

## **CFPHS Quarterly Report No. 12 and Annual Report October 2009 – September 2010**

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

October 2008

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## Community-based Family Planning and HIV & AIDS Services in Malawi Quarterly Report No. 12



*Delegates from the West African Countries AWARE II Project in the company of CFPHS project staff arriving at the Reproductive Health Unit in Lilongwe at the start of their tour to Malawi.*

### Annual Report Year Three

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 Program in Malawi.

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**Community-based Family Planning and HIV& AIDS Services in Malawi  
Quarterly Report No.12 July – September 2010**

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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 & AIDS services in rural communities.**

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USAID Malawi's Community-based Family Planning and HIV & AIDS Services (CFPHS) Project 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 Management Sciences for Health (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**

MSH and its subcontractors—Population Services International (PSI) and Futures Group International (FGI)—offer proven technical approaches and tools to work with the MOH to reposition FP and to improve access to HIV & AIDS services in rural communities of the eight target districts. We expect that by 2010, the CFPHS will have improved delivery of quality integrated FP /HIV & AIDS services for women, men, and young people. Project activities are in line with USAID Malawi's family planning and reproductive health (FP/RH) portfolio priorities for the next five years in supporting Malawi's strategic priorities as stated in the Joint Program of Work for the Health Sector-wide Approach (SWAp).

To achieve project outcomes, two strategies are being employed:

- Create demand and outreach through behavior 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 centers, 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 are being monitored through a selected list of core indicators as outlined in the Performance Management Plan (PMP).

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## Acronyms

BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavioral Change Communication
CBDA	Community-based Distribution Agent
CFPHS	Community Family Planning and HIV&AIDS Services program
CBO	Community-based Organization
COP	Chief of Party
DC	District Coordinator
DCOP	Deputy Chief of Party
DEC	District Executive Committee
DIP	Detailed Implementation Plan
DHMT	District Health Management Team
DMPA	Depot-Medroxy Progesterone Acetate
FGI	Futures Group International
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
FHI	Family Health International
GOM	Government of Malawi
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HPI	Health Policy Initiative
HPN	Health Population and Nutrition
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counseling
IC	Injectable Contraceptives
IEC	Information Education and Communication
IP	Infection Prevention
LC	Listeners' Club
LTPM	Long-term and Permanent Methods
M&E	Monitoring and Evaluation
MAM	Muslim Association of Malawi
MDHS	Malawi Demographic and Health Surveys
MOH	Ministry of Health
MSCE	Malawi School Certificate of Education
MSH	Management Sciences for Health
NGO	Non Governmental Organization
PMI	Performance Monitoring Improvement
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RH	Reproductive Health
RHU	Reproductive Health Unit
SDM	Standard Days Method
SO	Strategic Objective
STI	Sexually Transmitted Infections
TA	Traditional Authority
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
US	United States
VHC	Village Health Committee

## **Executive Summary**

The CFPHS project has completed the 3<sup>rd</sup> year of activity implementation. As a project, we look back at the past three years with satisfaction knowing that we have contributed our part and have an opportunity to continue directing our efforts to reducing fertility in Malawi and thereby contributing directly to improving the health status of Malawian families. Project Year 3 (PY3) was a period for consolidating the investments made in PY1 and PY2.

PY3 comprises Quarters 9 to 12 beginning from October 1, 2009, through September 30, 2010. During this period the project has consistently reached or exceeded its targets throughout the 4 quarters despite some daunting challenges. In Quarter 2, a Mid-term Evaluation was undertaken which had very positive outcomes. These outcomes in brief include exceeding most of the 19 project targets by the time of the evaluation, managing to provide family planning and HIV and AIDS services to the hard-to-reach and underserved areas. Where targets may not have been reached it was obvious that problems were beyond the reach of the program. A notable area is the HTC area where test kits were in short supply nationwide. Another challenge was the supply of Jadelle and DMPA. In regard to Jadelle and DMPA the short supply could also be attributable to an unexpected uptake in communities which the system was not yet ready for. Corrective measures were taken to increase the orders for these supplies.

On the whole, as a result of these successes, USAID decided to award a contract Modification Number 5 to add funds to the project in order to scale up two activities namely DMPA and HTC Services. DMPA was to be scaled up in all the 8 target districts and HTC services scaled up in 4 selected districts namely Kasungu, Salima, Mangochi, and Phalombe. In HIV and AIDS the project has been requested to scale up training of HTC counselors and increase coverage of HTC services. In addition, nutrition surveillance and TB screening were added to the project.

The success of the project approach in the delivery of HTC services at community level using Community-based Distribution Agents (CBDAs) prompted the National AIDS Commission to support the project with funds for scaling up HTC services in the remaining 4 target districts plus another additional 4 new districts, bringing the CFPHS impact districts to 12. These funds will provide training resources for 380 more HTC providers in addition to the 450 that will be trained with funds provided through Modification Number 5.

With additional funds provided through Modification Number 5 a database for managing data in the project started and will be completed in the Quarter 1 of Year 4. The database is going to ease data management in the project and greatly reduce the amount of time required to manage data. The time and energy saved will be used for better and more critical data analysis for project management.

The project's Behavioral Change Communication (BCC) initiatives have reached over 200,000 individuals using community and radio drama, Open Days, and clinic talks. The capacity of local drama groups has been improved thereby making drama performances a solid medium for passing on health messages to the community population. These local drama groups perform at health facilities as well as in the communities during Open Days. Drama has been found to be

very effective in increasing knowledge and health-seeking behaviors as seen in the increasing number of community members accessing FP and HIV/AIDS services. Community member now demand these services and are usually disappointed when HSAs and CBDAs cannot provide the services at the community level due to stock-outs.

Advocacy and policy activities continued to play a major role in the program. A major achievement during the just-ended year has been the completion and dissemination of the Integration Survey conducted to assess the level of integrating FP and HIV and AIDS at policy, programme, and health facility including the community level. Advocacy for the use of FP and HIV and AIDS services continues with a focus on the Muslim as well as the Catholic communities. In Muslim communities the program is working toward developing suitable messages which incorporate teachings of their faith, and in the Catholic communities the focus has been on the use of natural methods. Messages will be developed for the Muslim communities in the first Quarter of Year 4. Anecdotal reports show that many Catholic couples are interested in practicing natural methods, mainly cycle beads. In communities where cycle beads are introduced it has been discovered that couples from other faiths are getting interested in the method. Attempts will be made to train CBDAs in this method.

The program has from time to time in the year hosted various groups from USAID as well as other USAID funded programs. Noteworthy is the delegation from the AWAREII project in West Africa comprising twelve members from Sierra Leone, Burkina Faso, Togo, Ghana, and a representative of West African Health Organization (WAHO). The delegation focused their visit on the implementation of community-based administration of DMPA. The learning experience covered policy change, training, logistics management, and the integration of FP and HIV and AIDS program. The group also saw the integration of FP, HIV and AIDS and in some cases with MCH services where the HSAs are running Village Clinics and providing DMPA.

While PY3 was a highlight in terms of its consolidation efforts on the project, there were some constraints experienced, chief among them being the stock-outs of contraceptive commodities and reagents for HIV Testing and counseling. HTC services were the worst hit as there are really no alternatives as compared to contraceptives for which a woman might choose to get on to pills temporarily in the absence of DMPA and vice versa.

In the area of management, the project experienced a much higher level of staff turnover than would have been desirable. While the project boasts a full team at the turn of the year, this hides the fact that two key positions became vacant earlier in the year. In addition to this, the project also had to fill the District Coordinator positions in Mangochi, Kasungu, and Nkhotakota.

## **Quarter 12 Accomplishments**

In the reporting quarter, consolidation of programs continued in the form of supervision visits and review meetings. Review meetings were conducted in all subinterventions including HTC, natural family planning methods, Long-term and Permanent methods, and our behavioral change communication interventions including Listeners' Clubs and drama clubs.

A meeting to discuss the management of waste was also held during the quarter. The participants were drawn from all the 8 impact districts of the CFPHS projects. The meeting emphasized the importance of waste management and agreed on an action plan which included making an inventory of all health facilities with incinerators, and also holding orientations with CBDAs and their supervisors at the district level on how to better manage waste.

HTC trainings were also a highlight of the quarter. By the end of the quarter, 98 CBDAs received training in the provision of HIV testing and counseling services.

During the quarter, the project received and hosted a visiting delegation from West African countries in a consortium project called AWARE II. The visitors were interested in learning how Malawi had navigated the course of community DMPA provision.

## **Year 3 Accomplishments**

The project made significant inroads into implementation of various project activities during the year. In many areas the project has exceeded the targets set for Project Year 3—and the LOP targets have been exceeded in several other areas. This was one of the major findings from the mid-term evaluation that was conducted in the year. The MSH/BASICS presence in six of the eight target districts has significantly contributed to the achievement of the set targets. Out of the eight target districts, three are staffed by BASICS staff where one District Coordinator is implementing the two programs. Likewise three BASICS districts benefited from CFPHS project. This has meant staff; transport, office accommodation, and other necessities are shared between the two projects.

The year started with the introduction of the Standard Days Method (SDM) to the project's method mix. The method was initially introduced to cater to those, like Catholics, that found modern family planning methods morally objectionable. Trainings for SDM finished at the end of the first quarter. A total of 205 providers were trained. Monitoring visits during the subsequent quarters revealed that the method was being accessed not only by Catholics but also by many couples from other religious persuasions. The expressed interest by many couples in the use of cycle beads has led to considering scaling up the method to CBDAs in Project Year 4.

At the beginning of the year, the project was awarded the option year, extending the project duration from three to four years. At the beginning of Quarter 2 in Project Year 3, a modification was granted. The modification allowed the scaling up of DMPA in all the impact districts. This meant that the number of HSAs providing DMPA would be more than tripled, thereby increasing access to DMPA by communities. Target districts now have an average of 154 HSAs providing DMPA.

In Project Year 3, the project participated in a study meant to evaluate the provision of DMPA by HSAs. USAID contracted Family Health International (FHI) to conduct the evaluation. One important conclusion reached in this study was that the provision of DMPA by HSAs was safe and that it had led to increasing accessibility of FP in the community.

With the modification, also came an opportunity to expand the door-to-door HTC services offered by the project. While the DMPA scale up was implemented in all 8 target districts, HTC scale up was only implemented in 4 of the 8 impact districts namely: Kasungu, Salima, Mangochi, and Phalombe. The modification provided a crucial opportunity to expand the HTC service. By the end of Project Year 3 the project will have trained 100 new counselors making 176 counselors trained by the project. These trainings were expanded to include nutrition and TB screening to help integrate service delivery at the community level. These trainings will continue into Project Year 4.

The modification also provided funds to improve reporting systems in the project. To this end, an innovative pilot project was introduced in the year. The project involves the transmission of data (reports) via cell phones to a central hub at the district. This system has great potential as the different stages through which data has to pass (stages also sources of errors) is eliminated, thereby increasing the quality of data. It also eliminates the time and geographical barriers that characterize the current paper-based system.

