Final Assessment

Long-Term and Permanent Contraception (LTPC) and Postabortion Care (PAC) Programs 1999-2003

Malawi
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Glossary and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
BLM	Banja La Mtsogolo, a Malawian NGO and provider of substantial FP/RH services in Malawi
CA	Cooperating Agency, USAID terminology for the technical assistance agencies that USAID funds as its implementing partners
CHAM	Christian Health Association of Malawi
CO	Clinical Officer, cadre of health care provider in Malawi whose training approaches that of doctors in certain respects, including surgical skills.
COPE	EngenderHealth Quality Improvement Tool (Client-Oriented, Provider Efficient)
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development, the UK Government Department responsible for promoting sustainable development and reducing poverty.
DHMT	District Health Management Team
DHS	Demographic and Health Survey
Community COPE©	A participatory process and tools that assist staff to build partnerships with community members in order to improve local health services, making them more responsive to local needs and increasing community "ownership".
EngenderHealth, or EH	Established in 1943, EngenderHealth is a reproductive health organization that works worldwide to improve the lives of individuals by making reproductive health services safe, available and sustainable. EngenderHealth provides technical assistance, training and information with a focus on practical solutions that improve services where resources are scarce.
Facilitative Supervision	This approach to supervision emphasizes the supervisor's role in facilitating quality improvement among a team of staff. It emphasizes mentoring, joint problem solving and two-way communication between a supervisor and those being supervised.
FHI	Family Health International
FP	Family Planning
FS	Female Sterilization, one of the 4 methods of long-term and permanent contraception (LTPC).
HIV/AIDS	Acquired Immune Deficiency Syndrome, the disease caused by the Human Immunodeficiency Virus.
IP	Infection Prevention
IUD	Intrauterine Contraceptive Device
JHPIEGO	An NGO affiliated with Johns Hopkins University that provides technical assistance in reproductive health to developing countries.

LTPC	Long Term and Permanent Contraception, which includes four contraceptive methods: female sterilization, vasectomy, Norplant, and IUDs.
ML/LA	Minilaparotomy under Local Anesthesia, a methodology for providing FS without recourse to general anesthesia; the approach to FS in which EngenderHealth trains trainers and service providers.
MMR	Maternal Mortality Ratio. The number of maternal deaths per 100,000 live births.
MOHP	Malawi Ministry of Health and Population
MVA	Manual vacuum aspiration of the uterus
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
NSV	No-scalpel vasectomy, the vasectomy methodology that has been proven to have fewer complications than standard vasectomy, and which EngenderHealth has introduced into Malawi.
OJT	On-the-job training (also referred to as site-based or clinic-based training), a form of training that allows the healthcare provider to learn to provide a range of reproductive health services within her or his own work setting.
PAC	Postabortion Care
PATH	Program for Appropriate Technology in Health
PI	Performance Improvement
PID	Pelvic Inflammatory Disease
POP-FP	World Bank funded project operating in 3 districts, with which EngenderHealth collaborated on LTPC and PAC.
RH	Reproductive Health
RHU	Reproductive Health Unit of the MOHP, responsible unit for reproductive health activities in Malawi, including LTPC and PAC service delivery.
SC	Sharp curettage of the uterus
STI	Sexually transmitted infection
SWAP	Sector-wide approaches, defining characteristics being that all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds.
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers
USAID	The United States Agency for International Development, primary funding agency for EngenderHealth's LTPC and PAC activities in Malawi.

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Executive Summary

This Report provides a Final Assessment of the Long-Term and Permanent Contraception (LTPC) and Postabortion Care (PAC) programs in Malawi[1]. The Assessment was undertaken at the request of USAID, the major donor for these services in Malawi; it is the product of an 8-person, 5-organization Assessment Team drawn from organizations involved in FP/RH service provision: the Ministry of Population and Health (MOHP), Christian Health Association of Malawi (CHAM), Malawi Medical Council, Malawi Nurses and Midwives Council, and EngenderHealth. EngenderHealth led the conduct of the Assessment and generation of the Report.

Despite its dearth of human and financial resources for health and its great burden of overall disease (e.g., 15% of Malawians aged 15-49 are HIV+), Malawi has made remarkable progress in providing FP/RH services to its citizens in the past decade. Use of modern contraception, less than 5% before 1990, has risen markedly, to 26% by 2000 (Malawi DHS), and use of female sterilization tripled from 1992 to 2000, to 5%. Thus approximately 20% of modern method contraceptive usage in Malawi today is represented by female sterilization.

EngenderHealth, USAID's main vehicle for providing TA in LTPC and PAC, began working in Malawi in November 1999[2]. EngenderHealth's goal has been to help MOHP and CHAM increase access, quality and use of LTPC, to reduce morbidity and mortality from incomplete abortion, and to break the cycle of repeated abortion by providing post-abortion FP. EngenderHealth's strategy has been to provide needed equipment and supplies, relevant in-service training, and related TA, focused especially on quality, counseling, infection prevention, and supervision.

Key Findings and Conclusions:

Equipment and Supplies

- EngenderHealth met or exceeded its targets for provision of equipment and supplies for both LTPC and PAC, providing a wide range of surgical equipment and supplies needed to deliver quality services to 33 facilities for LTPC and 19 facilities for PAC.

- Renovations were completed of facilities at Rumphi District Hospital, Embangweni Mission Hospital and Malingunde Health Centre. Renovation work at Lilongwe Central Hospital was nearly completed – however, an operating light and floor tiles were not provided. Renovation of Kasungu District Hospital encountered difficulties with the contractor and work was not completed satisfactorily.

Training/Performance Improvement

- For the most part, EngenderHealth met or exceeded its quantitative training targets. Overall, 32 discrete training events were supported and conducted by EngenderHealth and its partners.

[1]From 1999-2003 and 2001-2003 respectively.

[2]EngenderHealth (AVSC International until 2000) also worked in Malawi with USAID support from 1989-1995, introducing services for female sterilization (ML/LA) and Norplant on a more limited scale.

Of Malawi's 205 Clinical Officers, as many as 119 (58%) were trained in some aspect of LTPC and/or PAC. Of Malawi's 379 RNs, as many as 151 (40%), were trained[3].

- Given the death of trained health care providers, EngenderHealth logically employed a "cascade" training strategy as a means to improve the quality and availability of services. Thus training of trainers was conducted first, and then those trained trainers trained additional service providers centrally as well as on the job (OTJ). Although sizeable numbers of trainers/service providers were trained, further cascade training via OJT at the district-level was limited, primarily because of manpower constraints and competing service demands.

- LTPC and PAC in-service training is now conducted in a more comprehensive and humanistic manner in Malawi, incorporating the latest international findings and standards.

LTPC and PAC Service Delivery

- Overall, EngenderHealth's inputs of equipment, supplies, renovation, training, and TA contributed to improved quality, availability and use of LTPC and PAC services:

    - LTPC services were introduced and/or strengthened in every MOHP Central and District hospital, and in a substantial proportion of CHAM's hospitals.
    - Demand/use of FS and Norplant was significant, with an average of over 4000 TLs performed annually, and Norplant use increasing notably in 2002 and 2003.
    - Vasectomy, on the other hand, was quite infrequently provided, due to minimal demand.
    - Comprehensive PAC services improved greatly, from being largely unavailable at the District level to being available in 22 facilities.
    - FP counseling post-MVA ranges from 90-100%, with FP post-MVA provided to 60-70% of clients; formerly such services were infrequently provided and less regularly linked.
    - IP practices are improved.

- The partnership between MOHP, CHAM and EngenderHealth (and among other CAs, most notably JHPIEGO) has been strong, collegial, and mutually supportive.

- There are marked constraints to LTPC and PAC service provision: shortage of financial and human resources for health (only a subset of whom are trained in LTPC and PAC); continuing attrition of trained personnel; and a great burden of disease. The supervisory system for LTPC, especially in the MOHP, is thus inadequate.

- EngenderHealth's work, to the extent that it was valued and effective, is a reflection of the type and extent of assistance provided by USAID to help improve Malawi's RH services.

Lessons Learned

- Quality of services can be improved, even in severely resource-constrained environments.
- Demand for services will increase when it becomes known that the services are available and that the quality of those services has been found to be acceptable.

[3]Some individuals received more than one type of training, thus these estimates of the percentage of Malawi's Clinical Officers and Registered Nurses trained are maximums.

- Attention must be given to all service system components, e.g.: equipment, supplies and commodities; pre-service/in-service training; other PI measures such as facilitative supervision; client/quality-oriented aspects such as counseling; and demand generation.
- The complement of trained providers (who are then available to provide services, as well as to further train others via OJT) is a major "rate-limiting" step in providing LTPC and PAC.
- To ensure quality and safety in providing surgical FP/RH methods, continued vigilance via effective, regular supervision is needed; supervision suffers when supervisors have not been trained to competency in the service that they are supervising.

Principal Recommendations for LTPC and PAC Services in the Future

Equipment and Supplies

1. The MOHP and DHMTs should plan and budget for LTPC and PAC equipment and supplies in their districts, to ensure a reliable supply.
2. The Central Medical Stores should have LTPC and PAC equipment and supplies registered in the essential equipment list and available in country.
3. The MOHP should follow-up with contractors hired to renovate sites and ensure that outstanding work is completed according to terms of the contracts.

Training

1. Additional centralized training for trainers in LTPC and PAC surgical skills will need to be continued, at facilities with proficient trainers and adequate caseloads.
2. Once trained, trainers should be supported at their home facilities to provide structured on-the-job training (OJT) to other appropriate clinical staff.
3. All COs and RNs currently untrained in LTPC and/or PAC should be trained.
4. After being trained to competency and certified, Enrolled Nurses should be eligible to provide both Norplant and PAC services, under regular supervision.
5. LTPC and PAC should be included in pre-service education for Doctors, COs and Nurses.

Long Term and Permanent Contraception Services

1. FS and Norplant, the most popular of the LTPC methods, should receive priority attention within LTPC training and service delivery.
2. Vasectomy (NSV) services should be consolidated at a few dedicated sites that have a trained vasectomist and adequate caseload; vasectomy should then be a referral service.
3. More attention/effort should be given to training COs and Nurses in IUD insertion and removal, so IUD services can be more widely known and accessed.

PAC Services

1. Comprehensive PAC services should be expanded to other sites where these services are currently not available, including rural hospitals and health centers.

Cross-Cutting Services

1. Infection prevention should continue to be strengthened in all facilities.
2. Counseling training and services should be intensified, and integrated into all RH services.

3. QI tools/activities that empower clients, providers and communities to make improvements with existing resources, e.g., COPE and Community COPE, should be widely used.
4. The MOHP should include COPE/Community COPE in its Essential Health Package.
5. Facilitative supervision and medical monitoring of LTPC and PAC are critical to maintaining quality and safety and should be priority activities; supervision and monitoring by competent providers should be done at least quarterly at each facility providing LTPC and PAC services.

Demand Generation for LTPC Services

1. Method-specific demand generation should be continued/increased.

Overall

1. Given the complexity of providing quality LTPC and PAC services, specialized external TA is still needed; such TA can add value and complementarity to SWAPs.

I. Methodology of Assessment

The Final Assessment Team was constituted, at the request of USAID, to assess the Long-Term and Permanent Contraception (LTPC) and Postabortion Care (PAC) programs in Malawi (See Appendix 1, Scope of Work). The Team was comprised of eight individuals representing five organizations that are involved in some aspect of the provision of LTPC, PAC and other RH services in Malawi: the Ministry of Population and Health (MOHP)/Reproductive Health Unit (RHU), Christian Health Association of Malawi (CHAM), Malawi Medical Council, Malawi Nurses and Midwives Council, and EngenderHealth. EngenderHealth led the conduct of the Assessment and generation of the Team's Report.

Prior to conducting fieldwork, the Team reviewed a wide range of relevant background materials, including LTPC and PAC strategies, site assessment reports, EngenderHealth subagreements, EngenderHealth interim reports, assessments and other data, MOHP and CHAM service statistics, DHS Reports, and USAID and DFiD Reports. Information-gathering instruments designed specifically for donors and other key informants, hospital managers, providers, and clients were also generated for use during the fieldwork (See Appendix 5).

