed during the national campaign.

Results of the National Circumcision Campaign

- The campaign from July to September 2013 yielded 8,798 male circumcisions by MCHIP, bringing the total circumcisions for the fiscal year to 13,499.
- MCHIP reached 58.6% of the set target for the campaign, and the national campaign yielded a total of 39,886 male circumcisions (66.5% of the set target), with MCHIP contributing 22% of this total.

MCHIP used a number of approaches and strategies that contributed to its success, including the following:

- Engagement of community-based organizations at campaign sites (taking services closer to the homes of clients to encourage clients who would prefer not to seek care at health centers)
- Active involvement of traditional leaders from the target communities in serving as champions and advocates for VMMC
- A combination of community-wide motivational talks, school visits, engagement of tea estate managers, and public lectures in which the communication team moved with the technical team (all innovations in outreach)
- Strong leadership and support of the District Health Officer (DHO), which resulted in district ownership of the campaign and highly motivated and inspired teams of providers

Overall, MCHIP learned that sound demand creation and community mobilization were essential for reaching national goals. When one partner was given the task of community mobilization, they were not able to adequately cater to the differing information needs at the district level. In addition, when demand creation and service delivery were separated, results

were not as strong. The MOH recommends that demand creation happen at least two weeks before the onset of a campaign, and MCHIP supports this. When demand-creation activities start only days before a campaign, it limits the number of participants coming in for services. The third activity in phase two was assessing how the program Helping Babies Breathe (HBB) had been implemented. HBB is an evidence-based educational program to teach essential neonatal resuscitation techniques to health workers in resource-limited areas. It was first rolled out in 2011 to 14 districts in Malawi, of which 10 were supported by MCHIP. During the rollout, there was need for further study, so a multiyear evaluation of the HBB program in Malawi was implemented in late 2011. The study aimed to measure the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi, and it was unique in that it included direct observation of routine delivery care and management of newborns not breathing at birth.

MCHIP's program in Malawi has been successful and sustainable. Tools and policies that were created by MCHIP have been integrated into the national health system and will drive practices in the future. MCHIP successfully documented the activities and experiences it initiated so that other donors and programs could benefit, and those programs are now continuing the efforts. For example, Jhpiego, an MCHIP partner and now the lead on implementing the bilateral support program for USAID Malawi, is continuing the infection prevention practices initiated with MCHIP funding. All VMMC technical activities are now being implemented under the MCHIP Associate Award and follow-on to this project, *Sankhani Moyonela* ("Smart Choice").

Introduction

Malawi is a southern African nation of approximately 13.3 million people. In 2009 it had a human development index rank of 160 out of 182. Sixty-eight percent of women and 81% of men are literate. The country has a young population and a total fertility rate of 5.7, the fifteenth highest in the world. The maternal mortality ratio rose by 80% from 1990 to 2000, to a rate of 1,120 maternal deaths per 100,000 live births (National Statistical Office and ORC Macro, 2001), before declining to 984 (DHS 2005) and then to 675 (DHS 2010). Family planning use has increased dramatically since 2004, when only 28% of married women were using a modern method. Currently 42% of married women use a modern method, with the increase primarily due to a continued increase in the use of injectable contraceptives. In Malawi, HIV prevalence is 12.9% for women and 8.1% for men, but since the last DHS in 2004, HIV testing has increased significantly. Currently, 72% of women and 51% of men have ever been tested and received their test results. During the decade, government expenditures on health have increased from 7.3% (2000) to 17.1% (2006) of total government expenditures. Because Malawi is eligible for funds from the Global Fund, the President's Emergency Plan for Aids Relief, the President's Malaria Initiative, and other large programs, much of the increase in the use of reproductive health services can be attributed to the increase in donor funding (as a percentage of total health expenditures), from 26.9% to 59.6% of general government expenditures, over the same period.

For the last seven years, the USAID Mission in Malawi has invested in improving maternal, newborn, and child health using an array of investment vehicles. From 2007 to 2009, the ACCESS Project addressed prevention of malaria in pregnancy and the adoption of healthy behaviors to improve maternal and newborn health. Following the ACCESS Project, the first phase of MCHIP assistance was implemented from 2009 to 2011. MCHIP/Malawi was designed to support the Ministry of Health (MOH) in the delivery of an essential health package and to support the USAID/Malawi's strategy for accelerating the reduction of maternal, neonatal, and child mortality and achieving the Millennium Development Goals. MCHIP/Malawi's prime programmatic objective was to increase utilization of maternal, newborn, and child health services and the practice of healthy maternal, neonatal, and child behaviors. The program focused on the following activities during phase one:

- MCHIP pioneered the household-to-hospital continuum of care model, which addressed maternal and newborn health issues at the community and facility level and within the enabling environment, using evidence-based interventions and best practices.
- Providing support to the national malaria in pregnancy campaign, MCHIP coordinated the distribution of long-lasting insecticide-treated nets in accordance with the national supply chain system. MCHIP also conducted national information, education, and communication campaigns focusing on use of the nets, uptake of intermittent presumptive treatment, and prompt care and treatment of malaria.
- MCHIP continued supporting Malawi's national performance and quality improvement (PQI) initiative by ensuring participation of all 24 district hospitals and four central hospitals in infection prevention and control (IPC), reproductive health, and prevention of mother-to-child transmission.
- To support national family planning programs, MCHIP continued social marketing efforts for the branded injectable and oral contraceptive products, through 300 licensed private-sector providers (working in 200 outlets) and supported mass media communication, interpersonal communication, and counseling activities to help promote access to and use of the private sector as an alternative source of family planning services.

- From 2010 to 2011 MCHIP facilitated the development of national standard operating procedures for voluntary medical male circumcision (VMMC) and implemented Malawi's first pilot initiative on VMMC, in Mulanje, resulting in the provision of male circumcision services to 4,348 men.
- In 2011, the Helping Babies Breathe (HBB) initiative was rolled out to 14 districts with support from USAID/MCHIP, Johnson & Johnson, and other development partners. As of December 2011, Malawi had 72 HBB trainers and 481 providers trained nationally, which created a pool sufficient to fast-track the MOH rollout plan for HBB.

These activities set the foundation for future USAID Mission programming, and in 2011 USAID awarded funds to a bilateral program called Support for Integrated Service Delivery as well as to MCHIP for phase two of its activities.

MCHIP, DECEMBER 2011–JUNE 2014

In 2011, the USAID Mission asked MCHIP to move to its second phase of assistance and concentrate on three specific areas: the introduction of two new vaccines; continuing to expand the VMMC program; and measuring the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi. This phase of assistance was implemented from 2011 to 2014.

MCHIP was requested to support Malawi in its effort to introduce the pneumococcal vaccine in 2011 and the rotavirus vaccine in 2012. In addition, MCHIP was responsible for improving the capacity of the MOH and Expanded Program on Immunization (EPI) staff to develop their skills and improve performance in new vaccination introduction and routine immunization. Its third immunization objective was to strengthen the platform for new vaccines by improving routine immunization monitoring and evaluation, data quality, and vaccine cold chain management at the national, zonal, district, and health facility levels. The fourth immunization activity was the integration of nutrition interventions (vitamin A capsules and deworming tablets) with a polio and measles supplemental campaign.

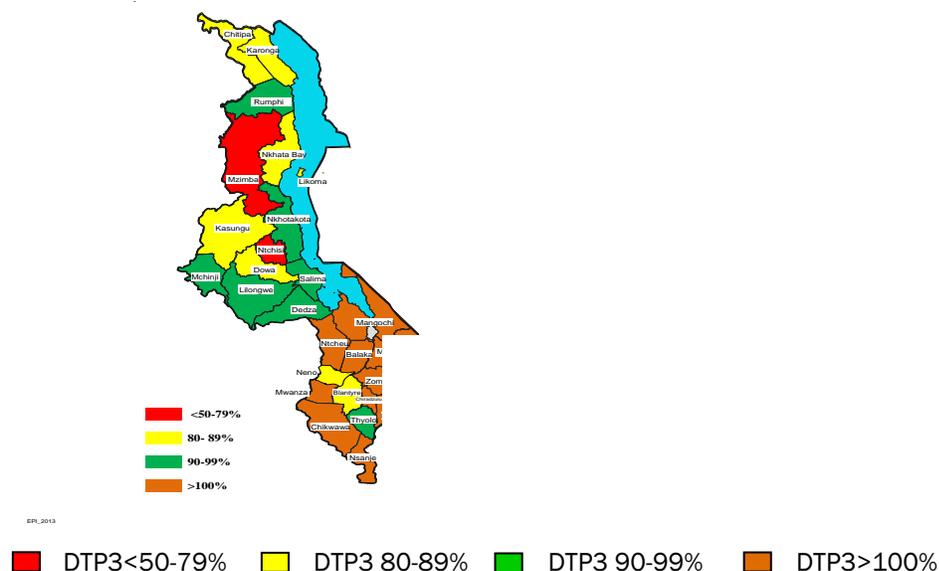
Following on the success of the MCHIP-supported VMMC campaign in Mulanje, MCHIP received additional funding to provide VMMC services targeting 8,100 males in Thyolo district. The VMMC project was initially implemented by building the capacity of the Christian Health Association of Malawi (CHAM) to provide VMMC services; the focus later transitioned to strengthening the capacity of the MOH to sustain VMMC services. MCHIP worked to train providers and orient support staff at Thyolo District Hospital, Malamulo Mission Hospital, and Thomas Health Center. MCHIP also supported quality assurance efforts, including the development and implementation of a waste management plan and strengthening of the monitoring and evaluation (M&E) systems.

After the HBB rollout in February 2011, the MOH identified a need to understand how the program was being implemented, as well as the associated results. MCHIP proposed to conduct a study, using USAID Washington and Mission funds, to measure the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi, in collaboration with the Ministry of Health. The results of the study will provide guidance and recommendations for further implementation of the VMMC scale-up in Malawi. Early results from the clinical simulations revealed that health care providers in the intervention group appeared to be significantly more skilled at bag and mask ventilation than providers in the comparison group.

Major Accomplishments

IMMUNIZATION

Figure 1. Immunization Coverage in Malawi



Malawi's national immunization program has high immunization coverage at the national and district levels (see Figure 1). However, due to the economic difficulties the country has faced in recent years, political and financial support for the immunization program has declined and serious problems have been noted in the systems supporting immunization programs. Countries need immunization policies and guidelines to guide the effective management of EPI programs. Malawi did not have an immunization policy when MCHIP immunization technical assistance began in 2011. Vaccine management also had some flaws. An assessment by MCHIP found that storage temperatures, maintenance of equipment, and vaccine management were adequate at all levels, but storage capacity was inadequate at the regional and district levels, distribution of vaccines was a challenge at the district level, and stock management was poor at the district and health facility levels. Malawi had not conducted any in-service training for service providers and recognized that this too was an area where they needed support and technical assistance.