Integrated service provision is the preferred mode of delivery for project services. In Project Year 3, the project continued to lobby for a more integrated approach in the provision of FP and RH Services with HIV & AIDS services. To that effect, an integration study was conducted. The study was finalized and its findings disseminated in July during the RH dissemination workshop. One of the findings of the integration study was that there was no generally agreed definition and concept of integration on the various levels of health service provisioning. The CFPHS, however, is a model and pioneer of service integration at the community level.

Policy and advocacy linkages with the Muslim Association of Malawi and the Quadria Muslim Association of Malawi continued. These efforts have led to the decision for the project to translate some advocacy materials from Mali to be used for advocacy within the Muslim community.

Our Behavioral Change Communication (BCC) interventions started late at the end of PY2. PY3 was therefore the highlight and year for results for our BCC interventions. Four main modes of communication were employed, namely radio drama (with Listeners' Clubs), community drama, Open Days and clinic talks. Over 216,000 people were reached through our BCC interventions in PY3. Open Days saw the project reach out to 52 percent of these people.

For details of the accomplishment by activity, please refer to Annex 1 of this report.

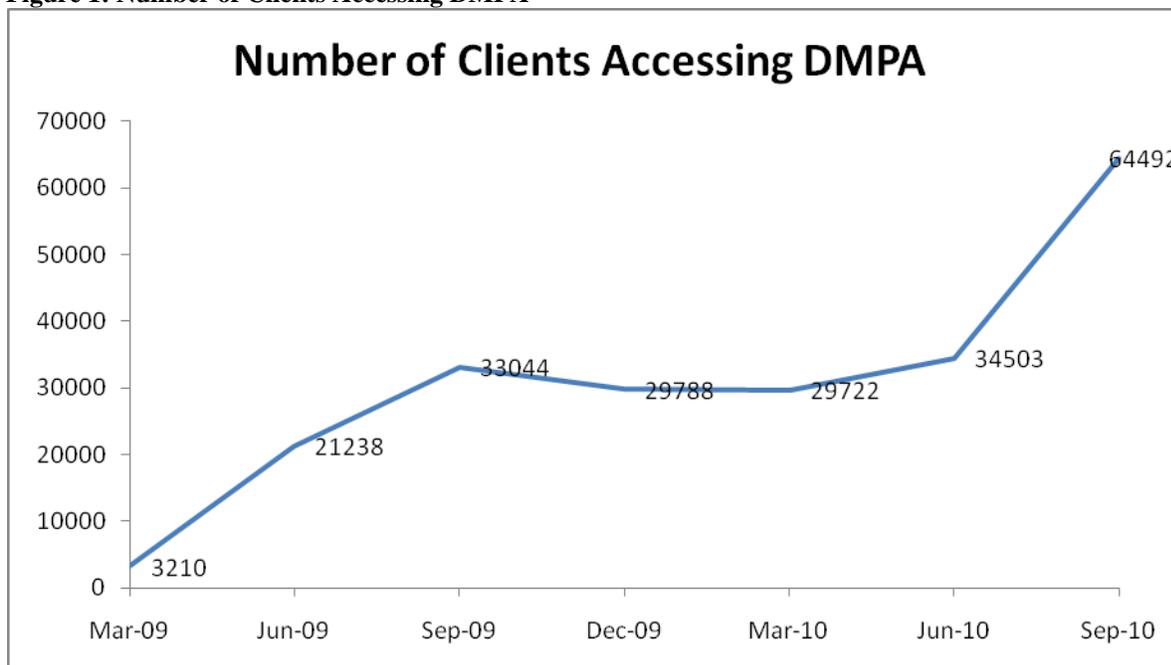
## Progress towards achievement of major activities

### Family Planning

#### Community-based DMPA

DMPA is one of the contraceptive methods that have won the preference of most women in the community. After a steady increase in PY2, the PY3 started from a very good note with over 33,000 women accessing DMPA both at the facility and the community level. This was followed by a December seasonal fluctuation of about 3,000 women. DMPA coverage picked up again in Quarter 11 (April–June 2010) to 34,503. Even though Quarter 11 was dogged by some DMPA stock-outs, there were all indications that this was the saturation point given the number of DMPA providers in the districts. After training over 800 new DMPA providers at the end of Quarter 11 and in Quarter 12, DMPA service provision was given a new lease on life, with client figures climbing to over 64,000 in Quarter 12 (see figure below). Even though this is a positive change from Quarter 11 figures, it is lower than what the project would have expected, mainly due to two major factors.

**Figure 1: Number of Clients Accessing DMPA**



The quarter under review was a peak period in terms of the levels of activity that were being implemented within the Ministry of Health. First there was a measles outbreak. In fighting this outbreak, HSAs were involved in this effort, which meant that they were not available to provide other services, including DMPA. Second, the large number of HSAs trained coincided with DMPA stock-outs such that a large number of them have not started practicing yet. (See challenges section on page 25 on how the project has dealt with DMPA stock-outs)

Introduction of DMPA in the community has proved to be a good move toward achieving better reproductive health because it has reduced the workload of health facilities; the services that

could be offered by the health facilities are now offered by HSAs in the community. This implies that the community can now access family planning services right at their doorstep, thereby giving the women ample time for their household chores. For those women whose husbands restrain them from having contraceptives, DMPA is good news. A woman can have the injection behind her husband's back; this explains why most women in the community prefer this contraceptive method—no physical mark is left.

### **RH Technical Exchange Network Meeting**

The project participated in three meetings of the RH Technical Exchange Network (TEN) facilitated by the MSH Global Technical Lead for RH. During the meeting CFPHS delivered a presentation on the work of CBDAs and HSAs. The presentation ignited a great deal of interest among the TEN members. The members asked a number of questions, primarily on the role of community health workers, how the project/the government plans to sustain the participation of CBDAs and HSAs in community health services provision, and what the coverage of injectables has been since the coming in of HSAs. The CFPHS presentation was a success, as the strategies applied in Malawi were shared and well received by other USAID-funded projects.

### **Action for West Africa Regional Project II (AWARE II) Visit**

The success story of the CFPHS interventions in Malawi attracted RH program managers from Burkina Faso, Sierra Leone, Ghana, Togo and the West Africa Health Organization (WAHO). These professionals visited the country under the sponsorship of the Action for West Africa Regional (AWARE) II project to learn how the CFPHS project implements community based injectable contraceptives. They visited the districts of Salima, Nkhotakota, and Phalombe to understand the coordination between facility and community based health workers. This provided an understanding of how community based workers are trained, supervised and motivated. It also provided an opportunity to demonstrate the flow of information and commodities from central level to community and vice versa.

The project continues to engage itself with DMPA activities to ensure sustainability of the successes gained. In the reporting quarter, several activities were implemented to consolidate the gains realized so far from DMPA:

### **Conducting DMPA Training**

During the reporting period, DMPA trainings were conducted in all the 8 impact districts namely Karonga, Kasungu, Balaka, Nkhotakota, Salima, Mangochi, Chikhwawa, and Phalombe. These trainings were done using the contract modification funds that will make it possible to increase access to community DMPA by training more Health Surveillance Assistants (HSAs) in the provision of DMPA. The project targeted HSAs based in the hard-to-reach areas.

### **Results:**

- A total of 348 HSAs and 35 supervisors were trained in the provision and supervision of community DMPA respectively.
- Each of the trainees had time to do a practical that enhanced their skills.
- Post-test results were comparing very favorably against pre-test results indicating knowledge gain.

- The latest training brings the total number of HSAs and supervisors trained to 885 (578 males and 298 females) and 117 respectively with a ratio of 1 to 8.

**Comments:**

- The training in Phalombe allowed the visiting delegation from West Africa (AWARE II) to observe the training session and learn what goes into organizing and training community DMPA providers.

**Conducting DMPA Supervision**

DMPA supervision was conducted in Phalombe, Chikhwawa, Karonga, and Mangochi. Its aim was to strengthen DMPA provision at the community level and to check the quality of services provided. This supervision was done through observation of the counseling session and the actual provision of DMPA.



Supervision Team in Chikhwawa meeting with DMPA Provider: from left to right, Joyce Wachepa (MSH), Judy Njikho (PSI), Virginia Faiti (MoH), Andrew Gedion (DMPA Provider) & Mexon Nyirongo (CoP – CFPHS Project).

**Results:**

- A total of 116 DMPA providers were supervised in the quarter. 20 were supervised in Chikhwawa, 40 in Phalombe, 35 in Karonga, and 21 in Mangochi.
- DMPA stock-out of 3 days was reported in Karonga at Kaporo Health Centre.
- Condoms and DMPA vials were distributed to providers during the supervision.

**Comments:**

- Good record-keeping by the community service providers.
- Client eligibility checklist being used correctly.
- HSAs refer clients to health centers for LTPM and other methods.

**Community-based Oral Contraceptives and Condoms**

The main outlets for Orals and Condoms in the communities are the Community-based Distribution Agents. In the quarter under review, three activities were implemented as follows:

**Conducting CBDA Supportive Supervision**

CBDA supportive supervision was done in Karonga, Phalombe, Chikhwawa, Mangochi, and Kasungu. The aims of the visits were threefold namely, a) to promote the spirit of volunteerism, b) to hold discussions with the CBDAs as regards their work, and finally c) to ensure that standards of service provision are being upheld. This is an ongoing activity that is collaboratively conducted by the Ministry of Health and the project. In addition to the three objectives, in Kasungu the supervision also focused on following up of CBDAs that had dropped out. This was done to gain a greater understanding of the high dropout rate experienced in the district.

**Results:**

- 73 CBDAs (25 in Karonga, 21 in Mangochi, and 27 in Chikhwawa) were supervised during the quarter.
- Condoms were in short supply. Those meant to replenish the stocks of CBDAs were not enough to go around.
- For Mangochi, the target was to supervise 26 CBDAs in the two zones; however, only 21 CBDAs (11 females and 10 males) were supervised. Five were not present at their homes when the supervision team visited them.

**Comments:**

- It is encouraging to note that CBDAs continue to work hard.
- Review meetings that followed soon after the supervision allowed an exhaustive discussion, while memories were fresh, of all the challenges that were observed during the supervision.
- Condoms are still not readily available as dual protection for FP clients.

**Conducting CBDA Review Meetings**

CBDA monthly review meetings were conducted in six districts namely Karonga, Mangochi, Phalombe, Balaka, Chikhwawa, and Kasungu districts. The aims of the review meetings were threefold; first, to encourage and mentor CBDAs in providing vital reproductive health services; second, to replenish the districts' supplies; and last, to update CBDAs on new developments. These meetings were conducted in the respective zones. Incentives in the form of allowances were paid out for the first time.

