



Mwayi wa Moyo (“A Chance to Live”) Project
Blantyre District, Malawi

Year One Annual Report
October 2012

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Submitted by:

Save the Children Federation, Inc.

54 Wilton Road, Westport, CT 06880

Telephone: (203) 221-4000 - Fax: (203) 221-4056

Contact Persons:

Eric A. Swedberg, Senior Director, Child Health and Nutrition

Theresa Abanilla, Grants Manager, Department of Health and Nutrition

Authors and Editors:

Luwiza Puleni, *Mwayi wa Moyo* Program Manager; Mayeso Mphande, *Mwayi wa Moyo* Operations Research and M&E Coordinator; Joby George, Director of Health, Save the Children Malawi; Karen Z. Waltensperger, Senior Advisor, Health-Africa; Winifride Mwebesa, Senior Director, Family Planning & Reproductive Health; Sharon Lake-Post, Editorial Consultant



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Table of Contents

	Page
Acronyms and Terms	3
Executive Summary	5
A. Key Progress and Main Accomplishments	5
B. Activity Status	8
C. System Strengthening: Local Partner Collaboration, Capacity Building, and Sustainability	13
D. Technical Assistance	14
E. Substantial Changes to Project Description	14
F. Information Requested During DIP Consultation	14
G. Information on Specific Types of Project or Years of Implementation	14
H. Mission Collaboration	14
I. Optional	14
Annexes	
Annex 1: Learning Brief	16
Annex 2: Workplan for the Coming Year	17
Annex 3: Papers, Presentations, News Coverage about Project, and Product	20
Annex 4: <i>Mwayi wa Moyo</i> M&E Table	21
Annex 5: Social and Behavioral Change Strategy for <i>Mwayi wa Moyo</i>	25
Annex 6: Innovation	40
Annex 7: Health Facility Assessment	41
Annex 8: Project Data Form	73

Acronyms and Terms

AHS	Adventist Health Services
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BC	Behavior Change
BCC	Behavior Change Communication
BLM	<i>Banja la Mtsogolo</i> -a Malawian NGO
CBDA	Community Based Distribution Assistants
CBMNC	Community Based Maternal and Neonatal Care
CCM	Community Case Management
CDD	Control of Diarrheal Diseases
CHAM	Christian Health Association of Malawi
CM	Community Mobilization
CMNH	Community Maternal and Newborn Health
COM	College of Medicine
COMREC	College of Medicine Research Centre
CSHGP	Child Survival and Child Health Program
DHMT	District Health Management Team
DHO	District Health Office
DIP	Detailed Implementation Plan
FANC	Focused Antenatal Care
FP	Family Planning
FPAM	Family Planning Association of Malawi
HBB	Helping Babies Breathe
HPP	Health Policy Project under Futures Group
HSA	Health Surveillance Assistant
HTSP	Health Timing and Spacing Practices
IDEA	Local NGO
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-governmental Organization
IR	Intermediate Result
ITN	Insecticide Treated Nets
IUD	Intrauterine Device
JSI	John Snow, Inc.
KPC	Knowledge, Practices, Coverage (Survey)
LAPM	Long-acting and Permanent Methods
PM&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
NGO	Non-governmental Organization
OR	Operations Research
PCM	Pneumonia Case Management
PPFP	Postpartum Family Planning

PPIUD	Postpartum IUD
PSI	Population Services International
PTM	Prevention and Treatment of Malaria
RESPOND	An NGO based in the US that will work in Malawi on policy advocacy on long-term and permanent FP methods in districts where USAID is providing funding on MNH. It also collaborates with EngenderHealth.
RHU	Reproductive Health Unit of the Ministry of Health
SBCC	Social and Behavior Change Communication
SC	Save the Children Federation, Inc.
SHSA	Senior Health Surveillance Assistant
SSDI	Supporting Service Delivery Integration (USAID bi-laterals that include SSDI-Services, SSDI-Policy, SSDI-Communication)
TA	Traditional Authority
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WRA	Women of Reproductive Age

Executive Summary

Save the Children, in partnership with the Ministry of Health (MoH) and with support from the United States Agency for International Development (USAID) Child Survival and Child Health Program (CSHGP) in Washington, DC, is carrying out a four-and-a-half-year (30 September 2011-31 March 2016) project called *Mwayi wa Moyo* (“A Chance to Live”). The project supports the MoH in its effort to reduce under-five mortality by applying life-saving interventions through delivery channels that are accessible, available, high quality, demanded and supported at the community level. *Mwayi wa Moyo* strives to work with the MoH and partners to streamline and integrate current community packages into a single coherent package of high-impact maternal, newborn, child health (MNCH) and family planning (FP) interventions that fills gaps in the Continuum of Care and delivers more interventions at better quality and less cost. The project therefore supports development and testing of an integrated community-based package for Health Surveillance Assistants (HSAs) and serves as a learning ground for redefining the role of the HSA in delivering high-quality services. The project’s Operations Research (OR) component is entitled: *Vertical vs. Integrated: Assessing the effectiveness of an integrated community-based MNCH and FP package in reducing missed opportunities.*

Mwayi wa Moyo is implemented in 17 health center (HC) catchment areas of Blantyre District, covering a total population of 538,413, in close partnership with the MoH, Blantyre District Health Management Team (DHMT), the Malawi College of Medicine (COM) in Blantyre, and other international and local partners. Project dates are from October 2011 to March 2016 Its four intermediate results (IRs) are: ***IR-1: Increased access to and availability of services; IR-2: Improved quality of services; IR-3: Increased demand for services and health practices; and IR-4: Enabled environment.*** Levels of effort for project interventions are: Maternal and Newborn Care (MNC) at 34%; Pneumonia Case Management (PCM) at 18%; Control of Diarrheal Diseases (CDD) at 18%; Prevention and Treatment of Malaria (PTM) at 18%; and FP at 10%. The project targets Blantyre District’s underserved rural and peri-urban communities, with a total beneficiary population of 538,413, of which 91,530 (17%) are children under five years old, 113,067 (21%) are women of reproductive age (WRA) (15-49 years old), with approximately 26,921 (5%) new pregnancies expected each year. This is the **first year annual report** covering program activities implemented from October 1, 2011 through September 30, 2012.

A. Key Progress and Main Accomplishments

Mwayi wa Moyo’s project activities in the first year were as follows: 1) recruitment and orientation of program staff; 2) project briefings and awareness creation meetings with MoH officials at national, district and zonal levels and at the community level with traditional authorities and other community leaders; 3) participation in meetings for collaboration and partnership with the College of Medicine, as our key partner in Operations Research; 4) Conduction of baseline surveys and Detailed Implementation Plan (DIP) workshop; 5) DIP submission and review; and 6) Signing of the Sub Grant Agreement with the College of Medicine.

Table 1: Summary of Major Project Accomplishments

Project Objective #1: Increased access to and availability of services			
Project Inputs	Activities	Outputs	Outcome
<ul style="list-style-type: none"> Funds MOH approved training manuals on FP, CNMNH and CCM Participants 	<p>IPTWG technical consultation workshop for integration of training modules for HSAs</p>	<p>Integrated modules developed as follows:</p> <ul style="list-style-type: none"> Module 1: Cross cutting issues encompassing: Interpersonal Communication Skills, Nutrition/exclusive breast feeding, Immunization, Infection Prevention, Growth monitoring and development, PPF, HIV and AIDS. Module 2 (Integrated MNCH+PPFP Community Mobilization) that encompassed Definition of Community Mobilization, PHASE I: Prepare To Mobilize, PHASE II: Organize the Community for Action, PHASE III: Explore Maternal, newborn and child health Issues and Set Priorities. Module 3 (Integrated Community Based Maternal and Newborn Health) courses included Maternal and Neonatal Health situation in Malawi and Interventions to reduce high maternal, neonatal and child mortality in Malawi such as focus ante natal visits/clinic and Module 4 that included Caring for children (0-2 months and 2-5 years) in the community, Welcoming the caregiver and child, Identify problems and Refer or treat the child. 	No outcome yet
<ul style="list-style-type: none"> Trainers Funds Integrated training manuals, integrated SBCC materials and integrated M&E Tools including registers 	<p>Training of 20 trainers on integrated modules for HSAs(these are national trainers from different districts including Blantyre)</p>	20 trainers trained	No outcome yet
<ul style="list-style-type: none"> Trainers Funds IMNH + HBB and PPF 	<p>Training of 17 health facility staff on IMNC + PPF from 17 health facilities under Mwayi wa Moyo catchment area</p>	17 Nurses/Medical assistants and clinicians trained	No outcome yet

Project Objective #-2: Improved Quality of services			
<ul style="list-style-type: none"> Funds MOH approved SBCC materials on FP, CNMNH and CCM Participants 	<p>IPTWG consultation workshop to develop integrated SBCC (strategy, messages, job aids, communication materials) – integrate HTSP and PPFP messages: Counseling Cards to be used by HSAs, Posters to be used by Healthy Facility staff during health education sessions and picture cards to be used by core groups, CBDAs and volunteers)</p>	<ul style="list-style-type: none"> Integrated MNCH+PPFP counseling cards developed Integrated MNCH+PPFP posters developed Integrated MNCH+PPFP picture cards developed 	No outcome yet
<ul style="list-style-type: none"> Funds MOH approved Supervisory and mentorship checklists on FP, CNMNH and CCM Participants 	<p>IPTWG consultation workshop to develop integrated supervision and mentoring tools</p>	<ul style="list-style-type: none"> Integrated MNCH +PPFP supervisory and mentorship checklists for HSAs developed Integrated MNCH+PPFP register developed 	No outcome yet
Project Objective #-3: Increased demand for services and practices			
<ul style="list-style-type: none"> Funds MOH staff 	District level orientation of Area Development Committees	8 orientation meetings in all Traditional Authorities in Blantyre conducted	No outcome yet
<ul style="list-style-type: none"> Funds MOH approved training manuals on FP, CNMNH and CCM and community mobilization Participants 	Workshop to develop training module on integrated MNCH+PPFP Community mobilization	Module 2 (Integrated MNCH+PPFP Community Mobilization) that encompassed Definition of Community Mobilization, PHASE I: Prepare To Mobilize, PHASE II: Organize the Community for Action, PHASE III: Explore Maternal, newborn and child health Issues and Set Priorities developed	No outcome yet
Project Objective #-4: Enabled environment			
<ul style="list-style-type: none"> Funds Transport 	MwM participation in national sub committees (FP, Safe Motherhood, IMCI)	Participated in one meeting at national level	No outcome yet
<ul style="list-style-type: none"> Funds MOH staff and other stakeholders 	Project implementation steering committee meetings	1 meeting conducted	No outcome yet
<ul style="list-style-type: none"> Funds Blantyre DHO South West Zone staff 	Orientation workshops for TAs and community leaders	One meeting conducted with all the Traditional Authorities in Blantyre	No outcome yet
<p>Operation Research Objective: To determine the effectiveness of <i>an integrated community-based package</i> in reducing the missed opportunities for delivering MNCH and FP interventions at every stage of the life cycle from pregnancy till the child is five years of age.</p>			

Transport Funds	Research protocol/concept development including Objectives of the study, study arms	OR concept and protocol developed and submitted	No outcome yet
Transport Funds	Sub Grant Agreement signing	SGA signed	No outcome yet
None	COMREC review and approval	COMREC approved protocol	No outcome yet

B. Activity Status

Table 2: Project Activity Status

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities (Completed, On target, Not yet on target)	Comments
IR-1: Increased access to and availability of services	IPTWG technical consultation workshop for integration of training modules for HSAs	On target	Currently in the process of pretesting. To be completed by end September
	Training of 20 trainers on integrated modules for HSAs	Completed	The TOT also formed a pretesting forum for the integrated modules
	Training of 17 health facility staff on IMNC + PFP	On target	Included HBB, Healthy timing and Spacing and FP
	49 HSA training on integrated modules 1-4	Not yet on target	To be completed in the first quarter of Year 2
	IPTWG consultation workshop to develop integrated supervision and mentoring tools	Completed	These will be rolled out during trainings as in the above training
	Facilitate access to provision of long term LAPMs through partners i.e. BLM	On target	Discussed with BLM during FP subcommittee meetings and FP USAID partners meetings
	Facilitate provision of equipment and supplies for trained health facility staff in IMNC + PFP i.e. JSI Deliver, UNICEF, UNFPA	Not on target	Liaised with UNICEF and JSI deliver and they indicated that they only provide these items in their respective program districts. Still identifying other avenues.
	Facilitate re-equipment and re-supply of HSAs & trained health facility staff (based on needs assessment)	Not on target	Liaised with UNICEF and JSI deliver and they indicated that they only provide these items in their respective program districts. Still identifying other avenues.

	Facilitate provision of equipment and supplies for trained HSAs in community integrated package i.e. JSI Deliver, UNICEF, UNFPA	Not on target	Liaised with UNICEF and JSI deliver and they indicated that they only provide these items in their respective program districts. Still identifying other avenues. MNH program too under Save the Children does not have.
IR-2:Improved quality of services	Facilitate requisition and distribution of health facility protocols from RHU	Not yet on target	To be completed in the first quarter of Year 2
	Orientation workshop for 15 district level mentors on facility-based MNCH providers and PFP	Not yet on target	To be completed in the second quarter of Year 2
	Facilitate roll out and consistent use of data collection tools	Not yet on target	To be completed in the first quarter of Year 2
	Advocate for consistent drugs and FP methods through participation in national and district level sub committees i.e. FP, safe motherhood, IMCI etc.	On target	Ongoing activity
	Train 30 mentors for HSAs and SHSAs on integrated MNCH + PFP mentoring-6 days	Not yet on target	To be completed in the first quarter of Year 2
	Clinical mentoring visits to health facilities	Not yet on target	To start after skilled birth attendants have been trained in IMNC+PFP
	Clinical mentoring of HSAs	Not yet on target	To start after the above training on mentorship has been completed
	IPTWG consultation workshop to develop integrated SBCC (strategy, messages, job aids, communication materials) – integrate HTSP and PFP messages.	On target	To be rolled out during trainings of HSAs on integrated modules
IR-3: Increased demand for services and practices	Conduct a situational analysis of CBDAs (mapping, supervision, supplies and reporting)	On target	Data captured during Health facility assessment
	Control area training of 49 HSAs in CM using current/existing training packages – 6 days	Not yet on target	To be completed in the first quarter of Year 2
	District level orientation of Area Development Committees	On target	Need to orient them to SBCC messages and new CM approach
IR-4:Enabled environment	Project implementation steering committee meetings	Not yet on target	To start in the first quarter of Year 2
	<i>Mwayi wa Moyo</i> participation in national sub committees (FP, Safe Motherhood, IMCI)	On target	Ongoing activity
	Orientation workshops for TAs and community leaders	On target	Need to orient them to SBCC messages and new CM approach

Financial management system

All financial and administrative procedures follow the standard external and internal operating rules and procedures of Save the Children and USAID for reporting and controlling expenses. The Grants Manager, Grants Officer, and Program Manager responsible for *Mwayi wa Moyo* liaise with the Director of Health, on a regular basis to discuss current project requirements and program direction in budgeting and financing. Monthly, quarterly and annual budget reports are developed by the Program Manager in coordination with the Grants Officer. All financial reporting and compliance is overseen by the Country Director and the Finance and Administration at the national office. The *Mwayi wa Moyo* team is updated on monthly basis on the status of the program budget against real expenditures and advising the program if they are under or over spending. The project has been receiving technical support from the Save the Children finance team located in Pretoria.

Human resources

Mwayi wa Moyo's first M&E/OR Coordinator, Brian Jumbe and the Training Officer, Jane Zgambo engaged in January resigned just after two weeks and one month respectively, to join SSDI program. The new staff members, Mayeso Mphande (M&E/OR Coordinator) and Timothy Bonyonga (Training Coordinator) joined in April, 2012.

Communication system and team development

In February, the SBCC Officer participated in CM using the CAC approach for MNH training in Thyolo where Save the Children is implementing the MNH program. The training prepares HSAs on how they can mobilise communities for MNH problems to enable them find solutions to these challenges themselves. This training was conducted for five days in January.

In April 2012, the M&E/OR Coordinator attended the M&E meeting at the Country Office. The objectives included:

- Orienting and re-orienting new and existing staff on Save the Children's M&E systems;
- Sharing practical experiences on the role M&E plays in projects and programming;
- Equipping staff with relevant M&E skills and capacity to manage M&E aspects;
- Discuss Save the Children's progress in attaining global child indicators; and
- Orient M&E experts on existing M&E reporting guidelines and principles.

The two-day meeting encouraged participation of all staff, for practical M&E sessions to promote cross learning. A review of M&E TWG TORs was done to incorporate input on how M&E can play a key role in supporting programs as they achieve their objectives. An action plan was developed that would assist team members to achieve their set objectives until the next meeting. The minutes will be circulated with key action plans for various staff across programs.

From 19-22 June 2012, the Training Officer attended CCM Supervision and Mentorship TOT in Mulanje. CCM Project organized a three-day training workshop on the revised supervision CCM checklist in Mulanje District. The main objective of the training was to update the primary CCM supervisors on the changes made to the checklist.

On 16th July, the M&E Coordinator attended an M&E meeting in Lilongwe. This meeting was organized by Gebrehiwot, Yosef a Regional M&E Specialist who facilitated the M&E workshop.