Fieldwork was conducted from August 11-22, 2003. Site visits, including assessment of facilities, review of records, and interviews of District Hospital staff and clientele, were conducted at 12 sites from all three regions of Malawi. These included high and less-high performing sites of both MOHP and CHAM[4]. In addition, almost all of the 33 sites involved in the LTPC program and the 22 sites involved in the PAC program had been visited by one or more Team members in the previous six months. Semi-structured interviews were also conducted with key informants from donor agencies (USAID, DFiD), implementing organizations (MOHP, CHAM), Cooperating Agencies (JHPIEGO, FHI, PATH), and other organizations involved in providing LTPC and PAC and related services (BLM, Story Workshop).

[4]See Appendix 3 for specific sites visited.

After the fieldwork, the Team reassembled, arrived at consensus conclusions and recommendations, and presented them in draft form to USAID (the principal donor for LTPC and PAC services) and to the MOHP and CHAM, for discussion and subsequent revision.

II. Introduction and Background

A. Malawi Context

Malawi has made remarkable progress in providing FP/RH services to its citizens in the past decade. Whereas use of modern contraception among married women age 15-49 was less than 5% before 1990, the contraceptive prevalence rate (CPR) rose markedly, to 14% in 1996 and 26% by 2000[5] (Malawi DHS). This increase has been fueled largely by an increase in the use of injectable contraception. But also noteworthy, particularly in the context of this Assessment, is that the CPR for female sterilization tripled from 1992 to 2000, to 5%. Thus approximately 20% of modern method usage in Malawi today is represented by female sterilization.

This improvement in CPR is all the more impressive in light of the fact that Malawi is the 9th poorest country in the world, with a per capita income of less than $200 in 1999, 60% of its populace below the poverty line, and continuing economic challenges, including a frequently fluctuating currency[6], large budget deficits and high inflation. In addition, female literacy beyond primary education is only 11.1%, with 27% of women having no education at all. Finally, the health sector is remarkably thin, with approximately 75 doctors, some 200 Clinical Officers, and fewer than 400 Registered Nurses and 2000 Enrolled Nurse/Midwives to serve Malawi's population of over 10 million citizens.

Malawi's health indicators and available resources for health are equally—and to a large extent, causally—challenged. The burden of disease is great: widespread and severe malaria; HIV seroprevalence in the population aged 15-49 of 15%; high infant mortality (IMR 104/1000 live births) and child mortality (Under-5 mortality rate 189/1000 live births); and high maternal mortality ratio (1120 deaths/1000,000 live births)—with 30% of that mortality estimated to be related to unsafe abortion[7]. Furthermore, despite the rapidly rising CPR, the Total Fertility Rate of 6.3 children/woman is one of the highest in the world, and total unmet need for FP is still substantial, estimated at 30%.

B. EngenderHealth in Malawi

EngenderHealth (which went by the name AVSC International until March 2000), worked in Malawi between 1989 and July 1995 with USAID funding. During this period, EngenderHealth provided financial support and technical assistance to initiate a program for ML/LA, initially through the CHAM hospitals. In 1992, with a request from the MOHP, EngenderHealth introduced minilaparotomy with local anaesthesia (ML/LA) in three district hospitals. In addition, EngenderHealth initiated the introduction of Norplant (NP) insertion and removal in the supported sites.

[5]Use of modern contraception thus rose by 3% annually from 1996-2000, very high by international standards, where a rise of 2% annually is considered evidence of a "strong" program effort. In addition, traditional methods fell off only minimally, indicating that the gains have been additive, not substitutive.
[6]Depreciation of the kwacha was 16% in just the 2+ weeks that the Team worked together.

[7]Mtimavalye, 1996; in addition to this estimated mortality, complications account for as much as 60% of acute gynecological admissions into both public and private health facilities in Malawi (Kinoti et al, 1995).

To ensure standardized techniques, voluntarism and informed choice for the surgical procedures, EngenderHealth trained clinicians and nurses from both the MOHP and CHAM in skills for ML/LA, NP insertion and removal, and counseling. By 31 July 1995 when the USAID/EngenderHealth funded program ended, EngenderHealth had established capacity for training in ML/LA, NP insertion and removal, and counseling at 22 sites; capacity for performing no-scalpel vasectomy (NSV) was established at 3 of the 22 sites. EngenderHealth had also established the capacity for medical monitoring and supervision, especially within CHAM. Part of the reason for the success of the initial USAID/EngenderHealth-supported program was the support by the MOHP and CHAM management/administration.

The Malawi program was managed from EngenderHealth's Kenya Regional Office from October 1999 until November 2001, at which time an experienced Malawian RH professional was appointed EngenderHealth's in-country Program Manager. This positive development has since allowed EngenderHealth to maintain a continuous presence in-country, which in turn allowed for better integration of EngenderHealth into the MOHP/RHU's program and better coordination with donors and other CAs.

EngenderHealth's Malawi Program Manager has continued in her role until the present, working closely with the RHU/MOHP on specific activities, providing technical assistance and advice, and serving on the RHU's Program Management Unit and Social Welfare Committee. In addition, EngenderHealth's workplan is incorporated into the workplan of the RHU. EngenderHealth has also provided assistance to the LTPC and PAC efforts from both the Kenya Regional Office and from New York headquarters for specific technical and financial needs (e.g., LTPC and PAC trainings and/or supervision, various needs assessments and/or evaluations).

In January 2002, following several PAC needs assessments conducted by MOHP, JHPIEGO, and EngenderHealth, comprehensive PAC[8] training and services, and renovation of selected facilities, became part of EngenderHealth's package of assistance to the MOHP and CHAM. EngenderHealth initially focused on the supply side of LTPC and PAC; in late 2002, a modest component of demand creation for LTPC was added via a subcontract with PATH, which worked with Story Workshop, a Malawian NGO.

EngenderHealth's LTPC[9] goal has been to help the MOHP and CHAM to increase access to, and quality and use of, long-term and permanent contraception (LTPC). EngenderHealth's PAC goal was to support the National PAC Programme to reduce maternal mortality and morbidity from complications of incomplete abortion, and to break the cycle of repeated abortion by providing post-abortion family planning.

[8]Comprehensive PAC services include not only effective pain management and emergency treatment of incomplete abortion and potentially life-threatening complications, but also post-abortion counseling and services for family planning, linkages to other RH services (e.g., STI, VCT, sub-fertility), and community awareness and involvement.

[9]The four LTPC methods generally available in family planning are female sterilization, vasectomy, Norplant and IUD. Of these four, female sterilization and vasectomy are considered to be permanent methods, while Norplant and the IUD are long-term, temporary methods. Female sterilization, vasectomy and Norplant are surgical methods and were the only methods that EngenderHealth was asked to work on with MOHP and CHAM.

EngenderHealth's specific strategy has been the same for both areas: provide the MOHP and CHAM with needed equipment and supplies, renovated facilities, a broad range of relevant in-service training (primarily of trainers), and related technical assistance focused especially on quality, counseling, infection prevention, and facilitative supervision. In turn this would expand MOHP and CHAM capacity to provide quality clinical/surgical LTPC and PAC services more widely in their facilities. In these ways EngenderHealth hoped to be a helpful partner, contributing to increased quality, availability, institutionalization and sustainability of services at MOHP and CHAM facilities, while ensuring that "ownership" was clearly Malawian.

III. Findings and Conclusions

A. Equipment, Supplies and Renovations

EngenderHealth met or exceeded its targets for provision of equipment and supplies for both LTPC and PAC. A wide range of standard equipment and supplies needed to deliver quality services (including backup equipment and supplies) was provided[10]. Types of equipment and supplies provided[11] included operating theater equipment, minilaparotomy kits and/or replacement instruments, no-scalpel vasectomy kits, Norplant sets, complete PAC equipment[12], other reusable surgical supplies, and air-conditioning units. The project provided five "Madame Zoe" models to the MOHP; the RHU retained them centrally for use in trainings as required rather than distribute to individual sites. In addition, three out of five hospitals[13] were renovated to standard to enable LTPC services to be provided.

Overall, in accordance with the 1999 Needs Assessment, EngenderHealth equipped and supplied 33 hospitals for LTPC services: all 24 MOHP hospitals (4 central, 20 district), and 9 (of the 20) CHAM hospitals. Materials for LTPC training and supervision, and IP manuals and wall charts, were also supplied to all 33 facilities In addition, in accordance with PAC needs assessments, 19 MOHP facilities (14 district hospitals, 4 rural hospitals, and 1 health center) and 3 CHAM facilities[14] were equipped and supplied to provide PAC services. Additional replacement kits and parts were also supplied to the Central Stores.

The MOHP planned and implemented renovations of selected health facilities under the terms of its subagreement with EngenderHealth. Renovations were completed of facilities at Rumphi District Hospital, Embangweni Mission Hospital and Malingunde Health Centre. Renovation work at Lilongwe Central Hospital lacked provision of an operating lamp and installation of floor tiles by the contractor. Renovation of Kasungu District Hospital also encountered difficulties with the contractor and work was not completed satisfactorily. Work outstanding includes

[10]Once these supplies and equipment reached Malawi, some difficulty and delay was encountered in the system's being able to get the material out to the needed sites for supply and renovation, though for the most part these bottlenecks have now been removed.

[11]See Appendix 6 for a complete, detailed listing of the types and amounts provided.

[12] See Appendix 7 for a list of PAC and specialized LTPC equipment provided.

[13]The renovated hospitals are Rumphi District Hospital, Embangweni Mission Hospital and Malingunde Health Centre. Sizeable in-theatre air conditioners were installed at Ekwendeni Mission Hospital and Nkhoma Hospital.

[14]Nkhoma, Malamulo and Embangweni Mission Hospitals.

electrical wiring, installation of a washing sink and a final coat of paint – the general quality of the work overall was poor.

Funding for sub-recipients is provided by EngenderHealth in the form of advances. Subrecipients report on these advances and their uses in quarterly financial reports. As of the end of the last MOHP subagreement, financial reports indicated an outstanding balance of $8,226 claimed by MOHP and awaiting reimbursement.

EngenderHealth routinely conducts audits of all USAID-funded subagreements over $300,000. In this instance, MOHP received subagreements totaling $351,369 from April 2000 through March 2003. Therefore, EngenderHealth hired an audit firm – KPMG – to review the subagreement with the MOHP, including the use of contractors for renovation of facilities. The audit will be finalized in November 2003 and will include the identification of any costs which may be disallowed for reimbursement because of incompletion or other reasons. In the meantime, the MOHP should follow-up with contractors to ensure that renovations are completed as per the terms of the contracts.

B. Training/Performance Improvement

In order to be maximally efficient, and in view of Malawi's marked shortage of health care providers, EngenderHealth employed a "cascade" training strategy as a means to improve the quality and availability of services. In this strategy, training of trainers was conducted first, and then those trained trainers trained additional service providers centrally as well as on the job (OTJ).

Training in LTPC was conducted across 1999-2003 and encompassed ML/LA, NSV and Norplant insertion and removal. PAC training was added in 2002. Training in crosscutting aspects of both of these services—infection prevention, counseling, facilitative supervision, and other quality interventions (COPE and Community COPE)—also was conducted across 1999-2003, either separately or as a component of many of the service-specific training events.

For the most part, EngenderHealth met or exceeded its quantitative training targets for LTPC, PAC, and cross-cutting services, as can be seen in Table 1, which presents a comparison of the training planned to the training accomplished. In addition, LTPC and PAC in-service training is now conducted in a more comprehensive and humanistic manner in Malawi, and this training incorporates the latest international findings and standards.

A sizeable number of trainers/service providers were trained, although further cascade training via OJT at the district-level was limited, primarily because of manpower constraints and competing service demands arising from the great disease burden the Malawi health system is confronted with.

Table 2 provides a different sort of overview of the training conducted by EngenderHealth, indicating the number of training events supported in different categories and overall, as well as the durations of trainings and the numbers and types of cadres trained. Overall, 32 separate training events were supported and conducted by EngenderHealth and its partners. Of Malawi's 205 Clinical Officers, as many as 119, or 58%, were trained in at least some aspect of LTPC and/or PAC. And of Malawi's 379 Registered Nurses, as many as 151, or 40%, were trained[15].