**Results:**

- 514 CBDAs were reached with the review meetings (87 in Karonga, 90 in Phalombe, 129 in Chikhwawa, 57 in Mangochi, 53 in Kasungu, and 98 in Balaka).
- In Kasungu, the review meetings established that there were 10 dropouts in the two TAs where the review meetings took place.
- 24 bicycles were distributed during the review meeting in Mangochi.
- Waste management was covered during the review meetings in Phalombe.
- There was a stock-out of Ovrette and Condoms in Chikhwawa.

**Comments:**

- The implementation of the honoraria has motivated CBDAs. We are beginning to see CBDAs who were inactive returning to the service. However, it is too early to say that they will be satisfied with the introduction of the honoraria.

**Conducting CBDA Refresher Trainings**

With funding from the World Health Organization, a CBDA refresher training was conducted in Karonga District at the beginning of the quarter in July. This was the second of such training sponsored by the WHO. The first refresher training was conducted in Quarter 11. The refresher training ran for a week.

**Results:**

- 24 CBDAs received were retrained.
- The training also included 4 secondary supervisors and 2 primary supervisors.

**Comments:**

- The project will continue collaborating with the Ministry of Health and the World Health Organization to ensure that more CBDAs are provided with the refresher training.

**Natural Family Planning Methods**

The project is currently promoting the Standard Days Method as a natural family planning method. An initial training of trainers (TOT) targeted 25 people from across the 8 impact districts. These TOTs trained a total of 205 providers, who have been providing the services since Quarter 9 (Oct through Dec, 2009). While the method originally targeted Catholics, it has aroused interest amongst non-Catholics as well. Efforts are under way to quantify the access to and the use of the method and will be reported in the subsequent quarters. The aim is to understand SDM's contribution to the method mix. In Quarter 12, review meetings were conducted as follows:

**Conduct SDM Review meeting**

The Standard Days Method review meetings were conducted in Chikhwawa, Balaka, and Karonga Districts in the reporting period. The purpose of the review meetings was to mentor SDM providers and review progress. The meetings were held in the different Catholic parishes of the districts. The initial trainings targeted couples who were marriage counselors in the Catholic Church.

**Results:**

- 68 SDM providers were reached during the review meetings in the quarter.
- 19 providers (9 couples, plus 1 male who came without a partner) participated in the review meeting in Chikhwawa.
- 15 SDM providers (9 male and 6 female) were reached with the review meeting in Balaka.
- 34 (17 female, 17 male) providers attended the review meetings.
- The meeting revealed that the method is helpful even to those who want to conceive, because it indicates the period of time during which conception is most likely to occur.
- 400 cycle beads were distributed during the review meetings in Karonga.

**Comments:**

- The method continues to be available among Catholics and non-Catholics.
- There is a great deal of interest in the provision of the SDM by the providers. The project has started data collection efforts in order to determine the popularity of the method.

**Health Facility Based Interventions**

Health facilities exclusively offer Long-term and Permanent Methods which include Jadelle, Sterilization, and IUCDs. They also offer other services at the community level including

DMPA, Orals, and Condoms. Selected HF staffs were trained in LTPM methods at the beginning of PY3. In the reporting quarter, activities included supervision and review meetings with providers as follows:

### **Long-term and Permanent Methods**

In the reporting period, supervision of long-term and permanent methods was done in Salima. In Karonga, a review meeting was organized. The aim of the supervision in Salima was to encourage those that were trained in LTPM methods to put their knowledge into practice, since they risk losing their skills if they do not practice. In Karonga, the review meeting focused on Jadelle providers, who discussed demand creation for Jadelle, Infection prevention, and the use of Microgynon, a combined oral contraceptive pill which has replaced Lofemenal.

### **Results:**

- 28 providers were reached (19 in Karonga and 9 in Salima)
- Supervision in Salima revealed that there was no Jadelle for two months (June and July) as a result of a stock-out of Lignocaine, a local anesthetic used in the process of inserting implants.
- In Karonga, the meeting discussed client eligibility for Jadelle and management of side effects.
- Participants were refreshed on the procedure for Jadelle insertion.
- The meeting also discussed strategies for the processing of equipment after use.

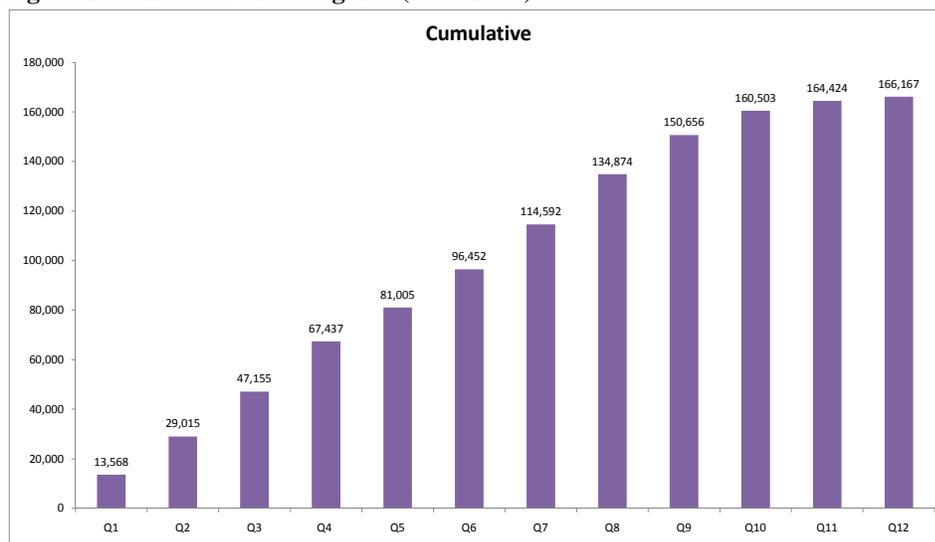
### **Comments:**

- Supply of Lignocaine has been restored and Jadelle provision resumed. Makion Health Centre was found to be a star performer in the provision of Jadelle.
- These meetings are proving to be very informative and help to update participants.
- The project will continue to hold these meetings to assure quality of LTPM services.

### **HIV Testing and Counseling**

PY 3 was a challenging year for HIV Testing and Counseling (HTC) services in the project because of a country-wide shortage of test kits. Problems with test kits came to the fore in Quarter 10 (Jan - March, 2010). These problems were then consistently reported as a challenge from all the 8 impact districts through Quarter 12 (July - September, 2010). Despite the shortage of test kits, performance in this area gradually increased even with the shortage of test kits, which ultimately was surprising. Figure 2 below shows cumulative figures for HTC since program inception. (See also challenges section on how the project has been dealing with the problem of test kit stock-outs)

**Figure 2 Cumulative HTC Figures (2007-2010)**



The project continued to implement activities which will ensure that once current constraints have been taken care of, i.e., once test kits become available, performance should pick up and the gaps created by the test kit stock-outs filled in. This has meant continuous demand creation through Open Days and motivational meetings by trained Community-based Organizations (CBOs) and HTC CBDAs. With funding from Contract Modification Number 5, trainings of CBDAs were undertaken for the districts of Phalombe, Salima, Kasungu, and Mangochi. These trainings and other major activities carried out in the past quarter are reported below:

### **Conducting HTC Training**

With funding from Modification Number 5, MSH in collaboration with the Ministry of Health conducted trainings in the reporting quarter in HIV Testing and Counseling. The main objective of the training was to equip participants with the knowledge and skills required to provide counseling and testing services to clients. The aim, of course, is to facilitate behavioral change in self, colleagues, and the community; this is the way forward in preventing HIV infection/ re-infection and promoting care for those infected and affected. Trainings are targeting the districts of Mangochi, Phalombe, Salima, and Kasungu. The first two weeks the training were dedicated to classroom work while the last week was a practicum on counseling and whole blood rapid testing.

#### **Results:**

- A total of 98 HTC Counselors were trained in the quarter in 6 sessions. This represents an 84% qualification rate among those that were invited to attend the trainings, 116 in total.

#### **Comments:**

- Trainings are currently ongoing. The project will continue to work with service providers (of accommodation and training venues) to ensure that the training takes place in the most conducive of places.
- The CBDAs who did not qualify as counselors were instructed to continue working in their various communities as HTC motivators.
- The project is contemplating a review of those who marginally failed; they could be encouraged to continue reading their manuals and asking their supervisors questions about the material so that they can re-sit the examinations at a later date.
- The project will continue to use aptitude tests to screen potential candidates for training, and coaching during training will be intensified for better pass rates.
- The training program may need to be evaluated for further insights into what could be improved.

### **Facilitating HTC Training Supervision**

The HIV Unit of the MOH conducted supportive supervision of the HTC training sessions that were held at Mponela and Mwanza Primary Health Care Centres. The objective of the supervision was to strengthen HTC trainings.

#### **Results:**

- Participant selection was done according to HTC Guidelines, which require that training participants have an MSCE or a JCE plus another qualification, e .g., as a teacher, a home crafts worker, or other community worker.
- Required learning aids were available; these included an LCD, a laptop, writing pads, printed training manuals for participants, and other materials.
- Five trainers worked with 20 participants; this is in accordance with the National guidelines.

#### **Comments:**

- The trainers were advised to use afterhours and weekends to cover more materials with the CBDAs. The trainers were also advised to take the time each participant required to understand the training material well in English.

### **Conducting Door-to-door HTC Review Meetings**

In the reporting quarter HTC counselor review meetings, in a roundtable format, were conducted in Nkhotakota and Chikhwawa. The meetings were held to check the progress of counselors in their work and to share experiences, strengths, challenges, and ways forward. Discussions also focused on improving the dialogue between the counselors and their supervisors, with a particular aim of helping to mitigate problems such as commodity flows. The HTC Coordinator briefed the counselors on new updates in the field of HIV/AIDS.

#### **Results:**

- 14 HTC CBDAs attended the meeting (7 in each district).
- Registration, documentation, and reporting were reviewed; CBDAs were briefed on the new Daily Activity Register (DAR) that was designed to check on the consumption of reagents.

- CBDAs were briefed on quality assurance and quality control, Proficiency Tests, SOPs and its benefits, and reasons for common errors in HIV tests.
- CBDAs reported that the supply of test kits had improved. CBDAs reported that continued work on HTC increased their competence in providing services.
- Retrospective data disaggregated by age was collected.

**Comments:**

- The project has bought bicycles to ease transportation for the CBDAs, which was mentioned as one of the major challenges in providing HTC Services.
- Proficiency tests and refresher courses need to be held frequently so that the CBDAs can continue to develop their skills.

**Conducting HTC Supervision**

HTC supervision was conducted in Karonga and Phalombe in the reporting period. Since the health facilities frequently had no test kits, the quality of service provision and the replenishment of HTC supplies were monitored. HTC Supervision was implemented as part of the monitoring system. This supervision mentored the CBDAs and reassured them that the problems in managing the supply of reagents were being addressed.

**Results:**

- 11 HTC CBDAs were supervised in the two districts (2 in Chikhwawa and 9 in Karonga).
- Sit-in counseling sessions were conducted at the health center.
- Reagents are still in short supply, e.g., in Karonga HTC kits were in short supply at health facilities; CBDAs received only 10 kits.
- In Chikhwawa the HTC counselors lacked testing reagents and could not offer services; clients were referred to the nearest health center for testing.