The workshop oriented key program staff on Global Indicators being tracked by Save the Children and how this can be assessed and collected using different approaches. The workshop gave an opportunity for Save the Children M&E staff from a number of programs to discuss several Save the Children global indicators to which they contribute. CS-27 team members became familiar with some of the organization's key health and child health parameters that directly affect our programming. The knowledge acquired will be used during monitoring, supervision and periodic program assessments

In August 2012, the OR/M&E Coordinator attended a Save the Children-sponsored training in Documentation, Communication and Photography conducted in Zomba, designed to orient key program staff in documentation, communications and photography. The training drew participants from several Save the Children programs, who are responsible for monitoring and reporting. The training equipped staff with the relevant capacity in documentation, shared experiences on best practices, and provided effective orientation on how to effectively manage program documentation.

Local partner relationships

Partnership with the MoH

Save the Children's main partner in the implementation of the program is the MoH specifically, the IMCI unit, the RHU at the national level and the Blantyre DHO at the district level. The MoH has been involved in this project since project conceptualization, including the development of the Integrated MNCH+PPFP.

National-level working group

Save the Children is an active member and participates regularly on the national Safe Motherhood and FP subcommittees which report to the lead organization- the SRHR Technical Working Group which meets quarterly. In special circumstances, these working groups also meet on an *ad hoc* basis. The Program Manager is a member of Safe Motherhood and FP subcommittees. The Program Manager has attended the FP Subcommittee meeting once since the inception of *Mwayi wa Moyo*.

The project will collaborate with the local NGO, *Banja la Mtsogolo* (BLM) and Queen Elizabeth Central Hospital, as well as with health facilities in the project area, to strengthen referral linkages for long-acting and permanent methods (LAPM) for FP. For PPFP, we will ensure a consistent supply of contraceptive methods at the community and facility levels by reinforcing the existing distribution system to minimize stock-outs. The project will be collaborating with USAID Deliver in the FP commodity/supply chain for Blantyre District to prevent stock-outs. The project will also ensure that the needs of volunteer Community-Based Distribution Agents (CBDAs) are factored into HC requisitions and work closely with HSAs and CBDAs to monitor stocks and prevent stock-outs.

PVO coordination/collaboration in-country

Save the Children consults regularly with the Mission on matters of *Mwayi wa Moyo* through consultations with the *Mwayi wa Moyo* Activity Manager, Deliwe Malema. *Mwayi wa Moyo* was invited to attend the FP partners meeting at USAID in July.

Other relevant management systems

None.

Update on Operations Research

Table 3: OR Study Progress and Achievements in Year One

OR Study Key Milestones <i>(i.e. Formative Phase)</i>	Related Key Activities <i>(as outlined in OR Concept Paper)</i>	Progress Status of OR Activities <i>(Completed, On target, Not on target)</i>	Comments <i>(challenges, contributing factors, change, etc.)</i>
Research protocol/concept development including objectives of the study, study arms	Develop and submit Operations research concept	Completed	
	Conduct OR consultative stakeholders meeting	Completed	The meeting provided guidance on the OR process
	Constitute and OR advisory group	Completed	The advisory group comprised of technical specialists from key institutions
Sub Grant Agreement signing	Signing of the SGA with COM	Completed	The agreement delayed in signing because of different financial processes between USAID/Save the Children and COM
COMREC review and approval	Develop, review and submit Research protocols	Completed	A series of reviews were conducted on the draft concept before its final submission
	IRB (COMREC) approval of research protocol	Completed	Input from COMREC was incorporated and changes made to initial draft concept. The concept was duly approved in July 2012
OR Baseline	Develop OR baseline questionnaires	On target	Draft tools developed as part of the final submitted OR Concept. Will be finalized by the end of October 2012
	Questions reviewed and finalized	On target	The tools to be finalized during the baseline training
	Conduct OR baseline population based survey	Not on target	Delayed transfer of funds due to different financial processes between COM and USAID/SC hence COM could not proceed with recruitment without funds. But this is now in progress. Baseline to be conducted by the first quarter in year 2
	OR mapping of implementing partners	Not on target	This is part of the OR Baseline
Documentation	Facilitate OR documentation	On target	This is a continuous process that is part of the OR. A documentation plan was developed and is part of the final submitted OR Concept.

Please see Annex 2 for a workplan for the coming year, and Annex 4 for an updated M&E Table.

C. System Strengthening: Local Partner Collaboration, Capacity Building, and Sustainability

During the DIP process meeting in February, *Mwayi wa Moyo* engaged INGOs including World Vision and Banja la Mtsogolo. This was to ensure a common ground for the implementation of the program. At the end of the DIP, as indicated in the introduction, the members created a *Mwayi wa Moyo* Steering Committee. This steering committee comprises several members from other INGOs who will guide the implementation of *Mwayi wa Moyo*. This group plans to meet twice a year. They were not able to meet in Year 1 as project implementation had not yet started and therefore did not have results with which to brief the steering committee.

Currently longer-acting methods including implants and intra-uterine devices (IUDs) can only be accessed at QECH and BLM clinics. To expand the range of contraceptive methods available, *Mwayi wa Moyo* will work with BLM to facilitate outreach clinics for LAPMs at fixed sites on specific health days (e.g., Child Health Days) or through mobile clinics in HtR areas. Working in facilities will also allow BLM to mentor providers and improve their capacity and confidence in inserting implants or IUDs. The high rate of facility deliveries also offers an untapped opportunity for mothers to access LAPMs. *Mwayi wa Moyo* will pilot the provision of postpartum intra-uterine devices (PPIUD) by partnering with SSDI and BLM to develop a training package, support training of providers in select facilities and ensure availability of equipment and supplies.

Mwayi wa Moyo has closely collaborated with Ministry of Health (MoH) in the development of integrated package. The Blantyre DHMT remains the project's principal implementation partner. The project team is currently located at Blantyre District Health Office (DHO) which enables easier access, support and collaboration. The project recognizes existing decentralized community structures as agents for effective program implementation. Key community players i.e. chiefs, local leaders, business people, members of the Area Development Committee (ADC) were orientated in the project for collaboration. The project collaborates closely with, and is accountable to, three key MoH units: RHU, IMCI Unit, and PHCU which played a key role in the development and finalization of integrated training, monitoring and mentorship tools.

Sustainability of the integrated approach will be reinforced with integrated supervision and monitoring. The project actively involved the DHO and other government departments in the development of supervision, monitoring and mentoring tools. Current experiences on the use and challenges faced were noted and addressed to ensure they are effectively adopted at district level. The project will train Blantyre-based mentors and supervisors to assist and conduct supervision which will encourage sustainability. The project recognizes the need for community ownership of project initiatives and therefore uses community volunteers as CM agents. The project will use Core Groups, Community Based Distribution Agents (CBDAs) and other volunteers like grandmothers to facilitate CM, which has proven to be an effective and sustainable approach towards community development.

D. Technical Assistance

Technical assistance (TA) will be needed next year for programmatic activities including annual reports review, and for program activities. This TA will be provided by Save the Children's Senior Director, Family Planning & Reproductive Health located in the home office in Washington, DC, as well as by the project's Technical Backstop, Karen Z. Waltensperger, Senior Advisor, Health-Africa Region, based in South Africa.

E. Substantial Changes to Project Description

There are no significant changes to the project description that would require a modification to the Cooperative Agreement.

F. Information Requested During DIP Consultation

All information requested during the DIP Consultation was provided in the revised DIP submitted to USAID in September, 2012.

G. Information on Specific Types of Project or Years of Implementation

Please see Annex 7 for the Health Facilities Assessment.

H. Mission Collaboration

Mwayi wa Moyo actively consults with the USAID Mission in Malawi. The Activity Manager for *Mwayi wa Moyo* at the Mission, Deliwe Malema was in attendance. She was also involved, during the DIP process, in the development of the OR concept through reviewing and editing. *Mwayi wa Moyo* also updates the Mission through monthly program reports to the Activity Manager, and is a member of USAID FP partners, group that meets quarterly to update partners on FP issues.

Mwayi wa Moyo also collaborates with SSDI-Services and SSDI-Communication by involving them in the development of the integrated MNCH+PPFP packages and meeting. The Program Manager for *Mwayi wa Moyo*, is a Master Trainer in Helping Babies Breathe (HBB) and has assisted SSDI-Services South West Zonal Office through facilitation of an HBB training for service providers in one of the SSDI districts in South West Zone. The Zonal Manager for South West SSDI- Services is a member of the OR Consultative Committee.

I. Optional

Any other relevant aspects of the project that may not be covered in these guidelines: **None.**

Annexes

Annex 1: Learning Brief

How did Mwayi Wa Moyo link integration of IMCH+PPFP into the national integration process with MoH, SSDI-Services, and other partners in Malawi?

Background: Save the Children, with funding from USAID (CSHGP) is implementing a four-and-a-half-year project called *Mwayi wa Moyo* (“A Chance to Live”). The project supports the MoH in its effort to reduce under-five mortality by applying life-saving interventions through delivery channels that are accessible, available, high quality, demanded and supported at the community level. The project supports development and testing of an integrated community-based package for HSAs and serves as a learning ground for redefining the role of the HSA in delivering high-quality services. Integration has shown that missed opportunities in practices and service delivery are minimized. For example, at the village clinics an HSA who is treating a sick child, can provide FP counseling the mother/family, leading to enhanced client satisfaction.

The MoH and partners are striving towards integration of Essential Health Package (EHP). This is why in the current National Health Sector Strategic Plan, the MoH has stressed that the EHP will be implemented in an integrated manner across clinics and technical areas to make EHP delivery as efficient as possible.

Process: To ensure that all partners buy in into the initiative, Save the Children had brief meetings with MoH staff at the national and district levels and met with the Deputy Director of the RHU, the IMCI Program Manager and Blantyre DHO who showed interest in the program. They indicated that in their own departments they have already started integrating some tasks from different roles which are time saving, reduce workloads and improve supervision and reporting. They indicated that they consider the OR, which is part of the project, critical to generating the evidence they need to restructure and plan their effort in integrated service delivery to clients.

During the DIP, *Mwayi wa Moyo*, involved several stakeholders including World Vision, and Banja la Mtsogolo (Marie Stopes) who shared their experience regarding community work and how *Mwayi wa Moyo* could improve on the challenges they face. At the end of the meeting, stakeholders selected the members of the *Mwayi wa Moyo* Steering Committee which included, IMCI, CCM, MNH staff from Save the Children, and participants from INGOs. The participants agreed that a smaller working group be created and staffed by individuals familiar with CCM and CMNH/CM-to be involved in the development of integrated CCM and CMNH + PPFP package.

Mwayi wa Moyo has involved MoH staff, partners from different organizations, SSDI-Service and Communication, and Save the Children staff in the development of the training package, integrated SBCC tools and integrated mentorship, supervisory tools and register. The project has also adapted the CM approach developed by SSDI-Communication being used by SSDI Integration. To avoid reinventing the wheels, *Mwayi wa Moyo* has mostly used already existing materials developed by MCHIP, Save the Children and the MoH.

Results: The MoH through the RHU, is also planning to integrate the MNCH+FP activities and has requested that the modules developed by *Mwayi wa Moyo* be adopted so that the integrated training package could be scaled up to all parts of the country. SSDI-Services will also adapt the same modules to include all components of the EHP for implementation in their districts.

Annex 2: Workplan for the Year Two
***Mwayi wa Moyo* Annual Work plan from October 2012- September 2013**

		Timeline for planned activities FY13			
		Oct- Dec	Jan- Mar	Apr- June	July- Sept
Cluster	Activity	1	2	3	4
Program Management	<i>Mwayi wa Moyo</i> Steering Committee meeting	x			x
	Program review meetings (country office)	x	x	x	x
	Stakeholder review meetings conducted	x			
	Engagement in district implementation plan process		x	x	
Monitoring and Evaluation	Facilitate role out and consistent data collection tools rolled out		x	x	
	District level systems and tools in place for ongoing documentation			x	x
	Success stories, case studies, documentaries, monographs documented	x	x	x	x
	Data Quality Assessment (DQA)	x	x	x	x
	Documentation exercise	x	x	x	x
	Annual reports submitted				x
Operations Research	Develop baseline questionnaires	x			
	Conduct baseline population-based survey	x			
	OR mapping of implementing partners	x			
	Data collection study questionnaires developed	x			
	Process documentation findings meetings			x	x

	Data Collection Study #1 (effectiveness of integrated community package)					X
Access to and availability of high impact interventions	Training of 17 health facility staff on IMNC + PFP	X				
	Train 49 HSAs in IMNCH and PFP	X				
	Control area training of 49 HSAs in CBMNC and FP including PFP	X	X			
	Training of existing 90 CBDAs in healthy timing and spacing of pregnancies and PFP.		X			
	Facilitate access to provision of long term LAPMs through partners i.e. BLM	X	X	X		X
	Facilitate provision of equipment and supplies for trained health facility staff in IMNC + PFP i.e. JSI Deliver, UNICEF, UNFPA	X	X	X		X
	Facilitate re-equipment and re-supply of HSAs & trained health facility staff	X	X	X		X
	Facilitate provision of equipment and supplies for trained HSAs in community integrated package i.e. JSI Deliver, UNICEF, UNFPA	X	X	X		X
Quality of interventions improved	Facilitate requisition and distribution of health facility protocols from RHU	X	X			
	Orientation of 15 district level mentors of facility based MNCH providers		X			
	Train 30 mentors for HSAs and SHSAs on IMNCH PFP		X			
	LMIS and FP data management training of 20 district and health facility based staff			X		
	Train 35 supervisors on IMNCH and PFP supervision for HSAs			X		
	Clinical mentoring visits to health facilities for HSAs mentoring		X	X		X
	Supervision visits to HSAs by DHMT and HF based supervisors and <i>Mwayi wa Moyo</i> team	X	X	X		X
	Facilitate roll out and consistent use of data collection tools	X	X	X		X
	Advocate for consistent drugs and FP methods through participation in national and district level sub committees i.e. FP, safe motherhood, IMCI etc.	X	X	X		X

Demand for interventions improved	Orientation of 200 members village health committees (VHCs) (2 per committee) and Agogo - 4 sessions in <i>Mwayi wa Moyo</i> program and CM approach		x	x	
	Control area training of 49 HSAs and community leaders in CM using current/existing training packages – 6 days		x		
	Orientation for existing 90 CBDAs on counseling for healthy timing and spacing of pregnancies			x	
	Establish contracts with radio stations (Zodiak, MBC, Maria) to channel MNCH/PPFP messages (budget allowing)			x	x
Environment enabled	Participate in national TWG on FP, IMCI and Safe Motherhood	x	x	x	x
	Bi annual Operations research TWG meetings	x			x
	Bi annual <i>Mwayi wa Moyo</i> Steering Committee meetings	x			x

CHANGES TO THE WORKPLAN

Most start-up activities in Year 1 have been achieved including the development of the training packages and submission of the OR protocol to COMREC for IRB approval. Most of the trainings have been included in the Year 2 workplan as above.

Annex 3: Papers, Presentation, News Coverage about Project, and Products

None as yet.

Annex 4: Mwayi wa Moyo M&E Table

Objective/ Result	Indicators	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
SO: USE of high-impact services and practices increased	<i>% of children age 0-5 months who were exclusively breastfed during the last 24 hours</i>	KPC Survey	BL, EL	67.5%	85%
	<i>% of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child</i>	KPC Survey	BL/EL	44.3%	65%
	<i>% of mothers of children 0-23 who are using a modern contraceptive method</i>	KPC Survey	BL/EL	56%	65%
	<i>*Couple Years of Protection (CYP) (#)</i>	Service statistics (all SDPS)	quarterly	9454	14000
	<i>*Acceptors new to modern contraception (#)</i>	Service statistics (HC, CBDA, HSA)	Ongoing – collated annually	5364	8582
	<i>% of children age 0-23 months who slept under an insecticide treated bed net the previous night</i>	KPC Survey	BL/EL	44%	65%
	<i>% of children with diarrhea in the last two weeks who received ORS or recommended home fluids</i>	KPC Survey	BL/EL	64.5%	80%
	<i>% of mothers who wash their hands before food preparation, before infant/child feeding, after defecation, and after attending to a child who has defecated</i>	KPC Survey	BL/EL	13%	45%
IR-1: Availability & Access to high-impact interventions increased	<i># of all HSAs trained in PFP</i>	District records, project reports	Tracked monthly, reported quarterly	0	148
	<i># of HtR-HSAs trained in CCM</i>	District records, project reports	Tracked monthly, reported quarterly	98	98
	<i># of all HSAs trained in CCM</i>	District records, project	Tracked monthly,	98	148

		reports	reported quarterly		
	<i># of all HSAs trained in CBMNC</i>	District records, project reports	Tracked monthly, reported quarterly	0	148
	<i># of all HSAs trained in Integrated Community Package</i>	District records, Project reports	Tracked monthly, reported quarterly	0	98
	<i># of health center workers trained in IMNC (including HBB)</i>	District records, project reports	Tracked monthly, reported quarterly	0	17
	<i># of health center-based KMC units functioning in Blantyre District</i>	District records, project reports	Tracked monthly, reported quarterly	0	7
	<i>% of mothers of children 0-23 months who report discussing PFP with a health worker or promoter during last pregnancy</i>	KPC Survey	BL/EL	43%	70%
	<i>% of mothers of children 0-23 months who received a post-natal home visit from an appropriate trained health worker within two days after birth</i>	KPC Survey	BL/EL	23%	50%
IR-2: Quality of interventions assured	<i># of service delivery points reporting no stock-outs of FP methods in past 3 months (by HC, HSA, CBDA)</i>	Supervision reports, project monitoring	Quarterly	9 HC 0 HSAs 0 CBDA	15 148 90
	<i># of CCM-trained HSAs with a continuous supply of key CCM drugs</i>	HFA, district drug reporting form, district records	Quarterly	98	148
	<i># of HSAs who live in their catchment areas</i>	HFA, district records	Quarterly	50	148
	<i># of HSAs supervised in the last 3 months</i>	HFA, supervision records	Quarterly	52	98
	<i># of HSAs supervised in last 3 months with reinforcement of clinical practice (mentored)</i>	HFA, supervision records	Quarterly	52	98