[15]Qualification is made because some individuals received more than one training; thus these estimates of the percentage of Malawi's Clinical Officers and Registered Nurses trained are maximums. On the other

Table 1: EngenderHealth Training Activities: Planned vs. Achieved

Planned Training in LTPC, PAC, and Crosscutting Topics	Training Achievements
1. Workshops for 14 female sterilization trainer/supervisors	32 trainer/supervisors trained in female sterilization
2. Provide materials for training and supervision for supervisors and establish site libraries.	Training materials and libraries established in 33 sites
3. Train National Coordinator, and District and site Supervisors (target number unspecified) on IP so as to train others	221 trained
4.Train 58 provider teams (CO/Nurse) in ML/LA and NP insertion and removals	50 teams trained
5. Train 92 FP providers in counseling	53 FP providers trained
6. Conduct TOT in surgical/clinical skills and IP to 5 Clinician/Nurse teams	7 clinician/nurse teams trained, plus 1 MOHP and 1 CHAM supervisor trained
7.Train 3 MD or CO/Nurse teams in NSV	7 Clinical Officers trained
8. Train 2 senior staff from each site on IP to update and orient at least 20 others	66 senior staff and 150+ other staff/providers trained
9. Conduct a 2-day orientation for 50 DHMT members on LTPC, FS, and IP	60 DHMT members oriented
10. Introduction of COPE Quality Improvement Tool at 15 MOHP facilities	COPE introduced at 2 MOHP facilities[16]
11. Introduction of COPE at 5 CHAM facilities	COPE introduced at 9 CHAM facilities
12. Train 22 teams (CO/Nurses) of trainers in comprehensive PAC services	22 teams of trainers trained in comprehensive PAC services
13. Train 14 faculty tutors in comprehensive PAC services	Train 14 faculty tutors in comprehensive PAC services

hand, the totals are augmented by the 122 District Health Management Team members oriented to RH and trained in Cost Analysis, the over 215 people trained specifically in IP (IP is also taught in all clinical trainings), and the 100-plus managers, providers and community leaders who were trained in and participated in the various COPE activities.

[16]Machinga and Kasungu District Hospitals

Table 2: Summary[17] of Training: 2000-2003, by Frequency, Category and Cadre

Number Of Training Events	Training Category	Length Of Training	Cadre		
			Clinical Officers	Nurses	DHMTs or Unspecified
1	TOT in Surgical Skills (ML/LA and Norplant)	2 weeks	8	8	
10	Surgical Skills for LTPC Providers	1 week	60	57	
3	FP/LTPC Counseling for Service Providers	1 week	10	43	
2	Facilitative Supervision and Medical Monitoring	2 weeks	18	10	
2	Orientation to RH for Policymakers, Donors	1 day			90
1	TOT in No-Scalpel Vasectomy (NSV)	1 week	7		
	IP for supervisor/trainers	3 days			215+
1	Cost Analysis Tool	3 days			32
7	COPE/Community COPE	3 days at each site			100+
2	TOT in PAC	2 weeks	10	10	
2	Training of PAC Providers	1 week	3	12	
1	Training of Faculty Members in PAC	1 week	3	11	
Totals: 32			**119**	**151**	**437+**

C. Services

Overall, EngenderHealth's catalytic role in providing the inputs noted above has served to help the MOHP and CHAM to improve the availability, quality and use of the LTPC and PAC services they provide at their hospitals. The partnership between MOHP, CHAM and EngenderHealth (and among other CAs, most notably JHPIEGO) has been strong, collegial, and mutually supportive. Since the vast majority of EngenderHealth's funding for its Malawi activities were provided by USAID, EngenderHealth's work, to the extent that it was valued and

[17]In addition to this summary of LTPC and PAC training, at the request of UMOYO Network, a field project of NGO Networks for Health (a global health partnership of ADRA, CARE, PATH, PLAN International and Save the Children US, funded by USAID), EngenderHealth also conducted a 3-day orientation workshop for 35 representatives from a variety of community- and facility-based HIV/AIDS and RH NGOs on the integration of HIV/AID/STIs with RH programs and services. Subsequent TA and TOT activity ensued, but is not the subject of this assessment.

effective, by extension is a reflection of the assistance provided by USAID in helping Malawi to improve its FP/RH services[18].

EngenderHealth's inputs of equipment, supplies, renovations, training, and specialized technical assistance contributed to substantial outputs and outcomes in terms of improved quality, availability and use of LTPC and PAC services at Malawian hospitals. LTPC services were introduced for the first time to five hospitals, and overall (including those five), LTPC services were strengthened in 33 facilities (24 MOHP and 9 CHAM hospitals) across all three regions of the whole of Malawi. This includes every MOHP central and district hospital and a substantial proportion of CHAM's hospitals.

From the standpoint of specific LTPC methods, demand/use of FS and Norplant was significant, as indicated in Tables 3 and 4. Over 4000 TLs were performed annually on average, and Norplant use increased notably in 2002 and 2003 (essentially offsetting declines in FS during those latter two years). Vasectomy, on the other hand, was quite infrequently provided, due to the minimal demand for vasectomy in Malawi[19]. (And, as indicated above, IUDs were not a focus of the LTPC program effort.)

Table 3: Cumulative LTPC Services Provided by Program, by Method and Year

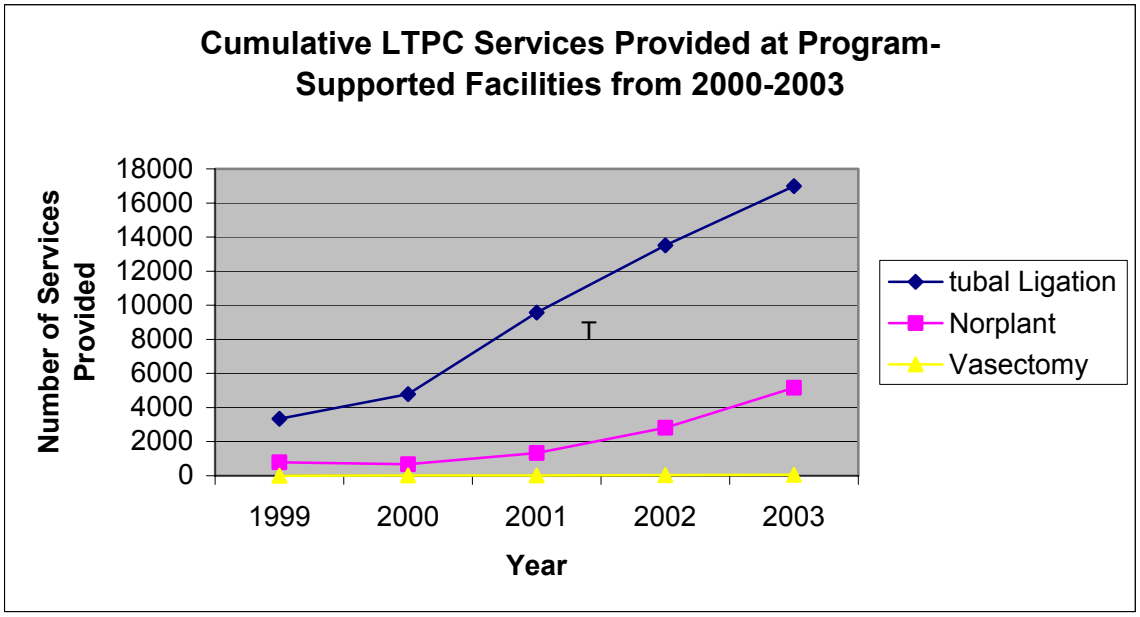
Year **Method**	**1999** (Baseline estimate)	**2000**	**2001**	**2002**	**2003*** (*=1/2-year totals)	**Cumulative Totals, 2000-2003**
Tubal Ligation (ML/LA)	3,336	4,780	4,789	3,952	3,374 (*1687)	16,985[20]
Norplant	780	674	652	1,487	2,342 (*1,171)	5,155
Vasectomy	5	12	9	19	12 (*6)	52

[18]LTPC and PAC assistance provided by EngenderHealth represents only a portion of the RH assistance USAID provides to Malawi, largely in the form of specialized technical assistance via various CAs.

[19]BLM, the other major provider of LTPC, had a similar experience during 1998-2002, with annual totals of vasectomies ranging from 32-93. Physicists distinguish between *effort* and *work*: effort is "pushing against the rock"; work is "moving the rock". A good deal of effort was expended in Malawi on vasectomy, but much less work was achieved.

[20]A *rough* estimate of the LTPC program's contribution to overall FS prevalence in Malawi is this: assuming a population of 10 million, with 25% of those being MWRA, 5% of whom (125,000) use FS, the 16,985 TLs reported from program facilities (for the past 3&1/2 years only) represents *almost 14% of total FS prevalence in Malawi*, a very sizeable number considering that FS performed in any of the years before 2000 will continue to be counted in the total FS prevalence until a woman is older than 49 years of age.

Table 4: Cumulative LTPC Services Provided, 2000-2003



D. Constraints

There are a number of constraints to LTPC and PAC service provision. These constraints are well known in Malawi, but bear mention here nonetheless. There is a marked shortage of financial and human resources for health. Compounding the situation, there is continuing, significant attrition of trained personnel due to transfer, departure (to private sector or via emigration) and disease[21]. Finally, Malawi is confronted with a great burden of disease[22]. In addition to these system-wide constraints, from the standpoint of LTPC and PAC services, there is still a shortage of health personnel trained in LTPC and PAC service delivery, as well as a paucity of available trained supervisors (in large part due to the competing demands that stem from the disease burden). This translates into an inadequate supervisory system for LTPC in the MOHP. Delays in provision of Norplant occasionally occurred, resulting in stockouts and therefore inability to provide a client's preferred LTPC method. The MOHP delayed for up to two years to distribute surgical equipment and supplies, provided by the project, to selected sites. It is uncertain what contributed to the delays, but this obviously had a negative impact on those sites effected.

E. Sustainability

[21]At the Team's debriefing conference with the MOHP, a senior official from the Lilongwe Central Hospital noted that his facility was losing two nurses a week to various causes—and already hospitals and health centers in Malawi are working at actual staffing levels significantly below planned/desired levels due to inadequacy of trained personnel and funds.

[22]For example: HIV seroprevalence of 15% among the general population aged 15-49; malaria widespread and deadly; under-5 mortality of 189/1000 live births; maternal mortality ratio of 1120/ per 100,000 live births.

Assessments of sustainability are necessarily somewhat speculative, since they entail predictions about an often-uncertain future. Nonetheless, the Assessment Team felt that a number of LTPC and/or PAC service components had reasonably good prospects of being sustained in Malawi. Most notable among these are: demand for ML/LA and Norplant; knowledge and skills of the trained providers who are still providing LTPC and PAC services[23]; a more comprehensive service approach, with more focus on quality, emphasizing such things as counseling, informed choice, and family planning post-MVA; greater availability of comprehensive PAC services (and of methodology other than sharp curettage); and a standardized approach to LTPC and PAC training and service delivery.

On the other hand, there are a number of components that are more threatened—mostly by the inadequacy of funds and personnel for health—and they are thus less likely to be sustained: continued availability of equipment, supplies, and contraceptive commodities; the current complement of trained providers; the ability to train currently untrained providers (either centrally or OJT); supervision of LTPC and PAC services, particularly their medical/surgical and safety aspects; maintenance of widespread LTPC and PAC service availability; and maintenance of current service quality.

F. Lessons Learned

Experience in the LTPC and PAC program effort the past few years has either brought to the fore or confirmed several important technical and programmatic lessons:

- Quality of services can be improved, even in severely resource-constrained environments.
- Demand for services will increase when it becomes known that the services are available, and that the quality of those services has been found by others to be acceptable—and demand will increase even more with focused demand creation efforts.
- Service systems are like chains: only as strong as their weakest links. Therefore attention must be given to *all* components (i.e., to supply and demand factors; and, within supply, to equipment, supplies & commodities, to pre-service and in-service training, to other performance improvement measures such as facilitative supervision, and to client/quality-oriented aspects such as courtesy, counseling, and choice.
- The complement of trained providers (who are then available to provide services, as well as perhaps further train others OJT) is a key "rate-limiting" step in providing and/or expanding LTPC and PAC.
- To ensure quality and safety in providing surgical FP/RH methods, continued vigilance via effective, regular supervision is needed.
- Supervision suffers when supervisors have not been trained to competency in the service that they are supervising.

[23]Of course, those providers who are minimally or not at all providing services for which they were trained will experience an inevitable diminution in skills over time.

- Complementary, strategic partnerships that draw on respective organizational strengths can mutually reinforce commitment and can contribute to noteworthy improvements in service quality, availability and use—and thus to program impact.

IV. Recommendations for LTPC and PAC Services in the Future

Equipment and Supplies

Although sites currently supplying LTPC and PAC services are, for the most part, fairly well equipped and supplied at present[24], future needs are likely, especially if demand for these services increases, as is also likely. Thus:

1. The MOHP and District Health Management Teams should plan and budget for equipment and supplies in their districts, to ensure a reliable supply. Funding from SWAPs may be a useful source of funds for this purpose.