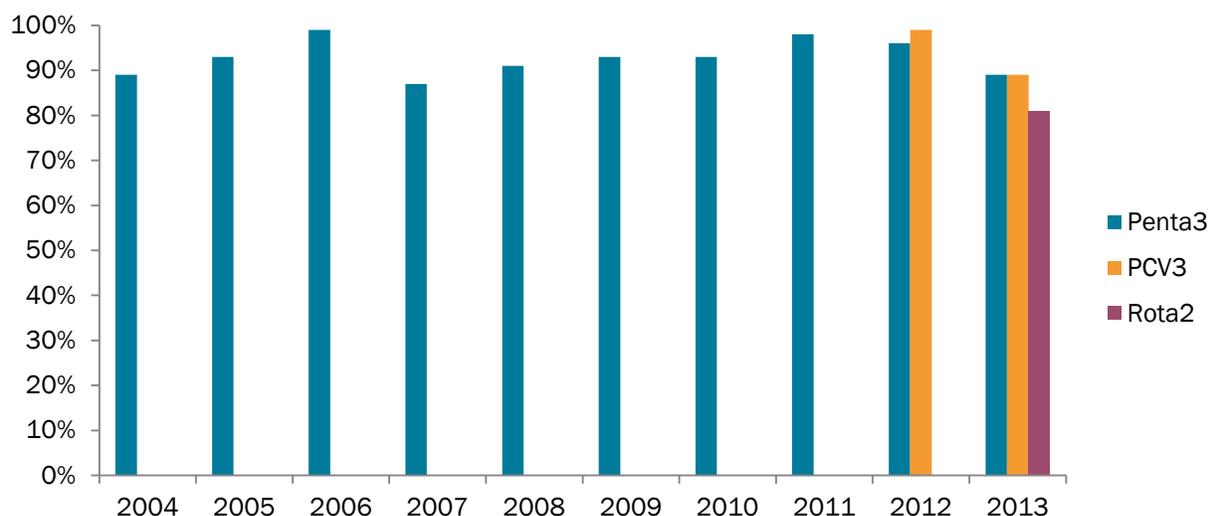
Thus, MCHIP began a series of assessments, training, and support for vaccine introduction to achieve its three objectives of supporting the introduction of two new vaccines, strengthening the routine immunization system, and improving cold chain management. The program accomplished the following:

- The pneumococcal vaccine (PCV) and rotavirus vaccine are now fully introduced into the national program, and the national level coverage of these new vaccines is equivalent to the other antigens administered at the same time, including the pentavalent and polio vaccines. At the end of 2013 national coverage of the PCV3 was 89% and rota2 coverage was 81%; this is equivalent to the pentavalent3 coverage of 89% This coverage was achieved in the following ways:
 - MCHIP reviewed training and social mobilization materials and co-facilitated the training of trainers workshop in the central zone; the program also supported the MOH and partners to conduct follow-up supervision visits on PCV introduction.

- MCHIP supported the zonal-level training of trainers for managers and service providers; a total of 341 district-level trainers from five health zones were trained. These trainings facilitated the cascade trainings that were conducted in all of the districts so the country could start administering the rotavirus vaccine.
- MCHIP ensured that all tools (health passport, performance form, and under-one register) were revised to include the PCV and rotavirus vaccines, thereby enabling improved routine data collection and reporting practices.
- Conduct refresher training in Multi Dose Vial Policy and wastage rate calculation.

The post-introduction evaluations of PCV and rotavirus vaccine, which were conducted with external support in July 2012 and June 2013, respectively, revealed that the introduction of the vaccines was smooth and successful. The vaccines are well-accepted by professionals at all levels and the community, and both vaccines have been fully integrated into the national immunization program (see Figure 2).

Figure 2. Malawi Routine Immunization Coverage, 2004–2013



To strengthen the system, MCHIP invested in both pre-service and in-service education:

- MCHIP supported the training of 1,838 health workers in Immunization in Practice (IIP) modules, which are used to train vaccinators and supervisors on basic immunization skills.
- At the end of the IIP training, every health facility providing immunization services had three trained health workers to provide these services. These trained health workers have improved the quality of immunization service delivery significantly in all health facilities that provide immunization.
- MCHIP sponsored two participants to attend an international workshop on curriculum development for pre-service education that was sponsored by the World Health Organization (WHO). As a follow-up to this workshop, MCHIP sponsored two workshops involving all training institutions and other stakeholders in the country. During the first workshop the training institutions reviewed and adapted the prototype curriculum and made recommendations and a plan of action for rolling out the curriculum. After the adaptation, MCHIP sponsored the induction of 30 lecturers from all the health training institutions on

the prototype curriculum. It is expected that they will be able to use the prototype curriculum to revise their immunization curriculum.

In cold chain management, MCHIP participated in the training of assessors and consolidation of recommendations after the cold chain assessment. The assessment of the cold chain indicated there were factors that were beyond MCHIP's ability to change, but the team was able to undertake some key activities:

- MCHIP supported the MOH in improving vaccine management by producing 750 vaccine and injection material stock books for health facilities. After these books were printed and distributed to all health facilities, vaccine management improved significantly, and as a result, the vaccine wastage rate is expected to decline.
- MCHIP made the following recommendations for the districts:
 - Improve procurement of gas and kerosene, and where possible consider replacing these refrigerators with solar-powered units.
 - Repair nonfunctioning refrigerators, ensure adequate fire extinguishers, and train staff on their usage.
 - Consider supplying two months' stock of vaccines and supplies.

POLICY AND GUIDANCE DEVELOPED AND DISSEMINATED

MCHIP assisted the Malawian national immunization team with developing an appropriate EPI policy. The first draft was prepared in November 2012 with MCHIP and WHO external support. MCHIP organized the policy development consultative meeting with stakeholders to solicit views from stakeholders on the policy direction. The policy is now final and awaiting MOH approval.

MCHIP also provided technical support for the finalization of the EPI reference field manual, which was completed in January 2013. The EPI field manual provides guidance on program implementation at all levels, and service providers and supervisors use the manual on a daily basis. UNICEF funded the field manual revision and MCHIP provided technical support in the revision. Health workers now have an updated immunization field guide, which includes the new vaccines and tools in the immunization program. The updated guide helps to improve the quality of immunization services in Malawi.



The Principal Secretary, Dr. Charles Mwansambo, giving a symbolic dose of rotavirus vaccine with the Minister of Health, Honorable Khumbo Kachale, holding the baby.

TRAINING SYSTEMS STRENGTHENED AND HUMAN CAPACITY INCREASED

Malawi had not conducted in-service training for several years, and it was agreed with the MOH/EPI that a training needs assessment (TNA) on immunization should be conducted to document training needs both in pre-service training institutions and in in-service training settings. MCHIP supported the TNA, which was conducted in May 2013 with MCHIP funding and external technical support. The key findings of the TNA were as follows:

- All training institutions have included EPI in their training curricula.

- In-service EPI training is held at all levels. However, the duration of training is not adequate and trainings are planned on an ad hoc basis.
- The national training guide is not available in most places.
- Training materials are available at the zonal and district levels, both in hard and electronic copies, but the quantities are very limited.
- All levels reported that there are unmet needs for immunization training.
- The most urgent needs for the district and health facility levels are Reaching Every District, cold chain and logistics, and IIP trainings.
- Health training institutions reported that the time allocated for EPI-related training is not adequate, and more than 60% of principals reported that their graduates benefit from in-service training before their service delivery assignment.
- The recommendations of the TNA were used to plan future MCHIP-supported training, including IIP training for health facility staff and the introduction of the EPI prototype curriculum in health colleges.



IIP training session in Mzimba South, 2012

Malawi MCHIP immunization officer was also part of that workshop. As a follow-up to this workshop, MCHIP sponsored two workshops involving all training institutions and other stakeholders in the country. During the first workshop the training institutions reviewed and adapted the prototype curriculum and made recommendations and a plan of action for rolling out the curricula. After the adaptation, MCHIP sponsored the induction of 30 lecturers from all the health training institutions on the prototype curriculum. It is expected that they will be able to use the prototype curriculum to revise their immunization curriculum.

Data quality was one of the challenges identified at the beginning of MCHIP's immunization project. MCHIP provided external technical and financial support to the MOH to conduct data quality self-assessments (DQSs) in 25 districts, which helped the program identify gaps in data generation, archiving, reporting, and use of data for action (see Figures 3 and 4). The recommendations of the DQS were

MCHIP supported the introduction of the EPI prototype curriculum for pre-service training institutions. However, the pre-service training institutions do not have a systematic curriculum for immunization, nor do they revise the immunization curriculum regularly, and the training of future program managers and vaccinators is often done with outdated materials. WHO organized a regional workshop in Abidjan, Cote d'Ivoire, to review the revised EPI training curriculum for medical and nursing schools, and MCHIP sponsored one lecturer from the University of Malawi Kamuzu College of Nursing. The

Capacity-Building Highlights

- MCHIP supported IIP training for 88 trainers in all districts of the country.
- Trainers trained 1,750 vaccinators and supervisors from 26 districts in Malawi, with CHAM training health workers in the remaining two districts.
- The program supported the printing of all eight IIP modules for the training.
- Every health facility providing immunization services had three trained health workers to provide these services.

incorporated into the Comprehensive Multi-Year Plan for Immunization and annual plan of action.