**Comments:**

- Community interest in the program remains high, so the project will continue to lobby for better supply chain management for reagents.

**Conducting HTC Retrospective Data Collection**

HTC retrospective data collection has been planned to collect HTC data disaggregated by age. Before FY3, HTC data were collected disaggregated by gender only. New PEPFAR indicators require that this data be disaggregated by age as well.

**Results:**

- Data was collected in Balaka.
- All the 11 HTC CBDAs were visited; the FP Coordinator and one MSH staff went through the registers.

**Comments:**

- All data will be collected by the end of the year.

## **Participating in an HTC Sub-technical Working Group Meeting**

CFPHS participated in the HTC Sub-technical Working Group meeting which was chaired by the Director of HIV and AIDS Department. The main agenda of the meeting was to review progress on HTC activities.

### **Results:**

The meeting reported on the following;

- Use of HTC Logbooks had been piloted in Rumphi, Lilongwe, and Mangochi districts. Evaluation process of the logbooks was under way. Information from the evaluation would assist how the logbooks will be rolled out to other districts.
- Door-to-door HTC Model is in place and had been rolled out to districts. MSH is one of the NGOs which has rolled out Door-to-door HTC to districts using CBDA Program.
- The system on HIV Logistics on test kits was reported to have been successfully piloted in the Northern Region. Based on lessons from the Northern Region, the system has been rolled out to Southern and Central Regions.
- Members were updated on the current HIV reagents stock status and on the reagents which were expected to arrive between September and December 2010. It was announced that Global Fund will be pay the handling fee on the HIV test kits.
- The recommendations of HTC Week Campaign evaluation report were presented. The following was agreed as the way forward:
  - HTC Week Campaigns should be continued.
  - HTC Week Campaigns to be biannual.
  - Districts to conduct the campaigns on their own convenient dates of the year.
  - Central level to increase support to districts which underperform.
  - Next campaign to be in September 2011; preparations to start this year.

### **Comments:**

- Condom stock-outs were raised as an issue of concern; NAC officials indicated that this should be resolved—NAC will distribute condoms and will pay for the handling fees using Global Funds.

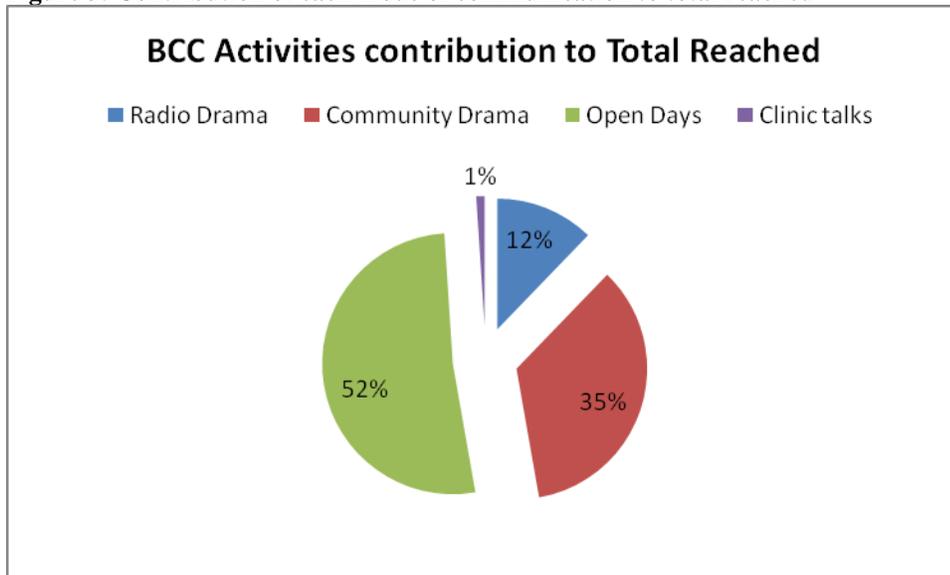
## **Demand Creation and Behavioral Change Communication**

Demand creation is one of the three strategies employed by the CFPHS project. This strategy has been key to the success of the project as it has helped to disseminate information about available services, where to find these services and, most importantly, dispel the myths surrounding contraceptives and HIV testing.

In PY3, the menu of demand creation activities included Open Days, clinic talks, community drama, and radio drama. A total of 216,000 people were reached with family planning and HIV and AIDS messages through these methods.

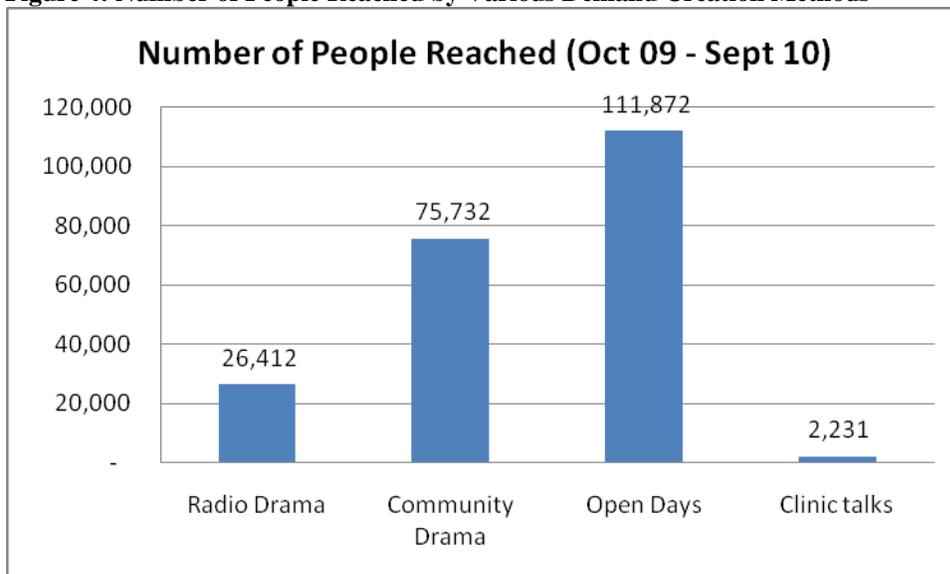
Figure 3 shows the contribution of each of these activities to the total number reached.

**Figure 3: Contribution of each mode of communication to total reached**



From the figure above, Open Days reached the largest number of people followed by community drama. Radio drama comes in third with about a 12 percent contribution to the total reached. The absolute figures are as shown in Figure 4. In PY3, 1969 people (983 males and 986 females) accessed HTC services during Open Days. Out of these, 60 were found positive representing 3 percent of all those tested.

**Figure 4: Number of People Reached by Various Demand Creation Methods**



In the past quarter, radio drama and community drama performances resumed in September after a short break. During the break, review meetings were conducted with the Listeners' Clubs and the drama troupes in order to strengthen these initiatives. Open Days and clinic talks continued throughout the year. All these activities are reported below:

## Conducting Open Days

During the quarter, 18 Open Days were conducted across the 8 districts. The aims of these Open Days were to address myths and misconceptions that have a negative impact on the use of family planning methods and to increase family planning and HTC services awareness in the communities. In addition to disseminating the FP message, HIV testing was also provided during all the Open Days except during one Open Day in Phalombe where there were no trained counselors in the area. All the Open Days were attended by different project partners and stakeholders both from the community and district level. In Balaka, the activities were held under the theme “RH issues everybody’s responsibility.”

### Results:

- A total of 38,873 people (20,012 males and 18,861 females) attended the Open Days.
- 619 people (285 males and 334 females) accessed HTC Services during these days.
- 19 people were found positive, representing 3% of all those tested.
- Total number of men attending the Open Days has increased because of the inclusion of football matches during the Open Days.



*Football Team Photo Op: Planning open days around such games as football has boosted male participation. Pic – CFPHS Project (PSI)*

### Comments:

- The football matches have contributed to attracting men to attend Open Days.
- The project will continue to explore innovative ideas to woo more men to FP activities.

## Conducting Community Drama Review Meetings

Review meetings for all the 24 community drama troupes were conducted in all the 8 districts. The aim of these review meetings was to review how the clubs had performed in the last 8 months, and to address issues affecting their performance and refresh their knowledge on family planning. As a way of assessing the performances, the drama clubs were asked to perform during the meeting and all areas which needed improvement were discussed. Community drama performances started in September and will run concurrently with radio drama, and the clubs will be performing two shows a month.

### Results:

- All the 24 drama troupes were reached.
- The drama club members would like to have IEC materials like pens and T-shirts to distribute during performances.

### Comments:

- The drama troupes continue to show commitment to performing in their various communities.

## Conducting Community Drama Performances

Community drama troupes started their performances during the month of September in all the 8 districts. There is a slight improvement in figures for Chikhwawa district which can be attributed to new community mobilization skills that were imparted to the groups during the review meetings conducted in August.

### Results:

- Family planning messages reached 8,558 people (3,371 males; 5,187 females).
- In September, 2 drama groups in Salima were visited and had their performances monitored.

### Comments:

- The project will continue to support drama groups' mobilization efforts to ensure increased patronage of the performances.



*Drama group in action during an Open Day activity. Pic Courtesy of CFPHS Project (PSI).*

## Conducting Clinic Talks

During the reporting period, 14 clinic talks were conducted in all the districts. Activities by the Listeners' Clubs in the catchment areas helped spice up the events through drama and music.

### Results:

- A total of 1,286 people (217 males and 1,069 females) were reached through the clinic talks.
- In Nkhotakota the number of men was higher because during the day of the clinic talk there was food distribution for children; a lot of men came with their wives to help them pick the items.

### Comments:

- The experience in Nkhotakota about men's involvement shows that the project needs to identify appropriate roles for the men to get them involved. It is a clear sign that men are concerned about their spouses and that they are willing to help.
- There is a good synergy between the various motivators (drama clubs, Listeners' Clubs) and the service providers (HSAs, CBDAs, and LTPM provider).

## **Conducting Supervision of Listeners' Club Activities**

There has been good attendance at the radio Listeners' Clubs meetings since they resumed on 25 August 2010.

### **Results:**

- A total of 2,872 people managed to listen to the first episode of the radio drama series through the Listeners' Clubs and out of these 1,222 were men and 1,650 were women. All the members that listened to the first program were recorded as new members.
- Spot-checks were conducted on 47 clubs during the quarter on the days and times the radio drama aired to not only check whether clubs were listening to the program but also to motivate the clubs.
- Some clubs, especially in Karonga and Chikhwawa, registered a low turnout of listeners.

### **Comments:**

- The project will continue to intensify supervision of the Listeners' Clubs for more people to attend.