2. The Central Medical Stores should have LTPC and PAC equipment and supplies registered in the essential equipment list and available in the country.

3. More training models[25] and training materials (e.g., training videos, VCRs, reference materials) for LTPC and PAC will be needed should demand for services increase as expected – these should be provided by the MOHP.

4. The MOHP should follow-up with contractors hired to renovate sites and ensure that outstanding work is completed according to terms of the contracts.

Training/Performance Improvement

Because of the acute shortage of health care providers that exists in Malawi at present and is likely to continue into the future[26], with only a subset of those health care providers trained and certified as competent to provide LTPC and PAC services, the following short-to-medium term strategies are recommended:

5. Despite the training of trainers that has already been conducted, additional centralized training for trainers in LTPC and PAC surgical skills will need to be continued, at facilities with proficient trainers and adequate caseloads.

[24]Some consumable surgical supplies and contraceptive commodities (e.g., Norplant, and skin sutures) were found to be in short supply during the Team's assessment visits. In the future, these and other supplies, e.g., minilaparotomy, Norplant and NSV kits, will also be needed.

[25]Such models foster a "humanistic" approach, whereby trainees are able to practice first on them and to develop a certain degree of confidence and competence before proceeding to training in the clinical setting, providing LTPC and PAC services to clients.

[26]While the Team was not asked to look at overall manpower and human resource issues, greater attention to factors that would increase retention of staff and decrease attrition is clearly needed for the entire health sector, not solely as these phenomena bear upon available LTPC and PAC service providers.

6. Once trained, these trainers should be supported at their home facilities to provide structured on-the-job training (OJT) in LTPC, PAC, and crosscutting quality improvement areas[27] to other appropriate clinical staff.

7. All Clinical Officers and Registered Nurses currently untrained in LTPC and/or PAC should be trained (either centrally or at those facilities[28] capable of providing good OJT.

8. After being trained to competency and certified, Enrolled Nurses should be eligible to provide both Norplant and PAC services[29], under regular supervision.

9. LTPC and PAC should be included in pre-service education for Doctors, Clinical Officers and Nurses[30].

10. As a longer-term solution[31], Malawi should increase its pre-service capacity to produce doctors, clinical officers, and nurses, and to certify those that are found competent to provide specific FP/RH services.

Long Term and Permanent Contraception Services

Female Sterilization (ML/LA) and Norplant

11. Because female sterilization and Norplant are presently the most popular of the four LTPC methods and likely to be so in the future, ML/LA and Norplant (and related support to ensure

[27]For example, infection prevention, counseling, facilitative supervision, and medical monitoring.

[28]Recommended OJT sites, which have competent and committed providers and adequate caseload, are: Nkhoma, Kasungu, Machinga and Ntchisi District Hospitals and all four of Malawi's Central Hospitals.

[29]Provision of Norplant and PAC by nurses has been studied in many countries. Nurses have been found to insert and remove Norplant and IUDs, and perform MVA, as effectively and safely as doctors (or COs). The key consideration is that the provider has been trained to competency and that supervision is regularly provided. Furthermore, in Malawi Enrolled Nurses are already trained in midwifery and are also carrying out most of the tasks entailed in PAC except for performing the MVA procedure itself, so this recommendation does not represent their needing to learn an entirely new set of skills or responsibilities. In the Team's debriefing of the MOHP a concern was raised that an EN's new responsibilities might raise the expectation of higher pay, but experience shows that most cadres are internally motivated to learn new skills (in order to be better providers), and that they understand one's pay is determined by one's cadre level.

[30]At the debriefing of the MOHP, the Team was asked if it could provide "scenarios" (options for consideration) with respect to a recommended "mix" of pre-service and in-service investments, perhaps under high, medium and low funding assumptions. The difficulty in providing such scenarios is that there is no easy formula for an optimal proportion of investment in pre-service education "versus" in-service training. (Furthermore, both have inefficiencies, though the nature, cause and remedy of the inefficiency differ). Neglect of in-service training will result in fewer services available today and thus in greater unmet need—a regressive step. Yet failure to invest in pre-service education will mean that one is forever having to "make up for the gaps" via in-service/on-the-job training. In short, both types of training are clearly needed and are worthy investments. Under severe resource constraints, however, in-service training—with vigilant attention to retention of trained staff as well—seems a greater necessity.

[31]Work to address this longer-term goal should commence now, as it will take time to make such an expansion a reality, and for it to have an impact at the service delivery level.

quality, safety, and method availability) should receive priority attention within LTPC training and service delivery.

No-Scalpel Vasectomy (NSV)

12. Because of continuing low demand, NSV services should be consolidated at a few dedicated sites that have a trained and committed vasectomist and an adequate caseload; vasectomy should then be considered a referral service.

Intra-Uterine Devices (IUDs)

13. The MOHP and CHAM should consider giving more attention to pre-service and in-service training of Clinical Officers and Nurses in IUD insertions and removals, so that IUD services can be more widely known and accessed.[32]

PAC Services

14. Comprehensive PAC services should be expanded to other sites where these services are currently not available, including rural hospitals and health centers.

Cross-Cutting Services

Infection Prevention (IP)

15. IP should continue to be strengthened in all facilities; this should include establishment/maintenance of an active IP Committee, regular provision by MOHP of necessary supplies and equipment (e.g., gloves, chlorine solution and other reagents), and regular provision of refresher training.

Counseling

16. Counseling training and services should be intensified, and integrated into all RH services (e.g., FP, PAC, STI, and HIV/AIDS services).

Quality[33]

[32]Although IUDs will never be as popular in Malawi as injectables or female sterilization, they are likely to be more popular than vasectomy and to be adopted by a sizeable number of women. This prediction is supported by data provided the Team by BLM: from 1998-2002, over 4000 IUDs were inserted at BLM's clinics, compared to 303 vasectomies. The numbers of IUD insertions provided annually by BLM were roughly comparable to the number of Norplant insertions provided at MOHP and CHAM facilities. In addition, recent studies have indicated that even in settings with high STI prevalence, the risk of PID is below 1% and decreases over time, so that 2o days post-insertion an IUCD user is no more likely to develop PID than a non-user. Similarly, studies in Kenya have shown that the IUCD may be safely used in carefully selected HIV-positive women.

[33]Any/all of these recommendations would improve quality of services; this recommendation speaks to activities that explicitly focus on quality assurance and quality improvement activities.

17. Quality improvement tools and activities that empower clients, providers and communities to make improvements with existing resources, such as COPE and Community COPE[34] should be widely introduced and used.

18. The MOHP should consider integrating COPE/Community COPE into its Essential Health Package.

Supervision

19. Because facilitative supervision[35] and medical monitoring[36] are critical to maintaining the quality and safety of LTPC and PAC services, MOHP and CHAM should make these priority activities.

20. Providers who have been trained and proven competent in LTPC and PAC[37] should be supervisors for these activities, in order to maintain quality standards and safety.

21. The MOHP and CHAM should allocate the necessary human and financial resources to allow facilitative supervision and medical monitoring to be done at least quarterly at each facility providing LTPC and PAC services.

22. A regular, reliable and efficient system of certification of Clinical Officers and Nurses who have been trained in LTPC and/or PAC should be instituted.

Demand Generation for LTPC Services[38]

[34]COPE (Client-Oriented, Provider-Efficient) is EngenderHealth's QI process and set of tools that empower healthcare staff, through a participative approach and using existing resources, to continuously assess and improve the quality of services their facility provides. COPE consists of four tools: self-assessment guides, a client interview guide, client-flow analysis, and an action plan. Community COPE extends COPE to the community by gathering feedback about local perceptions and health care needs/desires from communities, in order that the healthcare facilities can improve services to their clientele.

[35]Facilitative supervision means supervision is not an "inspection" but rather a constructive engagement between supervisor and supervisee (provider) that enables the provider to receive helpful suggestions to improve her or his service performance.

[36]Medical monitoring refers to a supervisor's observing service delivery and infection prevention practices, and providing feedback to help improve the quality and safety of those services. It is closely related to (or a subset of) facilitative supervision, and is key to medical quality improvement.

[37]Despite Malawi's move toward greater integration of both services and their supervision, the specific medical and surgical demands inherent in providing LTPC and PAC services means that supervisors will need to possess highly specialized LTPC and PAC expertise to be good supervisors of those services. If the plan to introduce Zones and interpose them between the central MOHP and the Districts becomes a reality, such specialized expertise should be present within each Zonal apparatus.

[38]Because EngenderHealth's formal demand creation effort was limited in scope and time (only 4 months available for implementation of mass media demand creation for LTPC), it has not been dwelled on in this Report. However the radio campaign, employing FP messages embedded into a popular radio soap opera, resulted in over 5600 letters requesting further information, suggesting that a longer and broader BCC effort, in conjunction with continuing attention to supply factors might result in additional use of services.

23. Method-specific demand generation for LTPC via radio and community-level interventions has shown promise and should be continued/increased.

Overall

24. Given the complexity of what is entailed in providing quality LTPC and PAC services, and the fragility of Malawi's fine performance to date in making LTPC and PAC services much more widely available, specialized external technical assistance in LTPC and PAC is likely to still be needed and of benefit. Such specialized external technical assistance adds value and complementarity to SWAPs.

APPENDICES

Appendix 1

Scope of Work
Final Assessment of LTPC and PAC Programs, 1999-2003

Background

Malawi, with per capita GDP of less than $200 in 1999, is one of the poorest countries in the world. The country has an estimated population of just under 10 million with a density of over 100 persons per km^2, densely populated by African standards. The population is growing at more than 2 percent annually.

Over the last few years, Malawi has faced significant economic challenges, including high inflation, a rapidly depreciating currency, and large budget deficits. It is also facing enormous health challenges: high maternal mortality (1,120 per 100,000 live births in 2000) and morbidity rates, high child mortality (203/1000 for those under 5 in 2000) and morbidity rates, and high HIV seroprevalence (15 percent for the 15–49 age group in 2000 according to the Malawi Demographic and Health Survey [MDHS]) and incidence of HIV/AIDS–related disease (now more than 70 percent of hospital inpatient admissions).

The family planning needs of Malawi are great and it is deemed a priority country by USAID's Office of Population. The country has one of the highest total fertility rates in Africa, at 6.7 children per woman. However, Malawi has seen significant increases in the national contraceptive prevalence rate (CPR), which is at 26 percent in the MDHS 2000, an increase from 14 percent in 1996.

There is a moderate level of demand for limiting births, with 42.3 percent of currently married women wanting no more children (DHS 2000). Unmet need for limiting (women who are not using contraception and want no more children) is 12.5 percent. Long-term and permanent methods' share of CPR is 4.9 percent, compared to 1.6 percent in 1992.

EngenderHealth (which went by the name AVSC International until March 2000), worked in Malawi between 1989 and July 1995 with USAID funding. During this period, EngenderHealth provided financial support and technical assistance to initiate a program for ML/LA, initially through the CHAM hospitals. In 1992, with a request from the MOHP, EngenderHealth introduced minilaparotomy with local anaesthesia (ML/LA) in three district hospitals. In addition, EngenderHealth initiated the introduction of Norplant (NP) insertion and removal in the supported sites.

To ensure standardized techniques, voluntarism and informed choice for the surgical procedures, EngenderHealth trained clinicians and nurses from both the MOHP and CHAM in skills for ML/LA, NP insertion and removal, and counseling. By 31 July 1995 when the USAID/EngenderHealth funded program ended, EngenderHealth had established capacity for training in ML/LA, NP insertion and removal, and counseling at 22 sites; capacity for performing no-scalpel vasectomy (NSV) was established at 3 of the 22 sites. EngenderHealth had also established the capacity for medical monitoring and supervision, especially within CHAM. Part of the reason for the success of the initial USAID/EngenderHealth-supported program was the support by the MOHP and CHAM management/administration.

As a buy-in to the Amended STAFH project, EngenderHealth returned to Malawi in 1999 with the following objectives:

- extend LTPM training of providers to reach 24 public sector and 10 CHAM hospitals in the country with these services
- provide specialized equipment and supplies for the delivery of LTPM services

Subsequently, in 2001, EngenderHealth was requested by USAID and the MOHP to assist with the assessment, introduction and scaling up of PAC services in Malawi. The initial phase of this project was evaluated by an EngenderHealth-led team in October 2002.