Figure 3. Data Quality Self-Assessment Findings on Quality of Immunization Services, 2012

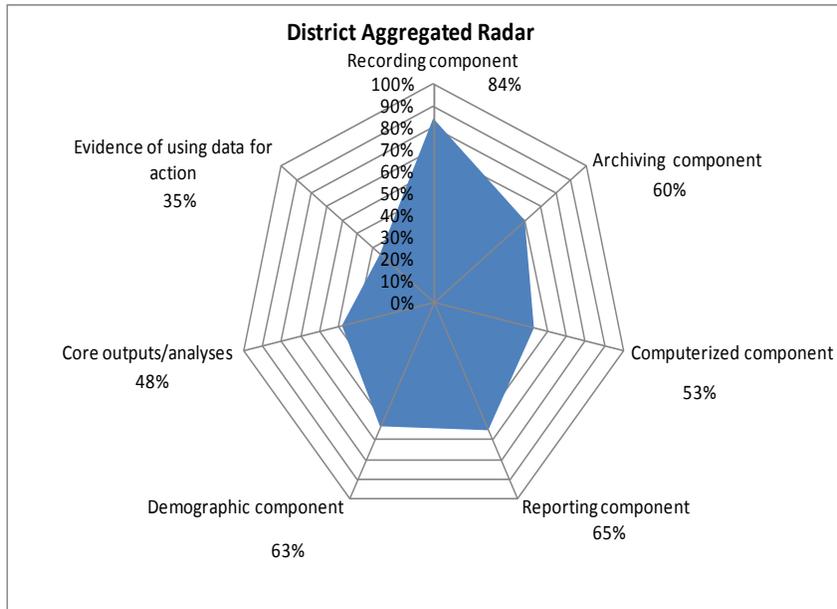
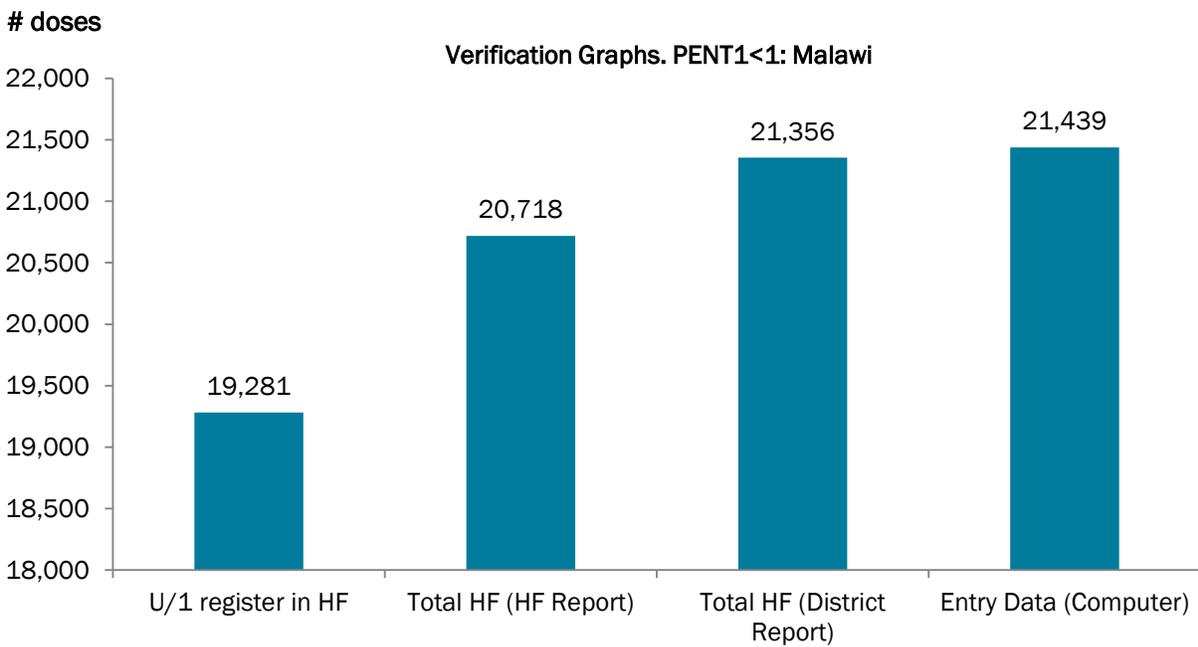


Figure 4. Verification Graph for Data Quality Self-Assessment, 2012



INTEGRATED MEASLES AND POLIO CAMPAIGN SUPPORTED

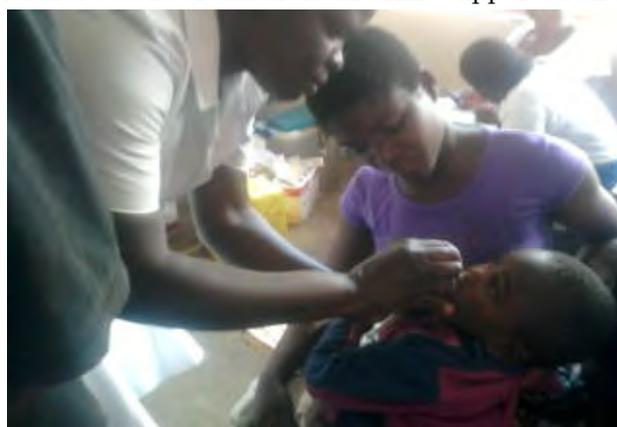


Health education band playing during the integrated SIAs launch in Blantyre

2013, integrating it with the polio vaccine because there were not adequate resources for integration with other child health interventions. USAID was called on to support the MOH with funding to cover a campaign that would integrate nutrition interventions into the measles and polio vaccine campaign. According to the 2010 Malawi Demographic Health Survey, 13% of all Malawian children are malnourished. The nutrition interventions that were to be included in the campaign were distribution of deworming tablets and vitamin A supplementation, which are critical interventions for improving the nutritional status of children. MCHIP supported the national launch of the integrated campaign through the training of more than 1,600 health workers and the orientation of more than 650 district officials. In addition, the project supported social mobilization activities for the campaign, which included 140 drama performances, briefings of 28 major media houses, and construction of two floats that stopped at all trading centers on the way from Mulanje and Mwanza to Blantyre, where the national launch was held.

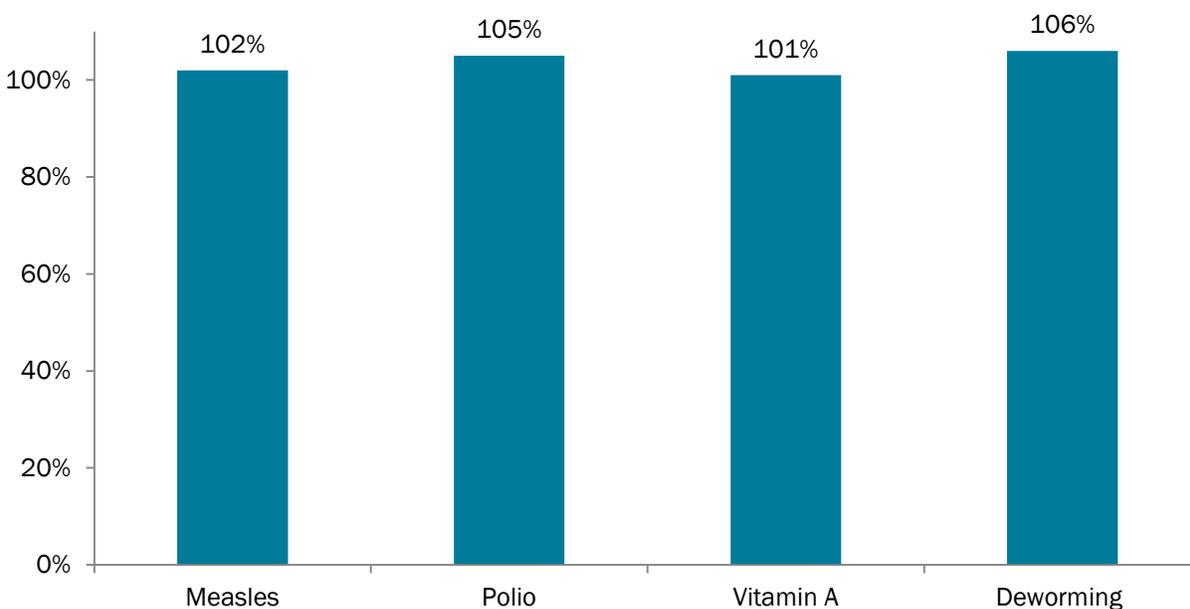
The integrated campaign, supported by MCHIP, was a great success, with high coverage for all four high-impact child health interventions in all 28 districts of Malawi (Figure 5).

Beyond routine immunization service delivery, WHO recommends implementing supplemental immunization activities (SIAs) for supplemental measles doses, through campaigns that cover a wider age group, to increase the immunity level among children under five and eliminate measles. Supplemental immunization is one way to control measles, and the WHO recommends conducting these supplemental campaigns every three years. It is recommended, however, that these measles campaigns are integrated with other high-impact child health interventions and not conducted as standalone activities. The MOH initially planned to implement a measles campaign in November



A nurse administering vitamin A at Holy Family Hospital in Phalombe

Figure 5. Campaign Administrative Coverage, November 2013



Source: EPI administrative SIA coverage

Note that in Malawi, even with routine immunization data, coverage rates of greater than 100% are commonly reported. It is anecdotally reported that this results from a problem with the denominators used to calculate coverage rates, meaning that population figures are inaccurately low and/or that children from districts in bordering countries are being vaccinated in Malawi. The other reason for coverage rates above 100% during the campaign is that some children greater than five years old are also vaccinated.

VOLUNTARY MEDICAL MALE CIRCUMCISION

The Malawi MOH has established five-year district-level targets to achieve at least 80% coverage by 2016 for males accessing VMMC services. Building on MCHIP's global experience with VMMC, the program worked within the enabling environment to ensure that policies and procedures were in place to support a national VMMC program, and established a pool of national VMMC trainers. MCHIP organized major VMMC outreach campaigns that coupled demand-generation activities with increased supply through the establishment of static VMMC sites that practice Models for Optimizing Volume and Efficiency (MOVE) principles. Campaigns showed strong numbers and demonstrated an approach that the MOH can replicate with additional VMMC campaigns to meet their national VMMC targets.

At the inception of the VMMC component in August 2012, MCHIP hired a VMMC Technical Advisor and formed a VMMC management team in Thyolo, representing all the VMMC partners in the district. The management team was chaired by the District Health Officer (DHO), and CHAM was the secretariat. Site assessments were performed with CHAM and the MOH.

Ten VMMC trainers were trained in the first quarter of FY 2013, adding to the national pool of VMMC trainers. Four of these trainers were from Thyolo, the target district, and all contributed to training other VMMC providers. Twenty-two VMMC service providers were trained, and they began providing VMMC services in Thyolo at both static and outreach sites. Supportive supervision visits and outreach services were also conducted in Thyolo.

THYOLO MINI VMMC CAMPAIGN

MCHIP supported the Malawi MOH's effort to organize and implement a three-week VMMC campaign in Thyolo district from March 18 to April 5, 2013. The campaign planned to offer continuous VMMC services in two fixed sites, Thyolo District Hospital and Malamulo Mission Hospital. In order to cover a large area within the district where limited or no VMMC services had been conducted, two community-based organizations (CBOs) were selected as outreach sites during this campaign. MCHIP set a target of 50 circumcisions per day and 1,500 for the entire campaign period.

In collaboration with the Thyolo VMMC Coordinator and the District Health Officer, MCHIP identified the human resources needed to form VMMC teams to serve at each service delivery site. Lead circumcisers were chosen from the pool of trained providers already established by MCHIP, and the teams received an orientation before services began.

MCHIP collaborated with the MOH and other stakeholders to initiate demand-creation activities to ensure clients sought services during the campaign period. Demand-creation activities started two weeks before the campaign period and continued through the first week of the campaign. These efforts were modest, relying on the use of Thyolo District Hospital's Health Information and Education team's public address system.

MCHIP conducted regular quality assurance checks, including adverse event monitoring and documentation, at each service delivery site. MOH-approved data collection tools (including client record forms and VMMC registers) were used for documentation at the campaign sites, and daily data entry and minor analyses were performed to continuously inform the campaign organizers on achievements and allow for any adjustments in implementation.