	<i>% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after fever began</i>	KPC Survey	BL/EL	19.1%	60%
IR-3: Demand for interventions improved	<i>% of children 0-23 months with chest-related cough or fast and/or difficult breathing in the last two weeks were taken to an appropriate health provider</i>	KPC Survey	BL/EL	65%	80%
	<i>% of mothers of children 0-23 who know at least two risks of having a birth to pregnancy interval of less than 24 months</i>	KPC Survey	BL/EL	62.3%	80%
	<i>Percentage of mothers of children 0-23 months who knew at least two danger signs for mothers during pregnancy</i>	KPC Survey	BL/EL	40%	75%
IR-4: Environment enabled	<i>% of core groups that have completed at least two CACs</i>	Project/districts records,	Quarterly, reported annually	0	45%
	<i>HSA job description redrafted to incorporate delivery of CCM+CBMNC+PPFP or Integrated Package</i>	National minutes TWG, other	Reported annually	N	Y
	<i>Integrated community package endorsed by MOH</i>	National minutes, other	Reported annually	N	Y
USAID COMPLIANCE MONITORING FOR FP	<i>USAID compliance monitoring completed quarterly</i>	Project records, compliance monitoring tools	Quarterly, reported annually	N	Y

*=CYP and New Acceptors to be calculated based on women of reproductive age

**=TBD to be completed at time of HFA

COUPLES YEARS OF PROTECTION FOR BLANTYRE		CYP COMPUTATION
Method of Family Planning	2011-12	
WCBA using condoms	4,302	35.85
WCBA using pills	15,278	1018.533333
WCBA using Depo Provera	24,359	6089.75
WCBA using Norplant	849	223.4210526
WCBA using IUCD	37	170.2
WCBA sterilized	206	1915.8
WCBA using oral LAM	0	0
		9453.554386
The updated conversion factors for CYP computation endorsed by USAID are as follows		
Method	CYP per Unit	
Oral Contraceptives	15 cycles per CYP	
Condoms (male and female)	120 units per CYP	
Monthly Vaginal Ring/Patch	15 units per CYP	
Vaginal Foaming Tablets	120 units per CYP	
Depo Provera Injectable	4 doses (ml) per CYP	
Noristerat Injectable	6 doses per CYP	
Cyclofem Monthly Injectable	13 doses per CYP	
Copper-T 380-A IUD	4.6 CYP per IUD inserted (3.3 for 5 year IUD, e.g. LNG-IUS)	
3 Year Implant (e.g. Implanon)	2.5 CYP per implant	
4 Year Implant (e.g. Sino-Implant)	3.2 CYP per implant	
5 Year Implant (e.g. Jadelle)	3.8 CYP per implant	
Emergency Contraceptive Pills	20 doses per CYP	
Standard Days Method	1.5 CYP per trained adopter	
Lactational Amenorrhea Method (LAM)	4 active users per CYP (or .25 CYP per user)	
Sterilization (male and female)*	10 CYP	
- Global	13 CYP	
- India, Bangladesh, Nepal	10.3 CYP	
- Other Asian Countries	10.5 CYP	
- Latin America and the Caribbean	9.3 CYP	
- Africa		
Note:* Because of marked differences in CYP for sterilization by country and by region (based on differences in median age at sterilization), countries should use the median value for their region (assuming their data on age at sterilization conform to those of the region).		

Annex 5: *Mwayi wa Moyo* Social and Behavioral Change Strategy

1. BACKGROUND

Save the Children Malawi is implementing a *Mwayi wa Moyo* (“A Chance to Live”) project with the aim of supporting the MoH in its effort to reduce maternal and under-five mortality by applying life-saving interventions demanded and supported at the community level. The project will implement an integrated community-based package of services delivered by HSAs and will serve as a learning opportunity of how to increase coverage, use, and effectiveness of high-quality maternal, newborn, child health (MNCH) and FP services for all Malawians. The project includes an Operations Research study that aims at designing and testing an integrated community focused strategy addressing barriers to implementing and scaling up of proven, high-impact MNCH and FP interventions, by ensuring improvement in their delivery and use to improved health outcomes.

The beneficiary population of the project is currently estimated at around 538,413 of which 91539 (17%) are children under five years old, 113,067 (21%) are WRA, and there are 26,921 (5%) new pregnancies expected each year. The *Mwayi wa Moyo* project seeks to benefit 91,530 children under five and 113,067 WRA (15-49) with an integrated health package.

Specifically, the goal of *Mwayi wa Moyo* is to reduce under-five mortality through its Strategic Objective of increased use of key MNCH services and practices; specifically: Intermediate Result IR-1: access to and availability of high-impact interventions increased; IR-2: quality of interventions assured; IR-3: demand for interventions improved; and IR-4: environment enabled.

2. PROBLEM STATEMENT-VERTICAL IMPLEMENTATION OF MNCH INTERVENTIONS

- Currently HSAs deliver a range of MNCH interventions in several packages (CBMNC/CM, c-IMCI/ACSD, CCM, FP, and HTC etc.). All these packages are delivered to caregivers separately.
- Supportive Social and Behavioral Change Communication (SBCC) and Community Mobilization (CM) are also fragmented and delivered separately.
- Some of the components of MNCH interventions, such as the CBMNH and the FP package, have special emphasis on CM and BCC, while the CCM package primarily focuses on service delivery.

2.1. RESULTS OF VERTICAL APPROACH

Among other things, a lack of integration of the packages has resulted in:

- Fragmentation of SBCC messages;
- Little coordination among the various CM and communication components of the different community-based interventions;
- Vertical approaches to supervision, monitoring and reporting;
- Workload imbalance on the part of the HSAs; and
- Improper planning and prioritization of work and high cost of training and implementation.

3. PROJECT INNOVATION

Mwayi wa Moyo intends to integrate the following community-based packages for HSAs: Community Case Management (CCM) package, and a Community Based Maternal and Newborn

Health (CBMNH) package. The project will also integrate PFP into maternal and newborn child health (MNCH) interventions.

In addition to integrating the above packages, supportive Social and Behavior Change Communication (SBCC) and Community Mobilization (CM) will also be integrated to increase demand, improve knowledge, generate interest, and encourage acceptance of MNCH practices at the community and household levels.

At the household level, the integrated SBCC and CM will target primarily WRA and women with children under five, men, and mothers in-law. At the community level, faith leaders, traditional leaders, VHC members and CBDAs will be targeted. After integration, *Mwayi wa Moyo* is going to implement the integrated community package as one service in the 17 HCs where the CCM program is already being implemented.

MWAYI WA MOYO SOCIAL AND BEHAVIOR CHANGE OBJECTIVES

See table below on page 30.

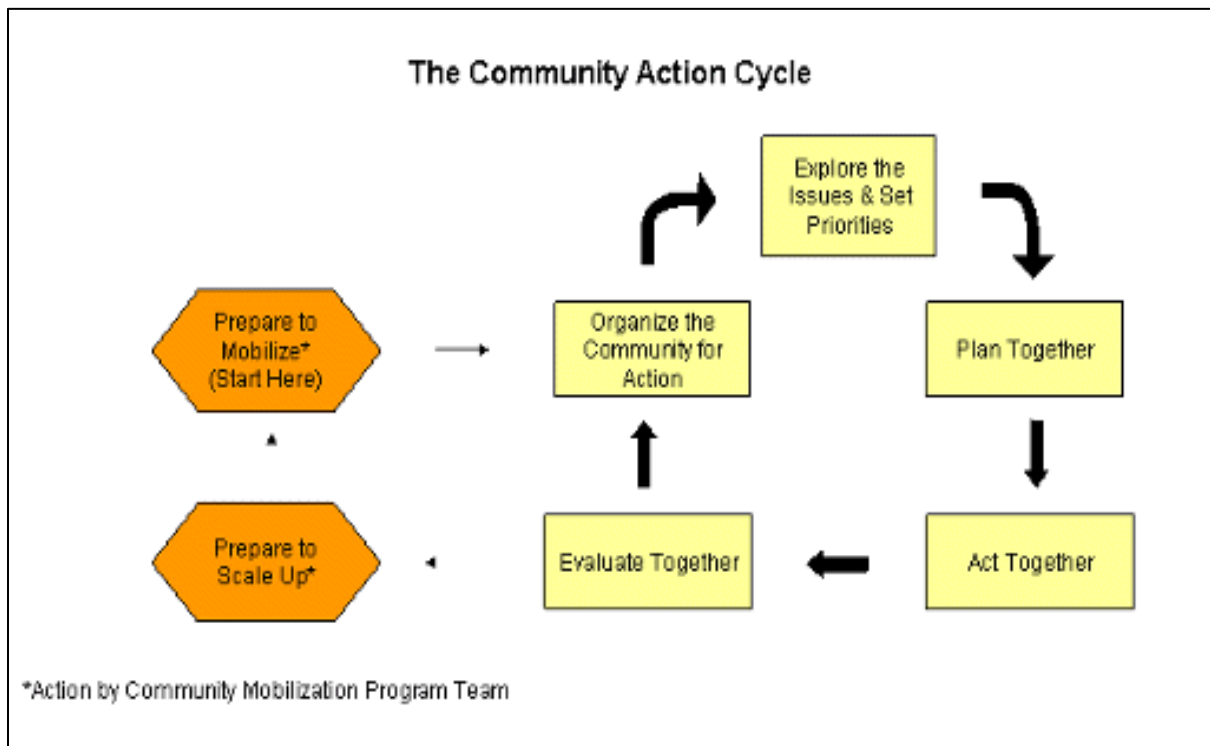
4. APPROACHES THAT WILL BE USED IN SBCC

- 4.1. Integrated Community Mobilization- Community Action Cycle approach
- 4.2. Use of integrated Job Aids i.e. Counseling cards and CM picture cards
- 4.3. Use of integrated posters at Healthy Facility level

5.1. Integrated Community Mobilization- Community Action Cycle approach

5.1.1. What is Community Mobilization?

CM is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health, education, food security, , and other needs, either on their own initiative or stimulated by others. This model has been drawn from SSDI-Communication Community Mobilization strategy which is incomplete at this time. More details will be added from the developed strategy to this model once the CM strategy is finalized.



5.1.2. Community Mobilization Goal

The CM goal is to empower communities and their most vulnerable and affected members in taking action to prevent illness and promote health.

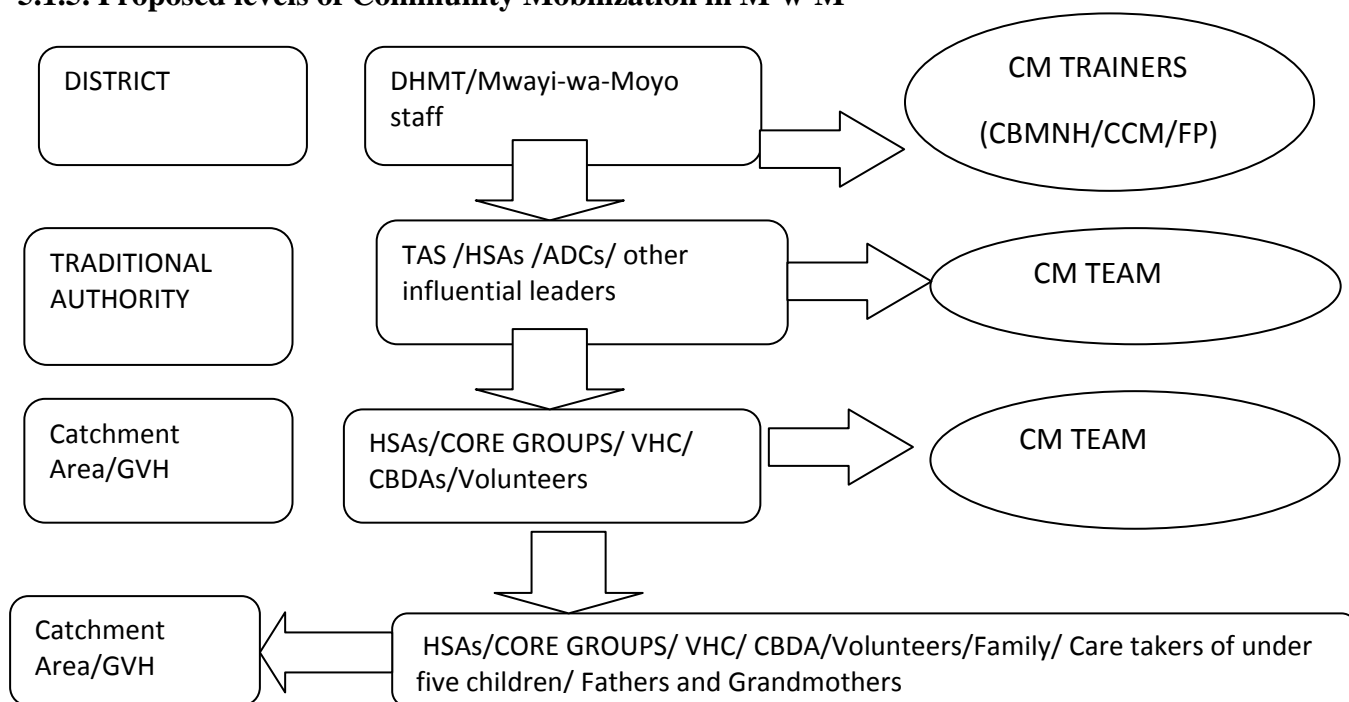
5.1.3. Objectives of Community Mobilization

- Strengthen communities' capacity to identify, prioritize health issues, plan and implement effective strategies to address these issues, and monitor and evaluate their progress.
- Reinforce the capacity of existing structures within targeted districts and communities to facilitate the roll out of the CAC.
- Support the existing community structures to identify and implement initiatives for social and normative change, accountability mechanisms, and decentralized planning.

5.1.4. Principles of CM

- Social change is more sustainable if individuals and communities most affected **own the process and content** of the messages.
- Communication for social change should be **empowering, horizontal, give voice** to the previously unheard members of the community, and be centered around **local content** and ownership.
- **Parents, families, communities** should be the agents of change.
- Catalyst (technical experts) to **support dialogue, debate, and negotiation** on issues that resonate with members of the community.
- Emphasis on outcomes should shift **away from individual behavior** to social, norms, policies, culture, and the supporting environment.

5.1.5. Proposed levels of Community Mobilization in M-w-M



5. Integrating Job Aids

Currently the IEC materials that are available are:

- A set of MNH picture cards that is used by core groups in the exploration phase during CM;
- CBNMH Counseling cards that are used by HSAs to counsel pregnant women;
- Kabanja counseling card that is used by community based distribution agents (CBDAs) to counsel women, men and couples on FP issues;
- Kulera flip charts that is used by CBDAs to counsel women, men and couples on FP issues; and
- PFP leaflets, posters and job aids developed by MCHIP/JHPIEGO.

5.1. The process to integrate the above into BBC job aids and the steps below were followed to achieve that:

- Review all Information, Education and Communication (IEC) materials to identify gaps and cross cutting issues (to find if any behavior goals have been missed in the existing IEC materials);
- A Behaviors and Barriers analysis was done (Motivations and Barriers to adoption of new behaviors) analyzed to make sure that these would be addressed in the integrated IEC materials;
- In consultation with the Health Education Unit of the MoH and other stakeholders, suggested which the IEC materials could be integrated;
- Came up with drafts of integrated SBCC tools; and
- Pretested the tools, finalize drafts and print final copies for use by HSAs, HF staff and Core groups in Thyolo District.

6. Integrating Job Aids

The project came up with the following integrated materials:

- 1 Integrated Counseling Card for HSAs to cover topics and desired behavior objectives from pregnancy to childbirth to PPF and child health;
- 1 Integrated set of picture cards- pictures to cover all topics from pregnancy, to childbirth to PPF and child health; and
- 1 Flip Chart/set of Posters for health facility use.

