

CFPHS Quarterly Report No. 3 - April – June 2008

Community-Based Family Planning and HIV/AIDS Services (CFPHS) Project

July 2008

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Community-based Family Planning and HIV & AIDS Services in Malawi

Quarterly Report No. 3



Quarterly Report for April –June 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by staff members of the Community-based Family Planning and HIV & AIDS Services in Malawi project.

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Community-based Family Planning and HIV & AIDS Services (CFPHS) in Malawi will contribute to reducing Total Fertility Rates and improving HIV and AIDS services in rural communities.

USAID/Malawi’s Community-based Family Planning and HIV & AIDS Services (CFPHS) Program provides a much-needed opportunity to assist the Government of Malawi in its efforts to improve the lives of the largest segment of its population (about 84 percent) who live in rural areas of the country. The MSH team has been working closely with the Ministry of Health (MOH) to strengthen family planning (FP) services and is designed to achieve sustainable results in the eight USAID-targeted districts.

The MSH, CFPHS Approach

Management Sciences for Health (MSH) and its subcontractors—Population Services International (PSI) and Constella Futures (CF)—offer proven technical approaches and tools to work with the MOH to reposition FP and to improve (i.e., increase) HIV & AIDS services in rural communities of the eight target districts. We expect that by 2010, the project will have increased the use of integrated, high-quality, accessible family planning/reproductive health (FP/RH) and HIV & AIDS services. The target groups include Malawian women, men, and young people. Program activities span all four intermediate results of USAID’s strategic objective of “increased use of improved health behaviors and services.”

To achieve project outcomes, two strategies will be employed:

- Create demand and outreach through behaviour change communication (BCC) and community networks. This strategy is based on the traditional manner in which Malawian communities address priority problems or common needs. Thus the provision of FP/RH and HIV & AIDS services will become demand-driven and sustainable.
- Define and develop the supply and capacity of community-based distribution agents (CBDAs) and providers from health centres, dispensaries, and referral hospitals in both the public and private sectors.

Project activities are therefore in keeping with these two strategies. Achievement of project outcomes will be monitored through a selection of indicators to be outlined in the Performance Management Plan.

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ACRONYMS

AIDS	acquired immune deficiency syndrome
BASICS	Basic Support for Institutionalizing Child Survival
BCC	behaviour change communication
CBDA	community-based distribution agent
CF	Constella Futures
CFHPS	Community-Based Family Planning and HIV/AIDS Services
CHAM	Christian Health Association of Malawi
CYP	couple of years of protection
DC	District Coordinator
DELIVER	A John Snow, Inc. (JSI) project
DHMT	District Health Management Team
DMPA	Depo Provera [®]
FP	family planning
GBV	gender-based violence
HEU	Health Education Unit (of the Malawi Ministry of Health)
HIV	human immunodeficiency virus
HSA	health surveillance assistant
HTC	HIV testing and counselling
IC	injectable contraceptive
IEC	information, education, and communication
LMIS	logistics management information system
M&E	monitoring and evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	nongovernmental organization
OC	oral contraceptive
PMTCT	prevention of mother-to-child transmission
PSI	Population Services International
RH	reproductive health
RHU	Reproductive Health Unit (of the Malawi Ministry of Health)
S&S	Simplify and Start
SDP	service delivery point
SPS	Strengthening Pharmaceutical Systems [Program]
STI	sexually transmitted infection
TA	technical advisor
TB CAP	Tuberculosis Control Assistance Program
TBD	to be determined
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

EXECUTIVE SUMMARY

The Community Family Planning and HIV & AIDS Services Project (CFPHS) has effectively moved from a preparatory stage, in which consultations were the predominant activity, to the implementation of program activities. During the third quarter of the program, CFPHS has seen the recruitment and training the first group of community-based distribution agents (CBDAs), conducting the program baseline survey, completion of staff recruitment, participation in a trip to Madagascar, supervisory trips to the field, and a continuation of collaborative efforts with the Basic Support for Institutionalizing Child Survival (BASICS) Project, the Strengthening Pharmaceutical Systems (SPS), S&S, and to some extent, the Tuberculosis Control Assistance Program (TB CAP).

Seven districts completed the training of the first group of CBDAs and sent them into the communities that had selected the trainees to begin providing family planning (FP) and HIV & AIDS services.

In total, 187 CBDAs were trained in the first group from districts of Balaka, Chikwawa, Karonga, Kasungu, Mangochi, Nkhosachota, and Phalombe. The only targeted district that has not trained CBDAs is Salima, primarily because of delays in identifying a suitable candidate for the position of District Coordinator (DC) and lack of transport. The issue of transport has been under discussion; a vehicle has been found by USAID and as soon as it is delivered, training will start in Salima.