The Thyolo campaign performed 2,833 male circumcisions (89% of the target) in just 12 days (March 18–30). The campaign lasted through April 5 (upon request of the DHO) and resulted in a total of 3,416 male circumcisions being performed in 17 days. This is 228% of the initial campaign target of 1,500 circumcisions. The huge success and high turnout of clients during this campaign are attributed to three unique approaches:

1. Engagement of CBOs as campaign sites (taking services closer to the home of clients to encourage clients who would prefer not to seek care at health centers)
2. The use of a different approach to demand creation, with a combination of community-wide motivational talks, school visits, engagement tea estate managers, and public lectures where the communication team moved with the technical team
3. Strong leadership and support of the DHO, which resulted in district ownership of the campaign and highly motivated and inspired teams of providers who worked tirelessly to ensure that few or no clients were turned back after knocking on the door for VMMC services

Results of the National Circumcision Campaign

- The campaign from July to September 2013 yielded 8,798 male circumcisions by MCHIP, bringing the total number of circumcisions for the fiscal year to 13,499.
- MCHIP reached 58.6% of the set target for the campaign, and the national campaign yielded a total of 39,886 male circumcisions (66.5% of the set target), with MCHIP contributing 22% of this total.

In addition to normal VMMC campaign operations, MCHIP also implemented VMMC services through fixed and outreach sites. A total of 951 male circumcisions were conducted in the third quarter of FY 2013 through routine facility service delivery, outreach, and the last week of the

mini-campaign discussed above, including a “mop-up” period of the campaign. The mop-up period is the special time designated for offering services to clients who sought services after closure of the campaign.

NATIONAL CIRCUMCISION CAMPAIGN CONDUCTED

Following the success of the mini-campaign, planning for the VMMC mass campaign in July–September 2013 began, with national-level coordination meetings, Thyolo district specific planning meetings, and development and review of plans. The national-level campaign was to involve Thyolo, Mulanje, Phalombe, Blantyre, Nkhosokota, and Lilongwe districts, with implementing partners including MCHIP, I-TECH, PSI, CHAM, and Banja La Mtsogolo. The target for the campaign was 60,000 circumcisions, 15,000 of which were to be contributed by MCHIP in Thyolo district. MCHIP supported the MOH in coordinating the campaign at the national level for all partners and districts involved. Each partner was responsible for its catchment area, with MCHIP being responsible for Thyolo district. MCHIP was a lead partner in coordination and was part of the national steering committee, which was responsible for planning, supervision at the national level, and decision-making on the campaign. MCHIP played a central role in managing data collection and reporting to the committee, including assisting partners with reporting templates and mentoring where necessary.

The campaign target was not met due to challenges in community mobilization for demand creation. All demand-creation activities for three districts (Thyolo, Phalombe, and Mulanje) were bestowed on a single partner, and catering to the needs of all three districts while delivering services at an optimum level proved challenging. In addition, the separation of demand from supply has repeatedly proved challenging as it can result in a lack of accountability between partners in measuring success. Most of the demand-creation activities started only a few days before the onset on the campaign, which conflicted with the MOH request that all demand-creation activities should start at least two weeks before the campaign.

One successful aspect of this mass campaign was the involvement of all VMMC partners in the country. Before this, only MCHIP had been conducting VMMC campaigns, and the coordinated campaign provided a great opportunity for other partners to learn how to conduct a VMMC campaign in Malawi.

Figures 6–9 show MCHIP’s life-of-project achievements for the VMMC initiative in Malawi.

Figure 6. Life-of-Project VMMC Trainings, Thyolo

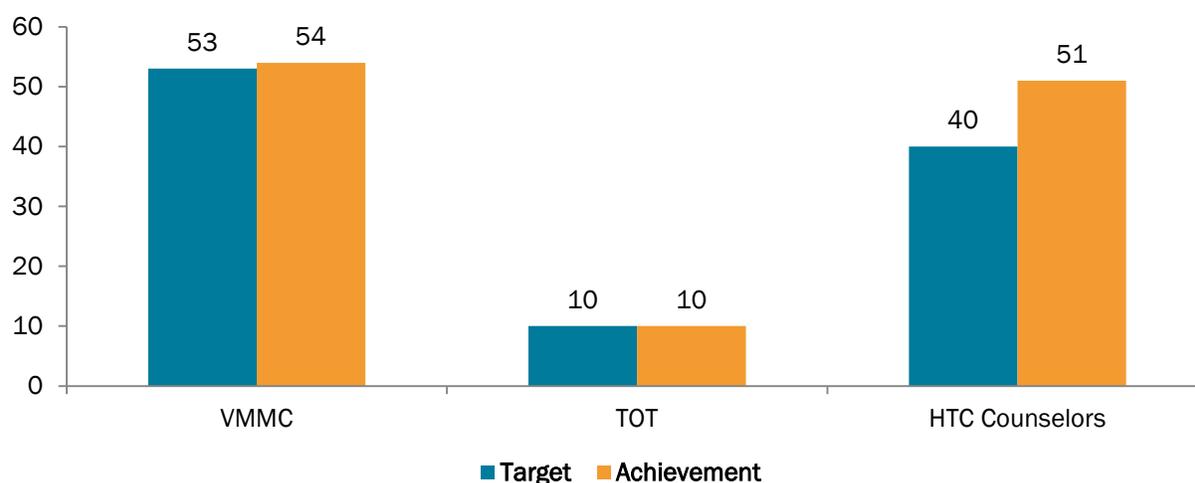


Figure 7. Cumulative VMMC Achievements over Life of the Project

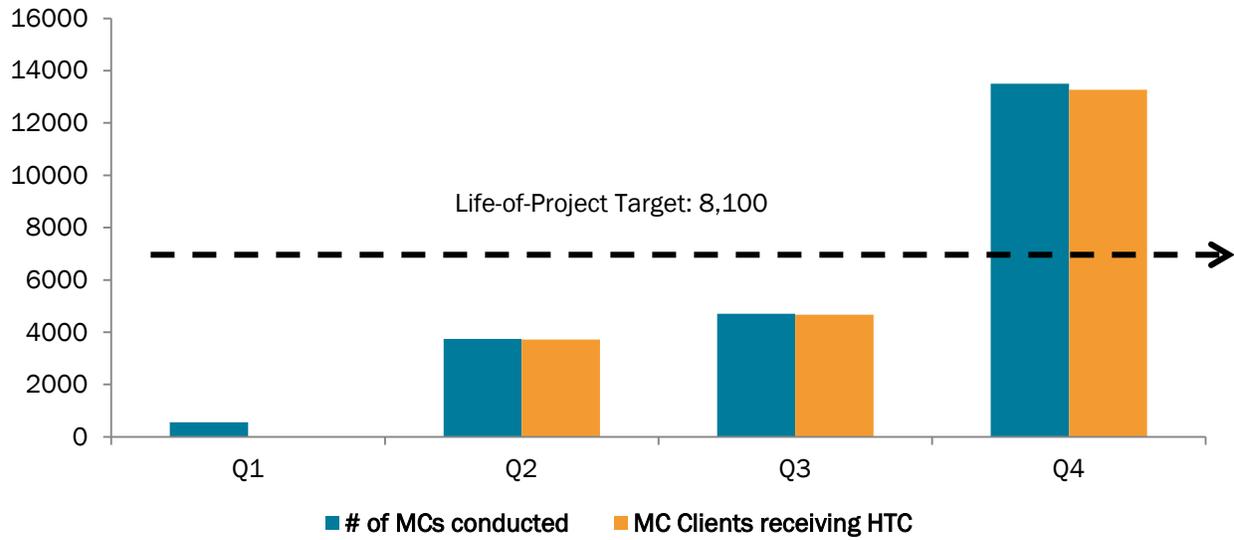
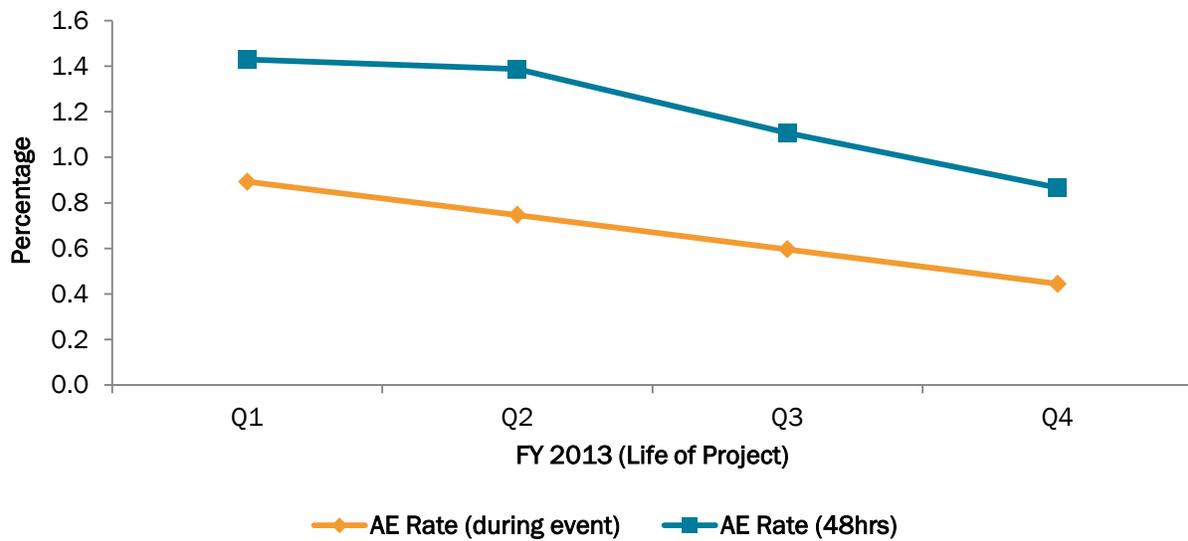
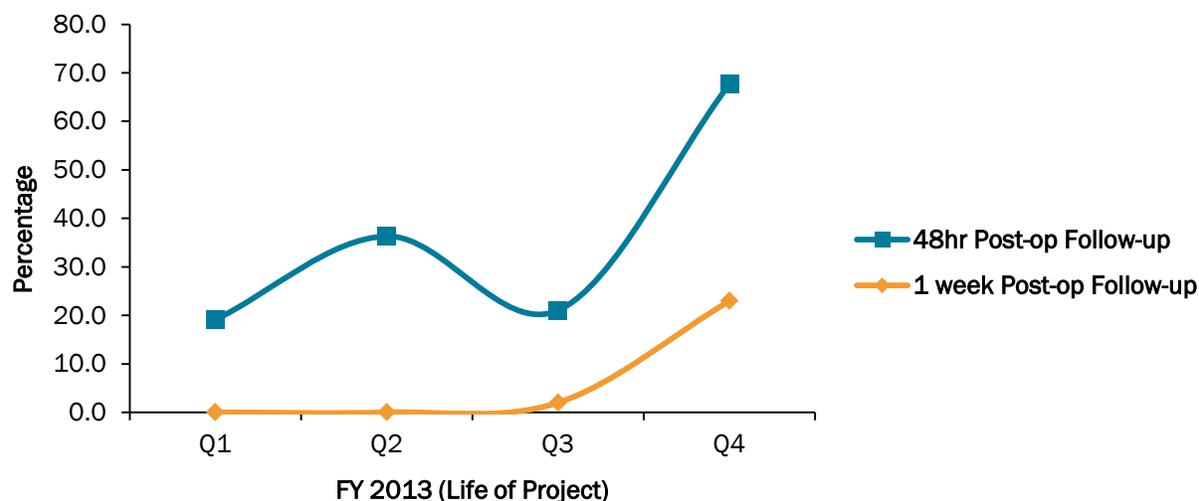