MWAYI WA MOYO SOCIAL AND BEHAVIOR CHANGE OBJECTIVES

Behavior change objectives	Motivations to adopting the proposed behaviors	Barriers to adopting the proposed behaviors	Activities to promote the behavior goals	Baseline Value	Target
<p>1. Increased number of women starting ANC within the first trimester</p> <p>Objectives of the goal:</p> <ul style="list-style-type: none"> • Increased % of pregnant mothers starting ANC within the first trimester • Increased % of pregnant mother confiding in core group member on the existence of a pregnancy within the first 3 months 	<ul style="list-style-type: none"> • Assessments, examination and treatment for danger signs will be noted and treated early • Mother will have safe and healthy pregnancy • Child will be born healthy 	<ul style="list-style-type: none"> • Cultural reasons (early pregnancy is shrouded in secrecy) • Waiting for pregnancy to settle before one starts telling people about it • Long distance to health facility • Lack of knowledge on the importance of starting ANC in the first trimester 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • Core groups facilitated meetings with communities to conduct health education sessions on different topics guide by the integrated picture cards • Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions on importance of starting ANC in the first trimester • Core groups and volunteer led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group/ volunteer led open day's events where Drama, Songs and Debates will be used to deliver this message • health education sessions at HF by nurses where posters will be used to deliver this message • Radio messages of model women who benefitted from the starting ANC within the first trimester 	25.6%	50%

<p>2. Increased number of mothers of children age 0-23 months who will have at least four or more antenatal visits when they are pregnant</p> <p>Objectives:</p> <ul style="list-style-type: none"> Increased % of pregnant mothers who will have at least four or more antenatal visits when they are pregnant 	<ul style="list-style-type: none"> Mothers will be told progress that their unborn bay is making at each visit Mothers will receive services i.e. Malaria prevention and Vaccines at the visits Assessments, examination and treatment for danger signs will be done and done early to save unborn babies life and mother's life Mother will have safe and healthy pregnancy Child will be born healthy 	<ul style="list-style-type: none"> Cultural reasons (pregnant women want to start ANC when tummy start to show which leaves them with little time or not enough to have the required four visits) Waiting for pregnancy to settle(culturally pregnancy settles after third month) before one starts telling people (including healthy worker)about it Long distance to health facilities which prevents mothers from going for more than one visit Lack of knowledge on the importance of services provided at HF to both mother and unborn baby Mothers feel like they have not received any services if health worker just talks to them and does not conduct any physical examination and provide other services like vaccines Bad attitude of some health providers towards the mothers <p>Additional issue could be the perceived QoC. Was this discussed? Do women value ANC? What care is provided/ is it what women expect/receive?</p>	<ul style="list-style-type: none"> HSA's home visit to counsel women using the integrated counseling card Core groups/volunteers led meetings with communities to conduct health education topics guide by the integrated picture cards Core groups/volunteers led counseling sessions with women of child bearing age where integrated picture cards will be used to guide the discussions Core groups/volunteers one on one meetings with women that reveal to them that they are pregnant Core group/volunteers lead open day events where Drama, Songs and Debates will be used to deliver this message health education sessions at HF by nurses where integrated posters will be used to deliver this message Radio testimonies of model women who benefitted from having more than one ANC within the first trimester 	<p>44.3%</p>	<p>65%</p>
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<p>3. Increased number of women able to identify at least two danger signs in pregnancy</p> <p>Objectives:</p> <ul style="list-style-type: none"> Increased % of pregnant mothers able to identify at least 2 danger signs during pregnancy Increased % of pregnant mother able to state where they should go for treatment when they experience any danger signs 	<ul style="list-style-type: none"> Women will be treated in time to save their life and that of the unborn baby Mother will have safe and healthy pregnancy Child will be born healthy 	<ul style="list-style-type: none"> Lack of knowledge of the danger signs Secrecy surrounding issues of pregnancy Lack of knowledge on the importance of having danger signs treated by a qualified person Lack of IEC materials in HCs to help health workers effectively teach about the danger signs <p>Counseling skills – how well do providers counsel women on danger signs? Do IEC materials exist and are they appropriate? Used?</p>	<ul style="list-style-type: none"> HSA’s home visit to counsel women using the integrated counseling card Core groups/volunteers facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards Core groups/volunteers led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions Core groups/volunteers led one on one meetings with pregnant women that have revealed to them that they are pregnant Core group/volunteers led open day’s events where drama, songs and debates will be used to deliver this message health education sessions at HF by nurses where posters will be used to deliver this message Radio testimonies of women who benefitted from having knowledge of the danger signs by nurses 	40%	75%
<p>4. Increased number of women able to make a birth preparedness plan and identify at least two reasons and importance of HF delivery</p> <p>Objectives:</p> <ul style="list-style-type: none"> Increased % of pregnant mothers 	<ul style="list-style-type: none"> Women will be treated if complications arise Baby will be treated if complications arise 	<ul style="list-style-type: none"> Lack of knowledge of danger of giving birth in the absence of a skilled worker Lack of knowledge of importance and advantages of giving birth at a HF in the presence of a skilled health worker i.e. in case of danger signs arising during labor 	<ul style="list-style-type: none"> HSA’s home visit to counsel women using the integrated counseling card Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate 	84.7 %	95%

<p>able to identify at least 2 advantages of a HF based delivery</p> <ul style="list-style-type: none"> Increased % of pregnant mother able to state the importance of having a birth plan 		<ul style="list-style-type: none"> Women fear being mistreated by nurses at HF during delivery Lack of good quality care of women at HF by health workers due to heavy work load and poor attitudes towards patients <p>How do women perceive the quality of care they received?</p>	<p>discussions</p> <ul style="list-style-type: none"> Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant Core group led open day's events where Drama, Songs and Debates will be used to deliver this message health education sessions at where posters will be used to deliver this message Radio testimonies of women who benefitted from having a Healthy Facility based birth Radio messages from nurses talking about what they are doing to improve service delivery in their hospitals during delivery to encourage more women to come and give birth at the HFs 		
<p>5. Increased number of mothers of children 0-23 who are using a modern contraceptive (FP) method</p> <p>Objectives: % of mothers accessing a modern contraceptive method % of mothers able to state the advantage of using a modern contraceptive method</p>	<ul style="list-style-type: none"> Mother will have time to rebuild her body strength Mother will have time to concentrate on taking care of her baby before having another baby Baby will have time to fully breastfeed before next pregnancy 	<ul style="list-style-type: none"> Lack of knowledge of importance of using a using modern contraceptive method Lack of access to modern contraceptive method women believe they are protected from another pregnancy through breastfeeding 	<ul style="list-style-type: none"> HSA's home visit to counsel women on PFP using the integrated counseling card both antenatal and postnatal they will be counseled on PFP health education sessions at HF by nurses where integrated posters will be used for all women of child bearing age Radio testimonies of women are successfully using FP methods discussing advantages of FP <p>Timing is crucial here: during ANC; intrapartum and immediately postpartum for methods such as PPIUD and TL where available</p>	56%	65%

<p>6. Mothers of children 0-23 months who will report discussing PPFp with a health worker or promoter during last pregnancy</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Increased % of mothers accessing PPFp • Increased % of mothers able to state the advantage of PPFp 	<ul style="list-style-type: none"> • Mother will have prevented the loss of any missed opportunities to accessing FP • Mother will not have to travel back to health facility for FP soon after giving birth 	<ul style="list-style-type: none"> • Lack of knowledge of importance of PPFp by providers and mothers • Lack of access to PPFp 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card. • health education sessions at HF by nurses where integrated posters will be used <p>Timing of counseling and content of messages is important nuance here</p> <p>Counseling materials need to be available</p> <p>Providers need to be trained in integrated counseling and on specific messages</p>	43%	70%
<p>7. Increased number of women using Lactation Amenorrhea (LAM) as their FP method</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Increased % of mothers with knowledge of what LAM method is • Increased % of mothers able to state the advantages of LAM/PPFP 	<ul style="list-style-type: none"> • Mother will have prevented the loss of any missed opportunities to using a FP method • Mother will not use a FP method that is cheap and does not involve anything external i.e. pills, injection, hormones. Use of LAM will reinforce EBF 	<ul style="list-style-type: none"> • Lack of knowledge of what LAM method is (by providers and clients :LAM criteria not clearly understood • Lack of knowledge of importance of PPFp • Women equate BF with LAM and do not understand that specific criteria need to be fulfilled for LAM to be effective; how importance of transitioning to another method when LAM criteria no longer met 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • health education sessions at HF by nurses where integrated posters will be used <p>Counseling materials explain LAM criteria; return to fertility and pregnancy risk and importance of transitioning to another method in order to achieve adequate birth spacing intervals</p>	43%	50%
<p>8. Increased number of mothers of children age 0-23 months who know that a woman should wait 24 months after a live birth before trying to get pregnant again</p>	<ul style="list-style-type: none"> • Women will have time to regain health and focus on other development and social issues • Husbands will have time to take care of their families and plan for new baby financially and otherwise 	<ul style="list-style-type: none"> • Lack of knowledge of danger associated with bearing children too soon after the birth of a child • Lack of knowledge of advantages of using FP to mother, baby, and husband 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards • Core groups/volunteers led health education meetings with women of child bearing age where integrated 	62.3%	80%

<p>Objectives:</p> <ul style="list-style-type: none"> Increased % of pregnant mothers able to state at least 2 advantages of HTS 	<ul style="list-style-type: none"> Child will grow up well before mother shifts her attention to a new pregnancy and new baby 		<p>picture cards will be used to guide and facilitate discussions</p> <ul style="list-style-type: none"> Core groups/volunteers led one on one meetings with pregnant women that have revealed to them that they are pregnant Core group/volunteers led open day's events where drama, songs and debates will be used to deliver this message health education sessions at HF by nurses where posters will be used to deliver this message 		
<p>9. Increase number of mothers of children 0-23 months who received a post-natal home visit from an appropriate trained health worker within two days after birth</p> <p>Objectives:</p> <ul style="list-style-type: none"> Increased % of mothers with knowledge of importance of postnatal check Increased % of mothers able to state the advantages of postnatal check to both mother and baby 	<ul style="list-style-type: none"> Postnatal Danger signs and newborn danger signs will be identified and treated early in both mother and newborn baby Mothers and baby's will be healthy 	<ul style="list-style-type: none"> Lack of knowledge of importance of postnatal check Lack of trained HW to conduct the postnatal check 	<ul style="list-style-type: none"> HSA's home visit to counsel women using the integrated counseling card Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant Core group led open day's events where Drama, Songs and Debates will be used to deliver this message health education sessions at HF by nurses where posters will be used to deliver this message 	23%	50%
<p>10. Increased number of women who can</p>	<ul style="list-style-type: none"> Children will get treated before they become too ill 	<ul style="list-style-type: none"> Lack of knowledge of danger signs 	<ul style="list-style-type: none"> HSA's home visit to counsel women using the integrated counseling card 	92.3%	95%

<p>identify at least two danger sign in children that would prompt them to go and seeking treatment from care giver</p> <p>Objectives: % of caregivers of children under five will correctly identify two danger sign in children to prompt them to seek care</p>	<ul style="list-style-type: none"> • Children will recover more quickly that if they had been treated when they were seriously ill • Mothers will have more time to do other household and community activities • Child will have less severe disease • Child will recover quickly 	<ul style="list-style-type: none"> • Lack of awareness of seriousness of disease and effects on child health • Attributing danger signs to things like teething • Mothers are negligent • Poor attitude of health workers at facility to caregiver 	<ul style="list-style-type: none"> • Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards • Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions • Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group led open day's events where drama, songs and debates will be used to deliver this message • Health education sessions at HF by nurses where posters will be used to deliver this message 		
<p>11. Increased number of mother with children age 0-23 months with a febrile episode during who will be able to seek treatment with an effective anti-malarial drug within 24 hours after the fever begins</p> <p>Objectives: % of caregivers of children under five will seek treatment with an effective anti-malarial drug within 24 hours after onset of fever</p>	<ul style="list-style-type: none"> • That child will get better quickly 	<ul style="list-style-type: none"> • Health facility far from home • Lack of knowledge of effects of fever on child • Lack of knowledge 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards • Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions • Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group led open day's events where drama, songs and debates will 	19.1%	60%

			<p>be used to deliver this message</p> <ul style="list-style-type: none"> Health education sessions at HF by nurses where posters will be used to deliver this message 		
<p>12. Increased number of children age 0–23 with diarrhea who received ORS or recommended home fluids</p> <p>Objectives:</p> <ul style="list-style-type: none"> Increased % of caregivers of children under five who are able to give children with diarrhea who receive ORS or recommended home fluids 	<ul style="list-style-type: none"> Child will recover quickly Child will get stronger faster 	<ul style="list-style-type: none"> Lack of knowledge on the need to start feeding and giving fluids during and after child’s illness Sick child may refuse to eat/drink Lack of availability of fluids Lack of commitment to feed the child Lack of diet diversification 	<ul style="list-style-type: none"> HSA’s home visit to counsel women using the integrated counseling card Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant Core group led open day’s events where drama, songs and debates will be used to deliver this message Health education sessions at HF by nurses where posters will be used to deliver this message 	64.5%	80%
<p>13. Increased number of mothers of children aged 0-5 months who exclusively breastfeed</p> <p>Objectives</p> <ul style="list-style-type: none"> Increased % of caregivers of children under five who are able to identify four critical points for hand washing 	<ul style="list-style-type: none"> Baby will be healthy Mother and Baby will use this as a bonding session Mother can use exclusive breast feeding as natural FP method (LAM) 	<ul style="list-style-type: none"> Lack of knowledge about the importance and advantages of exclusive breast feeding to baby Lack of knowledge about the importance of exclusive breast feeding to mother (LAM) 	<ul style="list-style-type: none"> HSA’s home visit to counsel women using the integrated counseling card Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions 	67.5%	85%

<ul style="list-style-type: none"> ▪ Increased % of caregivers of children under five who reported hand washing at four critical points 			<ul style="list-style-type: none"> • Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group led open day's events where drama, songs and debates will be used to deliver this message • Health education sessions at HF by nurses where posters will be used to deliver this message 		
<p>14. Increased hand washing practices at four critical points (hands before food preparation, before infant/child feeding, after defecation, and after attending to a child who has defecated)</p> <p>Objectives</p> <ul style="list-style-type: none"> ▪ Increased % of caregivers of children under five who are able to identify four critical points for hand washing ▪ Increased % of caregivers of children under five who reported hand washing at four critical points 	<ul style="list-style-type: none"> • Fewer episodes of diarrhea • Child will be healthier • Mother has more time for other household and community activities • Hands smell nice 	<ul style="list-style-type: none"> • Lack of knowledge about the importance and need for hand washing • Laziness • Lack of hand washing facility in and within households • Lack of availability of water 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • Core groups facilitated meetings with communities to conduct health education on different topics guide by the integrated picture cards • Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions • Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group led open day's events where drama, songs and debates will be used to deliver this message • Health education sessions at HF by nurses where posters will be used to deliver this message 	13%	45%
<p>15. Increased number of children age 0-23 months who slept under an insecticide treated bed net (</p>	<ul style="list-style-type: none"> • Fewer episodes of malaria • Peaceful sleep free of annoying mosquitoes • Child will be healthier 	<ul style="list-style-type: none"> • Misconceptions about bednets (suffocation, FP method) • Hot to sleep under net • 4 corner nets are difficult to 	<ul style="list-style-type: none"> • HSA's home visit to counsel women using the integrated counseling card • Core groups facilitated meetings with communities to conduct health education on different topics guide by 	44%	65%

<p>ITN/LLIN) the previous night</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Increased % of caregivers of children under five who are able to identify LLIN use as a way to prevent malaria • Increased % of caregivers of children under five who reported that their children are sleeping under a LLIN 		<p>hang up</p>	<p>the integrated picture cards</p> <ul style="list-style-type: none"> • Core groups led health education meetings with women of child bearing age where integrated picture cards will be used to guide and facilitate discussions • Core groups led one on one meetings with pregnant women that have revealed to them that they are pregnant • Core group led open day's events where drama, songs and debates will be used to deliver this message • Health education sessions at HF by nurses where posters will be used to deliver this message 		
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Annex 6: Innovation

OR Study Progress and Achievements in Year 1

OR Study Key Milestones (Mwayi wa Moyo and Summative)	Related Key Activities (as outlined in OR Concept Paper)	Progress Status of OR Activities (Completed, On target, Not on target)	Comments (challenges, contributing factors, change, etc.)
Finalize the Operations Research Protocol and Concept Paper for the <i>Mwayi wa Moyo</i> Project.	Submission of OR Concept	Completed	Several revisions were made to the initial concept which was shared during DIP Workshop.
	Signing of an MOU for the SGA with COM	Completed	The process delayed because of delayed OR Concept approval. COM does not sign SGAs before COMREC approval
	Conduct OR consultative stakeholders meeting	Completed	The meeting appointed a research advisory committee which will be responsible providing technical research support and advice
Conduct baseline	Questions finalized	Completed	
	Baseline questionnaires developed	Not on target	Draft baseline questionnaires done. The tools will be finalized after identifying enumerators and during training
	Protocols developed	Completed	The process involved participation of key partners
	Baseline survey implementation (data collection)	Not completed	The exercise delayed because the OR Concept was yet to be finalized. The recruitment of enumerators awaited SGA signing
Consultation workshop with Research Advisory Committee	Conduct a research advisory meeting	Not completed	This has been planned before roll out of baseline data collection process
	Conduct OR mapping of implementing partners	Not completed	This will be part of the baseline survey

Annex 7: Report of Health Facility Assessment



***Mwayi wa Moyo* (“A Chance to Live”) Project**

HEALTH FACILITY ASSESSMENT REPORT

Conducted in Blantyre District

Authored by

Mayeso Mphande (ORME Coordinator)

16th May 2012

Table of Contents

	Page
1.0 Introduction.....	42
2.0 Methodology.....	42
3.0 Key Observations and Challenges.....	42
4.0 Key Findings.....	43
4.1 Facility infrastructure.....	43
4.2 Summary of general purpose equipment and supplies.....	43
4.3 Communication and transport.....	45
4.4 Facility-based laboratory services.....	46
4.5 Human resources and health facility capacity.....	47
4.6 Trainings.....	50
4.7 Interventions.....	52
4.8 Guidelines.....	53
4.9 Essential drugs and commodities available at facilities.....	54
4.10 Recordkeeping.....	55
5.0 Lessons Learned.....	55
6.0 Stock-outs.....	55
7.0 Conclusion	57
 ANNEXES	
Annex 1: Summary of Assessment Facilitators.....	58
Annex 2: Schedule for Health Facility Assessment.....	59
Annex 3: Questionnaire Used During Health Facility Assessment.....	60

1.0 Introduction

Save the Children is partnering with the Ministry of Health (MOH), Malawi College of Medicine (COM), and Blantyre District Health Management Team (DHMT) to implement a four-and-half-year innovation project (30 September 2011-31 March 2016) entitled *Mwayi wa Moyo* (“A Chance to Live”). The goal is to reduce under-five mortality by increasing use of key Maternal, Newborn, and Child Health (MNCH) services and practices, including Family Planning (FP) that are accessed, of quality, demanded, and enabled.