The CBDAs have been well received in their catchment areas and have begun their work. Many of them have started community sensitization and, in most areas, have also started providing methods and doing referrals for FP.

In addition to training CBDAs, the training efforts also involved the primary and secondary supervisors of CBDAs (nurses, medical assistants, pharmacy technicians, and in some cases, clinical officers). Behaviour change and communication (BCC) and gender-based violence (GBV) have been incorporated in the CBDA curriculum and are being taught by the Communication/Gender Specialist.

The baseline survey, which dominated the activities of the second quarter, finally reached the implementation phase during this quarter. The survey was conducted by a consultant hired by CFHPS. The survey team helped to refine the survey instruments further and pretested them before going into the field to collect data. Both quantitative and qualitative data were collected and analyzed, and reports have since started coming in, although the program has faced a challenge in the production of the reports due to unforeseen circumstances. The results of this survey will be incorporated into the Detailed Implementation Plan, which is the main guiding document in the implementation of this program.

The program finalized the recruitment of the remaining staff and now has a full complement. The staff now includes the DC for Salima, the Policy/Advocacy Specialist, two administrative assistants, and a driver. As a result of the completion of the recruitment process, training in Salima will commence early in the next quarter, and we anticipate that the district will complete the two planned training sessions before the end of Year One. All the district offices have been furnished to provide a favourable working environment.

The program continues to complement other Management Sciences for Health (MSH) programs and benefits from the relationship. This relationship has helped tremendously in ensuring an MSH presence in all the eight target districts and provided a smooth take-off for all program activities in the non-CFPHS program presence districts. Through innovative approaches, MSH management has developed a joint quarterly work plan, which is being managed by a single coordinator in the BASICS and CFPHS shared districts. Supportive supervision is also helping to strengthen and consolidate implementation of both BASICS and CFPHS activities. This approach is proving cost effective in terms of capital and human resource investment. The SPS Project has also been working in close collaboration with the CFPHS program in looking into and advising on training CBDAs in storage and distribution of contraceptives. In the future, the program will assist with supervisory skills in storage and distribution of pharmaceuticals. The program is still exploring ways in which other programs could benefit the CFPHS program and vice versa.

The study tour to Madagascar was implemented during this quarter. Many lessons were learned, and a full report is expected to be disseminated along with studies conducted by the Health Policy Initiative project, which examined the use of community health workers in administering injectable contraceptives (IC). The dissemination meeting is planned early in the next quarter.

The major challenge is that transport for the CBDAs is likely to be a problem. The program does not have enough funds to procure bicycles for the 1,000 CBDAs to be trained by December 2008. The current 187 trained CBDAs do not have bicycles to enable them to cover their catchment areas. This problem, if not resolved, may lead to de-motivation and attrition among CBDAs.

PLANNED ACTIVITIES AND CFPHS ACHIEVEMENTS FROM APRIL TO JUNE 2008

Planned activities for the third quarter and what was achieved are summarized in table 1.

Table 1. Summary of Planned Activities and Associated Achievements during the Reporting Quarter

No.	Planned Activities	Achievements	Comment
1	Recruit and train CBDAs and their supervisors by districts	Trained 187 CBDA out of the annual target of 410 CBDAs Trained 56 supervisors out of the targeted 50 for Year One	The first session was completed in seven districts (all except Salima).
2	Facilitate training of CBDAs and CBDA supervisors	Trained 187 CBDAs and 56 supervisors	.
3	Recruit and deploy remaining district-based staff	Finalized recruitment of one DC and one administrative assistants	All staff have assumed their positions in the eight districts.
4	Conduct baseline survey, data processing, analysis, and reporting in all target districts	Designed, planned, and conducted baseline survey in all eight targeted districts	Data analysis and report writing are in process.
5	Facilitate dissemination meetings of baseline findings	To be carried out in next quarter	Draft reports are in process.
6	Conduct planning and implementation meeting with MOH, subcontractors, and the District Health Management Team (DHMT)	At the national level, various Technical Working Group (TWG) meetings were held with subcontractors and MOH. At district level, meetings were held with DHMT during supervisory visit and with DCs.	
7	Develop an integrated BCC strategy	Developed a draft GBV module and circulated it for final review to counterparts Reviewed and translated the "Interpersonal Communication for Behavior Change" module (second draft)	The activity awaits final review by MOH and other stakeholders.
8	Ensure that adequate contraceptives, sexually transmitted infection (STI) medicines, condoms, and HIV testing and counselling (HTC) kits are available at facility level	Conducted a monitoring and supervisory visit to one district and verified stock status	National reports of the HIV TWG indicated stock-outs of HTC kits and STI medicines.
9	Facilitate translation, printing, and distribution of job aids in FP, STI, and prevention of mother-to-child transmission (PMTCT) (e.g., Tiahrt posters)	Printed job aids for CBDAs training	A total of 600 copies were translated into Chichewa and are awaiting clearance in country.
10	Institute joint monitoring visits and facilitate monthly and quarterly joint program reviews	Conducted joint monitoring and supervisory trips to the field	
11	Support trainings; updates; and	Participated in a study tour to	Report and

