USAID ASSIST Project

Malawi Country Report
FY17

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Performance Period:
October 1, 2016 – September 29, 2017
USAID ASSIST Project

Applying Science to Strengthen and Improve Systems

Malawi Country Report FY17

Cooperative Agreement Number AID-OAA-A-12-00101
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SEPTEMBER 2017

DISCLAIMER
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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

Recommended citation

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<th>Full Form</th>
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<tr>
<td>ACT</td>
<td>Artemisinin-based combination therapy</td>
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<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ASSIST</td>
<td>USAID Applying Science to Strengthen and Improve Systems Project</td>
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<td>BCS</td>
<td>Blantyre Coma Scale</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<td>CCP</td>
<td>Center for Communication Programs</td>
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<td>CDACS</td>
<td>Country Development Cooperation Strategy</td>
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<td>CQI</td>
<td>Continuous quality improvement</td>
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<td>CSI</td>
<td>Child status index</td>
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<td>DEC</td>
<td>District Executive Committee</td>
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<td>DH</td>
<td>District hospital</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<td>ECD</td>
<td>Early childhood development</td>
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<td>EQA</td>
<td>External quality assessment</td>
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<td>FY</td>
<td>Fiscal year</td>
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<td>HC</td>
<td>Health center</td>
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<td>HES</td>
<td>Household economic strengthening</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HMIS</td>
<td>Health Management Information Systems</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>HTC</td>
<td>HIV testing and counselling</td>
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<td>IEC</td>
<td>Information, education, and counselling</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MDF</td>
<td>Malawi Defense Force</td>
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<tr>
<td>MOGCDSW</td>
<td>Ministry of Gender, Children, Disability, and Social Welfare</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MPHIA</td>
<td>Malawi Population-Based HIV Impact Assessment</td>
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<td>mRDT</td>
<td>Malaria rapid diagnostic tests</td>
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<td>NMCP</td>
<td>National Malaria Control Program</td>
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<td>OHA</td>
<td>USAID Office of HIV/AIDS</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>Persons living with HIV</td>
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<td>POS</td>
<td>Point of service</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>QA</td>
<td>Quality assurance</td>
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<td>QI</td>
<td>Quality improvement</td>
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<td>SOP</td>
<td>Standard operating procedure</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>URC</td>
<td>University Research Co., LLC</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VHC</td>
<td>Village health center</td>
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<td>VLS</td>
<td>Viral load suppression</td>
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<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
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<td>VSLA</td>
<td>Village savings and loan association</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1 Introduction

Malawi’s HIV prevalence rate is at 10.6% among the population 15-64 years old, with prevalence being higher among females than males (12.8% vs. 8.2%) (MPHIA 2015-2016 Reports). It is estimated that 900,000 people aged 15-64 are living with HIV and AIDS. More than half (58%) of those infected are girls and women (Malawi Demographic Health Survey, 2016). This has led to an increase in the number of orphans and vulnerable children (OVC) in the country that currently are estimated at 1.8 million (Malawi National Plan of Action for Vulnerable Children, 2015-2019). Almost half (49.6%) of Malawi’s girl children are married off before their 18th birthday, and 10% of boys and girls aged 6-13 years are not in school (Malawi Violence Against Children Survey, 2013). This situation creates a vicious cycle of poverty and inequality among vulnerable families. As a result, there is a lot of pressure on government and non-governmental organizations to provide and facilitate access to essential services such as health, food security, access to economic resources, child protection, and education.

OV C work: In 2009, the USAID Health Care Improvement Project, with support from the USAID Mission in Malawi and PEPFAR, began supporting the Ministry of Gender, Children, Disability, and Social Welfare (MOGCDSW) to develop quality standards aimed at guiding the delivery of services provided to vulnerable children and their families in Malawi. The Ministry endorsed the standards and recommended their scale-up. Starting from fiscal year (FY) 14, the MOGCDSW with support from the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project mobilized 151 villages through 10 community quality improvement (QI) teams in Balaka and Mangochi districts to apply QI approaches to improve the quality of social services provided to vulnerable children and their families. In FY16, ASSIST partnered with the One Community Project led by John Hopkins Center for Communication Programs (CCP) in seven districts (five new and two existing districts) to comprehensively support vulnerable communities being targeted by the project.

In FY17, ASSIST collaborated with the One Community Project to scale up the use of OVC standards using QI methods to improve health and social services among vulnerable children and their families to promote their resilience. ASSIST supported the 10 existing QI teams to highlight how they have achieved improvements in several selected service areas. ASSIST built the capacity of One Community Project engagement facilitators and project district officers from the other districts to apply improvement methods to improve services by learning from experiences of the existing QI teams in Mangochi District. This work was in line with the National Plan of Action for Vulnerable Children’s (2015-2019) specific objectives that promote access and building capacity of vulnerable families to access quality essential services. ASSIST Malawi’s work in FY17 contributed to the five PEPFAR 3.0 key agendas, particularly the agendas of promotion and protection of human rights for all and other vulnerable populations and promoting sustainability, partnerships, and impact. These activities are also aligned to the USAID’s Country Development Cooperation Strategy (CDCS, 2013-2018) Development Objectives of improving social development, increasing sustainable livelihoods, and exercising citizen’s rights.

Voluntary medical male circumcision (VMMC) work: In FY15, ASSIST’s work in Malawi expanded to support the Ministry of Health (MOH) to improve the quality and safety of VMMC in nine USAID-funded mobile and outreach teams in eight PEPFAR districts. In FY16, ASSIST Malawi expanded its provision of technical support in continuous quality improvement (CQI) to 10 MOH sites supported by the World Bank, bringing the total number of sites supported in CQI to 27 VMMC teams (17 PEPFAR and 10 World Bank-supported sites) in Malawi. In FY17, ASSIST built the capacity of the MOH and PEPFAR partners to continuously improve the quality of the VMMC services and facilitated peer-to-peer quarterly learning across these sites to expedite improvements.

