MCHIP Country Brief: Malawi

Selected Health and Demographic Data for Malawi	
Maternal mortality ratio (deaths/100,000 live births)	675
Neonatal mortality rate (deaths/1,000 live births)	31
Under-five mortality rate (deaths/1,000 live births)*	112
Infant mortality rate (deaths/1,000 live births)	66
Modern contraceptive prevalence rate	42.2
Total fertility rate	5.7
Skilled birth attendant coverage	72%
Antenatal care, 4+ visits	45.5%

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

Health Areas:

- Immunization
- Newborn Health
- HIV/AIDS

Program Dates	October 2011–June 2014					
Total Mission Funding	Redacted [redacted]					
Geographic Coverage	No. (%) of zones	100%	No. of districts	28	No. of facilities	30
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INTRODUCTION

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

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

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

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

Malawi's immunization program reflects the inherent difficulty of implementing a complex public health approach. On one hand, it had adequate to high coverage rates for basic vaccines,

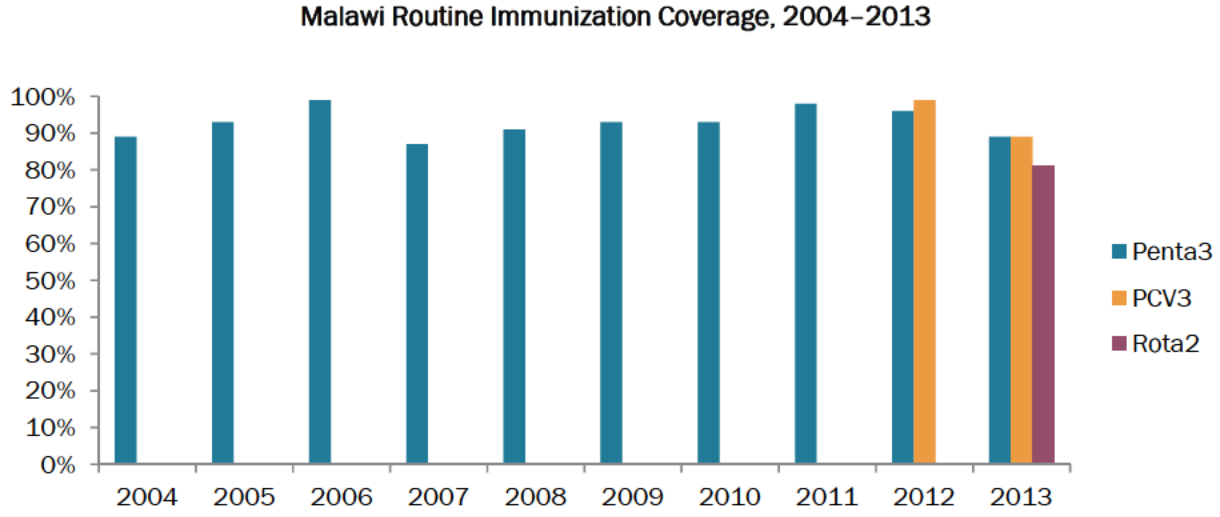
but on the other hand, its vaccine cold chain management and staff skills in running routine immunization programs were subpar. Thus, MCHIP had three objectives for its immunization programming:

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

KEY ACHIEVEMENTS

Immunization

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



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

1,800 providers in improved immunization practices. At the end of the Immunization in Practice (IIP) training, there were three trained health workers in every health facility providing immunization services, and the quality of service delivery improved significantly in all health facilities providing immunization.

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

Voluntary Medical Male Circumcision (VMMC)

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

Results of the National Circumcision Campaign

The campaign from July to September 2013 yielded 8,798 male circumcisions by MCHIP, bringing the total circumcisions for the fiscal year to 13,499.

MCHIP reached 58.6% of the set target for the campaign, and the national campaign yielded a total of 39,886 male circumcisions (66.5% of the set target), with MCHIP contributing 22% of this total.

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

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

Overall, MCHIP learned that sound demand creation and community mobilization were essential for reaching national goals. When one partner was given the task of community mobilization, they were not able to adequately cater to the differing information needs at the district level. In addition, when demand creation and service delivery were separated, results were not as strong. The MOH recommends that demand creation happen at least two weeks before the onset of a campaign, and MCHIP supports this. When demand-creation activities start only days before a campaign, it limits the number of participants coming in for services.

Newborn Health

The third activity in phase two was assessing how the program Helping Babies Breathe (HBB) had been implemented. HBB is an evidence-based educational program to teach essential neonatal resuscitation techniques to health workers in resource-limited areas. It was first rolled out in 2011 to 14 districts in Malawi, of which 10 were supported by MCHIP. During the rollout, there was need for further study, so a multiyear evaluation of the HBB program in Malawi was implemented in late 2011. The study aimed to measure the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi, and it was unique in that it included direct observation of routine delivery care and management of newborns not breathing at birth.

WAY FORWARD

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