Figure 8. Declining Adverse Event Rate for Male Circumcision



AE: adverse event

Figure 9. Increasing Post-Operative Follow-Up Rate



STRENGTHENED MONITORING AND MANAGEMENT

In addition to the VMMC campaigns and services organized by MCHIP, the project also coordinated harmonization of national M&E tools, including the VMMC database. MCHIP was involved throughout the year with the review of the national VMMC tools, including providing input for the revised tools. The project played a lead role in harmonizing the national mass campaign reporting structure, demonstrating the possibility of harmonized tools and an M&E structure. MCHIP supported the MOH in developing the VMMC reporting form in the DHIS2 data management platform. The use of DHIS2 in reporting national VMMC data was planned for full implementation in FY 2014.

MCHIP also consolidated the final VMMC waste management plan, which will be shared with other VMMC partners. Site-specific waste management plans were developed for Malamulo District Hospital and Thyolo District Hospital. The tool was used in its draft form during the mass campaign; at the time of this report, revisions and sharing with all partners were scheduled for the next quarter.

All VMMC technical activities are now being implemented under the MCHIP Associate Award and follow-on to this project, *Sankhani Moyonela* (“Smart Choice”).

HELPING BABIES BREATHE

Helping Babies Breathe is an evidence-based educational program that teaches essential neonatal resuscitation techniques to health workers in resource-limited areas. HBB was first rolled out to 14 districts in Malawi, with support from USAID/MCHIP, Johnson and Johnson, and other development partners, beginning in February 2011. Given the desire to rapidly scale up HBB throughout Malawi, the MOH, MCHIP, and partners identified a need to understand both how the program was being implemented and the associated results in terms of health system performance, provider competence, quality of care, and outcomes. With support from USAID, MCHIP and the MOH designed and implemented a multiyear evaluation of the Helping Babies Breathe program in Malawi. The study aimed to measure the quality, coverage, and impact of the Helping Babies Breathe newborn resuscitation intervention at the facility level in Malawi. The results of the study will provide guidance and recommendations for scale-up in Malawi. A similar evaluation is being conducted of the HBB initiative in Bangladesh. The Malawi evaluation is conducted in collaboration with Kamuzu College of Nursing and the MOH.

The MCHIP Malawi HBB study is notable for its use of direct observation of routine delivery care and management of newborns not breathing at birth. Because labor and delivery are long and complex, and birth asphyxia is rare, it is both beneficial and unusual to have observational studies rather than simple record reviews. Findings of the study included the following:

- Clinical simulations revealed that health care providers in the intervention group appeared to be significantly more skilled at bag and mask ventilation than providers in the comparison group. Providers were asked to complete two role-play case scenarios using the NeoNatalie. In both scenarios, the health workers in the intervention group scored higher on most steps, although the differences were not statistically significant for any individual step.
- The proportion of intervention facilities that had the equipment required for newborn care was higher in intervention facilities than in non-intervention facilities for most of the assessed supplies, especially bags and masks for newborn resuscitation. In intervention facilities, 41% of facilities did not have a copy of the HBB guidelines, while 72% of non-intervention facilities did not have the guidelines. Better availability of newborn equipment and HBB guidelines is likely related to the provision of newborn supplies and equipment as part of the HBB intervention. All providers trained in HBB are given an anatomic model, along with a bag and mask and penguin suction bulb, to take back to their facility.

However, a majority of the study findings were not significantly different between the intervention group and the control group. This is likely due to two issues:

- The data were collected as part of the first round of evaluations of a nationwide scale-up of the Helping Babies Breathe Initiative in Malawi. The scale-up is being implemented in a phased manner, and at the time of data collection a majority of the facilities included in the intervention arm had had only a relatively short duration of exposure to the HBB initiative. The nationwide scope and short duration of implementation presents logistical and managerial challenges in ensuring adequate supplies of required equipment and appropriately trained staff in the intervention facilities. This might be reflected in the lower scores for the intervention arm.
- Transfer of health workers between facilities is a common phenomenon in low-income countries like Malawi. It is likely that HBB-trained workers have been transferred from intervention to non-intervention facilities and vice versa. This “contamination” might be associated with the presence of HBB-trained workers in non-intervention facilities and the relatively higher scores for this study arm.

As of the time of this report, the HBB study was ongoing. Round two of data collection took place in September 2013 and data analysis is currently under way; it is anticipated that a national dissemination meeting will take place in June 2014.

INFECTION PREVENTION AND CONTROL AND INJECTION SAFETY

With support from MCHIP, Jhpiego Malawi assisted three health facilities—namely, St. Gabriel’s Hospital, Mlale Hospital, and Lumbadzi Health Center—with addressing IPC by building the capacity of service providers, managers, and support staff. The three facilities were supported in the implementation of Jhpiego’s innovative Standards-Based Management and Recognition® (SBM-R®) approach to improve IPC practices. The program has also provided facilities with key infection prevention equipment, including plastic buckets, waste bins, liners, aprons, gumboots, surgical gloves, heavy duty gloves, household gloves, sharp-proof boxes, goggles, chlorine powder, scrub suits, theater gowns, drapes, mackintosh, and many other items.

Following the end of program support from MCHIP in December 2012, the USAID-funded SSDI-Services project (led by Jhpiego) continued to provide onsite coaching, training, and

supportive supervision to these three facilities in the areas of critical identified gaps. In FY 2013, assessments were conducted at Mlale Hospital and St. Gabriel’s Hospital using MOH IPC standards (see Table 1), while at Lumbadzi Health Center the project continued to monitor progress using the PQI model.

Table 1. Assessments at Three Facilities

| PQI SCORES | | | | | |
|------------------------|--------------------------------|---|--|-------------------------------------|--------------------------|
| Name of Facility | Baseline Assessment (May 2013) | First Internal Assessment (August 2013) | Second Internal Assessment (November 2013) | MOH Mock Assessment (February 2014) | External Assessment 2014 |
| St. Gabriel’s Hospital | 53% | 66% | NA | 85% | 92% (March 14) |
| Mlale Hospital | 47% | 85% | 90% | -- | 87% (January 14) |
| Lumbadzi Health Center | 34% | 72% | 54% | NA | NA |

Table 1 depicts the results of the assessment conducted during FY 2013. Both St. Gabriel’s and Mlale Hospitals have witnessed consistent improvement, while Lumbadzi Health Center has been less consistent. Lumbadzi is a government hospital, and due to its financial challenges, the facility experiences scarcity and inconsistent availability of IPC resources such as chlorine, detergent, hand soap, and liners (these were provided as startup packs). These problems affect providers’ ability to maintain and sustain IPC practices. At St. Gabriel’ Hospital, infection prevention improved greatly as a result of intensive supportive supervision and coaching in the month of January. The MOH conducted a mock assessment during the first week of February, and the facility scored 85%; the assessors recommended an external assessment. The assessment was conducted March 18–20, and St. Gabriel’s Hospital was certified after scoring 92%.

During assessments the assessing team observes service providers’ performance in a number of areas and compares it against set standards. The observed areas include hand washing, management of general and medical wastes, decontamination, cleaning and sterilization of contaminated equipment, housekeeping, aseptic techniques during invasive procedures, traffic flow of patients, management of infectious case, post-exposure prophylaxis, management support (availability of infection prevention supplies), and others. Fourteen service areas are assessed using standard criteria (see the example below).

Mlale Hospital has shown positive movement toward institutionalizing IPC practices to ensure that clients receive safe care and providers are protected from injury and infection (Table 2). With results of 90% during the second assessment, conducted in November 2013, the facility formally invited the Ministry of Health Quality Improvement Support Team (QIST) for external verification. Mlale was externally assessed during the week of January 27–31, 2014, scoring 85%. The hospital was certified as a center of excellence in IPC.

Table 2. External Assessment of Mlale Mission Hospital, January 28–30, 2014

| | PRACTICE AREA | TOTAL CRITERIA | CRITERIA ACHIEVED | PERCENTAGE (%) |
|----|-----------------------------------|----------------|-------------------|----------------|
| 1. | Central sterile supply department | Not observed | | |
| 2. | Operating theater | 24 | 20 | 83% |

| | PRACTICE AREA | TOTAL CRITERIA | CRITERIA ACHIEVED | PERCENTAGE (%) |
|-----------------------------|---------------------------------------|-----------------|-------------------|----------------|
| 3. | Isolation systems | 10[08] | 7 | 88% |
| 4. | Labor and delivery | 19[14] | 14 | 100% |
| 5. | Casualty, medical, and surgical wards | 45[38] | 33 | 87% |
| 6. | MCH/FP clinic | 21[12] | 10 | 83% |
| 7. | Dental department | 14 | 12 | 86% |
| 8. | Laboratory | 20 | 17 | 85% |
| 9. | Postmortem | 12 | Not observed | -- |
| Supportive Functions | | | | |
| 10. | Administrative functions | 8 | 7 | 88% |
| 11. | Patient/client education | 4 | 3 | 75% |
| 12. | Food preparation | 7 | Not available | -- |
| 13. | Laundry | 7 | 7 | 100% |
| 14. | Waste management | 5 | 4 | 80% |
| Totals | | 207(154) | 134 | 87% |

The commitment and dedication of Mlale Hospital's top administrators and staff to proper infection prevention practices have contributed to the facility's remarkable progress in institutionalizing IPC. The photos below show how processes have improved with regards to privacy through provision of screens around the examination beds in the consultation rooms.



A nurse-midwife wears standard personal protective equipment (PPE) to guard against health care-associated infections during a spontaneous vaginal delivery at Mlale Hospital



Same consultation room with screens on examination couch (October 2013)



A support staff member wearing PPEs during cleaning



Handwashing area with posted handwashing procedure in a ward setting



Current status of laundry facility (November 2013)



Handwashing facility at a common toilet for guardians



Incineration area



Woven baskets in the laundry that were used to take hospital linen to and from the wards before IPC was introduced at the facility

Before the introduction of IPC at the facility in 2012, the incineration area was not secured and did not have a focal person responsible for managing waste. Now there is a staff member assigned to the area. Medical waste is kept at the interim storage area and then incinerated at specific times by this focal person. After incineration, ash is disposed into the secured ash pit. Previously the ash was disposed of in an open rubbish pit.