No.	Planned Activities	Achievements	Comment
	workshops, meetings, and study tours for FP, HIV, STI, and BASICS staff	Madagascar	dissemination findings will be undertaken next quarter.
12	Facilitate monthly district supervision feedback meetings (DHMT, supervisors and coordinators, CBDA supervisor, and technical advisors [TAs])	Facilitated quarterly meeting with district staff for a participatory development of the July-to-September budget and work plan	
13	Develop and disseminate stories and highlights	Produced two success stories for dissemination and publicity	The stories will be considered for posting on the MSH website and are included the quarter 3 report.
14	Produce and review monthly financial reports	Produced and shared monthly financial reports	
15	Conduct operational policy barriers research	Research conducted in two districts	Final report will be produced by next quarter.

DETAILS OF CFPHS ACHIEVEMENTS IN THE QUARTER

Recruitment and Training of CBDAs

- The CBDA training started at the end of April, following the finalization of training materials, teaching aids, and logistic arrangements.
- Preparation for the training was assisted with the support of partners from USAID/DELIVER, the Reproductive Health Unit (RHU) of MOH, DHMTs, and communities from respective districts.
- No training was done in Salima, the eighth district, since the DC was just deployed for duties during the third quarter. Trainings have been planned for next quarter.
- According to plan, 410 CBDAs are targeted for training, about 51 per district, by the end of the first year. By the end of the reporting quarter, seven districts had completed the first session of trainings (table 2 below), and a total of 187 CBDAs had been trained. Thirty-one primary supervisors, 24 secondary supervisors, and 7 primary technicians also received training.



Figure 1. Discussing FP topics, “Kulera,” during a CBDA training (*photo by Deliwe Malema*)

Table 2. The Cadre and Numbers of Trainees in the Ongoing CBDA Training as of June 2008

District	Dates of Training	Cadre	Female	Male	Total
1. Karonga	April 27 to May 17, 2008	CBDA's	13	13	26
		Primary Supervisor	0	4	4
		Secondary Supervisor	3	0	3
		Primary Technician	0	1	1
2. Nkhotakota	April 27 to May 17, 2008	CBDA's	3	24	27
		Primary Supervisor	0	4	4
		Secondary Supervisor	3	0	3
		Primary Technician	0	1	1
3. Kasungu	May 4–24, 2008	CBDA's	6	20	26
		Primary Supervisor	0	4	4
		Secondary Supervisor	2	2	4
		Primary Technician	1	0	1
4. Mangochi	June 1–20, 2008	CBDA's	8	23	31
		Primary Supervisor	0	3	3
		Secondary Supervisor	3	0	3
		P. Technician	0	1	1
5. Balaka	June 1–20, 2008	CBDA's	12	14	26
		Primary Supervisor	0	4	4
		Secondary Supervisor	3	0	3
		Primary Technician	1	0	1
6. Phalombe	May 4–24, 2008	CBDA's	16	9	25
		Primary Supervisor	2	6	8
		Secondary Supervisor	5	0	5
		Primary Technician	0	1	1
7. Chikwawa	June 1–20, 2008	CBDA's	2	24	26
		Primary Supervisor	0	4	4
		Secondary Supervisor	0	3	3
		Primary Technician	0	1	1
Cumulative totals by gender		Cadre	Female	Male	Totals
		CBDA's	60	127	187
		Primary Supervisor	2	29	31
		Secondary Supervisor	19	5	24
		Primary Technician	2	5	7

Source: CFPHS Project, June 2008.

Conducting Program Baseline Survey in All Eight Targeted Districts

- A consultant for the baseline survey was recruited, and the HIV & AIDS Advisor served as the field supervisor.
- Study instruments were drafted, reviewed, pilot-tested, finalized, and printed for application in the field.
- Data collection in all eight targeted districts, entry, and processing ended by the first week of June. Draft reports are being edited for finalization, and plans are underway for utilization and dissemination of the study findings.

- Unforeseen constraints in final production of the survey reports have led to similar late timing for incorporating the study results into the Detailed Implementation Plan.

Completion of Staff Recruitment, Deployment, and Induction of District-based Staff

- All district-based staff have been recruited and deployed to their respective locations. The newly recruited staff are the DC and administrative assistant in Salima, and the Policy/Advocacy Specialist, one administrative assistant, and a driver in Lilongwe. The Monitoring and Evaluation (M&E) Advisor was also replaced after announcement and interviews during the reporting quarter.
- DCs and administrative assistants came to the central office in Lilongwe for programmatic, financial, and administrative orientation to ensure a smooth start-up of programs in districts. Technical, financial, and administrative staff at the central office took turns explaining aims and objectives of various programs under MSH in Malawi, financial procedures, and administrative policies.