A BCC campaign for LTPM commenced in mid-2002 through a subcontract with PATH. Based on an assessment by PATH, the campaign design featured radio drama and ran through June 2003.

The objectives of the evaluation will be to:

Evaluate the implementation of the Malawi LTPM and PAC programs (1999-2003), including the following:

- Achievements
- Constraints and challenges
- Recommendations for future directions, including attention to sustainability issues

The evaluation should address the following types of questions. This list of questions is intended to be illustrative, and the evaluation team should modify/add questions as appropriate:

<u>Project strategy</u>

a) Were the activities/strategies included in the design of the project the best ones for accomplishing the technical objectives within the external environment?

<u>Project Implementation</u>

b) How effective was the implementation of the project?
c) How has the organization and management of the LTPM/PAC project influenced its accomplishments?
    - Quality of relationship with partners, Government of Malawi and other stakeholders in reproductive health?
    - Project's administrative, personnel and financial management

<u>Monitoring and Evaluation Review</u>

d) Is the project's approach to monitoring and evaluation appropriate?

<u>Recommendations</u>

e) What are the recommendations for future interventions of this type?

1. Methodology

EngenderHealth proposes an evaluation process with key participation from the major institutional partners, particularly MOHP and CHAM.

- Prior to conducting field work, the evaluation team will review existing literature and data, including LTPM and PAC strategies, site assessment reports, subagreements, trip reports, *Assessment Report of USAID's Amended STAFH Project* (December 2001) and other reports and documents reflecting EngenderHealth's work in Malawi since 1999.

- **Planning meeting with MOHP, CHAM, EngenderHealth and USAID** – At the planning meeting, the partners will review existing literature, identify key respondents, review/revise interview guides and other data collection instruments. Prior to the planning meeting, EngenderHealth will draft interview guides and other data collection instruments for review by the planning committee. Site selection will also be determined jointly prior to the planning meeting.

- **Interviews in Lilongwe and the field** – Key informant interviews will be conducted in each region. The evaluation team will conduct interviews with donor organizations, selected NGOs (including Banja La Mtsogolo), MOHP, CHAM, researchers, and other key respondents identified during the planning meeting. The purpose of these interviews will be to assess availability of long-term and permanent (LT&P) methods; to understand reproductive health systems and priorities in the different regions; to understand the health care training and logistics systems and constraints to provision of LT&P methods; to understand social and cultural influences on client and provider attitudes and behavior; and, in the absence of population-based data, to assess demand for LT&P methods. Group interviews may also be conducted.

- **Site visits** – The evaluation team will identify sites for visits in consultation with USAID, CHAM and MOHP. The sites should represent variety along the following dimensions: geographic location, type of facility, quality of services, and level of EngenderHealth support (money, technical assistance, with or without quality improvement approaches and tools in place.) The site visits will involve interviews with District Health Management Teams, service providers, and clients; observation of clinical service provision, infection prevention practices, and counseling; and a facility audit including examination of supplies and equipment and physical infrastructure. The purpose of the site visits is to gain a better understanding of the technical competence of providers, attitudes of providers and clients, constraints in training and service provision, clients' perception of their needs, and providers' needs in order to provide quality services.

- **Evaluation of trained service providers** – In addition to the site visits, to the extent possible, the evaluation teams will attempt to ascertain the whereabouts and capacities and activities of health service providers who were previously trained by EngenderHealth, the intention being to determine to what extent previously trained staff might be utilized as an existing resource.

- **Wrap-up and debriefing** – At the conclusion of the field visits, there will be a meeting of the evaluation team and key stakeholders in Lilongwe. The purpose of the meeting will be to share findings and get final inputs before preparing the report.

- **Report writing** – EngenderHealth will take the lead in writing the evaluation report, in consultation with our partners at MOHP and CHAM.

2. Composition of evaluation team

Dr. Roy Jacobstein, Medical Director of EngenderHealth – Team Leader, will manage the design of the evaluation protocol and data collection instruments, lead interviews with key informants. Responsible for writing the final report of the evaluation.

Deliwe Malema – Malawi country program manager, will serve as the key liaison between the evaluation team and Malawian institutions and colleagues. Will collaborate in design of evaluation protocols and collection of data.

Dr. Fredrick Ndede – Medical Associate with EngenderHealth, will be responsible for the assessment of the quality of services at the sites, including observation of clinical services, counseling and infection prevention, interviews with service providers.

Sheila Ndambuki – Program Associate for Malawi program, will be responsible for managing the logistics of the evaluation.

Representative of MOHP

Representative of CHAM

Representative of Medical Council or Nursing Council

3. Timing and duration of assignment

Two and a half weeks in August will be utilized for field work, including pre-testing of instruments and in-country debriefing for stakeholders. EngenderHealth will meet in Nairobi prior to the fieldwork to begin review and refinement of evaluation instruments and approaches.

4. Support required

The evaluation team will require the following support:

- one additional vehicle and driver
- logistical arrangements for field trips
- meeting space for the planning meetings and debriefing
- meetings to be arranged with key stakeholders in both MOHP and NGO sector
- office supplies, including flip chart, markers, masking tape, A4 paper and printer; there will also be photocopying requirements including overhead transparencies and/or an LCD projector for the debriefing

5. Deliverables

The team will prepare a Report that includes the following information:

- Executive Summary
- Introduction
- Background
- Methodology
- Status of provision of long-term and permanent methods and PAC services, including:
- Human resources
- Physical facilities
- Recommendations for future investment in LTPM and PAC

An outline of the report findings will be left in Malawi before departure of the team. (This will consist of the annotated version of the PowerPoint presentation made to USAID in debriefing). A completed written draft of the Report will be delivered to the Mission within one week of the Team Leader's return to the United States. Within two weeks of receiving consolidated written feedback from USAID on the completed draft, the final report will be submitted, with the goal to have the final report submitted before September 30, 2003 or shortly thereafter.

EngenderHealth will provide USAID with 10 hard copies of the final evaluation report and a copy on CD.

6. Contact persons – EngenderHealth: David Adriance/Deliwe Malema

7. Contact person – USAID/Malawi: Teresa Ingham

8. Date of Scope of Work: July 22, 2003

Appendix 2

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Appendix 3

SCHEDULE FOR LTPC /PAC EVALUATION
10TH-27TH AUGUST, 2003

DATE	TIME	ACTIVITY	FACILITATOR/ CONTACT PERSON
10th August 2003 Sunday		Arrival of New York and Nairobi staff	Deliwe and Ian
11th August 2003 Monday	8:00am-8:30 am 8:30am-5:00 pm	Arrival of the Evaluation team Team Preparation Activities	 Team Members
12th August, 2003 Tuesday	8:00am-9:30 am 11:00am-12 pm 2:00pm-3:00 pm 4:00 pm-5:00 pm	Briefing at USAID Briefing at MOHP Conduct interviews at RHU Conduct interviews at CHAM	Teresa Ingham/Mexon Nyirongo Dr Mpazanje Mrs Jane Namasasu Mrs Ruth Mwandira
13th August 2003 Wednesday	8:30am –9:30am 10:00am-11:30am 2:00pm–3:00pm 3:30pm – 4:30pm	Conduct interviews with POP FP Conduct interviews with JHPIEGO Conduct interviews with DIFID Conduct interviews with FHI	Team members

DATE	TIME	ACTIVITY	FACILITATOR
14th August 2003 Thursday	8:00am– 3:00pm	Visit Dowa District Hospital Visit Nkhoma Mission Hospital	Group 1 Group 2
15th August 2003 Friday	8:00am-3:00pm	Visit Mchinji District Hospital Visit Ntchisi District Hospital	Group 1 Group 2
16th August 2003 Saturday	8:00am – 4:00pm	Consolidate information from interviews and visits	Group 1&2
17th August 2003 Sunday	8:00am–5:00pm	Travel day to North and South	
18th August 2003 Monday	8:00am-5:00pm 7:00pm-9:00pm	Visit Rumphi District Hospital Visit Ekwendeni Mission Hospital Visit Queen Elizabeth Central Hospital Visit Chiladzulu District Hospital Dinner/discussions	Group 1 Group 2
19th August, 2003 Tuesday	8:00am-5:00pm 7:30-9:00pm	Visit Nkhatabay District Hospital Visit Mulanje Mission Mission Dinner/discussions	Group 1 Group 2

DATE	TIME	ACTIVITY	FACILITATOR
20th August, 2003 Wednesday	8:00am-5:00 pm 7:00pm-9:00pm	Visit Kasungu District Hospital Visit Machinga District Hospital Dinner/discussions	Group 1 Group 2
21st August, 2003 Thursday	8:00am-5:00pm	Report writing	Team Members
22nd August 2003 Friday	8:00am-5:00pm	Report writing	Team Members
23rd August 2003 Saturday	8:00am-5:00pm	Report writing	Team Members
24th August 2003 Sunday	8:00am-5:00pm	Report writing	Team Members
25th August 2003 Monday	10am-11:30am 2:30am-4:00pm	Debriefing USAID USAID	Team Members Team Members

Appendix 4

List of Contacts

Organization	Name	Postion/Title
USAID	Mexon Nyirongo Teresa Ingham	SRRH Advisor
MOHP	Dr Rex Mpazanje	Director of Clinical & Population Services
Reproductive Health Unit	Jane Namasasu	Deputy Director (RH)
JHPIEGO	Maryjane Lacoste	Programme Manager
POPFP	Mrs Masepuka	Programme Manager
CHAM	Ruth Mwandira	Executive Secretary
Dowa District Hospital	Dr Mathias Joshua	District Health Officer
Nkhoma Mission Hospital	Olive Sabani Kate Chimtengo	Acting Matron RN/Midwife
Mchinji District Hospital	Dr Njiku Beatrice Mwale	District Health Officer Matron/Trainer
Rumphi District Hospital	Mr Chabinda Mrs Mukandawire	District Health Officer District Nursing Officer
Ekwendeni Mission Hospital	Edwin Kachiwala	Clinical Officer
Nkhatabay District Hospital	Dr Munthali	District Health Officer
Kasungu District Hospital	Mr Mboye Duncan Chipula	Principle Clinical Officer Snr. Clinical Officer/Trainer
Mulanje Mission Hospital	A. Mazinga Mr. Gombwa	Administrator Clinical Officer

Chiradzulu District Hospital	John Kabichi Mr Priminta E. Mpinganjira D. Mpando	Ag. Distict Health Officer Clinical Officer Matron District FP Coordinator
Machinga District Hospital	Dr. Gonani Beata Zuza	District Health Officer Matron/Trainer
Banja La Mtsongolo	Walker Jiyani Linley Vinyo	Programme Director Deputy Programme Director
PATH-Story Workshop	Dingire Kuwendo	Coordinator

Appendix 5

Data Collection Instruments

Final Assessment Malawi LTPC and PAC Program, 1999-2003

Interview Guide
(Facility Managers and Providers)

August 15, 2003

INTRODUCTION

Hello. My name is _____ of _____ (organization).

I am part of an 8-person, 5-organization Team brought together by USAID to assess EngenderHealth's work in Malawi the past few years. We will also be making recommendations about the future in the areas of training, services, supplies and equipment for long-term and permanent contraception (LTPC) and post-abortion care (PAC) in Malawi. Our Team is made up of staff from EngenderHealth, the MOHP, CHAM, the Medical Council, and the Nursing Council.

Thus I would like to ask you some questions about EngenderHealth's program during that time period. But before we start, I want to thank you for your time and assistance and to reassure you that this is not an inspection and that there are no "right" or "wrong" answers in this discussion. Rather, your views and experience can help inform our judgments and recommendations. Also, individual respondents will not be identified in the Evaluation Report. So please feel free to share your point of view openly and frankly.

RESPONDENT INFORMATION

Name of Respondent: DATE:
Position of Respondent
Name of Facility:
Type of Facility (Circle One): (1) MOH, (2)CHAM (3) Other (Specify)
Region/District:
Interviewer:

TOPICS OF DISCUSSION

Opening question:

Overall, what have been the most important changes at your hospital because of EngenderHealth's work with you on LTPC and PAC (including training and provision of equipment/supplies)?

Specific program areas:

I. Equipment and Supplies

1. What type of equipment and supplies has EngenderHealth provided this facility?

2. Is the equipment still being used?

3. Are the supplies adequate? How do you replace them?

4. Has EngenderHealth helped with any kinds of renovation at your hospital?

5. Does your hospital still have equipment, supplies or physical infrastructure needs?

6. What would happen if EngenderHealth were not available to help provide you equipment and supplies in the future? (What services would be sustained/continued? What services would be difficult to sustain/continue?)