Secured ash pit for incinerated medical waste



Following IPC introduction, the management of the hospital procured the above plastic pails and basins to manage linens to and from the wards (October 2012)

St. Gabriel Hospital was also assessed externally by the MOH and was certified as a center of excellence after scoring 92% (see Table 3).

Table 3. External Assessment of St. Gabriel's Mission Hospital, March 18–20, 2014

| PRACTICE AREA | | TOTAL CRITERIA | CRITERIA ACHIEVED | PERCENTAGE (%) |
|-----------------------------|---------------------------------------|-----------------|-------------------|----------------|
| 1. | Central sterile supply department | 11 | 9 | 82% |
| 2. | Operating theater | 24 | 21 | 88% |
| 3. | Isolation systems | 10 [8] | 07 | 88% |
| 4. | Labor and delivery | 19 | 19 | 100% |
| 5. | Casualty, medical, and surgical wards | 45 | 40 | 89% |
| 6. | MCH/FP clinic | 21 [13] | 13 | 100% |
| 7. | Dental department | 14 | Not observed | -- |
| 8. | Laboratory | 20 | 20 | 100% |
| 9. | Post mortem | 12 | 10 | 83% |
| Supportive Functions | | | | |
| 10. | Administrative functions | 8 | 8 | 100% |
| 11. | Patient/client education | 4 | 4 | 100% |
| 12. | Food preparation | 7 | 6 | 86% |
| 13. | Laundry | 7 | 7 | 100% |
| 14. | Waste management | 5 | 4 | 80% |
| Totals | | 207(183) | 168 | 92% |

CONCLUSION

Since the introduction of IPC in the three facilities, there has been progress, particularly at Mlale Hospital and St. Gabriel Hospital, which have shown tremendous gains. General cleanliness in all the facilities has improved greatly. Mlale hospital has since received the status of center of excellence in infection prevention and control practices and St Gabriel is also scheduled to receive this honorary status. Staff and management of the facilities are committed to attaining the status of excellence in IPC despite their challenges. SSDI-Services will continue to provide ongoing supportive supervision and periodic assessment to monitor progress until Lumbadzi Health Center is externally assessed by the Ministry of Health. Ongoing supportive supervision at Mlale and St. Gabriel's will also continue under the SSDI-Services program.

Cross-Cutting Themes

Quality of Care

- At the end of the immunization practice training, every health facility providing immunization services had three trained health workers to provide immunization services; these trained health workers have improved the quality of immunization service delivery.
- As a result of MCHIP's technical support for the EPI reference field manual, health workers have an updated immunization field guide that includes the new vaccines and tools in the immunization program.
- Through external technical and financial support to the MOH, the program supported DQs in 26 districts, which helped the program to identify the gaps in data generation, archiving, reporting, and use of data for action, and to improve data quality.
- The HBB evaluation was conducted to assess and document lessons learned, best practices, and experiences with HBB, which will help to improve and validate the program for further use in Malawi and other country programs.
- The HBB study modified the MCHIP Quality of Care survey tools and the HBB simulation tools developed by the HBB consortium.
- The program provided support to three health facilities to improve IPC by building the capacity of service providers, managers, and support staff. The three facilities implemented Jhpiego's innovative SBM-R approach to improve IPC practices.
- The program provided facilities with key infection prevention equipment, including plastic buckets, waste bins, liners, aprons, gumboots, surgical gloves, heavy duty gloves, household gloves, sharp-proof boxes, goggles, chlorine powder, scrub suits, theater gowns, drapes, mackintosh, and many others.
- MCHIP conducted regular quality assurance checks for VMMC, including adverse event monitoring and documentation, at each service delivery site.

Scale-Up

- Data presented in the Helping Babies Breathe report was collected as part of the first round of evaluations of nationwide scale-up of the Helping Babies Breathe Initiative in Malawi.
- The Helping Babies Breathe evaluation report is expected to influence scale-up of the HBB initiative not only in Malawi but also across borders.
- MCHIP purchased 30 tents for utilization by service providers during provision of VMMC services in remote sites where accommodation is a challenge; these tents will support scale up of VMMC services under the Sankhani Moyanela project.

Integration

- The integrated measles SIAs followed WHO recommendations for integrating measles campaigns with other high-impact child health interventions rather than conducting them as standalone activities.
- MCHIP was called on to support the MOH with funding to cover a campaign that would integrate nutrition interventions into the measles and polio vaccine campaign; the nutrition interventions that were to be included in the campaign were distribution of deworming tablets

and vitamin A supplementation, which are critical to improving the nutritional status of children.

Community

- MCHIP provided external technical and financial support to the post-introduction evaluations of the PCV and rotavirus vaccines, which revealed that the introductions of both vaccines were smooth and successful, the vaccines were well accepted by professionals at all levels and by the community, and both vaccines have been fully integrated into the national immunization program.
- The program implemented a new and innovative VMMC demand-creation approach, with a combination of community-wide motivational talks, school visits, engagement tea estate managers, and public lectures, to attract community members to seek male circumcision services.
- A “doorstep delivery” VMMC setup was implemented to deliver circumcision services through community-based temporary sites, thus providing a convenient, innovative, and intimate approach that led to campaign success in the community.
- Traditional authorities were engaged to help sensitize and mobilize the community for VMMC services. The traditional authorities in turn engaged their subordinate chiefs, group village headmen, and headmen to assist in telling their people the importance of medical circumcision.

Recommendations and Way Forward

Immunization

- Malawi has maintained high immunization coverage for all antigens at both national and subnational levels, and the country has successfully introduced new vaccines, including PCV and rotavirus vaccine. However, there is concern over the quality of services, noted in poor data quality in some of the districts.
- MCHIP supported training of health workers with a minimum of three health workers per health facility, and this training should continue and reach all the health surveillance assistants and nurses in the country; mid-level management training should be conducted to improve the planning and management skills of health workers.
- MCHIP supported the revision of the pre-service curricula in all training institutions in 2014, but this activity needs follow-up as well, through visits to all training institutions in the country for curriculum review and a workshop to assess the status of implementation of the curriculum review.
- Malawi has introduced two new lifesaving vaccines with Global Alliance for Vaccines and Immunization support, co-financed by the MOH. However, there are limited resources for implementation of the program at all levels. Recommendations for the way forward include:
 - Supporting regular supportive supervision and on-the-job training at all levels;
 - Facilitating a national-level review meeting involving the districts and zones and a district-level meeting involving health facilities;
 - Conducting advocacy visits and meetings for the districts to allocate adequate budgets for vaccine transportation and fueling refrigerators and generators; and
 - Supporting Malawi's plans to introduce more lifesaving vaccines in the coming years, including the measles second dose, the inactivated polio vaccine, and the rubella vaccine.

Helping Babies Breathe

- Increase the availability of equipment related to newborn care and management of newborn asphyxia (bag and mask, penguin suction).
- Ensure that up-to-date guidelines and job aids are disseminated to facilities, especially those linked to managing obstetric and newborn emergencies like newborn asphyxia.
- Invest in incorporation of HBB into pre-service training for all skilled birth assistants in Malawi to ensure complete coverage.
- Through increased coverage of in-service and pre-service training on HBB and improved supportive supervision:
 - Encourage health workers to perform all the basic checks (pulse, temperature, blood pressure, urine, fundal height, and fetal heart tones) required to properly manage the labor, delivery, and postpartum phases;
 - Emphasize the need for respectful care and regular communication with delivering mother;
 - Improve the immediate care for non-asphyxiated newborns by promoting skin-to-skin contact, delayed cord clamping, and breastfeeding within one hour of delivery;
 - Emphasize regular practice with the NeoNatalie anatomic model to ensure adequate preparedness for a clinical emergency like newborn asphyxia; and

- Improve the immediate care for asphyxiated newborns by promoting stimulation, drying, and clearing of secretions followed by HBB protocol-based use of bag and mask ventilation.

Voluntary Medical Male Circumcision

Key lessons learned in the MCHIP VMMC component, which are helping to inform implementation of the follow-on VMMC project, *Sankhani Moyonela*, include the following:

- When MCHIP’s mini campaign initiative started, the DHO’s office took the driver’s seat during demand creation, ensuring that staff allocation to the campaign sites did not affect daily service delivery at the hospital and releasing some of the district vehicles to fill the need for transportation of clients, materials, and providers to the VMMC campaign sites.
- Involving the Thyolo DHO proved to be a key component for implementing a successful VMMC campaign, as the DHO led demand-creation activities and VMMC service provision. This further enhanced responsibility and accountability for the VMMC program. At Malamulo Mission Hospital, the DHO made daily follow-up visits to ensure preparation of the site for use in the campaign.
- Collaboration with the Thyolo DHO and other DHO’s in future districts should be the mainstay of the VMMC initiative in Malawi. It should be consolidated in day-to-day activities from the planning period to the implementation phase. Close collaboration, with the DHO taking the lead role, is recommended in VMMC programs in Malawi because it builds the capacity of the DHO to manage these campaigns.
- Collaboration with CBOs and traditional leaders is a critical entry point for raising awareness, getting buy in, and mobilizing communities for VMMC services.

The VMMC initiative in Southern Malawi continues with the MCHIP Associate Award, *Sankhani Moyonela*. The experiences from the MCHIP award are proving valuable in the implementation of the follow-on award, and increased targets for male circumcision show promise of a significant reduction in HIV transmission in the region.

Infection Prevention

Experiences from the MCHIP infection prevention component have helped to inform work in the USAID bilateral SSDI-Services project. The following recommendations will be incorporated into SSDI-Services activities, which will continue in targeted health centers:

- Monitor availability of PQI, infection prevention, and reproductive health standards in all wards and departments so that service providers access and use them when attending to patients.
- Strengthen coordination between the DHO and CHAM management teams to ensure availability of all PPE at all times.
- Provide ongoing supportive supervision and coaching, including conducting internal assessments to help facilities institutionalize IPC.
- Facilitate learning visits for providers to appreciate best practices in facilities that are doing well.
- Monitor availability of IPC supplies during clinical supervision.
- Monitor availability of PPE and use during clinical supervision.
- Lobby management to ensure availability of IPC supplies and PPE at all times in order to sustain learned practices.