Documented the MOH Decision to Allow Health Surveillance Assistants to Provide Injectable Contraceptives

As part of an effort to document the policy decision-making process, we met in May with several MOH personnel who were present at the senior management meeting in March 2008—the meeting at which the decision was made to allow health surveillance assistants (HSAs) to provide ICs. We produced a report from these discussions; the project will use the information to better understand the policy- and decision-making process including the decision rationale, processes involved for consensus building, arguments for and against the decision, and proposed steps for implementation. The report is still in draft but will be finalized in mid-July 2008.

Conducted Operational Policy Barriers Research

In May the program conducted research in Salima and Zomba regarding operational policy barriers in districts where HSAs are already providing ICs (prior to the MOH decision in March 2008). This research will be used to identify potential barriers to full scale-up and implementation of a community-based distribution strategy using HSAs and potentially other community-level health workers, such as CBDAs.

- Salima and Zomba constituted part of the best practices research regarding current experience at the district level. The team interviewed HSAs in both districts that had been administering ICs for a number of years—since 1999 in Salima and since 2002 in Zomba.
- Both districts allow HSAs to provide ICs only in those areas where a Roman Catholic Christian Health Association of Malawi (CHAM) facility is the only health centre in the area—and it doesn't provide FP services. Both districts reported that the demand for contraceptives in these areas was quite high, and they therefore felt compelled to devise a

solution for women in these areas to save them the long commute to another health centre.

- As a matter of clarification, not all HSAs in Salima and Zomba are allowed to provide ICs, only those in areas that lack alternative sources for FP services. Both districts reported that they have not been informed of any adverse effects related to IC administration by HSAs. The operational policy barriers report is still in draft, but will be finalized in mid-July 2008.

Participated in the Study Tour to Madagascar

The FP TA participated in a week-long study tour in Madagascar. One of the objectives of the Malawi delegation visiting Madagascar was to gain firsthand experience of Madagascar's efforts in using CBDAs to provide Depo Provera[®] (DMPA).



Figure 2. A field visit to one of the CBDA in Madagascar (photo by Deliwe Malema)

The key lessons learned from the study tour include that—

- The MOH in Madagascar made a firm decision to use CBDAs to provide DMPA
- The CBDA is an existing programme within FP; the programme uses approved training materials
- CBDAs are provided with kits that contain various requirements for their job
- Madagascar has an integrated data collection and reporting system
- Reporting rates are as high as 89 percent

Plans are underway, early next quarter, to conduct a stakeholders meeting for a briefing of the findings and to set steps for the way forward.

Conducted Supervisory Field Trips and Assessed Performance of Newly Trained CBDAs

After training CBDAs, a few districts have demonstrated remarkable performance in recruitment of new clients, making referrals for other methods, and conducting counselling sessions and introductory meetings. This performance was also ascertained in Nkhotakota district where the following achievements were recorded by one CBDA:

- For the month of June, four new clients were registered; the CBDA had distributed Lofemenol to three of them, and one client was effectively referred for DMPA.
- In the same period, the CBDA had conducted group and individual counselling; however, the number for individual, one-to-one counselling, was not quantified. Thirty women attended the conference. The CBDA had also addressed a group of 197 students at a secondary school.

Please see annex 1 (“Success Story 1: One CBDA’s Work in Nkhotakota District”) for further details.