Save the Children conducted a Health Facility Assessment (HFA) of all 17 health centers in Blantyre with the following objectives:

- To gather information on various baseline indicators which can contribute towards setting the benchmarks for *Mwayi wa Moyo* performance indicators, annual targets and overall project targets;
- To collect information that will provide a platform for programmatic decision making and determine project focus areas; and
- To ascertain health facility specific gaps, needs and baseline information on key aspects.

The assessment was conducted by *Mwayi wa Moyo* project staff from 17th April to 20th April 2012. This information complements the information from the baseline that was conducted in February which established benchmarks for some indicators to be tracked by the program. A *voluntary family planning risk assessment* will be conducted to complement health facility information.

2.0 Methodology

The HFA tool used was adopted from Support for Service Delivery Integration (SSDI). The tool was adjusted to meet the requirements of *Mwayi wa Moyo*. SSDI pretested the tool during their baseline assessment conducted in the southwest and southeast zones therefore; *Mwayi wa Moyo* did not repeat the pretest. The exercise included mapping of current services provision of Maternal Newborn and Child Health (MNCH), Community Case Management (CCM) and other family planning (FP) services provided by HSAs within their catchment areas. The assessment looked at the existing structures and capacities available in the HCs.

The assessment was conducted by the Operations Research Coordinator, Training Officer and the SBCC Officer for the *Mwayi wa Moyo* project. A one-day orientation was conducted for the assessment team to familiarize themselves with the tool. The assessment was conducted in the following health facilities; Soche, Madziabango, Chimembe, M'deka, Makata, Lundu, Chavala, Chilomoni, Chileka, Limbe, Dziwe, Lirangwe, Chikowa, Mpemba, South Lunzu, Namikoko and Mlambe. These HCs fall in the catchment areas where *Mwayi wa Moyo* will be implemented.

The questionnaire was administered to key health facility personnel i.e. Medical Assistants, Registered Nurses and Clinical Officers. Senior Health Surveillance Assistants (SHSAs) were required as co-respondents on key sections of the questionnaire. The completed questionnaires were entered into data entry template developed by the Operations Research and Monitoring Coordinator for *Mwayi wa Moyo* and analyzed using SPSS 16.

3.0 Key Observations and Challenges

Some key respondents could not recall some information because of changes in staffing in the health facilities over the years. Another reason was due to the fact that some of the available staff was working in the HCs temporarily while waiting for the permanent staff that were on vacation.

4.0 Key Findings

4.1 Facility infrastructure

The assessment indicated that 16 of the 17 health facilities (94%) are government owned and only one (Mlambe) is owned by CHAM. While 53% of the HCs have less than 10 beds, 41% have beds between 11-20 beds and only one facility has more than 100 beds. A good number of facilities (13) draw water from pipes (77%) while the rest draw water from boreholes and tanker trucks.

Table 1. Summary of beds, water source in the health centers

# of beds	Frequency	Percent	Water Source	Frequency	Percent
less than 10	9	52.9	pipe-borne	13	76.5
11-20	7	41.2	borehole	2	11.8
more than 100	1	5.9	tanker truck	2	11.8
Total	17	100.0	Total	17	100.0

Table 2. Summary of infrastructure available

		Frequency	Percent			Frequency	Percent
Electricity	yes	13	76.5	Landline Telephone	yes	1	5.9
	no	4	23.5		no	16	94.1
	Total	17	100.0		Total	17	100.0
Power back up	yes	3	17.6	Mobile Telephone	yes	7	41.2
	no	14	82.4		no	10	58.8
	Total	17	100.0		Total	17	100.0
Computers	yes	2	11.8	Internet Connectivity	yes	2	11.8
	no	15	88.2		no	15	88.2
	Total	17	100.0		Total	17	100.0

4.2 Summary of general purpose equipment and supplies

An assessment was also conducted of the availability of recommended drugs, equipment and supplies required for the optimal delivery of BEmONC/Integrated IMNC services. Statistics according to Table 3 indicated that 90% of all the health facilities had adequate supplies and

equipment, digital scale for newborn (47%) and thermometers (58%). Equipment and supplies that were in short supply include; surgical blades (47%) and oxygen machines (18). Only one health facility possesses an incubator. See Table 3 below.

Table 3. Summary of general purpose equipment and supplies

Name of Equipment	Frequency at Facility	Percentage
Latex gloves	14	82.4
Blood pressure machine	14	82.4
Stethoscope	15	88.2
Fetoscope	14	82.4
Microscope	5	29.4
Refrigerator	17	100
Adult weighing scale	17	100
Weighing equipment for under-5	16	94.1
Digital scale for newborn	8	47.1
Height Boards	16	94.1
Muac Tapes (for upper arm circumference)	17	100
Thermometers	10	58.8
Incubators	1	5.9
Oxygen system/cylinders/concentrators	3	17.6
Sterilizers (autoclave, pressure pots, boiling pots, etc.)	15	88.2
Decontaminant (e.g. chlorine, bleach)	16	94.1
Buckets for infection prevention	17	100
Disposable syringes and safety boxes	14	82.4
Surgical blades	8	47.1
Local Anesthetic (e.g. lidocaine)	17	100
Delivery kit	12	70.2
Cord clamps	14	82.4

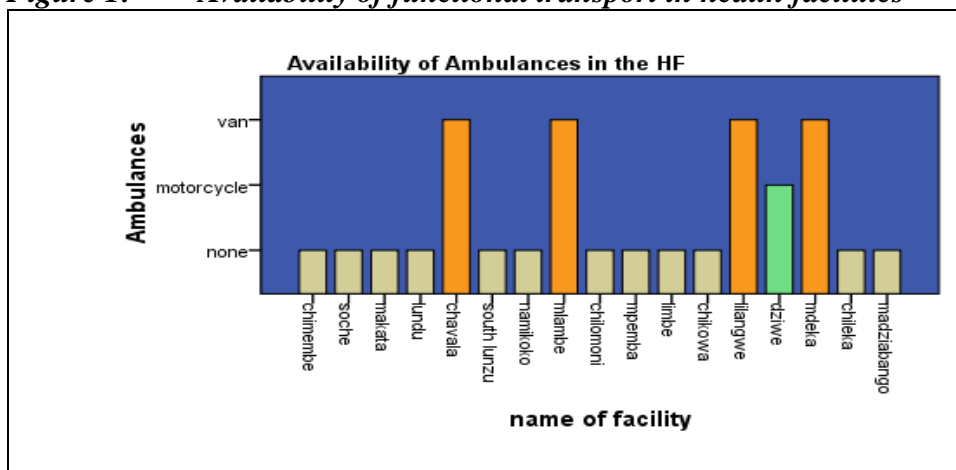
4.3 Communication and transport

Most countries in Africa suffer from weak referral systems – broadly defined to include the full range of steps from recognition of complications at the household level through the appropriate and timely treatment at a referral facility. Communication and transport are two elements at the center of a referral system and when used effectively and expediently can save women’s and their babies’ lives during pregnancy, childbirth and the postpartum period. Communication can serve to request transportation, to inform the receiving facility that a patient is en route and in what condition. Telephones or radios can also be used to obtain medical advice and to provide counter-referral measures.

All 17 health facilities have a functioning radio as a means of communication; 94% use landline telephone. The assessment indicated lack of access to internet connectivity (12%). A functioning mode of transport is essential for referral. In all surveyed facilities, 23% reported availability of a functioning motor vehicle ambulance; only one health facility reported the availability of a

functioning motorcycle ambulance (Figure 1). This indicates a shortage of functional and reliable transportation in the HCs for referral.

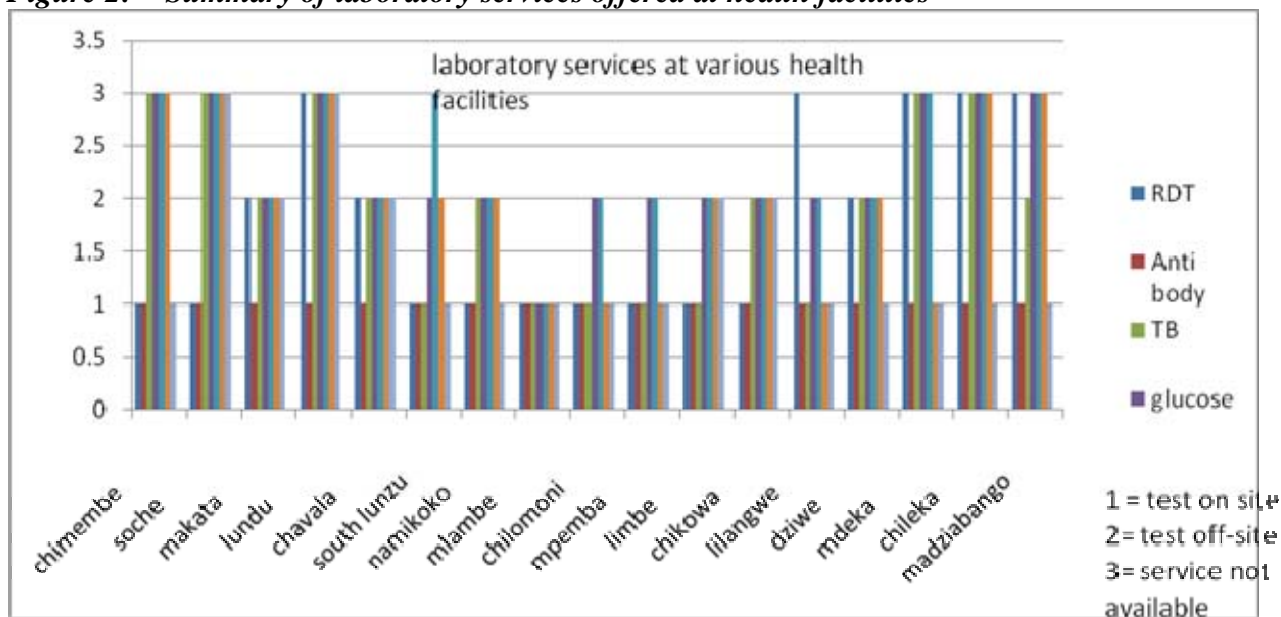
Figure 1: Availability of functional transport in health facilities



4.4 Facility-based laboratory services

Nearly all facilities reported that they provided focused antenatal care (FANC) services such as HIV Testing which is an entry point to PMTCT. Most of the health facilities do not conduct various required tests due to unavailability of required equipment and other relevant resources. Fifty-three percent (53%) of HFs conduct Malaria tests and 53% reported that hemoglobin and full blood tests are conducted off-site, which is a low percentage considering its importance on prevention of pregnancy, labor and postpartum complications. VDRL for syphilis is conducted in most of the health facilities (64.7%). Cancer on-site testing is done in some of the health facilities (29%) while some do off-site testing (41%) with four HFs reporting no service. Below is the figure showing all the tests done at the facility level.

Figure 2: Summary of laboratory services offered at health facilities



4.5 Human resources and health facility capacity

The functional review report produced by the Ministry of Health in October 2007 recommended the staffing levels for HCs as presented in Table 4. These staffing levels are ideal for effective functioning of health service facilities.

Table 4: MOH recommended staffing levels for institutions¹

	District Hospital	Rural Hospital	Urban Health Center	Rural Health Center
Clinical Officer/Technician	65	5	5	2
Nursing Officer	18	0	0	0
Nurse Technician	70	28	16	16
Medical Technician/Assistant	24	4	4	2
Laboratory technician	6	2	1	1

Mwayi wa Moyo project is being implemented in 17 health facilities of which Limbe, Chilomoni and South Lunzu are urban located while Mlambe is a CHAM district hospital. The minimum staffing complement for a rural HC includes at least two Medical Assistants and 16 Nurse/Midwives. The assessment indicates that there are high shortages of Clinicians in all health facilities. MOH recommends that rural and urban HCs have 16 nurse midwives/technicians. The assessment indicates that most of the rural HCs have shortages averaging less than three per facility, as per Table 5 below.

Table 5: Number of health worker cadres versus recommended target

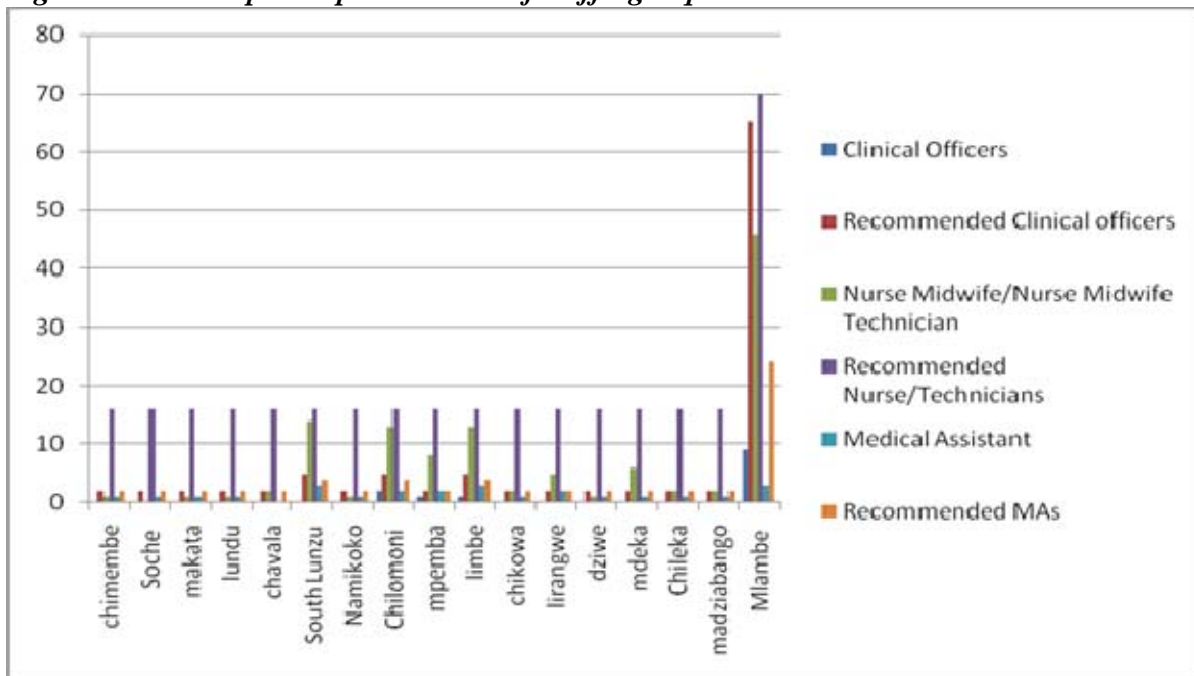
Health Center	Clinical Officers	Target for Clinical Officers	Nurse Midwife/ Nurse Midwife Technician	Target for Enrolled Nurse Midwife Technician	Medical Assistant	Target for Medical Assistants
Chimembe	0	2	1	16	1	2
Soche	0	2	0	16	1	2
Makata	0	2	1	16	1	2
Lundu	0	2	1	16	1	2
Chavala	0	2	2	16	0	2
South Lunzu	0	5	14	16	3	4
Namikoko	0	2	1	16	1	2
Chilomoni	2	5	13	16	2	4
Mpemba	1	2	8	16	2	2
Limbe	1	5	13	16	3	4

¹ Human Resource Section, MOH, October 2007.

Health Center	Clinical Officers	Target for Clinical Officers	Nurse Midwife/ Nurse Midwife Technician	Target for Enrolled Nurse Midwife/ Nurse Midwife Technician	Medical Assistant	Target for Medical Assistants
Chikowa	0	2	2	16	1	2
Lirangwe	0	2	5	16	2	2
Dziwe	0	2	1	16	1	2
Mdeka	0	2	6	16	1	2
Chileka	0	2	2	16	1	2
Madziabango	0	2	2	16	1	2
Mlambe	9	65	46	70	3	24

Mlambe Hospital, a CHAM supported facility has different recommended staffing requirements than the rest of the facilities. There are 13 clinical officers in all 17 HCs, 9 of which are from one facility (Mlambe). Meanwhile, 13 HFs (76.5%) do not have clinical officers and 82% of the facilities do not have State Registered Nurses (Mlambe Hospital has 7 of the 9). There are 26 Enrolled Nurses (41.2%) and 92 Nurse/Midwives (88.2%). There are few Laboratory Technicians in the health facilities; 14 HFs (82.4%) do not have Lab Technicians and only two facilities have Pharmacists. Thirteen (13) health facilities have Data Clerks responsible for HMIS while others have more than two staff, i.e. Chilomoni and Mlambe.