II. Training (LTPC, PAC, FP/RH Counseling, Supervision)

7. Please describe any training that has taken place for providers at this facility in ML/LA, Vasectomy, Norplant, IUD, and PAC (specify).

8. Who provided the training? (EngenderHealth?) (EngenderHealth-trained trainers?)

9. How many providers were trained? (Indicate numbers of each cadre and in each subject/skill area.)

10. How many of these trained providers are still providing services at this facility? (Indicate numbers of each cadre and in each subject/skill area.)

11. Have you yourself been trained? If so, by whom, and in what?

12. How have you used your training subsequently? (Trained others? Service delivery?)

13. Have you encountered any constraints in trying to use your training?

14. In your opinion, does this facility have sufficiently trained and proficient staff to provide long-term and/or permanent family planning methods?

15. Is there any training technical assistance you need from EngenderHealth in the future? **[Try to be specific about what respondent feels is needed.]**

16. What would happen if EngenderHealth were not able to keep providing you technical assistance in LTPC and PAC training in the future?

III. Long-Term and Permanent Contraception (LTPC): ML/LA, Vasectomy, Norplant, Infection Prevention, PAC, FP/RH Counseling)

17. Please describe the LTPC (ML/LA, V, NP, IUD) services offered at this facility. (Ask specifically about each one, to get a general sense of level of activity).

[Note to interviewer: Please be certain that you have service statistics that relate to LTPC from the site. EngenderHealth/Malawi should have this information; if not, gather it from the site during the site visit.]

18. What was the level or extent of these services at your facility before you received assistance from EngenderHealth?

19. Are there are any constraints to provision of any of the four LTPC methods here?

20. Is there any technical assistance you would like from EngenderHealth in the future in order to further strengthen these LTPC services?

21. What would happen if EngenderHealth were not able to keep providing you technical assistance in LTPC in the future? (What services would be sustained/continued? What services would be difficult to sustain/continue?

22. Have you received support in LTPC and/or PAC from any other organizations?

IV. PAC Services

23. If your facility has received PAC training, equipment and technical assistance from EngenderHealth, what difference has it made? (Were services available before? Are postabortion services available at this facility every day now? Are you seeing fewer septic clients? Etc.)

24. Please describe the linkage between your PAC and FP services?

[Note to interviewer: Review PAC service statistics to get a sense of (and note) service volume, number of "sick" (septic) patients, extent to which PAC clients got FP and the type of FP they got.]

25. Did the EngenderHealth PAC Assessment Team visit you last October? If so, have you been able to make any improvements since then? (Not applicable to all sites.)

26. Are they are any constraints to PAC service provision at your facility?

27. Is there any technical assistance you would like from EngenderHealth in the future in order to further strengthen your PAC services?

28. What would happen if EngenderHealth were not able to keep providing you technical assistance in PAC in the future? (What services would be sustained/continued? What services would be difficult to sustain/continue?)

V. Infection Prevention

29. Has this facility received any technical assistance, training, or updates on infection prevention? If so, who provided it and what kinds of support did your site receive?

30. Do you feel that the training and other support you received on infection prevention contributed to improvements in service delivery? What improvements took place? Is there any additional technical assistance or training needed?

VI. Quality Improvement

A. Medical Monitoring and Supervision

31. What kinds of technical assistance, if any, has this hospital received from EngenderHealth related to medical monitoring and supervision[1]?

32. Who conducts medical monitoring and supervision for this facility?

33. How often do medical monitoring and supervision visits occur?

34. What takes place during such visits? (Are they "facilitative"?)

35. Does this facility have other medical monitoring and supervision support needs? If so, what are they?

B. COPE

36. Has your site used COPE or Community COPE? If so, how has it been useful?

37. Apart from COPE, what other types of activities does this facility engage in to monitor and improve quality of services?

CLOSING

Thank you very much for taking the time to talk with us.

The information that you have given us will be very helpful in enabling better training and service assistance to be provided in Malawi.

[1]By medical monitoring, we mean observing service delivery and infection prevention practices and providing feedback to help improve the quality of those services.

Appendix 6

Data Collection Instruments

Questionnaire for Client Interviews

INTRODUCTION

Hello. My name is _____ of _____ (organization).

I am part of an 8-person Team brought together by USAID to review, document and assess EngenderHealth's work in Malawi from 1999-2003, and to make recommendations to USAID about its future assistance to Malawi in the areas of long-term and permanent contraception (LTPC) and post-abortion care (PAC). Our Evaluation Team is made up of staff from EngenderHealth, the MOHP, CHAM, the Medical Council, and the Nursing Council.

As you may know, EngenderHealth is a private voluntary organization whose mission is to improve women's and men's reproductive health worldwide. With support from USAID, EngenderHealth has been working with Malawian facilities such as yours to improve access to, and quality of, reproductive health and family planning services. Specifically, EngenderHealth has been providing technical assistance, equipment and supplies and training on Long-Term and Permanent Contraceptive Methods and on Post-Abortion Care.

Thus I would like to ask you some questions about EngenderHealth's program during that time period. But before we start, on behalf of the Team, I want to thank you for your time and your thoughtful responses.

I also want to reassure you that this is not an inspection and that there are no "right" or "wrong" answers in this discussion. Rather, we are interested in knowing what you think, so that your experience can help inform our judgments and recommendations. Also, individual respondents will not be identified in the Evaluation Report. So please feel free to share your point of view openly and frankly.

---

1. What service did you get today?

2. Did you get what you wanted?

3. Are you satisfied with the service? *(for satisfactory probe, about the facility, provider and the service)*

4. If you received FP, were you counselled on side effects

5. If you got surgery, was it painful?

6. How did you hear about this service

7. Do you have any suggestions on how to improve the services at this facility? (LTPC, FP, PAC)

Appendix 7 (Continued)

LTPC Equipment Supplied to the Malawi Program

Equipment from EngenderHealth to CHAM Sites	US$ /each	St. Annes	Nkhoma	Malamulo	Livingstonia	St. Lukes	Embangweni	Ekwendeni	St. Martins	Mulanje Mission	Total Items
Date Received in at Site		8 Mar, 01	1 Mar, 01	Mar, 01	Mar, 01	2 Mar, 01	Mar, 01	Mar, 01	Mar, 01	Mar, 01	
New York Purchase											
Airway, nasopharyngeal size 28	4	1	1	1	1	1	1	1	1	1	**9**
Airway, nasopharyngeal size 30	4	1	1	1	1	1	1	1	1	1	**9**
Aspirator, ext. bot, 4 catheters, stand. 220V/50Hz	281	1	1	1	1	1	1	1	1	1	**9**
Endotracheal tube, 7.5mm	4	1	1	1	1	1	1	1	1	1	**9**
Model, Norplant training arm kit#S519	35		1	1	1	1	1	1	1	1	**8**
Model, no-scalpel vasectomy scrotal	6		1	1							**2**
No-Scalpel Vasectomy kit	57									1	**1**
Model Zoe, pelvic	290										**0**
Norplant Kit	7	1	1	1	1	1	1	1	1	1	**9**
Instruments Uterine Elevator	28	4	4	4	4	4	4	4	4	4	**36**
Tubal hooks	15	4	4	4	4	4	4	4	4	4	**36**
Babcock forceps	10	4	4	4	4	4	4	4	3	4	**35**
Resuscitator manual	76										**0**
Sphygmomanometer, aneroid	30	2	2	2	2	2	2	1		2	**15**
Sterilizer, All American, 25qt, 220V	315	1	1	1	1	1	1	1	2	1	**10**
Operating table	1,800								1		**1**
Operating lights	320								1		**1**
Instrument Stand Mayo	188	1	1	1	1	1	1	1	1	1	**9**
Sutures (Catgut #0)	15	2	2	2	2	2	2		2	2	**16**
Re-usable Syringes - 20cc plastic	10										**0**
Stethoscope	5	2		2	2	2	2	1	2	2	**15**
Weighing machine	30	1	1	1	1	1	1	1	1	1	**9**
Thermometer, oral, Fahrenheit/Celcius	3										**0**
Air conditioner	760		1					1			**2**
Ambu Bag	5		1	1	1	1			1	1	**6**
Trainee Package #1 Supervisors Package	145		1	2	1	2	2	2		1	**11**
Local Purchase											
Wall Charts for Infection Prevention (decontamination)											
Wall Charts for Infection Prevention (sterilization)											
Buckets for Infection Prevention (20 litres)											
Buckets for Infection Prevention (10 litres)											
Large basins for Infection Prevention											
Medium basins for Infection Preventio											

					Appendix 7 (Continued)					
Equipment from EngenderHealth to MOH sites	**US$ /each**	Kasungu Dist. Hos	Zomba Central	Mzuzu Central	Queen Elizabeth	Lilongwe Central	Chipita Dist. Hos	Ntcheu Dist. Hos	Mangochi Dist. Hos	**Total Items**
Date Received in at Site		27-03-03	Apr, 03	Mar, 03	Mar, 03	Mar, 03	Mar, 03	Mar, 03	Mar, 03	
New York Purchase										
Airway, nasopharyngeal size 28	4	2	2	2	4	4	2	2	2	**20**
Airway, nasopharyngeal size 30	4	2	2	2	4	4	2	2	2	**20**
Aspirator, ext. bot, 4 catheters, stand. 220V/50Hz	281	1								**1**
Endotracheal tube, 7.5mm	4									**0**
Model, Norplant training arm kit#S519	35	1	1		1	1	1	1	1	**7**
Model, no-scalpel vasectomy scrotal	6									**0**
No-Scalpel Vasectomy kit	57									**0**
Model Zoe, pelvic	290									**0**
Norplant Kit	7	1	1		1	1	1	1	1	**7**
Instruments Uterine Elevator	28	2	2	2	2	4	2	2	2	**18**
Tubal hooks	15	2	2	2	2	4	2	3	2	**19**
Babcock forceps	10	2	2	2	2	4	2	2	2	**18**
Resuscitator manual	76	1	1		2	1	1	1	1	**8**
Sphygmomanometer, aneroid	30	1					1	1	1	**4**
Sterilizer, All American, 25qt, 220V	315	1								**1**
Operating table	1,800	1				1				**2**
Operating lights	320	1				1				**2**
Instrument Stand Mayo	188		1		1	1	1	1	1	**6**
Sutures (Catgut #0)	15	2					2	2	2	**8**
Re-usable Syringes - 20cc plastic	10									**0**
Stethoscope	5	1	1				1		2	**5**
Weighing machine	30	1					1		1	**3**
Thermometer, oral, Fahrenheit/Celcius	3									**0**
Air conditioner	760	1				1				**2**
Ambu Bag	5									**0**
Trainee Package #1 Supervisors Package	145	1	1	1			1	1	1	**6**
Local Purchase										
Wall Charts for Infection Prevention (decontamination)		20	20	20	20	20	20	20	20	**160**
Wall Charts for Infection Prevention (sterilization)		20	20	20	20	20	20	20	20	**160**
Buckets for Infection Prevention (20 litres)		4	4		4	4	4	4	4	**28**
Buckets for Infection Prevention (10 litres)		8	8		8	8	8	8	8	**56**
Large basins for Infection Prevention		4	4		4	4	4	4	4	**28**
Medium basins for Infection Prevention		4	4		4	4	4	4	4	**28**