Held Partnership, Technical, and Subcontractors Meetings

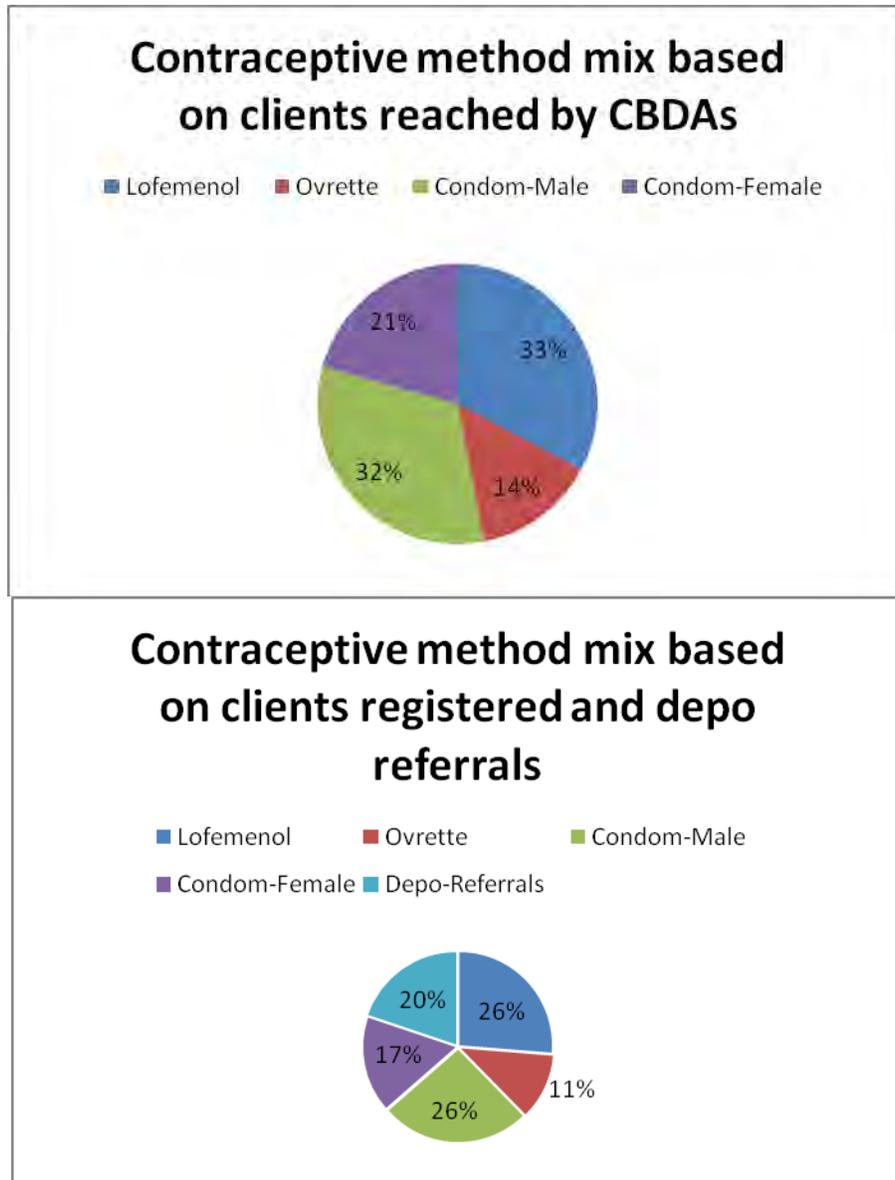
- District sensitization meetings on the MSH program were held with DHMT and District Executive Committees. Similar meetings were conducted with community leaders and partners who assisted in the process of selecting CBDAs, identifying suitable venues, and handling other related logistics for CBDA training.
- Joint planning meetings for CBDA training were held with the RHU of the MOH and USAID/DELIVER. The meetings helped identify CBDA trainers and logistics content appropriate for CBDA level.
- A meeting with subcontractors (PSI and CF) was held in Lilongwe to discuss the status of program implementation, communication, and other program issues. As implementation begins to pick up, such meetings will become routine to keep all parties up to date with program activities.

Other Related Developments

Measurement of Program Performance Based on Core Indicators

- With reference to table 3, the program performance has been measured during the quarter and compared to set targets.

- Based on the group sessions and meetings that were organized, it was reported that a total of 15,263 people had seen or heard a specific FP and RH message.
- In total, 98 counselling visits for FP and RH were carried out. Of the visits, 57 were for female and 41 for male counterparts.
- Within a month of CBDA activities, they managed to register new clients for oral contraceptives and for male and female condoms, and the CBDAs made referrals for DMPA. The method mix is represented in figure 3.



CBDAs in three districts (N=79)

Figure 3. The Method Mix.

Only three districts out of the seven submitted reports on service new clients and contraceptive dispensed in the month. This represents 79 CBDAs from the 187 trained (about 42 percent). The three reporting districts are the ones that had completed training in May, and the CBDAs were able to register clients for the month of June. Progressive improvement on contraceptive usage and contribution to couple years of protection by districts will be tracked over the time period of CBDA initiative.

Produced Two Success Stories on CBDA Performance

With technical guidance from the Communications Specialist from MSH-Boston, a success story based on the initial three months of activities of the CBDA was produced (annex 1). Guidelines and formats for producing success stories were shared with DCs. A story from Balaka district has also been developed for further dissemination (annex 2). Collaboration with the Communications Specialist from MSH-Boston will be maintained for further highlights of success stories using various channels including the MSH website.