## **Conducting Listeners' Club Review Meetings**

The main activity for the Listeners' Clubs in the quarter was the review meetings. These review meetings were conducted in all the 8 districts with all the club leaders. The aim of these review meetings was to discuss and find solutions to the challenges faced during the previous airing of radio programs. During the meetings the club leaders were also refreshed with basic knowledge of Family Planning, Gender-based Violence (GBV), Club Leadership and Management, and report writing.

### **Results:**

- The following issues came out of the review meetings:
  - Club leaders reported that in communities where the Listeners' Clubs are, people are now having accurate information on family planning, HIV/AIDS, STIs, and GBV.
  - Club leaders also felt that there was an increase in the number of people accessing family planning and HIV AIDS services from CBDAs, HSAs, and Village Health Committees.
  - Club members reported that community stakeholders (including some religious leaders and groups) have started to participate in family planning activities.
- The first episode of the radio drama was successfully re-aired on 25 August 2010 on MBC Radio 2. Two spot-checks to see how the clubs have started listening to the programs were carried out in Salima district and patronage was good; the clubs reported good reception of MBC Radio 2 FM.
- Discussion guides for episodes 1–15 were distributed to all the clubs during the review meetings.

**Comments:**

- The project will continue to conduct frequent supervision of clubs using existing tools. It will also facilitate more Open Days and encourage the participation of different stakeholders.

**Policy & Advocacy**

IN PY3, the project's policy efforts were focused on learning and disseminating lessons from service integration pioneered by the project. To this effect, a study on integration of FP and HIV and AIDS services was conducted. The study explored the definition, the purpose, the extent of integration and barriers to integration in Malawi. The results were presented at a national RH dissemination meeting as reported below. Also in the year, an evaluation of the DMPA by HSAs pilot was conducted. The evaluation was very positive, which further validated the project's policy efforts as a success.

Collaboration and dialogue with the Muslim communities continued throughout the year. Plans to disseminate the August 2009 Conference resolutions and to develop targeted FP/HIV&AIDS messages for Muslims are some of issues being discussed with the Muslim clerics.

In Quarter 12, the following activities were undertaken:

**Conducting National Level Dissemination of FP/HIV Integration Study Findings**

CFPHS collaborated with the Reproductive Health Unit and other FP SRH partners to conduct a national level dissemination meeting of SRH policy/guidelines documents and research studies. CFPHS cofunded the meeting and disseminated the FP/HIV/AIDS integration study results.

**Results:**

- The following documents were disseminated:
  - Results of the rapid assessment on SRH/HIV/AIDS linkages by FPAM.
  - Evaluation of the DMPA pilot by FHI.
  - The national reproductive health and rights policy.
  - The RAPID advocacy tool.
- About 90 participants from private and public sectors including representatives from all the District health offices attended the meeting.
- Stakeholders agreed on the need to move the integration of SRH and HIV& AIDS services agenda forward.
- FHI reported the success of the DMPA pilot. Stakeholders agreed on scaling up the DMPA initiative to the rest of the districts.

**Comments:**

- FPAM and CFPHS will continue to collaborate on the next steps regarding integration of SRH and HIV & AIDS services. The Integration steering committee members will be meeting to map out the next steps to address the gaps identified in the study findings.

- The evaluation of the DMPA pilot showed that the HSA provision of DMPA is: acceptable, safe, expands access to family planning; and that clients are satisfied with it. Most providers, supervisors, CBDAs, and HSAs support continued HSA provision of DMPA.

### **Travel to Futures Group Home Office by the Policy Specialist**

The Policy Specialist traveled to Futures Headquarters in WDC to: a) work with new Futures CFPHS Project manager; b) participate in Health Policy Initiative End of Project meeting; and c) share CFPHS project's policy work with USAID and Futures Group Headquarters.

#### **Results:**

- The Policy Specialist oriented the new project manager on CFPHS project activities and they worked together to finalize the project year 4 implementation plan for policy and advocacy work.
- The HPI EOP meeting provided good lessons on best practices in FP and HIV policy and advocacy work from other countries. Based on the lessons learned, CFPHS will work with MAM and QMAM to adapt some of the Mali FP advocacy tools for use in Malawi as part of the follow-up activities to the Malawi 2009 national conference on FP/HIV and Islam.
- The Policy Specialist presented the CFPHS project work and the DMPA policy change to both USAID headquarters and Futures headquarters.

#### **Comments:**

- USAID was satisfied with the achievements of the CFPHS project and assistance provided in repositioning family planning in Malawi. Further, USAID sees the project activities in Malawi as a model for Africa in successful implementation of community-based injectable contraceptive services by nonmedical workers.

### **Participating in FP Technical Subcommittee Meeting at RHU**

The quarterly FP technical subcommittee meeting was held on 16 September 2010 at Reproductive Health Unit Offices in the Ministry of Health. MOH and NGOs providing technical support in Family Planning and other stakeholders attended the meeting. The objective of the meeting was to share updates on activities carried out by members during the quarter.

#### **Results:**

The following updates were presented;

- **Introduction of Sino Implant in Malawi by FHI.** Sino-Implant had not yet received prequalification from WHO but was registered with the Pharmacy Medicines and Poison Board of Malawi (PMPB) which meant it could be procured in-country. Sino-Implants come with disposable Trocars for each set of implants, which is very convenient to use.
- **USAID-World Learning /Grant Solicitation.** The grants will scale up provision of FP by 2015 in-line with the Kampala conference. No grant has yet been awarded. USAID will sponsor people to do masters programs to enhance the capacity of RH management.

- **PSI-Social Marketing by CBDA study recommendations.** PSI, through MCHIP, conducted a feasibility study on social marketing by CBDAs. The study showed that clients were willing to pay a small fee for contraceptives in the community. The results were shared during an extraordinary FP subcommittee meeting held in August 2010. Recommendations were put forward and the RHU has agreed that the initiative be piloted in Phalombe district. Although this initiative is outside the scope of the CFPHS project it has great relevance in ensuring commodity security as an alternative source of supply.
- **IntraHealth Pre-service and In-service Training Module.** The committee agreed that the modules be presented to the SRH TWG.
- MSH shared a draft report on a visit by 13 members from West African countries (Togo, Burkina Faso, Sierra Leone, AWARE 11, and West Africa Health Organization) that came to learn more on community-based distribution of DMPA. The visiting team expressed gratitude to have gained hands-on experience in implementing a community DMPA programme and will replicate it in their countries.
- CMS reported on stock levels at the CMS warehouse and the only contraceptives in stock at that time were DMPA, pills, and condoms. The other commodities were out of stock.

## **Environmental Compliance**

Environmental compliance is an important consideration especially if the project produces waste. This waste needs to be managed as it can be a source of infection and therefore a hazard to human health. The project produces waste like used DMPA vials, blood lancets, contaminated cotton wool swabs, and used syringes, all of which can be harmful to the environment. Proper management of this medical waste is therefore of paramount importance to the project. One activity was implemented to mitigate environmental effects as follows:

### **Conducting Meeting on Environmental Compliance/Waste Management**

CFPHS conducted a daylong meeting with District Environmental Health Officers and MSH District Coordinators in the month. The objective of the meeting was to discuss management of medical waste arising from community-based HTC and DMPA activities. Management of waste at the community level is crucial in terms of environmental compliance and potential infection from hazardous medical wastes.

#### **Results:**

- Management Sciences for Health presented a keynote paper titled “Management of medical waste at community level.”
- The presentation highlighted the program activities of HTC provision by CBDAs and DMPA provision by HSAs at the community level as areas of concern.
- Through group discussions, the meeting agreed on the following as practical ways of handling waste:
  - In the home setting: increase basic knowledge about waste management by both the CBDAs and the community at large to be done through trainings, orientation, and follow-ups by HSAs and other secondary supervisors.
  - Waste should not be disposed of at household level.

- Use of a safety box and the disposal of waste at the nearest health facility to be emphasized.
- It was recommended that use of temporary incinerators should not be encouraged at the community level.
- During outreach clinics, transportation of waste to the nearest health facility was also encouraged.

**Comments:**

- As a way forward, the meeting agreed that all districts should come up with/compile a list of the health facilities with incinerators so as to guide follow-up actions such as the construction of incinerators.

**Increasing Access to FP & HIV Services**

Increasing access to FP and HIV services is being achieved through BCC activities. The following activities were implemented during the quarter:

**Conducting Private Provider Training**

On 17 September, training was conducted for Blantyre Water Board and ESCOM clinical staff in Blantyre. This training was in response to a request by ESCOM since they wanted to start offering family planning services through their clinics. The training covered contraceptive technology and syndromic management of STIs. The training was conducted by leveraging funds from MCHIP.

**Results:**

- 14 medical personnel (11 nurses, 2 Clinical Officers, and 1 Medical Assistant) attended the training.
- Participants showed great interest in offering SRH services in their company clinics.
- Participants felt that their knowledge had been refreshed, especially on how hormones work and on the update on management of STIs.
- Short-term FP methods were covered in the training.

**Implementation of NAC Activities**

A briefing meeting was conducted in Ntchisi and Nkhatabay districts on the experience of delivering technical assistance and training in Community-based Family Planning and HIV&AIDS in the eight focus districts in Malawi. The current NAC/MSH Project was introduced with the intention to scale up FP and HIV/AIDS services in other districts.

**Results:**

- The CFPHS background, rationale, current statistics, project goal, objectives and approaches, geographical scope of the project, challenges, and lessons learned were presented to DHMT members.
- The project goal and objectives, and the specific areas for community participation in the activities—including increasing community awareness for HIV&AIDS prevention and

support services; increasing their access to quality HTC services; improving quality of HIV&AIDS and HTC services in the community; using the door-to-door approach to improve coverage; and scale up.

**Comments:**

- Issues including identification and/or recruitment of CBDAs; trainings of trainers and training of supervisors and existing CBDAs; supervision at community level; quality assurance; provision of supplies (test kits, condoms, and oral contraceptives); and reporting were discussed during the meetings.

## **Monitoring and Evaluation**

Monitoring and evaluation is a vital component of the project. In terms of personnel, the section has grown from one individual to 10 individuals (4 CFPHS and 5 NAC Assistant Statisticians, plus 1 M&E Advisor) with two of these based at the country office. The growth in the section will allow better accounting of project outcomes. In PY3, data collection and management was one of the main activities, with the aim of standardizing data collection and management methods across the districts. A mid-term evaluation was also conducted during the year. In the reporting quarter, activities were implemented as follows:

### **Conducting Database Development and Training**

The CFPHS project experienced difficulties in the management of data collected at the district level. This data was transmitted to the central office using Excel files which were susceptible to manipulation during storage as well as in the process of analysis. It was also difficult to locate data as there was no central storage and retrieval system for the data. Having experienced such problems, the project decided to come up with a database system that would ease data entry, transmittal, storage, and analysis. A consultant was hired to develop the database. The project conducted training for the database which is currently in the final stages of development. The training targeted MSH staff and MoH staff in all the 8 districts.