Cross-Bureau-funded febrile illness work: In FY16, ASSIST received funding from the President’s Malaria Initiative through the USAID Office of Health Systems to implement an activity focused on improving the care of patients (specifically, children under age five and pregnant women) presenting at facilities with febrile illness. This activity is carried out in two intervention and one control district.
Scale of USAID ASSIST’s Work in Malawi

MOGCDW & MOH
(with PEPFAR partners & World Bank)

7 out of 28 districts (OVC)
19 districts (VMMC) (17 PEPFAR & 10 World Bank-supported)

24 QI teams (OVC)
27 QI teams (VMMC)
14 QI teams (febrile illness)

286 villages (OVC)
19,979 orphans and vulnerable children

~11 million out of 18.2 million

2 Program Overview

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
<th>At what scale?</th>
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<tbody>
<tr>
<td><strong>1. Improve quality of services for vulnerable children and their families</strong></td>
<td>7 districts (Mangochi Chikwawa, Blantyre, Zomba, Phalombe, Machinga and Mulanje)</td>
</tr>
<tr>
<td>• Build the capacity of communities to sustain evidence-based effective changes as model sites for learning by other communities</td>
<td>• 15 Traditional Authorities</td>
</tr>
<tr>
<td>• Improve the percentage of vulnerable children accessing quality essential services in six new districts through collaboration with One Community Project using an evidence-based OVC change package</td>
<td>• 286 villages</td>
</tr>
<tr>
<td>• 24 QI teams</td>
<td>• 24 QI teams</td>
</tr>
<tr>
<td><strong>2. Improve the quality and safety of voluntary medical male circumcision (VMMC)</strong></td>
<td>19 districts (8 PEPFAR-supported and 11 World Bank-supported districts)</td>
</tr>
<tr>
<td>• Improve the quality and safety of VMMC services provided by the MOH in selected accredited high-volume sites</td>
<td>• 27 QI teams (17 USAID and 10 MOH sites supported by World Bank)</td>
</tr>
<tr>
<td>• Build the capacity of VMMC sites and implementing partners to continuously improve the quality and safety of VMMC services at site level</td>
<td></td>
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<tr>
<td><strong>3. Institutionalize the capacity to examine and improve neglected health care processes</strong></td>
<td>Districts: 2 intervention (Balaka and Mchinji) and 1 control (Machinga)</td>
</tr>
<tr>
<td>• Phase I: Assess the quality of case management through a baseline survey of services.</td>
<td>• 1 district hospital, 3 health centers, and 3 Village Health Clinics in each district</td>
</tr>
<tr>
<td>• Phase II: Address gaps in quality of care of febrile patients.</td>
<td>• 14 QI teams</td>
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3 Key Activities, Accomplishments, and Results

Activity 1. Improve quality of services for vulnerable children and their families

BACKGROUND

Even though there has been progress in reducing the HIV prevalence rate in Malawi, it is estimated that there are still approximately 28,000 new cases of HIV annually among 15-64 year olds. Recent data shows that the prevalence of viral load suppression (VLS) among HIV positive adults aged 15-64 years in the country is 67.6%. Persons living with HIV (PLHIV) already on antiretroviral (ART) treatment is at 90%. However, there is a gap on HIV diagnosis with only 72.7% of PLHIV aged 15-64 reporting knowing their status (MPHIA, 2016).

HIV and AIDS affects the socio-economic capabilities of families in both urban and rural areas, thereby affecting the economic development of the country. In FY17, ASSIST intensified provision of technical assistance to the MOGCDSW by supporting a total of 24 Malawian community based organizations to improve the welfare of vulnerable children and their families using modern QI techniques. This support included linking families to HIV testing, linking them to household economic strengthening activities such as village savings and loan associations (VSLA) and engaging them to improve food security by using modern methods of farming. Since December 2013, ASSIST has supported the MOGCDSW in Malawi to improve services for vulnerable children, beginning with 10 community QI teams in two districts. In FY17, the OVC activities were scaled up to five additional districts, working closely with the One Community Project led by CCP to comprehensively support 286 vulnerable communities. About 28,000 vulnerable beneficiaries were registered, and of these, 19,979 are children.

KEY ACCOMPLISHMENTS AND RESULTS

- The MOGCDSW with support from ASSIST conducted three QI trainings for government extension workers from 20 community-based organizations (CBOs) in seven districts supported by the One Community Project (Oct 18-19, 2016, Luchenza, Thyolo District, Oct 20 – 21, 2016, Dedza District, and Mar 6 – 9, 2017, Lutchenza, Thyolo District). A total of 177 (115 male and 72 female) CBO members, District Social Welfare Officers, and One Community Project staff from Blantyre, Chikwawa, Mulanje, Phalombe, Mangochi, Zomba, Machinga, and Balaka attended one of the three training sessions. At the end of each training, the CBO members developed action plans to be implemented upon returning to their communities. The plans included formation of new community QI teams, conducting vulnerable household registration and updating the existing OVC registers. In addition, priority areas for improvement were identified using results from child status index assessments, then the teams conducted root cause analysis and developed improvement plans for the prioritized service areas.

- The MOGCDSW with support from ASSIST conducted nine rounds of field coaching visits to 24 community QI teams to monitor the progress of improvement work. (Nov 22-27, 2016; Jan 13-17, 2017; Feb 6-10, 2017; April 10-13, 2017; April 9- 21, 2017; May 8-12, 2017; May 22-26, 2017; May 26-30; and June 29-July 2, 2017). During these visits, the six existing QI teams in Mangochi District were supported to improve linkages of vulnerable beneficiaries to health services as well as other interventions to improve household food security, economic wellbeing, child protection, and early childhood development services. The 18 new teams in Chikwawa, Mulanje, Blantyre, Phalombe, Machinga, Zomba, and Mangochi were supported to build their capacity and skills in collecting quality vulnerable beneficiaries’ baseline data and how to summarize it, conducting child status index (CSI) assessments to identify priority areas for improvement and how to summarize CSI results, developing improvement aims, and conducting root cause analyses for the identified problems. In addition, the coaches also provided support and training on data management as well as team building where teams were encouraged to understand how they can improve team participation and manage improvement teams’ dynamics.
A QI field coaching visit at the community level in progress with ASSIST and the MOGCDSW Director of Child Affairs, May 2017. Photo by Linley Hauya, URC.