BCC, GBV Modules, and Inventory of IEC Materials

- The content for BCC was drafted and translated to Chichewa. It was shared with RHU for final review before adopting the module for use in training CBDAs.
- Development of the GBV module has been completed and reviewed. Feedback from stakeholders has been received and will help in finalizing the development of a manual. We also anticipate that a local gender consultant will be identified to ensure the integration of FP, HIV & AIDS, and GBV discussions in the manual.
- The Communication/Gender Specialist was in Lilongwe to familiarize herself with the program and meet other stakeholders. She was introduced to the MOH's Health Education Unit (HEU) and RHU. The HEU shared electronic copies of FP messages and materials. Strategies for a review and update of the information, education, and communication (IEC) messages and materials were initiated.

Quarterly Planning Meeting

- The CFPHS team developed a quarterly work plan for July to September with budgets in consultation with the districts.
- The CFPHS and BASICS programs developed a joint quarterly work plan that will facilitate resource sharing and supervision of activities.
- Monitoring approaches and structures were presented to DCs during a quarterly meeting. A consolidated quarterly reporting format covering both BASICS and CFPHS was introduced.
- The meeting offered an opportunity to review performance in the previous quarter, share experiences and challenges, jointly work out strategies to resolve problems that were

identified, and prepare consolidated work plans and budgets for the following quarter (July to September).

CONSTRAINTS TO PROGRAM IMPLEMENTATION

- Each CBDA's large coverage area presents a challenge, calling attention to transport necessities (i.e., bicycles) for their movement and justifying the need for more community staff of their calibre.
- Procurement of supplies and commodities must meet the demand of such essential working equipment at community level, as in the example of backpacks for CBDAs.
- The existing data management system is notably weak at the district level, and that weakness affects data quality from lower levels of the health centre and communities.

LESSONS LEARNED AND STRATEGIC OPPORTUNITIES FOR FUTURE WORK

Expanding FP and HIV & AIDS Services at the Community Level

- *Close the gender gap in recruitment of CBDAs.* In the second intake of CBDA training, selection criteria is being reviewed to accommodate opportunities for recruitment of more female CBDAs than was done in the first session.
- *Create demand for CFPHS.* At the community level, newly trained CBDAs and their supervisors are already creating demand by reaching out to the families with counselling messages and providing oral contraceptives in their respective villages. In a few centres, as reported and observed in one district, shortages of contraceptives were experienced as a result of the demand created. Logistic measures have been revised to maintain the required stock status.
- *Address the problem of the great distances between villages and clusters in the CBDAs catchment areas.* Currently, coverage areas for the CBDAs necessitate long travelling distances, as far as 20 square kilometres. Plans for training more CBDAs will reduce the workload and coverage areas, but the short-term need is for bicycles for the CBDAs. Bicycles should also be supplied with incentives, such as T-shirts, which MSH is in the process of procuring.
- *Advocate for CBDA provision of ICs.* Various dialogue will be used to generate discussion and policy review on CBDAs administering ICs.

Strengthen the Monitoring, Reporting, and Evaluation System

- *Conduct baseline survey.* Results of the baseline survey will assist in revising key indicators for tracking program performance. The other goals for direct utilization of the results include developing and updating BCC messages and materials.
- *Initiate timely reporting and maintenance of records.* CBDAs must use good reporting and archiving practices after completion of training has reinforced their commitment.
- *Improve on reporting of activities by CBDAs.* Effective reporting ensures good coverage for the numbers of people reached with FP, RH, and HIV messages. The actual numbers reached must be recorded by gender.
- *Develop a follow up mechanism.* Missing and unreported data must be tracked down to achieve high reporting rates.
- *Revise and standardize reporting.* Formats from district level should be adopted for systematic consolidation.

MAJOR PLANS FOR NEXT QUARTER

Major activities planned for next quarter include the following:

- Use and disseminate baseline survey results
- Train CBDAs—second session
- Complete of the Detailed Implementation Plan and incorporate the baseline findings
- Revise and maintain reporting tools; strengthen database management from district level, including strengthening of monitoring, supervision, and logistics for HIV test kits.
- Advocate for policy change for provision of IC by CBDAs
- Train CBDAs as HTC site counsellors
- Disseminate the Madagascar study tour findings
- Design protocols for piloting HTC by CBDAs and administration of ICs by HSAs
- Finalize reports on (1) documenting MOH decision to allow HSAs to provide ICs and (2) operations policy barriers research
- Translate baseline survey results into IEC materials at a workshop to be facilitated by PSI

TABLE AND ANNEXES

Table 3. Program Performance for the Third Quarter Using Key Indicators and Service Statistics