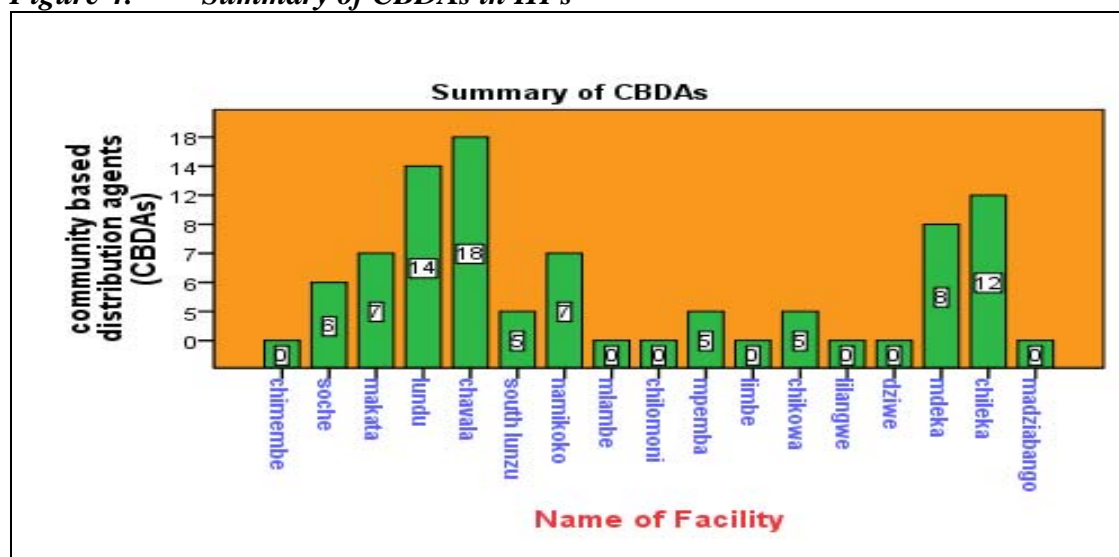
Figure 3: Graphical presentation of staffing requirements



Community Based Distribution Assistants (CBDAs)

In most countries, community based distribution (CBD) has proven to be the optimum way of reaching people in the rural areas where conventional methods of service delivery do not exist². The launch of the CBD program in Malawi has contributed significantly to the increase in the contraceptive prevalence rate (CPR). With 54% of the rural population are unable to access FP services within a 5km radius, community based distribution has become a successful alternative to bringing the products to the people³. The assessment therefore also aimed at identifying the number of CBDAs in the *Mwayi wa Moyo* catchment area who will be a vital component in the delivery of PFP.

Figure 4: Summary of CBDAs in HFs



The figure above shows that a few HCs have adequate CBDAs while most of them have inadequate numbers of CBDAs. The HC with the highest number of CBDAs is Chavala with 18 and at least seven HCs are without any CBDAs at all.

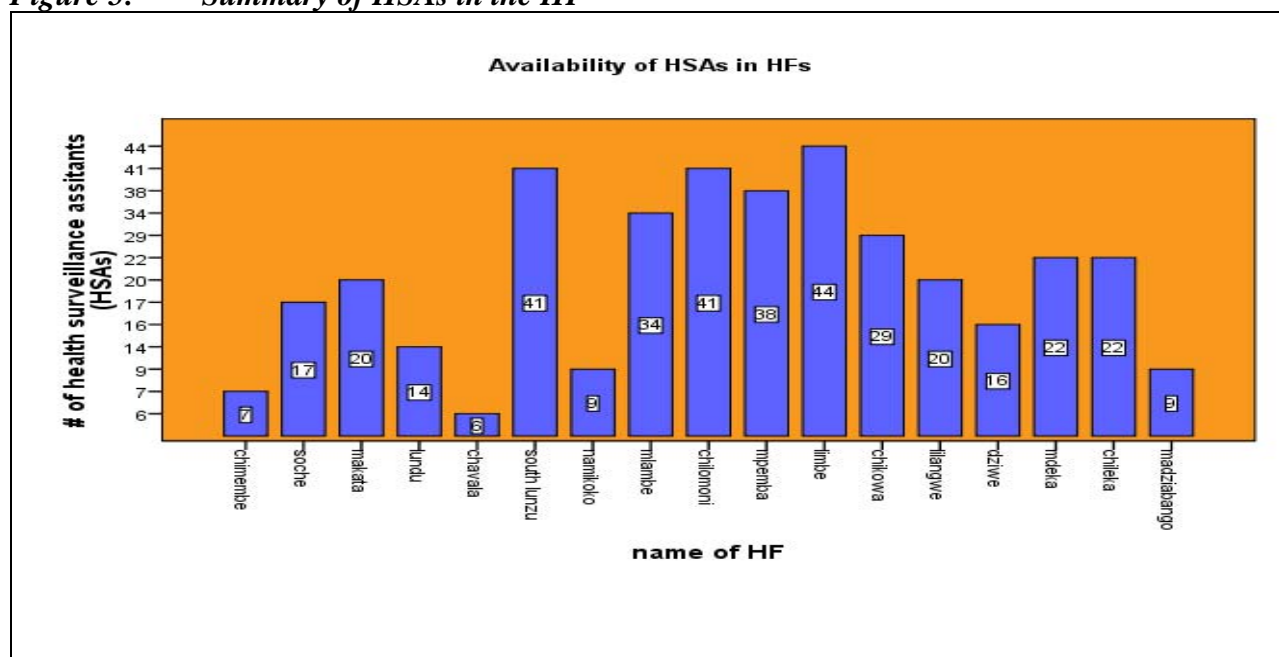
Health Surveillance Assistants (HSAs)

Research has shown that community health workers such as Health Surveillance Assistants (HSAs) can contribute to the reduction of maternal and neonatal deaths. An HSA is a primary health care worker serving as a link between district health services and the community. They live within the rural community they serve and as a result, villagers trust the HSAs more than the facility workers. The ideal ratio of HSAs per catchment area is 1 HSA to 1000 population. Below are the findings on the number of HSAs in the *Mwayi wa Moyo* catchment areas:

² Ndola P rata, Farnaz Vihidnia, Malcolm Potts and Ingrid Dries-Daffner. Revisiting community-based distribution programs: are they still needed? *Contraception* 72(2005) 402-407.

³ Solo, J., Issac Jacobstein, R., Malema, D., 2005. Repositioning family planning-Malawi case study: Choice, not chance. New York: The ACQUIRE Project/EngenderHealth.

Figure 5: Summary of HSAs in the HF



The graph shows that there are more HSAs in urban health facilities as compared to rural HCs which means people in the most remote and hard to reach areas are deprived of the adequate services available from these CHWs.

4.6 Trainings

The HFA indicates that several key health facility personnel have not received appropriate technical trainings to assist in the delivery of integrated maternal, newborn and child health. Less than 30% of skilled birth attendants have received trainings in IMNC, PPF, and CCM. HSAs who are key in promoting health services in the community have not received key trainings to provide community based maternal and newborn care. None of the HSAs in the surveyed health facilities (hard to reach areas) have ever been trained in PPF, CBMNC or Community DMPA. There are observable gaps among skilled personnel in the health facilities as reflected from the percentage trained in various health skills. Table 6 summarizes various key trainings that the *Mwayi wa Moyo* Project intends to integrate into one training package. Health facility-specific analysis of staff trained in various topics can be done separately to further understand the picture on the ground.⁴

Infection prevention and control safety (11%), Community Mobilization (15%), and Community Case Management (14%) are the only trainings that HSAs from the 17 health facilities have received while other trainings indicate insignificant values. This suggests that more than 80% of HSAs have not been trained to provide community based MNCH and motivate mothers on PPF. The assessment further indicates that some skilled personnel i.e. State Registered Nurses, Nurse, Midwife Technicians have been trained in some of the key health packages although IMCI (38%);infection prevention and control safety (34%) are the only trainings above 30%.

⁴ Further reference can be made to SPSS frequency outputs.

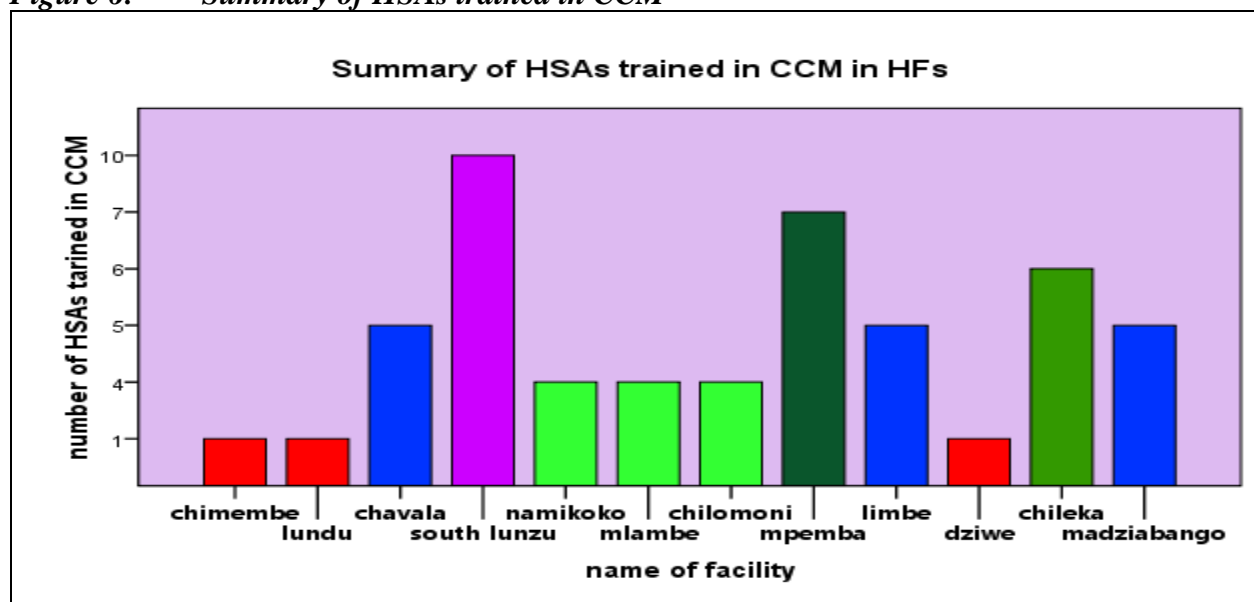
Table 6: Summary of key trainings attended by various personnel⁵

Type of Training	Skilled (COs & MAs) Denominator	%	Skilled (Nurses) Denominator	%	(HSAs) Denominator	%	(CBDAs) Denominator	%
Basic FP	38 ⁶	8	127	16	389	1	87	0
Injectable contraceptives	38	0	127	2	389	9	87	0
LATFP (IUCD & sterilization)	38	24	127	13	389	0	87	0
Youth friendly health services	38	13	127	7	389	4	87	0
Emergency contraception	38	24	127	19	389	0	87	0
Neonatal resuscitation (HBB)	38	5	127	17	389	0	87	0
IMCI	38	42	127	38	389	2	87	0
BEmONC	38	2	127	6	389	0	87	0
PPFP	38	5	127	2	389	0	87	0
IMNC	38	0	127	2	389	0	87	0
KMC	38	0	127	15	389	0	87	0
CBMNC	38	0	127	2	389	0	87	0
CCM	38	32	127	12	389	14	87	0
IYCF	38	3	127	6	389	0	87	0
PMTCT	38	26	127	20	389	1	87	0
Integrated ART/PMTCT	38	61	127	24	389	1	87	0
Infection prevention & control safety	38	39	127	34	389	11	87	0
HMIS	38	8	127	2	389	8	87	0
Community Mobilization	38	0	127	2	389	15	87	0

⁵ Percentage set to the nearest number.

⁶ The denominator is a summation of clinical officers, medical assistants and medical doctors.

Figure 6: Summary of HSAs trained in CCM



CCM is one of the key trainings to be integrated by the child survival project. This is a high impact intervention that Save the Children supports in Blantyre District. South Lunzu, Mpemba and Chileka registered more HSAs trained in CCM while Dziwe, Lundu and Chimembe had the least number of trained HSAs.

4.7 Interventions

The *Mwayi wa Moyo* project will integrate CBMNC, CCM and FP packages as part of HSAs training. Health facilities are currently implementing fragmented approaches (interventions) in the district through HSAs. The assessment indicated that several Health Facilities are offering a number of health interventions. Interventions that are not well covered include; CBMNC (35.6%), BEmONC (35.3%), and Gender/Gender-based Violence Counseling and Referral (11.8%). The assessment indicate that there is 100% of services i.e. growth monitoring, vaccinations, iodized salt promotion and CCM. The yellow shaded are some of the high impact interventions promoted by Ministry of Health.

Table 7: Summary of interventions currently offered by 17 HFs

Type of Health Intervention	Frequency	Percent
General Family Planning (FP) –Natural and Modern Contraceptives	16	94.1
Postpartum/ Post-Abortion Family Planning ⁷	11	64.7
Emergency Contraception	11	64.7
Long-Acting Family Planning Methods (Implants, IUCD, Sterilization)	14	82.4
FP for HIV positive women (FP/HIV Integration)	12	70.6
Youth Friendly Health Services (Family Planning, STI and HIV)	12	70.6
Gender/Gender-based Violence Counseling and Referral	2	11.8

⁷ The yellow shaded interventions are key will be prioritized in MwM program.

Type of Health Intervention	Frequency	Percent
Community-based FP Distribution Program (HSAs and CBDAs)	13	76.5
Focused Antenatal Care (FANC)	15	88.2
Basic Emergency Obstetrics and Newborn Care (BEmONC)	6	35.3
Post-abortion Care	10	58.8
Integrated Maternal and Newborn Care (IMNC)	9	52.9
Kangaroo Mother Care (KMC)	12	70.6
Helping Babies Breathe (HBB)	11	64.7
Emergency Triage Assessment and Treatment (ETAT)	10	58.8
Integrated Management of Childhood Illnesses (IMCI)	14	82.4
Child Immunization (EPI) and Growth Monitoring	17	100
EPI+ (new vaccines)	17	100
Community-based Maternal and Newborn Care (CBMNC)	6	35.3
Community Case Management (CCM) of Diarrhea, Pneumonia and Malaria	17	100
Promotion of optimal Infant and Young Child Feeding Practices (IYCF)	8	47.1
Nutrition, Education and Counseling on Essential Nutrition Actions (ENA)	13	76.5
Nutrition, Treatment, Care and Support for PLWHAs (NTCS)	11	64.7
Community-based Management of Acute Malnutrition (CMAM)	9	52.9
Promotion of Iodized Salt	17	100
HIV Counseling and Testing (HCT: including PITC and VCT)	16	94.1
Door-to-door HIV Counseling and Testing	4	23.5
Early Infant Diagnosis (DBS Sample Collection)	14	82.4
Early Infant Diagnosis (ELISA test for exposed babies after 18months of life)	10	58.8
HIV Counseling and Testing for Pregnant Women	14	82.4
PMTCT (ARV Prophylaxis : AZT/Nevirapine)	15	88.2
PMTCT (ART initiation- Option B+)	15	88.2
Antiretroviral Therapy (ART) Enrollment and Refill	16	94.1
Antiretroviral Therapy (ART) Refill only	16	94.1
Tuberculosis (TB) diagnosis (smear microscopy) and treatment	6	35.3
TB/HIV Integration (ART initiation in TB patients)	8	47.1
Community Outreach Services	16	94.1
Community Mobilization	15	88.2
KMC	11	64.7
Labor and Delivery Area	13	76.5
HCT	16	94.1

4.8 Guidelines

Guidelines are available to inform job aids relevant to specific information provided by the health system. Several interventions and approaches come with specific guidelines which are supposed to be available and accessible in the health facilities.

The assessment indicates that some facilities keep various guidelines that are displayed and accessible. There is a relationship between services provided by health facilities and the availability of respective guidelines. However, several facilities do not have guidelines despite indicating that the services were being offered.

Table 8: Summary of guidelines available at HFs

Name of Guideline	Frequency at Facility	Percentage
Reproductive Health Service Delivery Guidelines	13	76.5
National Sexual and Reproductive Health and Right (SRHR) Policy	7	41.2
Management of Malaria	16	94.1
Integrated Management of Childhood Illnesses (IMCI)	14	82.4
Kangaroo Mother Care (KMC)	9	52.9
Helping Babies Breathe (HBB)	7	41.2
Community-based Maternal and Newborn Care (CBMNC)	3	17.7
Integrated Management of Childhood Illnesses (IMCI)	12	70.6
Infant and Young Child Feeding Practices (IYCF)	5	29.4
Management of Adult and Adolescent Malnutrition (for Nutrition and HIV)	5	29.4
Community Case Management (CCM) of Diarrhea, Pneumonia and Malaria	14	82.4

4.9 Essential drugs and commodities available at facilities

The assessment suggests that most health facilities possessed essential drugs and commodities at the time of assessment. However, some commodities were not available in some facilities. A complementary stock-out assessment will be conducted to ascertain periods of drug sufficiency. Table 8 below presents only drugs and commodities that were in short supply (less than 50%). Otherwise all other essential drugs and commodities were adequately available in the facilities.⁸ The unavailability of male condoms (47.1%) and IUCD (17.6%) are areas that require deliberate attention.

Table 9: Summary of drugs and commodities in short supply

Name of Essential Drug/Commodity	Frequency at Facility	Percentage
Iron tablets	6	35.3
ROTA vaccine	0	0
Tetracycline eye ointment	8	47.1
Magnesium Sulphate	6	35.3
Ergometrine	1	5.9
Male condoms	8	47.1
Intrauterine device (IUCD)	3	17.6

⁸ These can be referred and accessed from SPSS output.

4.10 Recordkeeping

The assessment indicate that there are good recording and reporting systems as evidenced from the availability of various data collection forms and tools at the health facilities. All health facilities are reported to have registers for FP, Under-5, Under-1, Immunization, Growth Monitoring, CCM, HCT, TB and PMTCT. Other tools (registers) available include ANC, KMC, maternity, EID, and LMIS.

However, only one health facility reported having registers for Helping Babies Breathe (HBB), Community-based Maternal and Newborn Care (CBMNC) and CMAM Register . These interventions are not currently running in most HFs. Stock cards, requisition forms, and drug forms were indicated as some of the other tools available at the HFs.