- **All 24 teams were also supported on how to develop changes that can lead to improvement, depending on the priority service area each selected.** By the end of the July 2017, all QI teams had developed at least two improvement aims selected among the seven service areas stipulated in the minimum standards for orphans and vulnerable children. All teams had the compulsory improvement aim to improve HIV testing among vulnerable populations in order to promote HIV diagnosis and initiation on ART to contribute to the first and second 90-90-90 goals of the country by 2020.

- **The MOGCDSW with support from ASSIST conducted 6 quarterly learning sessions for 24 community QI teams** (Dec 6-8, 2016; Feb 22-24 2017; Feb 28 to March 2, 2017; June 12-15, 2017; June 20-23, 2017; and June 26-30, 2017). Learning sessions were conducted for the six existing QI teams in Mangochi and bi-annual learning sessions for the 18 QI teams in the seven districts. A total of 460 (320 males and 140 females) participants that included QI team members, district coaches, and national QI coaches from the MOGCDSW and ASSIST participated in these learning sessions.

QI team representatives from 7 districts discussing and sharing lessons and challenges in implementing social services using QI methods, March 2017. Photo by Linley Hauya, URC.
- Harvested changes in education performance and household economic strengthening activities. The learning sessions conducted in December 2016 focused on harvesting the effective changes the teams tested to improve social services in the communities for use in the new communities. The learning sessions organized for the newly established teams provided a platform for the QI teams to learn from their peers and to share progress and experiences on QI work. These sessions were also an opportunity for district and national coaches to provide feedback on the coaching sessions. The district and national coaches refreshed the QI members through presentations that focused on specific areas that the coaches identified as common gaps during the onsite field coaching visits. The topics that were presented in the learning sessions included targeted HIV screening and referral, developing changes for improvement, data management, health referral systems, conducting an in-depth root cause analysis, and skills for developing good changes.

- Kick-started improvement work in new teams. The learning sessions for the newly established teams focused on teams sharing how QI teams were established; collection of household data; conducting and summarizing CSI assessments; identifying priority areas for improvement; development of improvement objectives; root cause analysis; and testing of changes and sharing results on the specific improvement objectives. The learning sessions for the existing teams focused on sharing and reviewing the results achieved for each improvement objectives in addition to developing new improvement objectives focusing on early childhood development, psychosocial support, and child protection in addition to reviewing their yearly targets.

- Highlighted child protection issues and legal instruments to QI teams. In the June learning sessions, ASSIST engaged a child protection expert in Malawi’s child-related laws to train the QI teams on legal instruments that protect children and how to prevent and report gender-based violence. Teams acquired skills on how they can prevent, identify, report, or resolve child abuse and gender-based violence. Of particular importance were the skills the teams acquired on how they can ensure that all their QI activities do not enforce or put vulnerable beneficiaries at risk of any form of child abuse. At the end of the learning sessions, all teams developed action plans to be implemented upon returning to their communities.

- The MOGCDSW with support from ASSIST conducted a one-day meeting with the district QI teams from all 7 districts (June 25, 2017). The aim of the meeting was for the district QI coaches to share their experiences and challenges in the support of community QI teams. During the meeting, ASSIST in collaboration with the MOGCDSW refreshed the teams on the improvement process and their roles as coaches in the community and how they can build the skills of the QI teams as well as their own skills in coaching. The teams also had an opportunity to share challenges they face at district level. At the end of the meeting the coaches developed improvement objectives for the districts teams to implement when they returned to their districts.

- ASSIST supported the MOGCDSW to conduct quality data validation exercises with 10 existing QI teams in Mangochi and Balaka districts (Jan 2-6 and 17-20, 2017). The purpose of the data validation exercise was to review the validity, reliability, and integrity of the data that teams report to the districts and ASSIST. The assessment team reviewed the processes of collecting, compiling, analyzing, and documenting selected indicators in the service areas of health, education, and household economic strengthening. The results of the data quality assessments showed that QI teams’ data mostly matched the data that was reported to districts and ASSIST. In most cases, data collection, compilation, and analysis were clear. However, gaps were identified in other areas, including differences in the number of vulnerable children registered in schools and QI teams’ over reliance of the team on extension workers for collection and compilation of QI team reports. The assessors supported the teams to develop action plans for improving data quality.
• The MOGCDSW with support from ASSIST conducted District Executive Committee (DEC) meetings in five districts (Feb 13-17 and 21, 2017 and May 25-26 and 31, 2017). The aim of the meetings was to introduce the OVC minimum standards and explain how the standards can be used at the community level using QI approaches. During the DEC meetings, the MOGCDSW also explained the support ASSIST and One Community Project would provide to the districts. In addition, the MOGCDSW also shared the level of partnership existing between ASSIST, One Community Project, and the MOGCDSW. By the end of the DEC meetings, seven district QI teams were formed in Chikwawa, Mulanje, Phalombe, Mangochi, Zomba, Machinga, and Blantyre districts, respectively, to monitor and coordinate improvement of social services.

• The MOGCDSW with support from ASSIST and One Community Project conducted a stakeholders’ exit meeting in Balaka District (March 10, 2017). In the first quarter of FY17, ASSIST phased out its activities in Balaka District. The aim of the March meeting was to share results achieved by the four QI teams in Balaka District as a way of transitioning out of the district after USAID declared it a sustained district. As part of the transition plan, the MOGCDSW and ASSIST planned to identify stakeholders in Balaka District to continue working with the CBOs to support their vulnerable children and their families. By the end of the meeting, possible potential implementing partners were identified including GOAL Malawi, Sue Rider, and Baylor Pediatric Project.

• The MOGCDSW with support from ASSIST also participated in a District Executive Committee meeting in Balaka District (March 17, 2017), with the aim of sharing the results achieved by the four existing community QI teams and sharing the transition plan with the district. At the end of the meeting, the District Commissioner thanked ASSIST for the support rendered to the communities through the Balaka Social Welfare Office.

• Hosted an Ethiopian delegation for an exchange visit to the Kadyalunda QI team (March 12, 2017). The MOGCDSW hosted delegates from the Ethiopian Ministry of Gender who visited Malawi’s several OVC activities on child protection, youth, and economic strengthening. The main objective was for the delegation to appreciate and learn how CBOs in Malawi implement child protection interventions for vulnerable children. Kadyalunda CBO in Balaka District was supported by ASSIST since 2015 and was selected to be visited by the delegation. The team showcased how they implemented OVC standards using QI approaches to improve social services for vulnerable children.