				Appendix 7 (Continued)						
Equipment from EngenderHealth to MOH sites	**US$ /each**	Nkhata-bay	Mwanza	Dowa	Ntchisi	Thyolo	Dedza	Rumphi	Salima	**Total Items**
Date Received in at Site		Mar, 03	Apr, 03	Mar, 03	Mar, 03	Apr, 03	Mar, 03	Mar, 03	Mar, 03	
New York Purchase										
Airway, nasopharyngeal size 28	4	2	2	2	1	2	2	1	1	**13**
Airway, nasopharyngeal size 30	4	2	2	2	1	2	2	1	1	**13**
Aspirator, ext. bot, 4 catheters, stand. 220V/50Hz	281				1			1		**2**
Endotracheal tube, 7.5mm	4									**0**
Model, Norplant training arm kit#S519	35	1	1	1		1	1	1	1	**7**
Model, no-scalpel vasectomy scrotal	6									**0**
No-Scalpel Vasectomy kit	57				1					**1**
Model Zoe, pelvic	290									**0**
Norplant Kit	7	1	1	1	1	1	1	1	1	**8**
Instruments Uterine Elevator	28	2	2	2		2	2	2	2	**14**
Tubal hooks	15	2	2	4		2	2	2	2	**16**
Babcock forceps	10	2	2	2	2	2	2	2	2	**16**
Resuscitator manual	76	1		1	1		1	1	1	**6**
Sphygmomanometer, aneroid	30	1	1	1	1	1	1	1		**7**
Sterilizer, All American, 25qt, 220V	315				1	1	1	1		**4**
Operating table	1,800				1					**1**
Operating lights	320				1			1		**2**
Instrument Stand Mayo	188	1	1	1	1	1	1	1	1	**8**
Sutures (Catgut #0)	15			2	1			2		**5**
Re-usable Syringes - 20cc plastic	10									**0**
Stethoscope	5				1					**1**
Weighing machine	30				1			1	1	**3**
Thermometer, oral, Fahrenheit/Celcius	3									**0**
Air conditioner	760									**0**
Ambu Bag	5									**0**
Trainee Package #1 Supervisors Package	145	1	1	1	1	1	1	1	1	**8**
Local Purchase										
Wall Charts for Infection Prevention (decontamination)		20	20	20	20	20	20	20	20	**160**
Wall Charts for Infection Prevention (sterilization)		20	20	20	20	20	20	20	20	**160**
Buckets for Infection Prevention (20 litres)		4	4	4	4	4	4	4	4	**32**
Buckets for Infection Prevention (10 litres)		8	8	8	8	8	8	8	8	**64**
Large basins for Infection Prevention		4	4	4	4	4	4	4	4	**32**
Medium basins for Infection Preventio		4	4	4	4	4	4	4	4	**32**

Appendix 7 (Continued)

Equipment from EngenderHealth to MOH sites	US$ /each	Mulanje	Chik-wawa	Balaka	Karonga	Mzimba	Mach-inga	Chirad-zulu	Mchinji	Nsanje	MOHP	Total Items
Date Received in at Site		Apr, 03	Apr, 03	Mar, 03	Mar, 03	Mar, 03	Apr, 03	Apr, 03	Apr, 03	Apr, 03		
New York Purchase												
Airway, nasopharyngeal size 28	4	2	2	2	1	2	2	2	1			**14**
Airway, nasopharyngeal size 30	4	2	2	2	1	2	2	2	1	2		**16**
Aspirator, ext. bot, 4 catheters, stand. 220V/50Hz	281						1		1	2		**4**
Endotracheal tube, 7.5mm	4											**0**
Model, Norplant training arm kit#S519	35	1	1	1	1	1	1	1	1	1		**9**
Model, no-scalpel vasectomy scrotal	6		1									**1**
No-Scalpel Vasectomy kit	57					1	1					**2**
Model Zoe, pelvic	290										5	**5**
Norplant Kit	7	1		1	1	1	1	1	1	1		**8**
Instruments Uterine Elevator	28	2	2	2	2	2	2	2	2	2		**18**
Tubal hooks	15	2	2	2	2	2	2	3	2	2		**19**
Babcock forceps	10	2	2	2	2	2	2	2	2	2		**18**
Resuscitator manual	76		1	1	1	1	1	1	1	1		**8**
Sphygmomanometer, aneroid	30	1	1	1	1	1		1	1	1		**8**
Sterilizer, All American, 25qt, 220V	315	1	1	1	1							**4**
Operating table	1,800							1				**1**
Operating lights	320							1				**1**
Instrument Stand Mayo	188	1		1	1	1	1	1	1	1		**8**
Sutures (Catgut #0)	15					2		2	2			**6**
Re-usable Syringes - 20cc plastic	10											**0**
Stethoscope	5						1		1	1		**3**
Weighing machine	30								1	1		**2**
Thermometer, oral, Fahrenheit/Celcius	3											**0**
Air conditioner	760											**0**
Ambu Bag	5											**0**
Trainee Package #1 Supervisors Package	145	1	1	1	1	1	1	1	1	1		**9**
Local Purchase												
Wall Charts for Infection Prevention (decontamination)		20	20	20	16	20	20	20	20	20		**176**
Wall Charts for Infection Prevention (sterilization)		20	20	20	16	20	20	20	20	20		**176**
Buckets for Infection Prevention (20 litres)		4	4	4	4	4	4	4	4	4		**36**
Buckets for Infection Prevention (10 litres)		8	8	8	4	8	8	8	8	8		**68**
Large basins for Infection Prevention		4	4	4	4	4	4	4	4	4		**36**
Medium basins for Infection Preventio		4	4	4	4	4	4	4	4	4		**36**

Appendix 7 (Continued)

Equipment from EngenderHealth to MOH sites	Unit Cost in US$	Number of Units Supplied	Total Cost in US$
New York Purchase			
Airway, nasopharyngeal size 28	4	56	224
Airway, nasopharyngeal size 30	4	58	232
Aspirator, ext. bot, 4 catheters, stand. 220V/50Hz	281	16	4,496
Endotracheal tube, 7.5mm	4	9	36
Model, Norplant training arm kit#S519	35	31	1,085
Model, no-scalpel vasectomy scrotal	6	3	18
No-Scalpel Vasectomy kit	57	4	228
Model Zoe, pelvic	290	5	1,450
Norplant Kit	7	32	224
Instruments Uterine Elevator	28	86	2,408
Tubal hooks	15	90	1,350
Babcock forceps	10	87	870
Resuscitator manual	76	22	1,672
Sphygmomanometer, aneroid	30	34	1,020
Sterilizer, All American, 25qt, 220V	315	19	5,985
Operating table	1,800	5	9,000
Operating lights	320	6	1,920
Instrument Stand Mayo	188	31	5,828
Sutures (Catgut #0)	15	35	525
Re-usable Syringes - 20cc plastic	10	230	2,300
Stethoscope	5	24	120
Weighing machine	30	17	510
Thermometer, oral, Fahrenheit/Celcius	3	4	12
Air conditioner	760	4	3,040
Ambu Bag	5	6	30
Trainee Package #1 Supervisors Package	145	34	4,930
			$ 49,513
Local Purchase			
Wall Charts for Infection Prevention (decontamination)		**496**	
Wall Charts for Infection Prevention (sterilization)		**496**	
Buckets for Infection Prevention (20 litres)		**96**	
Buckets for Infection Prevention (10 litres)		**188**	
Large basins for Infection Prevention		**96**	
Medium basins for Infection Preventio		**96**	

Appendix 8

PAC Equipment Supplied to Malawi Program

No.	Item	Quantity	Unit Cost	Total
1	DVS-16 (DoubleValve Aspirator with 16 flexible Cannulae sizes 4-12mm)	68	35.10	2,386.80
2	PIP Kits (2 Double Valve Aspirators, 2 Single Valve Aspirators, 1 Single and 1 Double valve replacement set, 2 adapter sets, thirty 2cc Tubes of silicone, 1 set Denniston Dilators, 4 medium specula, 4 Atraumatic tenaculae, 2 sponge forceps, 2 long dressing forceps, 2 needle extenders and 32 flexible cannulae	68	365.25	24,837.00
3	IA18 Kits (2 Double Valve Aspirators, 1 replacement double valve set, thirty 2cc tubes of Silicone, adapters, and 18 Flexible cannulae	68	63.95	4,348.60

Appendix 9

Training Data for LTPC

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
March 5-17, 2000 (Follow-up, 8/2000)	TOT in Surgical Skills	(8) Clinicians/Nurses teams including 2 National Coordinators	Duncan Chipula Humphrey Mkochi Andrew Dimba Emmanuel Kaonga Dickson Mambulu Antone Mhango Ellen Banda Vitta Kaunda Grief Matemba Beatrice Mwale Zenaida Phiri Piyo Dimba Mercy Kokha	**EngenderHealth** Dr. Job Obwaka **MOHP** Beata Zuza	Kasungu, Rumphi, Mchinji, Machinga, Ntchisi District Hospital and Nkhoma, St Annes Mission Hospitals, CHAM and MOHP	The goal of the training was to develop a critical mass of master trainers in standardized clinical/surgical and supervisory skills, including improved infection prevention. During the follow-up in 2000, medical site visits were conducted by Julius Malewezi, Feddis Mumba, Job Obwaka, Deliwe Malema.
May 1-5, 2000	Training of VSC Service Providers	(5) Clinician/Nurse teams	Alick Kaonga Zex Kadam'manja John Mwase Janet Kaboko Eleanor Chadza Alliet Kupatsa Botha	**EngenderHealth** Dr Job Obwaka **MOHP** Duncan Chipula **CHAM** H. Mkochi	Ekwendeni, Malamulo Mission Hosp. and Chitipa, Mangochi, and Salima Dist Hospitals	To develop in-country capacity in LTPC skills (This was the first VSC Service Providers training course organized by MOHP/CHAM as a follow-up to the TOT training conducted in March 2000)
June 5-9, 2000	FP/VSC Counseling training	13 FP Providers, 1 Clinician & 2 National Coordinator (MOHP/CHAM)		**Consultant** Jane Asila **MOHP** Kitty Mhango	Mangochi, Machinga, Rumphi, Ntchisi, Mchinji, Kasungu & Salima Dist., St Annes, Embangweni, Livingstonia, St Martins, St Lukes Mission Hospitals	To expose clients to skills in Client Provider Interaction, Informed Choice & Counseling
June 12-23, 2000	Facilitative Supervision & Medical Monitoring W/shop	(8) Clinicians/Nurses teams	Vitta Kaunda Grief Matemba Humphrey Mkochi Beata Zuza Beatrice Mwale Zenaida Phiri Ellen Banda Dickson Mambulu	**EngenderHealth** Dr. Job Obwaka Dr. Joseph Ruminjo	Kasungu, Rumphi, Mchinji, Machinga District Hospital and Nkhoma, Malamulo, St. Annes Mission Hospitals	The goal of this training was to develop a group of supervisors able to conduct facilitative supervision and medical monitoring (The trainees were the Clinician/Nurse teams trained during the TOT)

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
	Cont'd… Facilitative Supervision & Medical Monitoring		Duncan Chipula Antone Mhango Moffat Sakala Emmanel Kaonga Andrew Dimba			
July 21-22, 2000	Orientation for Policy Makers	MOHP/CHAM policy makers & stakeholders in RH	60 Participants	**EngenderHealth** Dr. Job Obwaka Feddis Mumba	MOHP, CHAM, USAID, DHMTs, BLM, JHPIEGO, DFID	To promote an understanding of individual organization's roles and responsibilities to enable them provide needed support and technical assistance for LTPC program
Oct 30-Nov 3, 2000	Training of VSC Service Providers	(4) Clinician/Nurse teams	Prisca Nancy Makombe Lucy Yvonne Collen Abigail Bonongwe Henderson Lomosi Gryson Kumwenda Settle Misheck Priminta Chimwemwe Msukwa	**MOHP** Duncan Chipula **CHAM** M. Kokha, H. Mkochi and Piyo Dimba	Chiradzulu, Dowa, Nsanje and Karonga Dist. Hospital	To train LTPC service providers in standardized clinical/surgical skills
Nov 13-17, 2000	No-Scalpel Vasectomy (NSV)	6 Clinicians	Antonne Mhango Duncen Chipula Emmanuel Kaonga Dickson Mambulu Sylivester Simbi Humphrey Mkochi Amstead Kamkwatira	**Consultant** Dr. William Obwaka	Kasungu, Ntchisi, Rumphi, Dowa & Machinga Dist. Hospitals, Nkhoma & Malamulo Mission Hospitals and Banja la Mtsogolo	The goal of this activity was to provide competence-based training in NSV technique to seven trainees from MOHP, CHAM and BLM institutions
May 28-30, 2001	Cost Analysis Training	30 participants from MOHP and CHAM hospitals. They included DHMTs, hospital matrons and accountants		**EngenderHealth** Antony Mueke Sheila Ndambuki	MOHP, CHAM and BLM	To promote an understanding of the costing of services in the MOHP and CHAM by involving District Health Management Teams in the use of Cost Analysis Tool
July 1-6, 2001	Training of VSC Service Providers	(4) Clinician/Nurse teams	Hallex Mulinde Dellia Chikuse Dryton Makanjira	**MOHP** Duncan Chipula	Mwanza, Dedza, Chikwawa Dist. Hosp Nkhoma, Mulanje,	To increase the number of competent and trained service providers in clinical and surgical skills in LTPC