**Results:**

- There was active participation from both MSH staff and MoH staff in all the districts.
- The database raised a lot of interest as a result of the potential it holds in easing data management.
- MoH staff in Phalombe, for example, like the idea of the database and they asked the developer to expand it for use in other MoH purposes.
- The participants came up with very good ideas that led to further development of the database.

**Comments:**

- The database is a step in the right direction in providing a data bank for reference and ensuring consistent data is used in the project. It also reserves as a repository for all project data.

## **Work Plan Review**

During the reporting month, the project spent some time reviewing the work plan for Project Year 4. All sections of the project team participated in the review. Comments were received from the USAID Mission. The work plan has been resubmitted for final comments or approval as necessary.

### **Comments:**

- As the project winds down, this year will have only nine months of field activities and the remaining three months will be used to consolidate documentation on the status of implementing the project.

## **Challenges, Solutions, and Actions Taken**

### **Commodity Stock-outs**

More than anything else, commodity stock-outs have been the biggest challenge in Project Year 3. The stock-outs started in the second quarter of the year (Q 10 – January through March 2010) when the project started experiencing stock-outs and an extremely erratic supply of test kits in the district pharmacies. In the third quarter of the year (Q 11 – April through June 2010), the availability of test kits became more and more problematic. In this quarter also, the project experienced frequent stock-outs of DMPA and Condoms. In the reporting quarter, commodity stock-out problems continued. The commodities recorded as having been out of stock include test kits, DMPA, and Condoms. One district experienced a two-month stock-out of Lignocaine, a local anesthetic used in the insertion of Jadelle.

Having been hit by commodity stock-outs, the project increased its efforts in lobbying for the review of the supply chain management with the ultimate aim of eliminating bottlenecks in the system. To make this process smooth, the project made its data available for commodity quantification, a process that would allow the projection of commodities needed over time.

Realizing also that the burden for contraceptive procurement rests with the District Health Management, and anticipating the pressures that would be introduced in the procurement system by training extra providers, the project convened a meeting with district health managers to discuss their ability in providing contraceptives to the numbers to be trained. Planned training figures for each of the districts were presented during the meeting. All the eight districts present gave the project a green light to go ahead and train the providers. The injection of 885 DMPA providers in the 8 districts has introduced a shock to the contraceptive procurement system in the districts such that districts are, at least as evidenced by data in Q12, unable to continuously supply the providers with the contraceptives. This is a likely indication of the saturation point for the procurement system.

In response to the above, the project decided to halt the DMPA trainings to avoid further burdening the procurement system. To share the burden, the project intends to discuss with USAID the use of the remaining resources to train providers in districts other than the 8 impact districts. An opportunity exists to spread to new districts like Nsanje, Ntchisi, Nkhatabay, and Chiradzulu, in which the project has secured funding from NAC to scale up project activities.

### **Community-based Distribution Agents (CBDA) Supplies**

Community-based Distribution Agents require several supplies to facilitate their work. These supplies include bicycles to facilitate mobility, backpacks to facilitate ferrying of contraceptives and other job aids, and visibility materials. Of all these, bicycles were the biggest challenge. This problem started at the beginning of the year. However, as a result of inadequate resources, it was not possible to respond to these needs as quickly as the project would have wanted.

Additional resources became available through Contract Modification Number 5. These resources allowed the project to procure bicycles and other CBDA supplies. It is hoped that this will increase CBDA motivation and help return CBDAs to the project

## **Community-based Distribution Agents (CBDA) Dropouts**

CBDA dropouts were a major challenge in the year under review. The project initially trained 1003 CBDAs. Currently, the number of Active CBDAs stands at 858 across the 8 impact districts representing a 14 percent dropout rate. Some districts were more affected than others. For example, in Q 11 (April through June), Kasungu recorded a 47 percent dropout rate. This was clearly an outlier that skewed the dropout rate for the rest of the districts. In Salima, while there was a generally high dropout rate, the HTC project was most affected with 7 out of the 9 trained counselors dropping out. Anecdotal evidence suggested that for the case of Salima and other districts like Kasungu, some of the dropouts had been recruited to join the Ministry of Education as teachers. Many others have found paying jobs.

The project has implemented two major activities in response to the above challenge. First, the project started in Q12 with the implementation of honoraria to active CBDAs. This honorarium, (MK2, 500 per month) is meant to help with the maintenance of the bicycles as well as a transport and lunch allowance to the monthly meetings. This, it is hoped, will motivate the CBDAs and reduce the dropouts. To specifically respond to the inadequate number of HTC counselors, the project is training an additional 450 HTC counselors in 4 districts of Mangochi, Phalombe, Salima, and Kasungu. The project is planning to train a further 380 HTC counselors in the other districts of Nkhotakota, Karonga, Chikhwawa, Balaka, Nsanje, Chiladzulu, Ntchisi, and Nkhatabay, with funding from the National Aids Commission.

To further understand the situation of CBDAs, the project has planned a CBDA sustainability study that will look at the potential challenges to the sustainability of the approach and suggest possible solutions. A quick study is also planned to understand the complexities of recruited teachers serving as CBDAs concurrently.

## **Lack of Sets for Long-term and Permanent Methods**

Ninety six clinicians and nurses were trained in the provision of Long-term and Permanent Methods. One of the challenges that was noticed at the beginning of the year was the lack of surgical sets for providing these services. In response to the above challenge, the project has procured sets that it is hoped will ease the provision of these methods.

## **Medical Waste Management**

Management of medical waste generated from the project was also a challenge that was encountered earlier on in the year. CBDs had been advised to bring their medical waste to the Health Facilities for incineration, but staff later realized that incinerators were lacking. In response, the project identified resources through Contract Modification 5 to provide incinerators where they were needed. In addition; a meeting was convened in the reporting quarter to address the issue of medical waste management. In attendance were Environmental Health Officers from all the impact districts.

## **Community-based Distributors Coverage**

While the project had made tremendous efforts to ensure that FP and HIV/AIDS services are available in the hard-to-reach and underserved areas; many such areas were not covered by

Community-based Distributors (CBDs). In response to this challenge, the project has trained an additional number of DMPA providers and HTC Counselors. This will ensure that more underserved areas now have access to HTC Services as well as DMPA services.

### **Rise in Cost of Training DMPA Providers**

In Contract Modification Number 5, a total of 1,400 DMPA providers were to be trained. In the course of the training, a training review was undertaken. This review revealed that the project had trained 63 percent of the providers using 83 percent of the resources. This indicated a rise in the cost of training HSAs. One such cost was identified as accommodations, especially for Salima District.

# **Lessons, Best Practices, and Recommendations**

## **Lessons**

### **Commodity Availability and Training of Providers**

Funds provided from Modification 5 gave the project potential to train up to 1,400 new DMPA providers in the 8 impact districts. It however became clear that given an increased burden on the procurement system for contraceptives, the system would simply buckle and break under pressure. This system's breaking point is not an indication of service saturation; rather it is an indication of systemic limitations and priority setting. It is therefore important to always be aware of the system breaking point and be mindful that only an optimum number of providers are trained in order not to burden the system. More providers in this case can only be trained if interventions are implemented to assuage supply-side constraints. This will be borne in mind as we train more HTC providers.

## **Best Practices**

### **Door-to-door HTC Approach**

This approach has the potential to reach out to the most remote and underserved areas. It is exactly as a result of this that NAC is willing to support the initiative. More and more organizations are taking the approach on board.

### **Integration of FP and HIV Services**

The integration of FP and HTC services by community-based distributors has contributed to decreasing stigma and discrimination at the community level. More people are able to access HTC services in the privacy of their homes.

### **Community DMPA**

Community provision of DMPA is inarguably a best practice. Community DMPA provides access to DMPA to women who otherwise would have had to walk a long distance to a health facility to access it. Its availability in the community means that women have longer access to it during the day than they would at a health facility. It also means that even those women whose husbands may be opposed to contraception can have the injection without any noticeable scars.

## **Recommendations**

In view of the lesson learnt above thus keeping a delicate balance within the supply side, funds available to train the other providers should be used to make the method accessible in the other districts where the CFPHS is now implementing activities with NAC funds and other deserving districts depending on their RH indicators. This will ensure that more women are able to access DMPA and widen the project's impact area.

## Success Story: Sterilization—Leading by Example

by Ruthia Kainga and Peter Nyasulu



It's now all smiles in Nkhotakota for CBDAs as the misconceptions that the communities had toward sterilization fade away. At first, people in Nkhotakota, Traditional Authority Dambolawana, hated even the mention of the word sterilization because of the different myths surrounding that contraceptive method. Mervis Maulana, a CBDA, was heard saying, “there were tales in this area that sterilization is deadly for a good number of reasons, such as that bowels are tied in the process, therefore the abdomen becomes

distended, and this condition leads to severe stomach aches.”

The situation turned positive when three female CBDAs, Mervis Maulana, Monica Chisale, and Mai Ng'ambi (in the picture) made their decision to undergo Bilateral Tubal Ligation, done both to accomplish their final and preferred contraceptive method and to stand out in their community as examples of a successful contraceptive choice. After the operation, the three women proudly announced their choice to the community during one of the family planning meetings they usually conduct. The community was perplexed to hear that the women had risked their lives and keenly awaited the women's fates.

Days turned into weeks and weeks into months without the community making note of any defects in the women that could be attributed to the contraceptive method they chose. What was easily noted, however, were three healthy women who were still strongly carrying out their daily business, perhaps even better than before.

The three CBDAs shared their experience with those who believed the community's delusions about sterilization and were in doubt about the women's decision. The three women's experiences became a precious tool in convincing the community about the benefits of sterilization. A tremendous attitude change in the community was the result. Currently more and more men and women choose sterilization. Each of the CBDAs has since referred an average of 22 clients for sterilization, and the figures are expected to rise as the issue of sterilization is now most welcome in Nkhotakota.

## **Management Issues**

### **Earthquake in Karonga**

Earlier in the year, an earthquake hit Karonga and Chitipa districts. The earthquake destroyed infrastructure including building, roads, and hospitals, and with these, people's livelihoods. The project's activities were disturbed since our staffs were affected by the earthquake. Our clients were equally affected. However, project services did not stop; sometimes it is during these very times that reproductive health and HTC services are the most crucial.

### **NAC funding**

The project received funding from NAC to scale up the Door-to-door HTC initiative in the districts that are not covered by Modification 5 and in four other new districts of Nsanje, Chiladzulu, Ntchisi, and Nkhatabay.

### **Staff Turnover**

The project experienced a high staff turnover in the year. The positions of the FP Advisor, M&E Advisor, Administrative Assistant, and three District Coordinators were vacant and were replaced within the year. Anecdotal evidence suggests that the project had fallen behind other employers in improving staff working conditions. This challenge was tackled, however, and the project is confident that conditions and services for its staff are comparable to similar staff positions in other projects.

### **New Hires**

With funding from Modification 5, the project was able to hire new staff to assist with data management. These staff members include: Phindile Chitsulo, based at the Central Office; Eleanor Bisika, based in Kasungu; Ruthia Kainga, based in Salima; and Madalitso Kapyola, based in Mangochi. The position of Administrative Officer was filled by Suzan Lwanda, an MSHer who previously worked on our sister project, TBCAP.