Balaka District Executive Committee meeting being briefed on how QI is used to improve social services in the district, facilitated by Tiwonge Chimandule, Data Officer, ASSIST Malawi, February 2017. Photo by Linley Hauya, URC.
and their families. At the end of the visit, the delegates were impressed with the results and how the community QI team used QI methods to improve social services. The Ethiopian delegation reported that they were amazed at the improvement and the level of detailed presentation skills the CBOs visited in Balaka and Mangochi demonstrated during the presentation of results on education, health and food security service areas.

- **The MOGCDSW with financial and technical support from ASSIST conducted field exchange visits for 12 new QI teams** (March 13-16, 2017). The teams visited existing QI teams at Kadyalunda and Mpeya CBOs to learn how similar QI teams used QI methods to improve the lives of vulnerable children and their families. At the end of the learning visit, the QI teams developed a summary of lessons that the teams would incorporate into their existing improvement work.

Eighteen new CBO representatives visited Mpeya CBO in Mangochi District and Kadyalunda CBO in Balaka District to learn how the old CBOs started their improvement work and share the challenges they have met. Photos by Tiwonge Chimpandule, URC, and Andrew Nkhoma, MOGCDSW.

- **USAID Field visits to Mangochi District** (May 23-25 2017). One Community and ASSIST made detailed presentations and held discussions with the three member USAID visiting team. The following remarks and comments were made after the presentations:
  
  - One Community Project should seriously consider the sub-granting component in their OVC programming. It was mentioned that it makes no sense when CBOs capacity has been built to manage data for implementation and they are not given some resources to support the delivery of vulnerable children’s services and needs.
- We also need to find ways of ensuring that data in the targeted districts should trickle to the Child Protection Information Management System when it is ready in the targeted districts.

- The two projects were also encouraged to document processes where they realize achievements in the project outcomes.

- The two projects were also encouraged to support the improvement of early childhood development (ECD) services since this is now the priority of USAID particularly for children between the ages of 0-3 years. USAID is not only encouraging building of ECD structures but facilitating formation of parent’s community groups that play with children between the ages of 0-3 years for early stimulation. The ECD centres are being encouraged to identify local play materials.

A few recommendations were made to summarize the USAID Field visits in Mangochi Districts to the two implementing partners.

- The OVC portfolio has evolved each year. However, now USAID knows what it wants to achieve among OVC in developing countries. It knows that piece meal services will not help vulnerable families and their children. Identification of children is good but what we do when we identify children is critical.

- All implementing partners activities should align to the National Plan of Action because we are supporting the government to deliver services.

  - Sub granting is another component that needs to be done by service delivery partners, otherwise CBOs will not receive the support they need.

  - USAID commended ASSIST for coming up with the District QI teams to sustain improvement activities after the project ends. USAID encouraged ASSIST to build the capacity of the district teams in improvement during learning sessions and coaching sessions.

- **Participated in the USAID OVC Implementing partners field visits and meeting in Blantyre.** ASSIST participated in a meeting with all OVC implementing partners such as 4Children, One Community, ASPIRE, UNICEF and the Ministry of Gender Children Disability and Social Welfare. Implementing partners to share experiences with other OVC organisations on Case Management. ASSIST also got updates from USAID Malawi and Washington on the priority activities on the PEPFAR funded OVC programming.

**Results**

**Improving education performance of children in 20 targeted primary schools in Mangochi districts**

- In the first three quarters of FY17, the QI teams supported 14 primary schools to improve educational performance of pupils by supporting the schools to test and implement child-, school-, and community-level changes to improve education performance. Figure 1 is a summary of results of 14 primary schools that were supported by the 10 QI teams in Mangochi District (ASSIST phased out its support in Balaka District that had six schools supported by QI teams). In the first term, there was an overall decrease in the performance of pupils in 2016-2017. Some of the reasons for the drop in school performance included the onset of rains which affected the attendance of pupils towards the end of the term due to flooded rivers and cancellation of some lower classes that usually have their classes outside classroom blocks under trees. In addition to these factors, most schools have challenges in performance due to the shift into new classes, particularly in the first term while children get acclimatized to new class teachers’ teaching methods. During the terms 4, 7 and 11 it was noticed that the performance of these first academic terms (September – December) would drop the performance across the years. ASSIST engaged the teams to address the challenges that led to poor performance by identifying changes that led to improvement. Across all the terms, it was observed...
that the schools were still struggling to improve the performance of the learners as the overall performance dropped further particularly in Term 11. Some of the reasons for the poor performance included: low participation of school teachers and head masters in improvement activities that affected the testing of changes in the schools. In schools where the head teachers were active in QI activities, they motivated the school teachers to engage in QI activities unlike in schools where a representative of the head teacher was a member of the QI team. In term 11, ASSIST worked with the newly established district QI teams, particularly representatives from the District Education Office, to specifically support the teams to select changes that really improved primary school performance.

**Figure 1. Percentage of children who pass termly exams, 15 out of 20 primary schools, Mangochi districts (Sept 2013 – July 2017)**

- **Despite term 10 and 11 typically being challenging, Chilore is one of the primary schools that has consistent average increases in education performance results, compared to the other schools.** The school has managed to improve the education performance over 11 terms but also began reducing the performance gap that existed between boys and girls in termly performance as shown in **Figure 2**. The termly pass rate of Chilore Primary School in term 10 was 84%, with a pass rate of 85% for boys and 83% for girls, whereas in Term 1 it was 45% and 40%, respectively. The team introduced changes such as weekly assessments and early classes for standard 6 and 7 to boost their performance. The teachers paid more attention to the girls' performance and encouraged them to improve their grades. As the team tested and implemented these changes, the gap that previously existed between boys and girls gradually was reduced.