No.	CFPHS Indicators	Disaggregated by	Targets		Achievements to Date		Comments
	A. FP and RH Services		Over the Life of the Project	During Project Year One	No.	Percentage of Project Year One Target	
1	Number of new approaches (e.g., tools, technologies, operational procedures, information systems) successfully introduced		TBD	2	0	0	New approaches are under review and development.
2	Couple years of protection (CYP) in USG-supported programmes		TBD	73,316	0	0	Clients usage data started being recorded in June.
3	Number of people trained in FP and RH (with USG funds), both men and women	Total	TBD	450	201	44.7	
		Male	TBD	225	139	61.8	
		Female	TBD	225	62	27.6	
4	Number of counselling visits for FP and RH as a result of USG assistance, both women and men	Total	TBD	25,000	98	0.4	Activity registration started in June.
		Male	TBD	12,500	41	0.3	
		Female	TBD	12,500	57	0.5	
5	Number of people that have seen or heard a specific FP and RH message	Total	TBD	300,000	14,341	4.8	
		Male	TBD	150,000	3,451	2.3	
		Female	TBD	150,000	10,890	7.3	
6	Number of policies or guidelines developed or changed to improve access to and use of FP and RH services		TBD	1	0	0	Policies are under review.
7	Number of USG-assisted service delivery points (SDPs) providing FP counselling or services		TBD	45	0	0	To be determined
8	Number of USG-assisted SDPs experiencing stocks-outs of specific tracer medicines		TBD	30	0	0	To be verified

No.	CFPHS Indicators	Disaggregated by	Targets		Achievements to Date		Comments
			Over the Life of the Project	During Project Year One	No.	Percentage of Project Year One Target	
9	A. FP and RH Services Number of people reached through community outreach that promotes HIV & AIDS prevention through abstinence, being faithful, or both	Total	TBD	55,000	1,299	2.4	Only three districts have started implementation.
		Male	TBD	27,500	266	1.0	
		Female	TBD	27,500	1,033	3.8	
10	Number of people trained to promote HIV & AIDS prevention through other behaviour change beyond abstinence, being faithful, or both	Total	TBD	16	0	0	Planned for next quarter
		Male	TBD				
		Female	TBD				
11	Number of individuals reached through community outreach that promotes HIV & AIDS prevention through other behaviour change beyond abstinence, being faithful, or both	Total	TBD	55,000	0	0	Planned for next quarter
		Male	TBD				
		Female	TBD				
12	Number of people trained to promote HIV & AIDS prevention through other behaviour change beyond abstinence and being faithful	Total	TBD	8	0	0	
		Male	TBD				
		Female	TBD				
13	Number of targeted condom service outlets		TBD	8	0	0	Under conceptualization
14	Number of individuals trained in HIV-related stigma and discrimination reduction	Total	TBD	250	187	74.8	
		Male	TBD	125	127	101.6	
		Female	TBD	125	60	48.0	
15	Number of service outlets providing counselling and testing according to national and international standards		TBD	8	0	0	
16	Number of individuals trained in counselling and testing through FP project according to national and international standards	Total	TBD	16	0	0	Planned for next quarter
		Male	TBD		0	0	
		Female	TBD		0	0	
17	Number of individuals counselled and tested for HIV who have received results (excluding TB)	Total	TBD	136,000	1,638	1.2	
		Male	TBD	68,000	1,313	1.9	
		Female	TBD	68,000	325	0.4	

No.	CFPHS Indicators	Disaggregated by	Targets		Achievements to Date		Comments
			Over the Life of the Project	During Project Year One	No.	Percentage of Project Year One Target	
18	A. FP and RH Services Number of local organizations provided with technical assistance for HIV-related institutional capacity-building		TBD	35	0	0	
19	Number of individuals trained in HIV-related institutional capacity-building	Total	TBD	250	0	0	Planned for next quarter
		Male	TBD		0		
		Female	TBD		0		
	B. Supporting indicators (for CYP)						
20	Quantity of contraceptives dispensed by CBDAs						
	Lofemenol						218
	Ovrette						56
	Condom, male						4,003
	Condom, female						71
21	Number of new clients registered by CBDAs						
	Lofemenol						106
	Ovrette						46
	Condom, male						105
	Condom, female						67
	DMPA referrals						80
22	Number of drop-outs						
	Lofemenol						0
	Ovrette						0
	Condom, male						0
	Condom, female						0

Source: District monthly reports (CFPHS)

Annex 1. Success Story 1: One CBDA's Work in Nkhotakota District

Only three weeks after FP and HIV & AIDS integrated training, Emmanuel Chirwa, an articulate 26-year-old newlywed, is able to fully describe contraceptive methods and has already started to meet clients in the villages he serves in Nkhotakota, a rural district in Malawi that has a contraceptive prevalence rate of 28 percent. During a supervision visit, Mr. Chirwa went through a flipchart on FP methods, explaining in detail each contraceptive method, stating confidently that “this is the way I was taught and how I am conducting my counselling sessions.” Mr. Chirwa is one of 1,000 CBDAs that will be trained in FP and HIV & AIDS counseling and contraceptive distribution by the CFPHS Project in eight target districts in Malawi.