5.0 Lessons Learned

- It has been observed through analysis that many health facilities are currently offering several key health interventions despite results indicating that most of them have not been trained in respective health packages. The positive response could also be attributed to failure to differentiate or understand these various trainings by the respondents. This could also be partly attributed to how questions were structured and presented to the respondents which might likely affect their response.
- Poorly managed transition/handover processes when an officer leaves the facility makes it difficult for the successor to locate information about the facility.

6.0 Stock-outs

An assessment on stock-outs was conducted in all 17 health facilities where *Mwayi wa Moyo* will be implemented. A generic tool for drug stock-out assessment was adopted and administered to Health Facility In-Charges. The assessed drugs are key to CCM, CBMNC and FP.

Table10: Summary of Stock-outs in Health Facilities

Name of Drug	% Available and Observed	% Not Available	% with Stocks in 3 Months	% of Stock-outs in 3 Months	Average # of Stock-out days ⁹	Some Expired	None Expired
Cotrimoxazole tablets	47.1	52.9	23.5	76.5	12 (5/17)	0	100
Lumefantrine+ Artemisinin (LA)	82.4	17.6	29.4	70.6	21 (5/17)	5.9	94.1
Paracetamol tablets	35.3	65.7	47.1	52.9	25 (7/10)	0	100
Eye ointment per national policy	76.5	25.5	29.4	70.6	31 (5/17)	0	100
Injectable antibiotics	88.2	11.8	17.6	82.4	33 (4/17)	0	100
Iron tablets (Ferrous with folate)	58.8	41.2	35.3	64.7	27 (5/17)	0	100
Vitamin A capsules	29.4	70.6	64.7	35.3	14 (10/17)	17.7	82.3
First-line Antimalarial (LA)	88.2	11.8	47.1	52.9	19 (7/17)	5.9	94.1

⁹ This average is only for those who reported to have stock-outs the previous three months. The brackets represent the proportion of HCs reported to have stock-outs

Name of Drug	% Available and Observed	% Not Available	% with Stocks in 3 Months	% of Stock-outs in 3 Months	Average # of Stock-out days ⁹	Some Expired	None Expired
Second-line Antimalarial (Quinine)	76.5	24.5	41.2	58.8	14 (6/17)	0	100
Fansidar for IPTp	88.2	11.8	29.4	70.6	30 (3/17)	11.8	89.2
Mebendazole	52.9	47.1	58.8	41.2	17 (7/17)	11.8	89.2
Measles Vaccine	94.1	5.9	5.9	94.1	0	5.9	94.1
Tetanus Toxoid Vaccine (TTV)	94.1	5.9	0	100	0	0	100
BCG vaccine	94.1	5.9	17.6	82.4	14 (3/17)	0	100
Polio vaccine	94.1	5.9	23.5	76.5	7 (3/17)	0	100
Pentavalent vaccine	94.1	5.9	11.8	91.2	14 (2/17)	0	100
Tetracycline eye ointment	76.5	23.5	29.4	70.6	24 (5/17)	0	100
Antihypertensive drugs	88.2	11.8	23.5	76.5	40 (3/17)	5.9	94.1
Magnesium Sulphate	41.2	58.8	64.7	35.3	90 (8/17)	0	100
Anticonvulsants	41.2	58.8	58.8	41.2	18 (9/17)	5.9	94.1
Oxytocin	76.5	23.5	11.8	88.2	0	0	100
Ergometrine	17.6	82.4	43.8	56.2	15 (8/17)	5.9	94.1
Oral contraceptive pills	29.4	70.6	70.6	29.4	25 (9/17)	0	100
Injectable contraceptives	56.2	43.8	81.2	18.8	21 (11/17)	0	100
Male Condoms	11.8	88.2	43.8	56.2	24 (7/17)	0	100
Female Condoms	70.6	29.4	11.8	89.2	60 (2/17)	5.9	94.1
Implants	88.2	11.8	23.5	76.5	31 (1/17)	0	100
Intrauterine device (IUCD)	23.5	76.5	52.9	47.1	90 (5/17)	0	100
RUTF, F75, F100, Resmol	70.6	29.4	47.1	52.9	31 (6/17)	0	100

According to the assessment, there is significant shortage of FP methods. This corresponds to the voluntary family assessment results that were conducted in the same area. The assessment indicates the availability of injectable contraceptives (29.4%), IUD (23.5%), male condoms (11.8%) and oral contraceptive pills (29.4). The only available FP methods are implants (88.2%).

There were also significant shortages of ergometrine (17.6%). However, there was good availability of oxytocin (76.5) observed from the assessed health facilities. The other drugs that were in short supply are magnesium sulphate (41.2%), anticonvulsants (41.2%), vitamin A capsules (29.4%) and paracetamol tablets (35.3). Almost all health facilities had significant availability of various vaccines during the time of the assessment; i.e. measles, BCG, Tetanus Toxoid Vaccine (TTV), Polio and pentavalent (94.1%) respectively.

The assessment further indicates that there are significant stock-outs in the previous three months for all drugs except for vitamin A capsules (64.7%), mebendazole (52.9%), and Magnesium

Sulphate (64.7%) which were available in most of the health facilities in the past three months, as detailed in Table 10 above.

There are insignificant cases of drug expiration in most of the health facilities; three health facilities(17.7%) were observed to have some expired vitamin A capsules. Some fansidar for IPTp and mebendazole were reported to be expired in two HFs. Additionally, some female condoms, ergometrine, antihypertensive drugs, measles and LA were reported to have been expired in one health facility.

7.0 Conclusion

The HFA was effectively conducted in all the health facilities which are within the *Mwayi wa Moyo* catchment zone. The program provided technical and resource support. The Blantyre District Health Office provided support through communication to the health facility respondents. The assessment unearthed a key picture that will enable *Mwayi wa Moyo* to complete and fill gaps at the facility level and ensure the quality of care by skilled birth attendants, after creating demand at the community level. The benchmarks will help the program implement its monitoring and evaluation plan (M&E Table) and its Detailed Implementation Plan (DIP). Voluntary FP risk and stock-out assessment will be assessed separately and will complement this report.

ANNEXES

Annex 1: Summary of Assessment Facilitators

Name of Data Collector	Position	Contact
Mayeso Mphande	ORME Coordinator	mamphande@savechildren.org
Timothy Bonyonga	Training Officer	tbononga@savechildren.org
Naomi Kalemba	SBCC Officer	nkalemba@savechildren.org

Annex 2: Schedule for HFA

ID	Name of Health Center	Name of Medical Personnel	Contact	Date of HFA	Personnel
1	Chilomoni	Dalitso Billy- CO	888119449/88 8138874	17 th April 2012	PM, ORME, FP & MNC
2	Limbe	R Mzumara- MA	884317192/09 99260720	17 th April 2012	PM, ORME, FP & MNC
3	Chileka	Mandala-CO	999150962	18 th April 2012	PM, ORME, FP & MNC
4	Chimembe	Mrs. Phambana-NMT	888144654	18 th April 2012	PM, ORME, FP & MNC
5	Dziwe	Mwalape Dulani	0888014004/9 99167190	18 th April 2012	PM, ORME, FP & MNC
6	Namikoko	Precious Kadzinja-MA	992032333	18 th April 2012	PM, ORME, FP & MNC
7	Lundu	Mike Matewere-CO	999365720	18 th April 2012	PM, ORME, FP & MNC
8	Mdeka	Samson Chima	999758809	19 th April 2012	PM, ORME, FP & MNC
9	Lirangwe	Falid James	995632452	19 th April 2012	PM, ORME, FP & MNC
10	South Lunzu	Young Chisanga-SMA	888313284	19 th April 2012	PM, ORME, FP & MNC
11	Soche	Rashid Msadala - MA	0999471170/8 84024147	19 th April 2012	PM, ORME, FP & MNC
12	Mlambe	Daudi-CO	888359165	20 th April 2012	PM, ORME, FP & MNC
13	Makata	Makura	881547355	20 th April 2012	PM, ORME, FP & MNC
14	Chikowa	Kanjere Mwakambewa	0888897200/0 994829869	20 th April 2012	PM, ORME, FP & MNC
15	Chabvala	Effie Magombo	0995544903/0 888452215	20 th April 2012	PM, ORME, FP & MNC
16	Madziabango	James Sebastiano	888670014	21 st April 2012	PM, ORME, FP & MNC
17	Mpemba	Koyokwa - CO	999341395	21 st April 2012	PM, ORME, FP & MNC

Annex 3: Questionnaire used during Health Facility Assessment

Mwayi wa Moyo Project

Facility Baseline Assessment Questionnaire

Name and Code of Interviewer:

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1- Facility Rapid Situation Analysis

Section A – Facility Interview

Administer this questionnaire to Key Informants in the facility, including Environmental Health Officers, Facility Health Providers and Health Center In-charges in the facility.

Circle appropriate figure (code), and if only one option is possible and write the code out in the box provided.

001	Date of Interview	dd/mm/yy	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			
002	Respondent's Name					
003	Respondent's Job Title					
004	Respondent's contact information (telephone, email, other)					

i. Facility Background Information

102	District			
103	Facility Name			
104	Facility Type	1. Health Center 2. Hospital	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>	
105	Facility Ownership	1. Ministry 2. CHAM	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>	

ii. Infrastructure and Technology Resources

201	Number of beds	1. Less than 10 2. 11- 20 3. 21-50 4. 51-100 5. More than 100	<input type="checkbox"/>
202	Main source of water	1. Pipe-borne 2. Open Well 3. Bore-hole 4. Surface 5. Rain 6. Tanker Truck	<input type="checkbox"/>
203	Is there electricity facility (ESCOM or Solar)?	1. Yes 2. No	<input type="checkbox"/>
204	Does the facility have a power back-up (e.g. generator, inverter, solar)?	1. Yes 2. No	<input type="checkbox"/>
205	Landline telephone	1. Yes 2. No	<input type="checkbox"/>
206	Mobile phone	1. Yes 2. No	<input type="checkbox"/>
207	Radio communication	1. Yes 2. No	<input type="checkbox"/>
208	Computers	1. Yes 2. No	<input type="checkbox"/>
209	Internet connections	1. Yes 2. No	<input type="checkbox"/>

iii. General Purpose Equipment and Supplies

Only check Yes, if equipment is available and functional

301	Latex Gloves	1. Yes 2. No	<input type="checkbox"/>
302	Blood pressure machine	1. Yes 2. No If yes: number	<input type="checkbox"/>
303	Stethoscope	1. Yes 2. No	<input type="checkbox"/>
304	Fetoscope	1. Yes 2. No	<input type="checkbox"/>
305	Microscope	3. Yes 4. No	<input type="checkbox"/>
306	Refrigerator	1. Yes 2. No	<input type="checkbox"/>
307	Adult weighing scale	1. Yes 2. No	<input type="checkbox"/>

308	Weighing equipment for under-5 (manual/Salter Harris)	1. Yes 2. No Specify type.....	<input type="checkbox"/>
309	Digital scale for newborn	1. Yes 2. No Specify type.....	<input type="checkbox"/>
310	Height Boards	1. Yes 2. No	<input type="checkbox"/>
311	Muac Tapes (for upper arm circumference)	1. Yes 2. No	<input type="checkbox"/>
312	Thermometers	1. Yes 2. No	<input type="checkbox"/>
313	Ambulance (Circle all that apply)	1. Van 2. Motorcycle 3. Bicycle 4. None	
315	Incubators	1. Yes 2. No	<input type="checkbox"/>
316	Oxygen system/cylinders/concentrators	1. Yes 2. No	<input type="checkbox"/>
317	Sterilizers (autoclave, pressure pots, boiling pots, etc.)	1. Yes 2. No	<input type="checkbox"/>
318	Decontaminant (e.g. chlorine, bleach)	1. Yes 2. No	<input type="checkbox"/>
319	Buckets for infection prevention	1. Yes 2. No	<input type="checkbox"/>
320	Disposable syringes and safety boxes	1. Yes 2. No	<input type="checkbox"/>
321	Surgical blades	1. Yes 2. No	<input type="checkbox"/>
322	<i>Local Anesthetic (e.g. lidocaine)</i>	1. Yes 2. No	<input type="checkbox"/>
323	Delivery kit	1. Yes 2. No	<input type="checkbox"/>
324	Cord clamps	1. Yes 2. No	<input type="checkbox"/>

iv. Facility-based Laboratory Services

401	Hemoglobin and full blood count	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
402	Giemsa stain for malaria	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
403	HIV-antibody test	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>

404	Smear microscopy for Tuberculosis (TB)	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
405	Blood Glucose levels	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
406	Urinalysis	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
407	Cervical Cancer (VIA)	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>
408	VDRL for syphilis	1. Test done on-site 2. Test done off-site 3. Service not available (no referral)	<input type="checkbox"/>

v. Human Resources

How many of the following employees work full time in this facility?

	Cadre	Number
501	Clinical Officers	
502	Medical Assistants	
503	State Registered Nurses / Midwives (SRNM)	
504	Enrolled Nurse Midwives	
505	Nurse/Midwifery Technicians	
506	Laboratory Technicians/Assistants	
507	Pharmacists/ Drug dispensers	
508	HMIS personnel/Records Assistants/Data Clerks	
509	HIV Counselors	
510	Health Surveillance Assistants (HSAs)	
511	Community-based Distribution Agents (CBDAs)	
512	Home Craft Workers	
513	Area Environmental Health Assistants	

vi. Training

Insert number of trained staff in the appropriate cell

	In the last two years, how many staff currently working in this facility have received any of the following training while working in this facility or elsewhere?	Medical Doctors	Clinical Officers	Medical Assistants	State Registered Nurses (SRN)/ Midwives	Enrolled Nurse /Midwives or Nurse Technician	HSAs	CBDAs	TOTs <i>(only ask this at district/ central hospitals)</i>	HMIS/ Records Assistants <i>(data clerks)</i>
601	Basic Family Planning									
602	Injectable contraceptives <i>(only for HSAs and CBDAs)</i>									
603	Long-Acting Family Planning Method (Implant, IUCD or Sterilization)									
604	STI Management and Treatment									
605	Youth Friendly Health Services (Family Planning, STI and HIV)									
606	Emergency contraception									
607	Gender/Gender-based Violence									
608	Focused Antenatal Care (FANC) including IPTp									
609	Neonatal Resuscitation (Helping Babies Breathe)									
610	Integrated Management of Childhood Illnesses (IMCI)									
611	Basic Emergency Obstetric and Newborn									

	In the last two years, how many staff currently working in this facility have received any of the following training while working in this facility or elsewhere?	Medical Doctors	Clinical Officers	Medical Assistants	State Registered Nurses (SRN)/ Midwives	Enrolled Nurse /Midwives or Nurse Technician	HSAs	CBDAs	TOTs <i>(only ask this at district/ central hospitals)</i>	HMIS/ Records Assistants <i>(data clerks)</i>
	Care (BEmONC)									
612	Postpartum Family Planning									
613	Post-abortion Care									
614	Cervical Cancer									
615	Integrated Maternal and Newborn Care (IMNC)									
616	Kangaroo Mother Care									
617	Emergency Triage Assessment and Treatment (ETAT)									
618	Acute Respiratory Tract Infection (ARI)									
619	Community-based Maternal and Newborn Care (CBMNC)									
620	Community Case Management (CCM) of Diarrhea, Pneumonia and Malaria									
621	Infant and Young Child Feeding Practices (IYCF)									
622	Essential Nutrition Action (ENA)									
623	Nutrition, Treatment, Care and Support for PLWHAs (NTCS)									
624	Community-based Management of Acute Malnutrition (CMAM)									
625	New Growth Standards									

	In the last two years, how many staff currently working in this facility have received any of the following training while working in this facility or elsewhere?	Medical Doctors	Clinical Officers	Medical Assistants	State Registered Nurses (SRN)/ Midwives	Enrolled Nurse /Midwives or Nurse Technician	HSAs	CBDAAs	TOTs <i>(only ask this at district/ central hospitals)</i>	HMIS/ Records Assistants <i>(data clerks)</i>
626	HIV Counseling and Testing (PITC or VCT)									
627	HIV Testing using Dried Blood Spot (DBS)/EID									
628	Prevention of Mother-to-child Transmission (PMTCT)									
629	ART Care and Treatment (including treatment of HIV/AIDS opportunistic infection)									
630	Integrated ART/PMTCT									
631	Post-exposure Prophylaxis (PEP)									
632	TB/HIV Integration									
633	Infection Prevention and Control/Injection Safety									
634	Diagnosis and Treatment of Malaria (including ACTs)									
635	Malaria prevention using ITN									
636	HMIS									
637	Community Mobilization									

vii. Interventions

Are any of the following interventions/services currently being provided in the facility?