- **In term 11 the gap between boys and girls at Chilore Primary School increased again.** This was due to challenges the primary schools have during the rainy season. A lot of children, particularly girl children, do not come to school consistently due to the farming activities in the communities. This is a result of families depending on girls to be at home preparing meals for young children while the rest of the adults go to their farms. As a result, even during the sessions where schools facilitate lesson reviews in the quarter, girls sometimes do not even participate and just turn up for end-of-term exams. QI teams are trying to help families understand through sensitizations and parent-teacher dialogues why it is crucial to send all children to school consistently.
Figure 2. Sex-disaggregated percentage of children who passed termly exams, a comparison of 14 schools with Chilore Primary School, Mangochi District (Sept 2013 – Jun 2017)

Changes tested at Chilore Primary School to improve education performance of children:
- Oriented School Management Committees, guardians & local leaders on proposed changes
- Intensified community meetings where parents were counselled on the importance of supporting girl children to regularly attend school
- Monitored daily attendance
- Intensified bi-weekly continuous assessments
- Head teacher encouraged innovations and openness among teachers to improve performance

Most vulnerable families in Malawi also face persistent food insecurity and poor economic wellbeing at the household level. Due to this, QI teams also chose to work with vulnerable households to address food security and economic wellbeing at the household level. The teams
linked with existing structures such as agriculture extension workers to support the improvement team with modern methods of farming to achieve high productivity and improvements in economic welfare.

**Improving household food security and economic wellbeing among vulnerable families**

- **During Q1-Q3 of FY17**, the 12 QI teams supported vulnerable households to improve food security and household economic wellbeing though engaging the households in different activities, **hence promoting resilience among vulnerable families.** Some of the activities included: guiding households to practice modern methods of farming both in land preparation and selection of seed, use of farm inputs and post-harvest handling; engaging the households to establish kitchen gardens; and linking vulnerable guardians to village loan and savings associations and encouraging them to engage in wetland farming during the dry season, in as well as engaging in small businesses.

- **As of August 2017**, 3,618 out of 6,265 families were supported by the 16 community QI teams that have an improvement aim on food security and household economic strengthening. Of the total number of the households registered with the QI teams, 28% have been linked to Village Savings and Loan Association (VLSA) schemes to access small loans to start small-scale businesses in the communities from a baseline of 0% as shown in **Figure 3**. This was done by having QI teams encouraging and guiding the vulnerable families to participate in household economic strengthening activities like Village Savings and Loans and small business ventures at the community level. The vulnerable beneficiaries were also encouraged to adopt some modern farming practices, follow up vulnerable households and link them to existing government structures (e.g., the agriculture extension services to build the capacity of farmers on how they can use different methods of farming on various types of land). Over the past few years, there has been a noticeable positive trend among the vulnerable households supported each year to take up modern farming practices. The number of communities supported in household economic strengthening activities increased from six in January-March 2017 to 16 from April-June 2017 due to the scale-up of ASSIST QI activities in six more districts.

- **In total**, 18,361 vulnerable beneficiaries in the 16 communities in the five districts have been reached with household economic strengthening interventions, benefitting 7,533 children in the targeted households.
Figure 3. Percentage of vulnerable households participating in household economic strengthening activities in 16 communities in 5 districts (March 2015 – Aug 2017)

- Mpeya QI team is one of the 16 QI teams that has reached more vulnerable families than their original target. Mpeya CBO began its improvement work on improving food security by targeting 119 vulnerable households in 2015. In 2016, the CBO after observing that they had reached almost 100% of their targeted beneficiaries increased their target to 587 vulnerable beneficiaries. The team selected four effective interventions in the household economic strengthening service area to spread...
to the newly targeted households. One of the interventions which gave noticeable improvements in terms of improving food security was promoting use of modern methods of farming among vulnerable households. The team used their volunteers and the Agriculture Extension Workers to demonstrate to vulnerable households how to adopt the recommended interventions such as modern methods of farming and linking these vulnerable guardians to the Village Savings and Loan Associations to boost their small-scale businesses at the household level.

**Linking vulnerable beneficiaries to access and utilize health services**

- **Vulnerable families are more likely not to access and utilise available health services in the communities such as HTC due to limited knowledge, cultural beliefs, and limited resources to travel to the health facilities.** This is why when the PEPFAR Malawi team announced that HIV partners should focus on improving HIV diagnosis, ASSIST encouraged all 24 QI teams to pursue an improvement aim on improving HIV diagnosis among vulnerable populations. In FY17 the teams designed changes to encourage more vulnerable beneficiaries to access HIV testing and counselling (HTC) services at community and household levels, particularly for adolescents. QI teams emphasized improving health linkages for vulnerable beneficiaries contributing towards the country’s 90-90-90 goals. At the beginning of year, the national HIV response team shared results and updates that showed more gaps in reaching the first 90%. Following this revelation, the QI teams were guided to focus on promoting targeted HIV testing and referrals to ensure they contribute to achieving the first 90% which is on HIV diagnosis. ASSIST trained all the QI teams in how they can conduct screening for HIV referral that is targeted, in order to increase yield in HIV testing. The team developed and tested different changes and started collecting data disaggregated by age and sex to see if there was an improvement in testing and any gender differences in accessing HTC. The most effective changes that teams implemented included the door-to-door counselling and linking with other HIV treatment partners to conduct door-to-door HIV testing as well as conducting open days for the partners to test the mobilized beneficiaries.

- **There has been a gradual increase in the numbers of vulnerable beneficiaries who test for HIV and know their status and are linked into HIV care in the 24 CBOs who are serving a total number of 31,699 vulnerable beneficiaries.** By August 2017, 18 CBOs were reporting, and so far, 41 of female vulnerable beneficiaries have tested for HIV, while 41% of male vulnerable beneficiaries have tested for HIV and know their status in the 18 communities in Blantyre, Chikwawa, Mulanje, Phalombe and Mangochi Districts. **Figure 4** compares the number of vulnerable beneficiaries tested in the 18 communities with comparison of Chapola CBO data.