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
	Cont'd… Training of VSC Service Providers		Ruth Finyani D. Chigumukire Catherine Shire M. Manjol Gama J. Mwamba W. A. Mwenifumbo S. Msiska Hild Guassi Emmanuel Nyirenda	**MOHP** E. Kaonga A. Mhango **CHAM** Mercy Kokha	St. Lukes & Livingtonia Mission Hospitals	
July 23-Aug 3, 2001	Facilitative Supervision & Medical Monitoring W/shop	(8) Clinicians/Nurses teams	Zenaida Phiri Antone Mhango Andrew Dimba Beata Zuza Duncan Chipula Baeatrice Mwale Hazzie Mula Slyvester Simbi Henderson Lomosi Lucia Collen Moffat Sakala Dennis Kamanga Humphrey Mkochi Piyo Dimba Mercy Kokha	**EngenderHealth** Dr. Job Obwaka Dr. Joseph Ruminjo	Kasungu, Rumphi, Mchinji, Machinga, Ntchisi, Dowa, Mzimba, District Hospital and Nkhoma, Malamulo, St. Annes Mission Hospitals & BLM	To increase the skills and number of clinicians and nurses able to conduct facilitative supervision and medical monitoring (This was a follow-up to a similar training activity in June, 2000)
Aug 19-1 Sept, 2001	COPE Introduction	Supervisors from 3 hospitals		**EngenderHealth** Theodora Bwire **Consultant** Emily Matwale	Sites visited: Malamulo SDA Hospital Kasungu and Machinga Dist. Hospitals	To supervise and improve the quality of services provided
October 15-19, 2001	Training of VSC Service Providers	(4) Clinician/Nurse teams	Michael Udedi Catherine Ussi Annie Chalowa Alfred Chalira Thom Sauzande Hazzie Mvula Austains Gumbo	**MOHP** Duncan Chipula Beata Zuza Antone Mhango **CHAM** H. Mkochi	Machinga, Kasungu, Mulanje, Rumphi & Mchinji Dist. Hosp.	To increase the number of competent and trained service providers in clinical and surgical skills in LTPC. The clinician trained in Mchinji was to replace Mr Dimba who was transferred to Ntcheu

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
Dec 3-13, 2001	Training of VSC Service Providers	6 Clinician/Nurse teams	Jessie Kaunda Jane Mughogho Clement Simuchimba Joseph Pett Mughogho Innocent Nyangulu John Kabichi Ellen Mpinganjira Mtambo Peter Nyasulu Lawrence Chulu Verydear Laisi Boulvazio Ndovie	**MOHP:** Duncan Chipula Zenaida Phiri Antone Mhango **CHAM:** Humphrey Mkochi	Chitipa, Chiradzulu and Ntchisi District Hospitals	Training was aimed at ensuring that the 24 district hospitals supported by EngenderHealth have clinicians and nurses competent in LTPC
Feb 28-Mar 8, 2002	Training of VSC Service Providers	(6) Clinician/Nurse teams	Rose P. Ngoma Lonnie Kamlomo Kanyasho S. Malunga Ethel J. Nyirenda Naomi M. Guba Worried M Gausi Alafat J. K. Tembo Janet Mvula Fred L. D. Zainga Euance T. Mphenzi	**MOHP:** Duncan Chipula Zenaida Phiri Antone Mhango CHAM: Humphrey Mkochi	Chitipa, Ntchisi & Chiradzulu District Hospitals	To continue to increase the number of competent and trained service providers in clinical and surgical skills in LTPC
March 10-15, 2002	Training of VSC Service Providers	6 Clinician/Nurse teams	Ishmael Nyirenda Tamara Chirwa Madetsa Belito Kate Chimtengo Noel Mataya Matthias Dhlamini Mirriam Chiumia Wak Banda Martha Chitowe Timothy Sabuni Mary Kubwalo Mussa Banda Hilda Petani	**MOHP:** Duncan Chipula **CHAM:** Humphrey Mkochi	Embangweni, Nkhoma, ABC Clinic, St. Annes, Mulanje & Malamulo (all CHAM sites)	On-going training of service providers to increase the number of competent service providers in LTPC

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
June 10-11, 2002	Follow-up orientation workshop for policy/decision makers	Policy/Decision Makers and other key stakeholders	49 Participants	**EngenderHealth:** Deliwe Malema **CHAM Secretariat:** Joe Theu **Reproductive Health Unit:** Julius Malewezi Joyce Nyasulu	MOHP, CHAM, USAID and JHPIEGO	To foster effective partnership in the implementation of reproductive health programs in Malawi
Sept 30-4 Oct, 2002	Training of LTPC Service Providers in ML/LA and Norplant Insertion and Removal	4 Clinician/Nurse teams	Dr. D. G. Kamwana Dr. J. M. Mughogho P. Nkhoma Judith Nzondo Queen Hamie Martin Msukwa Edwin Kachiwala Mercy Matewere	**MOHP:** Duncan Chipula **CHAM:** Humphrey Mkochi Mercy Kokha Piyo Dimba	Emabwangeni, Ekwendeni, Nkhoma, Mulanje and Malamulo Mission Hospitals	On-going training of service providers to increase the number of competent service providers in LTPC
March 17-21, 2003	Training of LTPC Service Providers in ML/LA and Norplant Insertion and Removal	3 Clinician/Nurse Teams	Sandra Marino Wyson Moyo Ellen Chilzhadwe Kenwell Chibambo B. Ngulube K. Nkhone	**MOHP:** Duncan Chipula Antone Mhango Beatrice Mwale Ellen Banda	Balaka, Thyolo, Ntcheu & Nkhatabay District Hospitals and Lilongwe Central Hospital	To increase the number of competent service providers in LTPC
March 24-28, 2003	FP/LTPC Counseling training	19 FP providers	Francesca Kachingwe Mary Chande Zacharia Jezman Florence Mdazizira Gomezgani Genda G. Madina Rumours V. Lumala N. Jumah Gresham Lumbe	**MOHP:** L. Uta Mrs. Chisiza Julius Malewezi **CHAM:** Dezele Mhango	St. Lukes, Embangweni, Mulanje Mission, Nkhoma, Malamulo, Nsanje, Mzuzu, Chipita, Monkey Bay Community Hospital, Balaka, Dowa, Dedza, QECH, Ntchisi, Mwanza and Ekwendeni	The target group was family planning providers who work with FP clients to provide them with knowledge and skills in counseling

DATE	CATEGORY OF TRAINING	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
	Cont'd FP/LTPC Counseling training		Litress Jamu Tiwonge Nkhana Betty Kadzakumanja Susan Njingambewe Bonificio Ndovi Msenga Ngwira Mirriam Munthali N. Sapao Felix Manjolo Bridget Malenga			
March 31-4 April, 2003	FP/LTPC Counseling Training	18 FP Providers	Elizabeth Chigumkire Stephen Kazembe Hlupekire Mhera George Kasawala T. Sichnga Leonard Mchombo Mary Mkandwire Agatha Mlinda Enala Mkandawire Gaily Graysham Esmie Mpinganjira Lilian Maputu Rita Banda Emmanuel Nyiranda Vivian Kamanyauli Henry Ndholvu Willes Bitoni Adiaida Nyemba	**MOHP:** L. Uta Mrs Chisiza Julius Malwezi **CHAM:** Dezele Mhango	Nkhoma, Malamulo, Embangweni, St. Martims, Rumphi, Machinga, Ekwendeni, St. Annes, Nkhatabay, Mchinji, Chiradzulu, Thyolo, Zomba, Chiwawa, Mzimba, Salima, Ntcheu and Livingstonia	The target group was family planning providers who work with FP clients to provide them with knowledge and skills in counseling
April 28-2 May, 2003	Trainee follow-up and medical monitoring	7 LTPC sites visited		**LTPC Supervisors:** Antone Mhango Zenaida Phiri Beatrice Mwale	Mulanje, Thyolo, Machinga, Chiradzulu, Balaka, Ntcheu, Nkhatabay	To enhance performance and ensure standardization of LTPC techniques

DATE	CATEGORY OF TRAINING	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
April 28-3 May, 2003	Training of LTPC Service Providers in ML/LA and Norplant Insertion and Removal	5 Clinician/Nurse teams	Gomezgani Genda Abudullah Saidi A.Chingama Maurine Stephenson Benjami Soko Ma C'Ojana Robert Chamza Matson Denzi Suave Gomwa Tobias Mapulanga Juliana Soko Madalitso Phiri	**MOHP:** Duncan Chipula Antone Mhango Beatrice Mwale Ellen Banda **CHAM:** Humphrey Mkochi Piyo Dimba	Malamulo, Mulanje, Livingstonia, Embangweni, St. Lukes	On-going training of service providers to increase the number of competent service providers in LTPC

Appendix 10

Training Data for PAC

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
Jan 13-26, 2002	TOT in Comprehensive Post Abortion Care	10 Clinicians and Nurses	A.T.U. Rombe G.P. Sulumba E.D.K. Monjeza E. Mwale Mike Kantikana T. Sichinga Wiza Chilongo Emily Karonga Henderson Lomosi M. Chalira	**MOHP:** Beata Zuza **EngenderHealth:** Dr. J. Ruminjo Deliwe Malema	Machinga, Kasungu, Rumphi, Dowa District Hospitals, Queen Elizabeth Central Hospital and Malamulo Mission Hospitals	The goal of the training was to develop a critical mass of master trainers in standardized knowledge and skills needed for performing MVA.
Feb 17-28, 2002	TOT in Comprehensive Post Abortion Care	10 Clinicians and Nurses	Lyod Liwonde Patricia Kawonda Eunice Masinja Belito Madetsa Alexander Sembo Violet Banda Uzehlaphi Phoya Settie Priminta Bernedetta Mazibuko Klementi Simchimba Felicia Chawani	**MOHP:** **EngenderHealth:** Dr. J. Ruminjo Deliwe Malema	Ntcheu, Chiradzulu, Chitipa District Hospitals, Queen Elizabeth Central Hospital, Nkhoma Mission Hospital and Reproductive Health Unit	The goal of the training was to develop a critical mass of master trainers in standardized knowledge and skills needed for performing MVA.
Apr 21-26, 2003	Training in Comphrensive PAC for Service Providers	14 Clinicians and Nurses	Julita Malava Nkhindo Nkunika Alberto Mbalasiya Joyce Gondwe McDonald Msadala Lucy Chitete Gerald Lingson Vella Chizonda Zondiwe Banda Julia Chilinda Dyna Khonde	**MOHP:** Tambudzai Rashidi Beata Zuza **EngenderHealth:** Deliwe Malema		To provide participants with knowledge and skills needed for performing MVA as well as preventing and managing complications related to the procedure.

DATE	CATEGORY OF TRG	CADRE OF TRAINEES	NAMES OF TRAINEES	TRAINERS	TRAINEE INSTITUTIONS	GOAL
	Cont'd … Training in Comphrensive PAC for Service Providers		Catherine Mzembe Benjamin Soko Emmanuel Nyirenda			
May 25-29, 2003	Orientation for Faculty Members	14 Clinicians and Nurses	Petro Chirambo Duncan Chipula Sostein Kuyeli Vennie Arcado Sr. E. Nampuntha Mphatso Mary Nguluwe Evelyn Chonzi Wyness T. Gondwe L. Chilikutali Lignet Chepuka Christopher Finye Lexa Pangani Dyson Mwandama Mrs. Kabuluzi	**MOHP:** Beata Zuza T. Rashidi **Engenderhealth:** Dr. F. Ndede Deliwe Malema	Malawi College of Health Scuences, Kasungu District Hospital, St. Luke's Nursing School, Nkhoma School of Nursing, Ekwendeni Nursing School, St. Joseph's Nursing School, Trinity Nursing School, Kamuzu College of Nursing, Mulanje Mission College of Nursing Malamulo College of Nursing and Kamuzu College of Nursing	To provide participants with knowledge and skills needed for performing MVA as well as preventing and managing complications related to the procedure.
June 16-20, 2003	Training in Comphrensive PAC for Service Providers	10 Clinicians and Nurses	H. Gondwe Kondwe Ngwira Mwambetanta I Chamba Gogoda Kwangwasi B. Ngoma B. Ngulube I. Sibale	**MOHP:** B. Zuza E. Karonga G. Sulumba Miss Masinja D. Chipula	Mponela, Chintheche, Ndirande, Ngabu, Mitundu, Embangweni, Nkhatabay	To provide participants with knowledge and skills needed for performing MVA as well as preventing and managing complications related to the procedure.