Annex 1: Indicator Matrix

Immunization

| Indicator | Direction of Change (+) or (-) | Unit of Measure | FY 2012 Target | FY 2012 Achievement | 2013 Target | FY 2013 Achievement | 2014 Target | FY 2014 Semi-Annual Achievement | 2014 Annual |
|--|--------------------------------|-----------------|----------------|---------------------|-------------|---------------------|-------------|---------------------------------|-------------|
| Goal: Morbidity and mortality due to vaccine preventable diseases reduced and this contributes to the reduction in infant and child mortality rates | | | | | | | | | |
| Intermediate Result 1.1: PCV introduced nationwide and M&E conducted with MCHIP support | | | | | | | | | |
| Indicator 1.1.1 New vaccines introduced | + | | NA | NA | 2 | 1 | NA | NA | |
| Indicator 1.1.2 Percentage of children less than 12 months of age who received PCV3 | + | Percent | 95% | 113% | 95% | 91% | 95% | 89% | |
| Indicator 1.1.3 Percentage of children less than 12 months of age who received Rota vaccine | + | Percent | NA | NA | 94% | 87% | 95% | 87% | |
| Indicator 1.1.4 Percentage of children less than 12 months of age who received penta3 through USG supported programs | + | Percent | 95% | 97.8% | 95% | 90% | 95% | 82% | |
| Indicator 1.1.5 Number of supportive supervision visits conducted with MCHIP assistance | + | Percent | 4 | 2 | 4 | 0 | 2 | 1 | |
| Intermediate Result 1.2: Rotavirus vaccine introduction plan of action developed and rotavirus vaccines introduced successfully | | | | | | | | | |
| 1.2.1 Number of H/W trained in Rota introduction | + | Number | NA | 341 | NA | NA | NA | NA | |
| 1.2.2 Rota Post-Introduction Evaluation (PIE) conducted | + | Number | NA | NA | 2 | 1 | NA | NA | |
| 1.2.3 Percentage of children less than 12 months of age who received Measles vaccine | + | Percent | NA | NA | 95% | 87% | 95% | 90% | |

| | | | | | | | | | |
|--|---|--------|----|-------------------|----|-------|-------|-------|--|
| 1.2.4 Number of EPI management tools revised to reflect new vaccine information | + | Number | NA | NA | 9 | 9 | NA | NA | |
| Intermediate Result 2.1: Immunization training materials updated with MCHIP support | | | | | | | | | |
| 2.1.1 Number of EPI Curriculum adapted | + | Number | NA | NA | NA | NA | 1 | 2 | |
| 2.1.2 Number of tutors oriented to EPI prototype curricula | + | Number | NA | NA | NA | NA | 30 | 29 | |
| 2.1.3 Routine Immunization field guide revised | + | Number | 1 | 0 | 1 | 1 | NA | NA | |
| Intermediate Result 2.2: HWs capacity improved with MCHIP supported trainings | | | | | | | | | |
| 2.2.1 Number of health workers trained in Immunization in Practice (IIP) ToTs | + | Number | NA | Postponed to FY13 | 88 | 88 | NA | NA | |
| 2.2.2 Number of health workers trained in Immunization in Practice (IIP) | + | Number | NA | Postponed to FY13 | NA | 1,406 | 410 | 618 | |
| 2.2.3 Number of people trained on integrated measles, polio, vitamin A and deworming SIAs | + | Number | NA | NA | NA | NA | 1,970 | 2,303 | |
| Intermediate Result 3.1: Immunization data quality improved with MCHIP supported assessments and feedback provided to subnational level | | | | | | | | | |
| Intermediate Result 3.2 - Improved vaccine and cold chain management | | | | | | | | | |
| 3.1.1 Number of districts where Data Quality Self-Assessment (DQS) findings implemented | + | Number | NA | 8 | NA | NA | 17 | 21 | |
| 3.1.2 Number of districts reporting negative dropout rate reduced | + | Number | 0 | 4 | 0 | 3 | NA | NA | |
| 3.1.3 Number of coverage surveys conducted | + | Number | NA | NA | NA | NA | 1 | 1 | |
| 3.1.4 EVM assessment conducted | + | Number | 1 | 0 | 1 | 1 | NA | NA | |
| 3.1.5 EVM improvement plan developed | + | Number | NA | Postponed to FY13 | 1 | 1 | NA | NA | |

| | | | | | | | | | |
|--|---|--------|----|----|----|----|--|--|--|
| 3.1.6 Number of social mobilization activities conducted: • media personnel trained • national launch • drama performances • band performances | + | Number | NA | NA | NA | NA | | <ul style="list-style-type: none"> • 30 • 1 • 140 • 12 | <ul style="list-style-type: none"> • 28 • 1 • 140 • 12 districts |
|--|---|--------|----|----|----|----|--|--|--|

Voluntary Medical Male Circumcision

| INDICATOR | FY 2013 (LOP) TARGET | FY 2013 (LOP) ACHIEVEMENT | NOTES |
|--|----------------------|--|---|
| 1. Number of health workers trained in VMMC | 53 | 54 | 22 providers trained in Oct–Dec 2012 quarter, 18 in the Jan–Mar 2013 quarter, and 14 in the Apr–Jun 2013 quarter, bringing the total number of trained providers to 54, against a year’s target of 53. |
| 1b. Number of health workers trained in VMMC training of trainers | 10 | 10 | 100% achieved. The trainers were identified and trained in the first quarter to assist in the series of district trainings that were planned. |
| 1c. Number of HIV testing and counseling counselors trained in VMMC package | 40 | 51 | 21 trained in third quarter and 30 trained early in the fourth quarter; more were trained than targeted to take care of mass campaign needs. |
| 2. Number of males circumcised as part of a minimum package of male circumcision for HIV prevention services | 8,100 | Neonate: 0 < 15: 6,058 15 to 24: 6,120 25 to 49: 1,258 50+: 63 Total: 13,499 | This is a revised target covering the fiscal year (i.e., October 2012 to September 2013). 560 were circumcised in first quarter, 3,190 in the second quarter, 951 in the third quarter, and 8,798 in the fourth quarter. Use of campaigns in the second and fourth quarters helped the program to reach more males. |
| 3. Number of individuals who received testing and counseling services for HIV as part of male circumcision | 90% | 13,267 (98%) | The remaining 223 clients had recent HIV test results or were known HIV+, and nine had opted out of HIV testing. |
| 4. Number of adverse events during the procedure | <2% | 60 (0.4%) | No moderate or severe adverse event occurred in the April–June 2013 quarter. |
| 5. Number of adverse events within 48 hours | <2% | 117 (1.5%) | The denominator is the number of circumcised males who came for follow-up care, and this is for all follow-up care. |
| 6. Number of adverse events within seven days | <2% | 0 | Most clients came once within the 48 hours or a bit late (1–4 days after circumcision). |

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

Annex 2: Success Stories

USAID'S MCHIP ENSURES THAT CHILDREN VACCINATED IN MALAWI ARE REALLY IMMUNIZED

The USAID-funded MCHIP project assists the Malawi Ministry of Health (MOH) with the roll-out of lifesaving vaccines, including the pneumococcal conjugate vaccine-13 and the rotavirus vaccine. It is estimated that these vaccines alone will substantially reduce under-five mortality caused by illnesses such as diarrhea, pneumonia, and meningitis in Malawi.

According to the latest Demographic and Health Survey, conducted in 2010, approximately 81% of Malawi's children are fully immunized. However, when the MOH recently conducted a supportive supervision visit with MCHIP assistance, health

worker knowledge on how to keep vaccines in good condition was discovered to be low. Less than half of the health workers surveyed could conduct a simple test to determine if a vaccine had ever been frozen. Slightly more than 10% of facilities had expired vaccines in the refrigerators. The consequences of not using proper immunization practices can be catastrophic: Children who have been vaccinated could in fact be un-immunized, which would leave them unprotected from these serious, life-threatening illnesses. In fact, one MCHIP staff member noted that the finding of poor immunization practices “poses a serious threat. Even if more children are being vaccinated in facilities (as shown by the high coverage rates), maybe some are not immunized due to poor practice.”

One of the objectives of the MCHIP immunization project is to improve the capacity of health workers to develop skills and improve the performance of new vaccine introduction and routine immunization. The IIP modules are a course designed by the World Health Organization, with substantial input from MCHIP, to train frontline immunization workers. Malawi had not conducted the IIP training for quite some time due to a lack of resources. Identifying this crucial gap in capacity-building, USAID, through MCHIP, supported IIP training in 23 districts throughout the Malawi, training a total of 1,406 health workers. Health surveillance assistants, the backbone of Malawi's health workforce, appreciated the training and suggested that all health surveillance assistants would benefit.

During a post-immunization evaluation of rotavirus vaccine introduction, no expired vaccines were observed. Furthermore, during a follow-up visit conducted by MCHIP in a Mzimba North health center, a box containing reminder (or “tickler”) cards used to identify infants who have missed vaccinations was in use. When the MCHIP employee asked the health worker how this system was developed in the health center, the health care worker explained, “We learnt this [practice] from that IIP training. We now follow all the children who have missed their vaccinations in a month.” In this era of outbreaks of measles and polio and other illnesses, it is exciting to know that health care workers are conducting follow-up in communities to ensure that all children are fully immunized to reduce under-five mortality. MCHIP is working with the MOH to improve the quality of vaccination services to ensure that vaccination results in full immunization.



USAID ENSURES THAT HIGH-IMPACT CHILD HEALTH INTERVENTIONS ARE DELIVERED TO MALAWI'S CHILDREN

The USAID-funded MCHIP immunization project assists the Malawi Ministry of Health (MOH) with the rollout of lifesaving vaccines, including the pneumococcal and rotavirus vaccines. It is estimated that these vaccines alone will substantially reduce the under-five mortality in Malawi by causes such as diarrhea, pneumonia and meningitis. MCHIP also provides technical support to improve routine immunization in Malawi.

In addition to routine immunization service delivery, the WHO recommends implementing SIAs for supplemental measles doses, through campaigns that cover a wider age group, in order to increase the immunity level among children under age five and control or eliminate measles. WHO recommends that supplemental campaigns should be conducted every three years and that they should be integrated with other high-impact child health interventions and not conducted as standalone activities.



A nurse administering vitamin A at Holy Family Hospital in Phalombe

In 2010 there was a measles outbreak in Malawi that resulted in a reported total of 118,712 measles cases and 249 deaths, representing a case fatality rate of 0.21%. Consequently, the MOH conducted a measles campaign to contain the outbreak and a series of follow-up Child Health Days in July 2013. Malawi's routine immunization coverage rate is 88% for the first dose of measles vaccine. The MOH initially planned in November 2013 to integrate a measles campaign with the polio vaccine campaign because there were not adequate resources for integration with other child health interventions.

Then USAID was called upon to support the MOH with funding to cover a campaign that would integrate nutrition interventions into the measles and polio vaccine campaign. According to the 2010 Malawi Demographic and Health Survey, 13% of all children are malnourished. The nutrition interventions that were to be included in the campaign were distribution of deworming tablets and vitamin A supplementation, which are critical to improving the nutritional status of children. The global recommendation is to supply vitamin A and deworming tablets every six months to all children under the age of five. November 2013 was an ideal time for the nutrition interventions to be included in the campaign because the last series of Child Health Days had occurred in July.