  - **Chapola is one of the teams in Mangochi District that has encouraged a lot of its vulnerable populations to access HIV testing and counselling services.** Chapola has made good progress raising testing from 0% in December 2015 among their 1,864 vulnerable beneficiaries to 37% among females by June 2017 and from 0% to 34% among males during the same time period. The volunteers in this community provide house-to-house counselling to encourage people to go for HIV testing. Chapola is a fishing community so volunteers frequently find only women at home because men tend to be the fishermen and are out of the house most of the day. So, it is usually females that who are at home and are counselled and they usually accept to go for testing, contributing to the higher numbers of females accessing HTC services. The QI team developed some changes to specifically reach the male spouses who are mainly fishermen and are rarely available at the household level by having testing services at the beach for some days in a week to improve HTC services among men who are highly mobile and are vulnerable to HIV.
As the teams were collecting data on HTC, they disaggregated the data by age and sex. No major gaps were noticed on sex-disaggregated data as shown in Figure 4. However, HIV testing data showed that among all age groups, the 20-24 year-olds and 25-49 year-olds were accessing HTC the most (Figure 5) and that people in the 20-49 age range had the highest HIV-positivity rates (12-21%). In total, 9418 vulnerable beneficiaries in the 18 communities, in the five districts were reached with HIV testing from January to August 2017, and of these 3686 are children.
Figure 5. Number of vulnerable beneficiaries linked to HTC and number identified as HIV-positive, by age, 18 CBOs in 5 districts (Jan – Aug 2017)

SPREAD OF IMPROVEMENT

ASSIST completes transition of its technical assistance to the MOGCDSW on September 29, 2017. ASSIST has worked with the MOGCDSW since 2013 to build the capacity of the Ministry at the community, district, and national levels to apply quality improvement methods in improving social services. District QI teams were established in all seven targeted districts and trained in QI methods, and these district teams participated in coaching sessions and quarterly learning sessions to strengthen their skills and understanding of the improvement processes. At the community level, the MOGCDSW will continue to support the districts to spread the use of the OVC minimum standards using QI methods to improve the wellbeing of vulnerable children and their families. In addition, One Community Project will continue supporting the already established and trained QI teams in the seven districts, and these will serve as learning sites for other CBOs as the One Community Project plans to spread its support to more CBOs in HIV high-burden communities.

Activity 2: Improve the quality and safety of VMMC services provided by the MOH in selected accredited high-volume sites

BACKGROUND

ASSIST supports two USAID-funded implementing partners who are delivering VMMC services through 17 mobile/outreach and static sites: Eight sites are supported by Population Services International (PSI), and nine sites are supported by Jhpiego. In January 2017, ASSIST started supporting 10 MOH static sites supported by the World Bank to integrate CQI approaches in VMMC service delivery (following baseline assessments conducted in November 2016). In total, ASSIST provided CQI support to 27 CQI teams in Malawi during FY17, in facilities located in 21 of the 28 districts of the country. ASSIST also supported the MOH national coaches to facilitate CQI assessments and coaching of all 27 sites to improve their compliance with WHO and national standards of quality VMMC care.
KEY ACCOMPLISHMENTS AND RESULTS

CQI activities with 10 MOH/World Bank-supported district hospitals

- **Conducted baseline and follow-on assessment of 10 MOH World Bank-supported VMMC sites** (Nov 13-19, 2016 and May 8-12, 2017, respectively). The MOH HIV and AIDS Department with support from ASSIST conducted a baseline assessment of 10 VMMC World Bank-supported sites being implemented by MOH (two in the North, four in the Central region, and four in the South). The baseline assessment was done on November 13-19, 2016 to measure quality of VMMC services provided in the 10 facilities and see how best to support the teams using CQI methods. In May 2017, the same 10 teams underwent a follow-on assessment using the same methodology. The baseline and follow-on assessment report was completed and shared with the MOH and USAID Mission (July 2017).

- **The MOH HIV and AIDS Department and ASSIST staff facilitated a CQI training of the district hospital VMMC teams with the aim of supporting teams to comprehensively use QI processes in VMMC service delivery** (Jan 16-20, 2017). In total, 58 providers from 10 MOH VMMC facilities supported by World Bank were trained. This training guided the teams on how to have vibrant and functional teams and how to develop and work through the improvement plans to achieve desired quality VMMC services in the targeted districts. The teams were also taught how to effectively use data being generated by the teams to make informed decisions to improve VMMC service delivery.

- **Conducted bi-monthly coaching visits to 17 USAID-supported VMMC teams** (Nov 20 – Dec 2, 2016, May 1-5, 2017, and June 19-23, 2017). The MOH HIV and AIDS Department with support from ASSIST conducted field visits to the 17 VMMC USAID-supported QI teams under PSI (8 sites), Jhpiego (4 sites), and Department of Defense (5). The visits aimed at supporting teams to comprehensively use QI processes in VMMC service delivery. This support guided the teams on how to have vibrant and functional teams and how to develop and execute improvement plans to achieve desired quality VMMC services. The teams were also taught how to effectively use data they themselves generated to inform decisions about how to improve VMMC service delivery. The coaching visits were also used as an opportunity for MOH coaches to strengthen their skills in CQI for sustainability.

- **The MOH HIV and AIDS Department with support from ASSIST conducted bi-monthly coaching visits to the 10 VMMC World Bank-supported sites** (April 3-14, 2017). The visits aimed at supporting teams to apply QI to comprehensively strengthen VMMC service delivery processes. This support guided the teams on how to strengthen the functionality of the team and supported them in carrying through on their improvement plans to address the gaps identified during the baseline assessment.

- **Learning session for 10 MOH teams** (April 24-15, 2017). This learning session was conducted to share lessons and results of their improvement plans and discuss issues identified during the baseline assessments, such as understanding of denominators used to calculate proportions on improvement indicators. By the end of the meeting, the teams refined their improvement plans and developed action plans outlining how they planned to address the quality gaps identified during the baseline CQI assessment. Teams also shared progress on trends on HIV referrals, adverse events, gender integration, circumcisions by age group, and 48-hour and 7-day post-op follow-up.

- **Follow-on assessment of 10 MOH/World Bank-supported VMMC sites** (May 8-13, 2017). The follow-on assessment observed that the 10 MOH/World Bank-supported teams had a mean score of 64% across all the service areas—a substantial improvement over the 37% mean score observed during the baseline assessment. The maximum mean score of the teams was 89% (up from the maximum mean score at baseline of 53%), while the minimum mean score was 45%. Teams performed very well in registration, group education, and information, education, and communication.
(IEC) and in individual counseling and HIV testing, which had mean scores of 80% each. During the follow-on assessment, some teams, such as Kasungu District Hospital and Mangochi District Hospital VMMC sites, demonstrated remarkable improvements across the service areas assessed, while others, such as Nsanje, Salima, and Mzimba North VMMC sites, are improving in some areas more than others. There are still some service areas which the MOH teams are still struggling with which include: Monitoring and evaluation (mean improvement from 19% to 39%) and male circumcision (mean improvement from 44% to 56%) (Figure 6). After the assessments, the teams developed specific action plans to clear some of the identified gaps at the facility site.