### **Mid-term Evaluation**

A mid-term evaluation was conducted in the second quarter of the year. The evaluation was largely positive. The project has not yet received a report of the evaluation.

### **Deputy Chief of Party's Departure**

The Deputy Chief of Party who was also Director of Operations for MSH has left the project and the MSH Malawi program to take a new post in a regional MSH USAID funded project based in Pretoria, South Africa.

## **Annex 1: Major Plans for Year 4**

Project Year 3 activities focused on consolidating service delivery, supportive supervision, mass communication, and advocacy for supportive policies and/or practices. Project Year 4 will continue to consolidate service delivery, conduct some replacement training, and prepare for project conclusion and handover.

The total work plan budget for Project Year 4 is \$3,762,865. This amount is spread out across the nine outcome areas as indicated in the work plan. The amount includes \$1,130,492 in the Training line item. These funds will be expended on a number of training and other activities, including:

- Monthly review meetings for CBDAs. These will also serve as refresher training sessions
- Training of CBDAs in HTC and TB screening through the door-to-door method
- Training of CBDAs in couple counseling
- Training of CBDAs in nutrition promotion counseling
- Training of HSAs in administration of DMPA
- Refresher DMPA training for HSAs
- DMPA review meetings
- Procurement of supplies/incentives for CBDAs and HSAs

It should also be noted that our subcontractors, particularly PSI, have access to funds to support such activities as community drama clubs and radio Listeners' Clubs and other mass communication activities such as Open Days. For this reason, most of the resources in Project Year 4 are focused on supportive supervision and effective monitoring. The availability of the two new vehicles is quite important in this regard.

## Annex 2: Activities Planned and Associated Achievements for the Quarter

Activity No.	Activity Description	Achievements	Comments
<b>Increased Access to Community FP/RH and HIV/AIDS Services</b>			
<b>Train CBDAs in Integrated FP/RH and HIV/AIDS Services</b>			
1.A.1.2	Train CBDAs in HTC /TB Screening	98 CBDAs trained in HTC	The remaining 352 CBDAs will be trained in the first quarter of PY4
1.A.1.3	Train CBDAs in couple counseling	0	All CBDAs to be trained in the first quarter of PY4
1.A.1.4	Train CBDAs in nutrition promotion and counseling	0	All CBDAs to be trained in the first quarter of PY4
1.A.1.5	Train supervisors in HTC, TB Screening and Early Infant Diagnosis	0	All CBDAs to be trained in the first quarter of PY4
1.A.1.8	Procure drums and erect on concrete stands to use as incinerators for environmental waste management	0	Waste management meeting held Inventory of incinerators under way Incinerators to be erected first quarter of PY4
<b>Strengthen Contraceptive Delivery Systems</b>			
<b>Educate all partners about requirements for proper handling of each method</b>			
1.B.1.3	Facilitate procurement and distribution of Contraceptives / Condoms / DMPA	Achieved	Monthly reports available on stock status
<b>Ensure CBDAs have continuous supply of Contraceptives / Condoms / DMPA and HIV Test Kits</b>			
1.B.2.1	Monitor consumption, replenishment and utilization of FP Contraceptives by CBDAs	Achieved	100% of CBDAs had NO stock-outs of oral contraceptives. However, almost all CBDAs had stock-outs of both male and female condoms due to national level stockouts.
1.B.2.3	Ensure CBDAs have a continuous supply of test kits	0	Lots of stock-outs experienced due to national level stock-outs. This continues to be a challenge.
1.B.2.4	Monitor utilization and replenishment of test kits for community HTC	0	Monitoring ongoing; all CBDAs have experienced test kit stock-outs for reasons above
<b>Increased innovative approaches to expand contraceptive methods available to women.</b>			
<b>Introduce Provision of injectables in selected demonstration areas</b>			
1.C.5.11	Conduct supervision	Achieved	Supervision was done in the quarter
1.C.5.12	Conduct HSAs and Supervisors review meetings	Achieved	Review meetings were done in the quarter
<b>Train Health Workers in Tubal Ligation, Vasectomy, and Jadelle</b>			
1.C.7.1	Conduct quarterly review meetings with LTPM providers	Achieved	Meetings conducted
1.C.7.2	Advocate for procurement of BTL, Jadelle and vasectomy sets at district level	Achieved	Advocacy meetings conducted at both national and district levels; equipment procured by both MoH and MSH
<b>Review / Address policies which restrict women's FP choices</b>			
1.C.10.2	Participate in regional, district and	None	There were no Dawa meetings;

	community dawas (meetings of Muslim women groups) and make FP/HIV/AIDS presentations		MSH was invited to one annual community meeting; ongoing effort to be carried into PY4
<b>Improved quality of Family Planning &amp; HIV/AIDS Services</b>			
Monitor quality of care being provided by all CBDAs, HSAs, and LTPM providers			
1.F.6.1	Assess CBDAs, HSAs and LTPM providers adherence to IP standards	Achieved	All providers (76 HTC/CBDAs, 361 HSAs, and 96 LTPM providers) were supervised at least once during the course of the year; adherence to IP standards was part of the supervision
1.F.6.2	Conduct FP compliance assessments and client exit interviews		Ongoing
1.F.6.3	Assess health centers for PQI/IP standards and practices for suitability of provision of Jadelle Insertions	Achieved	Undertaken through regular supervision by FP Coordinator in each district
1.F.6.10	Monitor quality of care being provided by all CBDAs, HSAs and LTPM providers	Achieved	Conducted through regular supervision by District Coordinators.
1.F.6.11	Train Supervisors in HTC Quality Assurance	None	To be done in first quarter of PY4
<b>Integration of Family Planning and HIV/AIDS and STI Prevention</b>			
Integrate all HIV community-based activities into the role of CBDAs; counseling, referral for testing, and psychosocial support (to include promotion of abstinence, being faithful and other behavioral change practices)			
1.G.3.1	Develop HIV/AIDS referral forms to facilitate linkages and referral for other services	None	Decision made to use already existing MoH referral forms; forms to be reviewed in PY4 to accommodate door-to-door HTC provision
1.G.3.3	Incorporate HIV/AIDS into standardized supervisory monitoring tool to be used in all districts	None	HIV/AIDS to be incorporated into referral form after review of form in PY4
<b>Strengthened district and community provision and management of FP/RH and HIV/AIDS Services</b>			
Train the DHMT in performance monitoring and improvement (PMI)			
1.H.2.1	Conduct training for DHMT in performance monitoring and improvement and in leadership and management	None	Training for DHMTs postponed to PY4
Support DHMTs to position family planning as a priority health intervention with the DIP			
1.H.3.2	Participate in DIP quarterly review meetings to monitor progress	Achieved	DCs participated in all DIP development sessions at district level
Collaborate with BASICS program to enhance CFPHS initiatives in 6 overlapping districts			
1.H.4.1	Conduct joint quarterly monitoring visits	Achieved	Joint monitoring visits conducted
1.H.4.2	Facilitate monthly/quarterly joint program review meetings	Achieved	Meetings conducted on regular basis
<b>Support facilitative supervision of FP and HIV/AIDS/STI Services</b>			
1.H.5.1	Support monthly facilitative supervision by FP/HIV/AIDS Advisor	Achieved	Facilitative supervision visits conducted regularly
1.H.5.4	Facilitate quarterly supportive supervision of HTC counselors	Achieved	Quarterly supervision conducted
<b>Project Management: Monitoring and Evaluation</b>			
Develop and manage project databases and analyze data regularly for input to project reports and to respond to other USAID requests			
A.1.3	Track key and custom performance indicators for monitoring at MSH and	Achieved	Performance indicators tracked every month; number reduced to 17 following

	key partners, district, health centre, and community levels		reduction of number of HIV indicators
A.1.5	Conduct data audit process for all the 8 target districts	Achieved	Data audit conducted
A.1.5.1	Conduct data quality assessments' exercise every six months in all the 8 target districts	None	Exercise restricted by turnover of M&E advisors
A.1.5.2	Review district coordinators quarterly reports and provide documented feedback	Achieved	Quarterly reports reviewed and commented upon
A.1.5.3	Conduct monitoring and supervision visits on FP compliance	Achieved	Monitoring and supervision visits conducted
A.1.5.4	Support refresher course for district staff in integrated HMIS	Achieved	Refresher course conducted
A.1.6	Hire 4 Assistant Statisticians (1 per district) to facilitate data collection from HTC counselors – an average of 100 data sources per district	Achieved	Assistant Statisticians hired
<b>Project Management: Communication</b>			
USAID and other clients are provided with program information in a timely manner			
B.1.1	Submit Year 4 Annual work plan and budget details	None	Was submitted on time
B.1.4.1	Submit quarterly report to USAID Malawi	Achieved	Quarterly report submitted
Program results are disseminated according to a planned strategy for communication			
B.2.1	Develop and disseminate success stories and highlights	Achieved	Success stories developed and disseminated
B.2.2	Develop press releases as needed	Achieved	1 press release submitted to Mission in collaboration with K4H (World Population Day)
B.2.4	Maintain/update package of materials that can be used to brief a variety of audiences	Achieved	5 documents developed, including project brochure
B.2.5	Disseminate information on project progress to MoH and other stakeholders	Achieved	Financial report submitted to Ministry of Finance and quarterly reports submitted to DHMTS and RHU
B.2.6	Provide project information appropriate for USAID website.	Achieved	Article on Dawa meeting appeared on USAID website; also 5 success stories submitted to USAID