Women visiting Chambe Health Center in Mulanje to vaccinate their children

Through MCHIP, USAID supported the national launch of the integrated campaign, training more than 1,600 health workers in the northern region and orienting more than 650 district officials. In addition, MCHIP supported social mobilization activities for the campaign,

including 140 drama performances, briefings of 28 major media houses, and construction of two floats that stopped at all trading centers on the way from Mulanje and Mwanza to Blantyre, the site of the national launch.

With support from USAID, through MCHIP, Malawi's integrated measles and polio vaccination campaign was a great success, with high coverage for all four high-impact child health interventions in all 29 districts of Malawi, averaging coverage rates of 100%. Interventions like these offer comprehensive child health care to Malawian children and help to prevent the spread of diseases.

“JUST LIKE GETTING CIRCUMCISED AT HOME” A MARRIED MAN’S STORY OF GETTING CIRCUMCISION SERVICES THROUGH AN INNOVATIVE “DOOR STEP” DELIVERY APPROACH



Our Choice Together: Kizito and his wife, Triza, holding their baby at their home



Kizito getting through the circumcision procedure

Thyolo, Malawi – When the outreach roadshow advertising free male circumcision services arrived in the village of Helimani, Kizito Liyasi was curious enough to attend an information session. A grocer with a wife and baby boy, Kizito was moved by a man’s personal decision to be circumcised as part of a comprehensive strategy to prevent the spread of HIV. He headed home to discuss the free health service with his wife.

Along the way, Kizito met several male friends who dissuaded him from undergoing the procedure, arguing that he didn’t need to be circumcised because he was married. Kizito’s wife, Triza, saw it differently, sharing with him the health benefits of circumcision that a local nurse had explained to her. A group education session at the nearby Ntambanyama CBO provided further information for the 20-something father. Together, he and his wife decided that medical male circumcision was right for their family. “I was convinced I needed to do this,” he says.

Kizito is among the 3,416 men who were circumcised during the three-week-long Jhpiego-led voluntary medical male circumcision (VMMC) campaign in Thyolo district that ended April 5. The campaign was implemented under MCHIP in collaboration with the Christian Health Association of Malawi and the Malawi Ministry of Health (MOH).

Kizito is older than most of the clients who participated in the services held at Thyolo District Hospital, Malamulo Mission Hospital, and Nkusa and Ntambanyama CBO centers. But, as he rightly stated, age shouldn’t be a factor in choosing VMMC. “It is not about how old you are; as for me it is about focusing on the high benefits of circumcision. It’s never too late for my hygiene and safety. It’s just the right time. I can protect my wife from cervical cancer. It’s more than a choice to me. It’s a responsibility,” says Kizito, who queued up for services with the younger clients and talked with them during the group education sessions.

For Kizito, the convenience of getting the service at the local Ntambanyama CBO, an outreach site near to his home and a place that is not a regular health facility, added to his motivation. “It is like the hospital came to my village. I couldn’t ask for more with the service available for free. I knew I could easily walk a short distance back home after the procedure. In a way, you can say it is like I have been circumcised at home,” explains Kizito.

The campaign's innovative and comprehensive approach to circumcision and the input from his wife jointly influenced Kizito. The group education sessions he attended dispelled myths about circumcision he had heard and educated him on VMMC's health benefits. "All my life I had never thought about getting circumcised. What for? It was not part of my culture and religion," says Kizito, adding that stories and hearsay linked circumcision to sexual pleasure and certain cultures and religious sects.

But the conversation with his wife proved most persuasive. To Kizito's surprise, Triza had no reservations. She was happy to encourage him and even shared her knowledge about the benefits of male circumcision:

"During one of my antenatal visits, the nurse at the hospital was teaching us about cervical cancer. She mentioned that male circumcision helps reduce the chance for cervical cancer as well as penile cancer and, most importantly, HIV...I never told my husband then because I was not sure how he would take it. He might have been angry with me. I was also worried about agreeing to pay around 1,500 Kwacha for the service at Malamulo (Hospital) while we are struggling to get other daily necessities in our home. Now that he initiated the issue himself and the service is being offered freely and near, I encouraged him to go for it for the safety of our family."

Kizito Liyasi's successful participation in the VMMC campaign in Thyolo is a testament to a married man's motivation in choosing circumcision, family decision-making, and a uniquely organized campaign to deliver services at community-based outreach service points in the catchment areas of the static sites. With most of the villages located far from the hospital-based sites, the community-based outreach sites made it more convenient for most clients and created local excitement about the campaign. This innovative approach also helped to reduce the chances of high client turnover at a single site, which could affect the quality output of the providers.

The "doorstep delivery" setup, which provides circumcision services through community-based temporary sites, proved the clincher for Kizito, who likened it to "getting circumcised at home"—a convenient, innovative, and intimate approach that significantly led the campaign to exceed its initial target of 2,500, and providing comprehensive circumcision services to more than 3,000 males in just 17 days.

“WITH THE PEOPLE, FOR THE PEOPLE” APPLAUDING ACTIVE LOCAL LEADERSHIP AND OWNERSHIP OF THE SUCCESSFUL VOLUNTARY MEDICAL MALE CIRCUMCISION CAMPAIGN IN THYOLO

By Joel Suzi



Eager: Men waiting for a male circumcision clinic to open at Thyolo District Hospital



Using local structures: Local chiefs allowed the use of Ntambanyama CBO as a community-based outreach site for medical male circumcision

Thyolo, Malawi – An air of expectation and eagerness was evident as young and adult men filed in to get circumcised at Thyolo District Hospital, Malamulo Mission Hospital, and Nkusa and Ntambanyama CBOs. The same level of excitement was apparent in the communities surrounding the service points when the voluntary medical male circumcision (VMMC) campaign was conducted in Thyolo district under the USAID-funded Maternal and Child Health Integrated Program (MCHIP) in collaboration with the Christian Health Association of Malawi and the Ministry of Health (MOH). Community leaders and their people worked with the District Health Office and other partners to sensitize community members and ensure the functioning of community-based sites.

The focus on and interest in a localized campaign was inspired and driven by a coordination approach led by the local District Health Officer. While Jhpiego and other external partners assisted with technical and material resources from the training of providers to equipment and supplies, the campaign was spearheaded by local stakeholders at community and district levels. “The idea to have the campaign in our district started and was nurtured locally and the other partners only came in to support already existing enthusiasm,” explains Dr. Andrew Likaka, DHO for Thyolo.

Before awareness activities led by the JHU-CCP BRIDGE II Project were rolled out, district health authorities had already started engaging community leaders and holding awareness meetings in the communities. Later, they involved MOH and MCHIP in meetings with traditional leaders, school teachers, and community health and development groups to encourage support ahead of the campaign. Letters of notice were sent around the villages and workplaces, especially to tea plantations.

The Thyolo DHO elaborates how local champions built local trust and ownership from the start through to the end and defined the success of the campaign. “We knew where to set up outreach sites to get many clients as well as when most people are not busy in their gardens or the plantations.” The district and community teams are familiar with the local area; thus, they were in the best position to decide the locations for service sites and appropriate timing of services and to define the community’s specific needs and approaches.

“There have been cases where other programs have failed to draw popular support when outside partners went to the communities on their own without district level leadership...especially on such culturally delicate sexual and reproductive health topics.” Staying in the district and regularly interacting with community leaders and groups gives the district health authorities an advantage in earning local trust. Support for the cause is more likely than it would be if external organizations introduced the idea to the people. Considering this background, the Thyolo district health officials went ahead of MCHIP and Ministry of Health central officials to mobilize local stakeholders.

“The chiefs and community groups addressed meetings about the campaign and allowed us to operate outreach sites within their local CBOs considering our existing amicable relationship strengthened through collaboration on other health campaigns.” Most significantly, community leaders stirred community participation and allowed use of community-based structures in which outreach sites were established. With most of the villages located far from the static sites, the community-based outreach sites guaranteed close and convenient access to the VMMC services, which encouraged most potential clients to show up. Not surprising, 3,416 men were circumcised in just 17 days, exceeding the initial target of 2,500.

Looking ahead, Thyolo district intends to apply the lessons from the recently concluded campaign to planning for another round with wider coverage and to re-strategize routine services at the district hospital and other health centers. “The district and communities are already organized, the demand is still there, and we expect the same level of partnership with Jhpiego and others to bring in their valued support for wider access,” concludes Dr. Likaka, Thyolo District Health Officer.

IMPROVED INFECTION PREVENTION BY ENGAGEMENT OF COMMUNITIES, HEALTH WORKERS, AND MANAGEMENT AT MLALE COMMUNITY HOSPITAL

Reports by health workers and findings of initial assessments identified the following key challenges contributing to the risk of infection in most of the health facilities in Malawi: lack of training or orientation of health workers, support staff, management, and communities on IPC; poor or lack of dissemination of IPC standards; and lack of materials for hygiene, cleaning, and waste disposal.

With funding from USAID, MCHIP has been collaborating with the Malawi Ministry of Health (MOH) to implement a performance and quality improvement initiative in infection prevention, aimed at improving infection prevention practices in health facilities in order to reduce the risk of infection transmission to clients, providers, and the community.

One of the facilities supported in this initiative is Mlale Community Hospital in Lilongwe district in the Central Region of Malawi. Before the initiative, the facility reported inadequate availability of IPC resources and supplies such as buckets, brooms, brushes, mops, detergents, and gloves. In addition, there was frequent blockage of the toilets because patients and guardians were using items such as maize cobs and stones when using the toilets. This practice resulted from patients' and community members' lack of knowledge of how to use water toilets because no initiative had been made to familiarize patients and guardians with the toilets.

In response, MCHIP collaborated with the DHO and Mlale Health Center authorities to conduct supportive supervision and assessments and engage stakeholders through Quality Improvement Support Teams (QISTs) consisting of health workers, support staff, management, and community members. As a result of this engagement, the management of the Mlale Hospital was able to purchase some IPC supplies. To address the problem of toilet blockage, the facility educated the community on how to use the toilets and the hospital management agreed to subsidize the cost of toilet paper. These collaborative initiatives have tremendously improved the situation at Mlale. The service rooms, wards, and the grounds are manifestly clean and there are no more blockages of toilets!

Annex 3: List of Materials and Tools Developed or Adapted by the Program

- In depth National Surveillance Review
- Comprehensive review of EPI program
- National Report for Integrated EPI Supportive Supervision
- Closeout Report October 2009 - February 2012
- EPI Pre-Service and In-Service Training Needs Assessment Report
- Malawi Experience on PMTCT-MNCH Integration
- MH and Community Interventions
- Field manual for Introduction of Rotavirus vaccine
- Improving Maternal and Newborn Health in Malawi Communities
- Improving Quality of Infection Prevention and Control Practices in Malawi