Figure 6. Comparison of average scores by VMMC service area between two assessments, 10 MOH teams (May 2017)

- The MOH HIV and AIDS Department with support from ASSIST trained 13 PSI and 5 MOH supported QI teams (July 10-13, 2017). The 38 participants were from old and new PSI and MOH teams. The training aimed at supporting teams to comprehensively use QI processes in VMMC service delivery. Following the new recruitment of new staff, PSI staff were trained in CQI methodologies to improve the numbers of staff who were able to use CQI methods. Participants were equipped on how they can use CQI in improving daily VMMC service provision. They were also taught how to effectively use data being generated by the teams to make informed decisions to improve VMMC service delivery.

CQI support for 17 USAID-supported VMMC sites in Malawi

- The MOH HIV and AIDS Department with support from ASSIST conducted coaching visits to 11 VMMC USAID-supported QI teams under PSI (8 sites) and Jhpiego (3 sites) (Nov 20 – Dec 2, 2016). The visits aimed at supporting teams to comprehensively use QI processes in VMMC service delivery such as developing new improvement aims and changes after achieving the first aims. This support guided the teams on how to have vibrant and functional teams, how to develop and work through the improvement plans, and how to use the VMMC quality data being generated by the teams to make informed decisions to improve VMMC service delivery.
The MOH, with support from ASSIST, conducted quarterly learning sessions for five Malawi Defense Force VMMC teams, eight PSI, and four Jhpiego teams (Dec 10-14, 2016 and May 15-19, 2017). The learning sessions were conducted to help the teams accomplish the following:

- Review the assessment gaps and action plans and update the status of the quality gaps.
- Develop new action plans outlining how the teams will address remaining gaps in quality of VMMC services.
- Share progress on trends on HIV referrals, adverse events, circumcisions’ done across the age groups, 48-hour and 7-day post-op follow-up across all the teams.
- Shared with the MDF teams how to integrate gender in VMMC service delivery. The teams were taught how gender can be integrated and how evidence shows that the quality of VMMC services
improves when gender is integrated in the VMMC services. The teams were also taught how important it was to collect sex-disaggregated data to improve specific indicators in 48 and 7-day post-operation follow-up as well as adverse event rates.

- Shared lessons and results of implementing their improvement plans and discussed issues identified during the coaching visits, such as understanding of denominators used to calculate proportions on improvement indicators. By the end of the meeting, the teams refined their improvement plans and developed action plans outlining how they planned to address the quality gaps identified during the previous CQI assessments. Sites that had already reached 100% were taught how to maintain their achievements.

**Quarterly learning session for USAID-supported implementing partners, Blantyre, Malawi, May 2017. Photo by Stephano Mjuweni, URC.**

- **Conducted a CQI training for quality assurance (QA) managers of PSI** (June 9, 2017). A total of 10 PSI QA managers were trained in CQI techniques and methods of helping VMMC sites use CQI methods to improve VMMC service delivery.

- **Conducted follow-on assessment of 17 USAID-supported VMMC teams** (June 5-17, 2017). The MOH HIV and AIDS Department with support from ASSIST conducted follow-on assessments to 17 PEPFAR-supported sites being implemented by the Malawi Defense Force (MDF) (5), Jhpiego (4) and PSI (8). The follow-on assessment sought to ensure the quality sustainability of VMMC services provided in the 17 facilities and see how to support the teams further using CQI methods.

**Results**

- **ASSIST has supported the 16 USAID-supported teams to track the trends of VMMC clients that came back for post-operation follow-up. Figure 7** shows the proportion of circumcised clients who returned for their 48-hour post-operation follow-up from the 16 USAID-supported teams as well as the 10 World Bank-supported MOH teams that are quickly learning from the results and effective changes from the PEPFAR-supported teams to improve the 48-hour post-operation follow-up. Some of the changes that the teams tested included:
  - During counseling sessions, counselors gave in-depth instructions emphasizing the need for clients to turn up for a 48-hour post-operation visit.
  - Assigning some providers to make phone calls to clients that had scheduled appointments to remind them of the appointment dates.
o Using expert clients and community mobilizers to track 48-hour post-operation clients in their targeted communities and establishing a separate register to track follow-up clients.

o Selected providers would go early in the morning at agreed picking points in the communities to review VMMC clients on these selected points.

o Community mobilizers were told to keep the names of clients they brought to the VMMC site for circumcision and check whether all their clients came for 48-hour post-op follow-up.

o Local leaders in some areas were selected as community mobilizers, and they would bring all clients for 48-hour post operation follow-up checks.

o Providers emphasizing the importance of 48-hour follow-up throughout the VMMC process at the sites, from group counselling to discharge points.

**Figure 7. Percentage of VMMC clients who return for their 48-hour post operation review, 26 outreach and static sites compared to 10 MOH sites (Nov 2015 – Jun 2017)**

**Changes tested to improve 48-hour follow-ups at MOH sites**
- Emphasizing to VMMC clients during counselling to return for 48 hour post operation follow ups
- Making arrangements with nearest health facilities to review the VMMC clients at 48 hour follow up
- Making phone calls to VMMC clients that do not turn up during outreach clinics
• The VMMC QI teams also worked on improving HIV referrals of identified HIV positive clients at the VMMC sites. Figure 8 shows that the proportion of VMMC clients who were identified HIV positive and referred for HIV care and sexually transmitted infections (STI) treatment and management in the supported sites increased from October 2015 - August 2017.