The CFPHS project is working with Malawi's MOH to reduce the total fertility rate from 6.0, as reported in Malawi Demographic Health Survey 2004, to 4.9 children per woman in 2010 by increasing the contraceptive prevalence rate from 28.1 percent in 2004 to 40.6 percent by 2010. One of the key strategies to empower women in countries, such as Malawi, that are working to alleviate poverty and improve health standards is to regulate fertility. This effort represents a formidable challenge given that by 2015, Malawi will have an estimated 3.65 million women needing access to contraceptives services. Because more than 80 percent of these women live in remote areas—some 40–80 kilometres away from the nearest health centre and most having no access to transport other than walking—MSH and its partners have devised a new strategy. They are promoting fully functional services to clients in rural areas by revitalizing a network of CBDAs trained in FP and HIV & AIDS integration.

The CBDAs—men, women, and youth—are selected by the traditional authorities, who are community leaders of group villages. The assigned tasks of CBDAs will contribute to lowering fertility while also addressing the high prevalence of HIV. During May 2008, 27 CBDAs and seven supervisors completed the training, which was facilitated by MSH and its partners.

In less than a month, the results are already evident. In a follow-up visit with Mr. Chirwa, one of the newly trained CBDAs, his record book showed that he had already registered four new clients, distributing oral contraceptives to three and referring one to a local hospital for DMPA. He demonstrated almost complete retention of the information on contraceptive methods that he had learned at the training and showed that he was appropriately storing contraceptives in a storage box, as well as keeping his files and records in order.



Figure 4. Newly trained CBDA Emmanuel Chirwa during a visit at his house (*photo by Deliwe Malema*)

Mr. Chirwa had also conducted group counselling with 30 females who had attended a meeting he had convened, and he had addressed a group of 197 students (93 female and 104 male) at a secondary school to share FP and HIV & AIDS messages with them.

Annex 2. Success Story 2: New Hope in Senior Traditional Authority Chanthunya, Balaka District

Ilifa Dalisoni was 46 years old when she had her twelfth child. Five of her children have passed away. Living her life in the Balaka district of Malawi, Ilifa had little access to FP services. Predominantly a rural setting where people have little education, few resources, and poor access to distant health service delivery points, Balaka has a contraceptive prevalence rate of 17.4 percent, compared to the already low national average of 28 percent. In the Senior Traditional Authority of Chanthunya, where Ilifa lives, not only must people travel long distances to the health centre, but the centre is owned by the Catholic church, so it supports only natural family planning methods.



Figure 5. Mrs. Ilifa Dalisoni (the woman on the far left) poses for a picture with some of her children and a CBDA (in red).

Ilifa's struggles are commonplace in regions across Africa where basic health care is not guaranteed, much less FP/RH services. Fifty-eight percent of all married women in Malawi report they use no contraception at all. Among the long list of obstacles—including age, poverty, religion—a lack of access combined with a lack of general knowledge form the greatest barrier for most families.

In June 2008, through the CFPHS Program, MSH trained 26 CBDAs in Balaka. Selected from areas that are a significant distance from health facilities, CBDAs are responsible for providing people living in their catchment areas with education on reproductive health and modern contraceptive methods, immediate access to oral and barrier contraceptives, and referrals to the local health facility.

One of these CBDAs met Ilifa and gave her information on the benefits of family planning as well as a supply of oral contraceptives. Ilifa says she wished the project had come eight years earlier, when she could have used what she learned today to make healthy decisions about her family planning. Her daughters have already been in contact with the CBDA and are learning about the variety of options they have once they reach adulthood.



Figure 6. Mrs. Chrissy Lazaro (second from the right)

Countering negative beliefs about contraceptive methods is an important aspect to improving access to FP. Mrs. Chrissy Lazaro also had 12 children, beginning when she was 15. Three children have since died. Mrs. Lazaro also attributed her current family status to lack of FP services in her area, “if only people could be given adequate information about the benefits of family planning, they would stop avoiding family planning services because of various beliefs they have.”

When recruiting for CBDAs by reaching out to the traditional authorities in Balaka, district and CHPHS staff delivered IEC messages on the importance of FP and the prevention of STIs and HIV & AIDS—a primary concern in a nation where nearly 1 million people die from AIDS annually. Communities showed great interest and were eager to have these services in their communities. Most chiefs pledged to support the program and ensure its sustainability in their communities.

CBDAs trained through the CFPHS program are continuing to deliver those messages. In Balaka, one CBDA, Mr. Machilikia, is being highly praised by his chief and local headman for his efforts. In the month since his graduation, he has already conducted three community sensitization campaigns where he reached out to 151 females and 113 males with FP and HIV & AIDS messages. The Group Village Headmen continue to express their hope that when people are better able to plan their families, they will then be able to focus more on developing their communities.

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