## Annex 3: Details of PY3 Accomplishments

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

Review of PY 3 Annual Work Plan accomplishments

Project Year 3: 1 October 2009 to 30 September 2010

Outcome No.	Sub-outcome No.	Activity No.	Activity Description	Targets	Budget (at Outcome level)	Timeline												Comments	Target met
						2009	2010												
						Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1.A	Increased access to community FP/RH and HIV/AIDS services				\$258,286														
	1.A.1	Train CBDAs in intergrated FP/RH and HIV/AIDS services																	
		1.A.1.1	Refresher training for CBDAs	750		X	X	X										Done as review meetings; 2 days in each district between Oct - Dec 2009	750
		1.A.1.2	Attend the Family planning workshop in Uganda	1		X												FP Advisor & Policy Specialist attended workshop in Uganda in Nov 2009	1
	1.A.3	Link with PSI's ongoing social marketing strategy to engage private clinics, pharmacists and NGOs in the provision of low-cost contraceptives																	
		1.A.3.1	Conduct detailing visits to registered private medical providers to engage them in social marketing.	205		X	X	X	X	X	X	X	X					Target reached	205
1.B	Strengthened Contraceptive Delivery systems				\$51,221														
	1.B.1	Educate all partners about requirements for proper handling of each method																	
		1.B.1.1	Review CBDA intergrated data collecting tools	2		X												2 tools reviewed, Integrated tally sheet & Monthly summary; Changes to be incorporated in Yr 4	2
		1.B.1.2	Monitor national level stocks and distribution system of FP contraceptives	2		X												Activity on-going; reports compiled on quarterly basis through collaborative effort with USAID Deliver	4
		1.B.1.3	Facilitate Procurement and distribution of contraceptives/condoms/DMPA	12		X	X	X	X	X	X	X	X	X	X	X	X	Monthly reports available on stock status	11
	1.B.2	Ensure CBDAs have continuous supply of contraceptives/condoms/DMPA and HIV Test Kits				X	X	X	X	X	X	X	X	X	X	X	X		
		1.B.2.1	Monitor consumption, replenishments and utilization of FP contraceptives by CBDAs	100%		X	X	X	X	X	X	X	X	X	X	X	X	100% of CBDAs had NO stockouts of oral contraceptives. However, almost all CBDAs had stockouts of both male and female condoms due to national level stockouts.	100%
		1.B.2.2	Print and distribute integrated tally sheets for data collection for contraceptives and test kits	12,000		X												Tally sheets printed and distributed; on-going activity	Over 12,000
		1.B.2.3	Ensure CBDAs have a continuous supply of test kits	90%		X	X	X	X	X	X	X	X	X	X	X	X	Lots of stockouts experienced due to national level stockouts. This continues to be a challenge	0%
		1.B.2.4	Monitor utilisation and replenishment of test kits for community HTC	90%		X	X	X	X	X	X	X	X	X	X	X	X	Monitoring on-going; all CBDAs have experienced test kit stockouts for reasons above	0%
1.C	Increased Innovative Approaches to Expand Contraceptive Methods available to women.				\$139,690														
	1.C.3	Pilot the feasibility of having CBDAs provide standard days method service (cycle beads)																	
		1.C.3.1	Develop scope of work and terms of reference for the operational research on cycle beads.	1		X												Scope of work developed and ToRs; study to be implemented 1st Quarter PY4	1
		1.C.3.2	Develop protocols for operational research	1		X												Draft tools developed	1
		1.C.3.3	conduct operational research	1			X	X										Study to be implemented 1st Quarter PY4; there was a break in availability of cycle beads which prevented further progress with study	0
		1.C.3.4	Review and finalize the SDM training manuals	2		X												Piloting of manuals on-going; review and finalization in PY4	0
	1.C.4	Develop policy guidelines for community based distribution of injectable contraceptives in coordination with MOH/RHU and National RH TWG.																	
		1.C.4.1	Review guidelines for community based distribution of injectable contraceptives.	1					X									Guidelines have not been revised due to delay in implementing evaluation of DMPA; expected to be revised in PY4	0
	1.C.5	Introduce provision of injectables in selected demonstration areas																	
		1.C.5.1	Participate in USAID evaluation of DMPA in the nine pilot districts				X											Evaluation conducted; dissemination done but report not yet released	





		I.H.5.3	Participate in Quarterly Zonal DHMT meetings	16	X			X											Regularity of zonal meetings affected by availability of MoH	5
		I.H.5.4	Facilitate quarterly supportive supervision of HTC counselors	8	X			X			X								Quarterly supervision conducted	Exceeded
<b>1.1</b>	<b>Policy and Guidelines for Social Marketing and CBD of injectables.</b>																			
	<b>1.1.3</b>	<b>Develop and pilot policy and guidelines for social marketing and community-based distribution of injectables.</b>																		
		1.1.3.1	Develop guidelines for community-based social marketing of contraceptives	1							X								Social marketing is currently against MoH policy of free health service provision; consultations between RHU and CFPHS on this are on-going	0
<b>Project Management</b>																				
				<b>\$1,034,464</b>																
	<b>A. Monitoring and Evaluation system instituted</b>																			
	<b>A.1</b>	<b>Develop and manage project databases and analyze data regularly for input to project reports and to respond to other USAID requests.</b>																		
		A.1.1	Develop/adapt/maintain data management information system for use by the project	1	X	X													System in place; work being undertaken to improve it through use of structured database	1
		A.1.2	Train all AAs and DCs on the use of the management information system	16			X												Training conducted (number exceeded due to staff turnover)	21
		A.1.3	Track key and custom performance indicators for monitoring at MSH and key partners, district, health centre and community levels.	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Performance indicators tracked every month; number reduced to 17 following reduction of number of HIV indicators	24
		A.1.4	Adapt/maintain data collection and collation tools for each level as highlighted in A.1.3 above incorporating key indicators identified for each level for systematic routine monitoring.	3		X	X	X	X	X	X	X	X	X	X	X	X	X	4 data collection tools developed: i) SDM data collection ii) SDM register iii) Review Meetings registered and iv) CBDA supervisory checklist. Also adapted MoH's HTC Retrospective Data Collection Tool	5
		A.1.5	Conduct Data Audit process for all the 8 target districts	8	X					X							X	Data audit conducted	8	
		A.1.5.1	Conduct data quality assessment exercise every six months in all the 8 target districts	16						X							X	Exercise restricted by turnover of M&E advisors	2	
		A.1.5.2	Review district coordinator's quarterly reports and provide documented feedback	16	X			X			X			X				Quarterly reports reviewed and commented upon	32	
		A.1.5.3	Conduct monitoring and supervision visits on FP compliance	12		X	X	X	X	X	X	X	X	X	X	X	X	X	Monitoring and supervision visits conducted	12
		A.1.5.4	Support refresher course for district staff in integrated HMIS	24		X	X	X	X					X	X	X		Refresher course conducted	24	
	<b>A.3</b>	<b>Plan and implement baseline and end-of-project household surveys</b>																		
		A.3.3	Participate in mid term program assessment by USAID	1				X	X										Program assessment done	1
		A.3.4	conduct a survey on sustainability of CBDA programme	1						X	X								There has been inadequate timeframe to evaluate sustainability issues since not all inputs for CBDAs have been provided; survey to be conducted in PY4	0
	<b>B. Communication</b>																			
	<b>B.1</b>	<b>USAID and other clients are provided with program information in a timely manner</b>																		
		B.1.1	Submit Year 4 Annual work plan and budget details	1													X	To be submitted in time		
		B.1.3	Submit Updated Detailed Implementation Plan(DIP)	1	X														No changes to DIP so no need for resubmission	1
		B.1.4	Submit the following required documents to USAID DEC	6																
		B.1.4.1	Submit quarterly reports to USAID/Malawi.	3			X			X			X						Submitted	4
		B.1.4.2	Submit Semi annual reports to USAID/Malawi	1						X									Submitted	2
		B.1.4.1	Submit SOPIR	1						X									Submitted	2
		B.1.4.2	Submit Annual Report	1	X														Submitted	1
	<b>B.2</b>	<b>Programme results are disseminated according to a planned strategy for communication</b>																		
		B.2.1	Develop and disseminate success stories and highlights	5	X		X		X				X						Success stories developed and disseminated	5



## **Annex 4: Volunteer Motivation**

The Community-based Family Planning and HIV and AIDS project works through a network of Community-based Distributors; CBDAs and HSAs; to provide integrated, high quality and accessible family planning and HIV Testing and Counseling services to communities within the hard-to-reach and underserved areas. The project employed this approach following observations that despite the growing population and the high prevalence of the HIV and AIDS pandemic, there was a lack of medical staff at all levels of the health systems in Malawi to cater to this increased demand for health care, let alone meet the demand in the hard-to-reach areas. The situation is exacerbated by the paucity of available health centers in the hard-to-reach areas. These CBDAs are ordinary community members who are recruited and trained to provide the family planning and HIV testing and Counseling services to their fellow community members on a voluntary basis.

In the course of project implementation, the project has experienced some challenges with regards to the retention of these volunteers; 1003 CBDAs in all the 8 districts. Presently 145 of these CBDAs have dropped out of the program, representing a 14% dropout rate. Most of the drop outs have secured gainful employment like teaching. Volunteer motivation was realized to be the major contributing factor to maintaining these CBDAs within the project. The motivation of people to volunteer has long fascinated those researching and working alongside volunteers and understanding the underlying motivational drives of those who volunteer is fundamental to the success of projects that work through volunteers in the implementation of their activities. What actually motivates a person to volunteer is a complex and vexing question, yet understanding these motivations can be of great assistance to organizations in attracting, placing and retaining volunteers (J. Esmond, 2004).

The project, therefore, is working toward devising strategies to retain the CBDAs. Some are incentives like providing honoraria, bicycles, and refresher trainings. The project expects the dropout rate to go down once these strategies are put in place.

The honoraria are given during the review meetings that are conducted monthly in all the districts. During these meetings, the CBDAs meet with their supervisors, and this also provides a forum for the CBDAs to share experiences and challenges pertaining to their work. Experience has shown that some CBDA dropouts are returning to the program following this development.

Anecdotal evidence suggests the long distance to the nearest Health Facility as a major factor deterring the CBDAs commitment to their work. As such, bicycles have been distributed to all the CBDAs currently active in all the districts. Refresher courses have been organized in order to cement the CBDAs' skills and this may consequently serve as a motivating factor as they will feel that their work is being recognized.

The project expects that CBDAs who are currently active will become more committed to their work. It also expects few or no CBDA dropouts following the implementation of these strategies.

## **Annex 5: Project Travel & Mission Visits**

### **USAID Project Visits**

#### **Mponela HTC Training**

The HIV & AIDS Prevention Specialist visited the HTC Training sessions in Mponela. This was a monitoring visit.

#### **Visit to Balaka and Mangochi**

In preparation for the mid-term evaluation, the USAID mission in Malawi visited the projects in Balaka and Mangochi. This was also a successful monitoring visit.

### **Project Travels**

#### **Country Lead's visit to Malawi**

The home office country lead for Malawi visited the project in May 2010 to provide support to the project. The country lead would like to ensure that opportunities for synergies are appropriately utilized by the different projects currently funded by USAID and implemented by MSH in Malawi.

#### **International Travel**

The Policy Specialist traveled to the Futures Group International home office in the US. The aim of the visit was to orient the new project focal person; to participate in the Health Policy Initiative end-of-project meeting; and to share CFPHS project activities and accomplishments with USAID and Futures Headquarters. In May 2010, the specialist traveled to Kigali to attend a USAID-led international family planning meeting, joining 11 other African countries. The meeting was a follow-up to the Kampala international family planning conference; and its aim was to help countries discuss key components that would accelerate the FP program's achievement of MDGs. Malawi came up with an action plan that is currently being operationalized.

Earlier in the year (Nov 2009), the specialist and the FP advisors traveled to Kampala, Uganda, to represent the project at an international FP conference. The focus of the conference was sharing best practices and researching evidence that would convince policy makers to move FP into their development agendas so as to meet the high unmet need for FP.

In August 2010, the HIV & AIDS Advisor traveled to the International HIV & AIDS Conference that was held in Vienna. The HIV Advisor presented on the project's door-to-door approach to HTC services.