701	General Family Planning (FP) – Natural and Modern Contraceptives	1. Yes 2. No	<input type="checkbox"/>
702	Postpartum/ Post-Abortion Family Planning	1. Yes 2. No	<input type="checkbox"/>
703	Emergency Contraception	1. Yes 2. No	<input type="checkbox"/>
704	Long-Acting Family Planning Methods (Implants, IUCD, Sterilization)	1. Yes 2. No	<input type="checkbox"/>
705	FP for HIV positive women (FP/HIV Integration)	1. Yes 2. No	<input type="checkbox"/>
706	Youth Friendly Health Services (Family Planning, STI and HIV)	1. Yes 2. No	<input type="checkbox"/>
707	Gender/Gender-based Violence counseling and referral	1. Yes 2. No	<input type="checkbox"/>
708	Community-based FP Distribution Program (HSAs and CBDAs)	1. Yes 2. No	<input type="checkbox"/>
709	Focused Antenatal Care (FANC)	1. Yes 2. No	<input type="checkbox"/>
710	Basic Emergency Obstetrics and Newborn Care (BEmONC)	1. Yes 2. No	<input type="checkbox"/>
711	Post-abortion Care	1. Yes 2. No	<input type="checkbox"/>
712	Integrated Maternal and Newborn Care (IMNC)	1. Yes 2. No	<input type="checkbox"/>
713	Kangaroo Mother Care (KMC)	1. Yes 2. No	<input type="checkbox"/>
714	Helping Babies Breathe (HBB)	1. Yes 2. No	<input type="checkbox"/>
715	Emergency Triage Assessment and Treatment (ETAT)	1. Yes 2. No	<input type="checkbox"/>
716	Integrated Management of Childhood Illnesses (IMCI)	1. Yes 2. No	<input type="checkbox"/>
717	Child Immunization (EPI) and Growth Monitoring	1. Yes 2. No	<input type="checkbox"/>
718	EPI+ (new vaccines)	1. Yes 2. No	<input type="checkbox"/>
719	Community-based Maternal and Newborn Care (CBMNC)	1. Yes 2. No	<input type="checkbox"/>
720	Community Case Management (CCM) of Diarrhea, Pneumonia and Malaria	1. Yes 2. No	<input type="checkbox"/>

721	Promotion of optimal Infant and Young Child Feeding Practices (IYCF)	1. Yes 2. No	<input type="checkbox"/>
722	Nutrition, Education and Counseling on Essential Nutrition Actions (ENA)	1. Yes 2. No	<input type="checkbox"/>
723	Nutrition, Treatment, Care and Support for PLWHAs (NTCS)	1. Yes 2. No	<input type="checkbox"/>
724	Community-based Management of Acute Malnutrition (CMAM)	1. Yes 2. No	<input type="checkbox"/>
725	Promotion of Iodized Salt	1. Yes 2. No	<input type="checkbox"/>
726	HIV Counseling and Testing (HCT: including PITC and VCT)	1. Yes 2. No	<input type="checkbox"/>
727	Door-to-door HIV Counseling and Testing	1. Yes 2. No	<input type="checkbox"/>
728	Early Infant Diagnosis (DBS Sample Collection)	1. Yes 2. No	<input type="checkbox"/>
729	Early Infant Diagnosis (ELISA test for exposed babies after 18months of life)	1. Yes 2. No	<input type="checkbox"/>
730	HIV Counseling and Testing for Pregnant Women	1. Yes 2. No	<input type="checkbox"/>
731	PMTCT (ARV Prophylaxis : AZT/Nevirapine)	1. Yes 2. No	<input type="checkbox"/>
732	PMTCT (ART initiation- Option B+)	1. Yes 2. No	<input type="checkbox"/>
733	Antiretroviral Therapy (ART) Enrollment and Refill	1. Yes 2. No	<input type="checkbox"/>
734	Antiretroviral Therapy (ART) Refill only	1. Yes 2. No	<input type="checkbox"/>
735	Tuberculosis (TB) diagnosis (smear microscopy) and treatment	1. Yes 2. No	<input type="checkbox"/>
736	TB/HIV Integration (ART initiation in TB patients)	1. Yes 2. No	<input type="checkbox"/>
737	Community Outreach Services	1. Yes 2. No	<input type="checkbox"/>
738	Community Mobilization	1. Yes 2. No	<input type="checkbox"/>
739	FANC	1. Yes 2. No	<input type="checkbox"/>
740	KMC	1. Yes 2. No	<input type="checkbox"/>
741	Labor and Delivery Area	1. Yes 2. No	<input type="checkbox"/>
742	HCT	1. Yes 2. No	<input type="checkbox"/>

viii. Guidelines (Available and Accessible)

801	Reproductive Health Service Delivery Guidelines	1. Yes 2. No	<input type="checkbox"/>
802	National Sexual and Reproductive Health and Right (SRHR) Policy	1. Yes 2. No	<input type="checkbox"/>
803	Management of Malaria	1. Yes 2. No	<input type="checkbox"/>
804	Integrated Management of Childhood Illnesses (IMCI)	1. Yes 2. No	<input type="checkbox"/>
805	Kangaroo Mother Care (KMC)	1. Yes 2. No	<input type="checkbox"/>
806	Helping Babies Breathe (HBB)	1. Yes 2. No	<input type="checkbox"/>
807	Community-based Maternal and Newborn Care (CBMNC)	1. Yes 2. No	<input type="checkbox"/>
808	Integrated Management of Childhood Illnesses (IMCI)	1. Yes 2. No	<input type="checkbox"/>
809	Infant and Young Child Feeding Practices (IYCF)	1. Yes 2. No	<input type="checkbox"/>
810	Management of Adult and Adolescent Malnutrition (for Nutrition and HIV)	1. Yes 2. No	<input type="checkbox"/>
811	Community Case Management (CCM) of Diarrhea, Pneumonia and Malaria	1. Yes 2. No	<input type="checkbox"/>
812	Brochures, posters, or other materials including counseling cards (please specify)		

ix. Essential Drugs and Commodities (available at the facility)

901	Injectable antibiotics	1. Yes 2. No	<input type="checkbox"/>
902	Oral antibiotics	1. Yes 2. No	<input type="checkbox"/>
903	Oral Rehydration Solution (ORS)	1. Yes 2. No	<input type="checkbox"/>
904	Iron tablets (Ferrous with folate)	1. Yes 2. No	<input type="checkbox"/>
905	Vitamin A capsules	1. Yes 2. No	<input type="checkbox"/>
906	First-line Antimalarial (LA)	1. Yes 2. No	<input type="checkbox"/>
907	Second-line Antimalarial (Quinine)	1. Yes 2. No	<input type="checkbox"/>
908	Fansidar for IPTp	1. Yes 2. No	<input type="checkbox"/>

909	Mebendazole	1. Yes 2. No	<input type="checkbox"/>
910	Measles Vaccine	1. Yes 2. No	<input type="checkbox"/>
911	Tetanus Toxoid Vaccine (TTV)	1. Yes 2. No	<input type="checkbox"/>
912	BCG vaccine	1. Yes 2. No	<input type="checkbox"/>
913	Polio vaccine	1. Yes 2. No	<input type="checkbox"/>
914	PCV	1. Yes 2. No	<input type="checkbox"/>
915	ROTA	1. Yes 2. No	<input type="checkbox"/>
916	Pentavalent vaccine	1. Yes 2. No	<input type="checkbox"/>
917	Tetracycline eye ointment	1. Yes 2. No	<input type="checkbox"/>
918	Antihypertensive drugs	1. Yes 2. No	<input type="checkbox"/>
919	Magnesium Sulphate	1. Yes 2. No	<input type="checkbox"/>
920	Anticonvulsants	1. Yes 2. No	<input type="checkbox"/>
921	Oxytocin	1. Yes 2. No	<input type="checkbox"/>
922	Ergometrine	1. Yes 2. No	<input type="checkbox"/>
923	Oral contraceptive pills	1. Yes 2. No	<input type="checkbox"/>
924	Injectable contraceptives	1. Yes 2. No	<input type="checkbox"/>
925	Male Condoms	1. Yes 2. No	<input type="checkbox"/>
926	Female Condoms	1. Yes 2. No	<input type="checkbox"/>
927	Implants	1. Yes 2. No	<input type="checkbox"/>
928	Intrauterine device (IUCD)	1. Yes 2. No	<input type="checkbox"/>
929	RUTF, F75, F100, Resmol	1. Yes 2. No	<input type="checkbox"/>

x. Referrals

1000	Does this facility receive case referrals from other facilities?	1. Yes 2. No (skip to 1003) <input type="checkbox"/>	
1001	What types of health facilities refer cases to this facility? <i>(Circle all that apply and insert the number of facilities referring cases to your facility)</i>	Facility Type	Number referring cases to your facility
		1. Hospital	
		2. Health Center	
		3. Dispensary	
		4. Health Post	
		5. Village Clinic	
1002	Does this facility refer cases to higher facilities?	1. Yes 2. No (skip to 1005) <input type="checkbox"/>	
1003	What types of facilities are cases referred to? <i>(Circle all that apply)</i>	1. Central Hospital 2. District hospital 3. Rural/community Hospital 4. Health Center 5. Others, please specify..... <input type="checkbox"/>	
1004	Which of the following communication systems are available for referral at the facility? <i>(Circle all that apply)</i>	1. Landline 2. Cell Phone 3. Radio communication	
1005	Is there a functional ambulance (Van or Motorcycle) set aside for referrals	1. Yes 2. No <input type="checkbox"/> Please specify type.....	
91006	Does your facility use Referral Forms/Tool to make referrals? <i>(check if referral form is available)</i>	1. Yes 2. No <input type="checkbox"/>	
1007	Is there a mechanism for referral feedback	1. Yes 2. No 3. Please specify..... <input type="checkbox"/>	

2 -Registers and Records Review

xii. Facility Registers Available and Accessible

1201	Family Planning (FP) Register	1. Yes 2. No	<input type="checkbox"/>
1202	Under-5 Children Register	1. Yes 2. No	<input type="checkbox"/>
1203	Under-1 Children Register	1. Yes 2. No	<input type="checkbox"/>
1204	Immunization Register	1. Yes 2. No	<input type="checkbox"/>
1205	Growth Monitoring Register	1. Yes 2. No	<input type="checkbox"/>
1206	ANC Register	1. Yes 2. No	<input type="checkbox"/>
1207	KMC Register	1. Yes 2. No	<input type="checkbox"/>
1208	HBB Register	1. Yes 2. No	<input type="checkbox"/>
1209	Maternity Register	1. Yes 2. No	<input type="checkbox"/>
1210	Community-based Maternal and Newborn Care (CBMNC) Register	1. Yes 2. No	<input type="checkbox"/>
1211	CCM Register	1. Yes 2. No	<input type="checkbox"/>
1212	HCT Register	1. Yes 2. No	<input type="checkbox"/>
1213	ART/PMTCT Register	1. Yes 2. No	<input type="checkbox"/>
1214	TB Register	1. Yes 2. No	<input type="checkbox"/>
1215	Exposed Child Follow-up Register (EID)	1. Yes 2. No	<input type="checkbox"/>
1216	CMAM Register	1. Yes 2. No	<input type="checkbox"/>
1217	NTCS Register	1. Yes 2. No	<input type="checkbox"/>
1218	Logistics Management Information System (LMIS) Tools	1. Yes 2. No	<input type="checkbox"/>
1219	If yes to 1218 , list the available LMIS tools		

Thank you for your time

Annex 8: Project Data Form

Child Survival and Health Grants Program Project Summary

Sep-22-2012

Save the Children (Malawi)

General Project Information

Cooperative Agreement Number: AID-OAA-A-11-00058
SC Headquarters Technical Backstop: Karen Waltensperger
SC Headquarters Technical Backstop Backup: Winifride Mwebesa
Field Program Manager: Luwiza Soko Puleni
Midterm Evaluator:
Final Evaluator:
Headquarter Financial Contact: Theresa Abanilla
Project Dates: 10/1/2011 - 3/31/2016 (FY2011)
Project Type: Innovation
USAID Mission Contact: Miriam Lutz
Project Web Site:

Field Program Manager

Name: Luwiza Soko Puleni (Program Manager)
Address: Save the Children
Private Bag 254
Blantyre , Malawi 265 Malawi
Phone: 265 01 847828/9
Fax: 265 01 847 826
E-mail: lpuleni@savechildren.org
Skype Name: luwiza.soko

Alternate Field Contact

Name: Joby George (Director of Health Programs)
Address: Box 30373
Off Mchinji Road
Lilongwe , Lilongwe 265 Malawi
Phone: +265 111 753 888
Fax:
E-mail: jgeorge@savechildren.org
Skype Name: joby.george

Grant Funding Information

USAID Funding: \$2,000,000 PVO Match: \$666,600

General Project Description

Save the Children, a 2011 Innovation category grantee, is implementing the *Mwayi wa Moyo* "A Chance to Live" Project in Blantyre District, Malawi. The project goal is to reduce under-five mortality through increased use of high-impact maternal, newborn and child health (MNCH) interventions (services and practices), including post-partum family planning (PPFP). Save the Children is supporting the Ministry of Health (MOH) to streamline and integrate the current community packages into a single coherent package that fills the gaps in the continuum of care and delivers more interventions at better quality and less cost.

Mwayi wa Moyo will incorporate family planning with objective to increase use of key postpartum family planning (PPFP) services and practices among mothers with children under two and their partners. Save the Children will work with the MOH to strengthen the integrated package to include PPFP. A "no-missed" opportunity intervention will seek to amplify the number of mothers reached with information and services during the first two years postpartum. In addition, Save the Children and partners will identify effective approaches to reducing the high teenage pregnancy rate in Malawi.

Project Location

Latitude: -13.25	Longitude: 38.30
Project Location Types:	Peri-urban Rural
Levels of Intervention:	Health Center Health Post Level Home Community
Province(s):	Southern Region
District(s):	Blantyre District
Sub-District(s):	--

Operations Research Information

OR Project Title:	Vertical Vs Integrated: Assessing the effectiveness of an integrated community-based MNCH and FP package in reducing missed opportunities along the life cycle continuum
Cost of OR Activities:	\$190,000
Research Partner(s):	Department of Pediatrics and Child Health, College of Medicine, University of Malawi
OR Project Description:	The operations research (OR), which is being carried out in partnership with the Department of Pediatrics and Child Health of the College of Medicine (COM), will evaluate the effectiveness of the integrated community package delivered by HSAs that incorporates CCM, CBMNC, and PPFP to inform programs on achieving impact at scale.

Partners

College of Medicine (Subgrantee)	\$190,000
Ministry of Health (National level and DHMT) (Collaborating Partner)	\$0
USAID/SSDI-Services (bilateral project) (Collaborating Partner)	\$0
Mother2Mother (Collaborating Partner)	\$0
Development Aid from People to People (DAPP) (Collaborating Partner)	\$0
Banja la Mtsogolo (Collaborating Partner)	\$0
National Statistics Office (NSO) (Collaborating Partner)	\$0
World Vision (Collaborating Partner)	\$0
USAID/SSDI-Communication (bilateral project) (Collaborating Partner)	\$0

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Interpersonal Communication
Health Services Access Strategies:	Addressing social barriers (i.e. gender, socio-cultural, etc) Implementation in a geographic area that the government has identified as poor and underserved
Health Systems Strengthening:	Quality Assurance Supportive Supervision Task Shifting Developing/Helping to develop clinical protocols, procedures, case management guidelines Developing/Helping to develop job aids Monitoring health facility worker adherence with evidence-based guidelines Providing feedback on health worker performance Monitoring CHW adherence with evidence-based guidelines Community role in supervision of CHWs Review of clinical records (for quality assessment/feedback) Coordinating existing HMIS with community level data Community input on quality improvement
Strategies for Enabling Environment:	Advocacy for revisions to national guidelines/protocols Stakeholder engagement and policy dialogue (local/state or national)
Tools/Methodologies:	Rapid Health Facility Assessment Community-based Monitoring of Vital Events

Capacity Building

Local Partners:	National Ministry of Health (MOH) Dist. Health System Health Facility Staff Health CBOs Government sanctioned CHWs
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Interventions & Components

Control of Diarrheal Diseases (18%) - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Zinc - Community Case Management with Zinc (Implementation) - Community Case Management with ORS (Implementation)	IMCI Integration	CHW Training HF Training
Malaria (18%)		
Maternal & Newborn Care (34%) - Neonatal Tetanus - Recognition of Danger signs - Newborn Care - Post partum Care - Child Spacing - Integation. with Iron & Folic Acid - Normal Delivery Care - Birth Plans	IMCI Integration	CHW Training HF Training
Pneumonia Case Management (18%) - Case Management Counseling - Access to Providers Antibiotics - Recognition of Pneumonia Danger Signs - Zinc	IMCI Integration	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	Year	Target	Actual
Female	2012	30	
Male	2012	60	
Female	2013	40	
Male	2013	70	
Number of People Trained in Child Health & Nutrition			
Gender	Year	Target	Actual
Female	2012	30	
Male	2012	60	
Female	2013	40	
Male	2013	70	
Number of People Trained in Malaria Treatment or Prevention			
Gender	Year	Target	Actual
Female	2012	30	
Male	2012	60	
Female	2013	40	
Male	2013	70	

Locations & Sub-Areas

Total Population: 538,413

Target Beneficiaries

	Malawi - SC - FY2011
Children 0-59 months	91,530
Women 15-49 years	113,067
Beneficiaries Total	204,597

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster				
Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	179	300	59.7%	7.9
Percentage of children age 0-23 months whose births were attended by skilled personnel	254	300	84.7%	5.8
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	54	80	67.5%	14.5
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	171	220	77.7%	7.8
Percentage of children age 12-23 months who received a measles vaccination	114	130	87.7%	8.0
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	85	130	65.4%	11.6
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	77	130	59.2%	11.9
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	29	152	19.1%	8.8
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	80	124	64.5%	11.9
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	67	103	65.0%	13.0
Percentage of households of children age 0-23 months that treat water effectively	240	300	80.0%	6.4
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	231	300	77.0%	6.7
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	132	300	44.0%	7.9
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	56	300	18.7%	6.2
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	121	220	55.0%	9.3
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	133	300	44.3%	8.0
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	168	300	56.0%	7.9
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	69	300	23.0%	6.7

Rapid Catch Indicators: Mid-term

Rapid Catch Indicators: Final Evaluation

Rapid Catch Indicator Comments

The Mwayi wa Moyo Baseline (KPC Survey) was conducted in February 2012. The report was reviewed and finalized for adoption