Figure 8. Percentage of VMMC clients identified and referred for HIV and STI services, 26 VMMC mobile clinics (Oct 2015 – Aug 2017)

• Supported USAID Washington to organize a training in VMMC External Quality Assessment and Continuous Quality Improvement (March 21-23, 2017). The USAID Office of HIV/AIDS (OHA) requested ASSIST Malawi to organize a USAID External Quality Assessment (EQA) training for the region’s Missions and USAID IPs. The request was based on a desire to increase knowledge of key issues in VMMC programming (including management of adverse events, tetanus mitigation, and linkage of HIV-positive clients to care) and to enhance the overall efficiency of VMMC EQAs. Training materials were developed by the ASSIST South Africa team based on previous EQA-CQI trainings conducted for OHA. The training was designed to provide an in-depth explanation of EQA and orientation regarding conducting an EQA, as well as demonstrate and practice the use of the VMMC QUAL™ online application that is used to capture EQA data.

• The EQA training in Malawi was conducted March 21-23, 2017, in Blantyre, Malawi. The session was attended by USAID staff from Washington DC, as well as representatives from the Malawi and Namibia missions. In addition to USAID staff, the following organizations/entities were represented:
In total, the training in Blantyre was attended by 54 participants. ASSIST staff from Malawi and South Africa led various sessions.

Supported USAID to carry out a VMMC EQA in Malawi (March 24-28, 2017). The VMMC external quality assessment (EQA) was led by USAID and the Malawi Ministry of Health (MOH). ASSIST Malawi, South Africa and headquarters provided 10 staff to support the EQA implementation and logistics. Staff from AIDSFree Project (JSI and Jhpiego) and PSI (Malawi and Zimbabwe) also participated on the EQA team. The EQA team assessed nine outreach sites in the southern region of Malawi: Abba Clinic, Chipini Health Center, Chipwaila Health Center, Limbe Clinic, Makata Health Center, Misanjo Health Center, Mulungu Alinafe, River of Life, and Thomas Health Center.

SPREAD OF IMPROVEMENT

Upon finalization and dissemination of the OVC standards in 2014, and supporting 10 communities in two districts to implement the standards using the QI approach (2015-2017), ASSIST demonstrated through the results achieved by the 10 QI teams that communities can improve the wellbeing of vulnerable
children and their families. A total of 15,128 beneficiaries were supported through this approach by the end of FY16. To further spread the approach, In FY17, ASSIST partnered with the One Community Project in six districts to support the delivery of vulnerable children’s services in 18 more communities. ASSIST used effective changes that worked in the initial 10 CBOs to enhance improvement in the new communities. A total of 24 QI teams in seven districts were being supported to improve social services, reaching a total of 28,000 vulnerable beneficiaries in 286 villages.

Activity 3. Institutionalize the capacity to examine and improve neglected health care processes

BACKGROUND

This activity focuses on the care of patients (specifically, children under age five and pregnant women) presenting at facilities with febrile illnesses in three districts (two interventions and one control) in Malawi. In Phase I, ASSIST conducted an assessment to understand the process of care and systems that support it at three levels of the health care system in each district: one district hospital (DH), three health centers (HC), and three village health centers (VHC), for a total of seven sites in each district, 21 sites total. In Phase II, initiated in FY16 and completed at the end of FY17, ASSIST worked with 14 health facilities and QI teams in the two intervention districts (Balaka and Mchinji) on continuous skill building through learning sessions, on-site coaching, and weekly telephone coaching to build capacity in QI principles and techniques, how to continuously collect data on various indicators using assessment tools, and tracking changes on their respective aims.

KEY ACCOMPLISHMENTS AND RESULTS

Accomplishment and Results:

- **Collected core indicator data** (Oct 2016 – Mar 2017). The intervention districts continued collecting monthly data on core indicators using the following tools: 1) the facility assessment, 2) assessing treatment of uncomplicated febrile illness in children under five years of age, 3) assessing treatment of severe febrile illness in children under five years of age, and 4) assessing treatment of febrile pregnant women.

- **The PMI team from Washington and the USAID/PMI Malawi Mission visited three QI teams** (Nov 2016). The aim was to observe the real coaching activities that ASSIST carries out with QI teams. The team visited Mchinji District Hospital, Mkanda Health Centre, and Mozi Village Clinic. The QI teams presented their improvement aims, change ideas that have been tested, the results observed, etc.

- **Conducted a series of skill-building and learning sessions with Mchinji and Balaka demonstration districts** (Oct 2016, Jan 2017). The National Malaria Control Program (NMCP) with support from ASSIST conducted skill-building sessions for the two intervention districts to help the teams identify problems affecting delivery of care to children under five years and pregnant women presenting with febrile illness (Oct 2016). The NMCP with support from ASSIST conducted learning sessions for 14 QI teams from the two intervention/demonstration districts (Jan 2017). The learning sessions were attended by NMCP officers, District Health Officer (DHO) and District Medical Officer (DMO) from Balaka District Hospital, malaria coordinators from the two districts, HMIS Officers, clinicians, laboratory technologists/technicians, nurses, health surveillance assistants, pharmacy/drug dispensers, and VHC volunteers. In total, there were 80 QI team members who attended the session.

- **Conducted on-site monthly coaching to 14 QI teams** (Oct 2016 – Mar 2017). The ASSIST staff in collaboration with NMCP officers conducted on-site coaching to the 14 sites to help the QI team members continuously search for problems affecting delivery of care to children under five years and pregnant women presenting with febrile illness.
• **Collected end-line assessment data for the intervention/demonstration and control sites** (Mar 2017). The same four baseline core indicator data tools were used.

• **Improved the clinical care services for febrile under-five children by having all the services at one area (consultation, mRDT, registration, dispensing, and directly observed treatment) at Balaka District Old Hospital** (Aug 2016-Mar 2017) (see Figure 9). The clinic for children under age five for the Balaka District Hospital (just like many other clinics in Malawi) had a long, complicated patient flow process. The QI team changed the patient flow process to have all services for febrile under-five children at one station. The creation of one-point clinical station improved the patient outcomes by:

  1. Reducing patient waiting time. Patients received treatment at the earliest time possible at the clinic.
  2. Removed unnecessary walking distances within the hospital (i.e., from consultation to the laboratory, back to the consultation, registration and pharmacy). Patients were satisfied with services.
  3. Having all the health workers at one place has created an opportunity for constant clinical discussions to improve the patient care among health workers.
  4. None of the patients absconded as all the services were offered at one point.

**Figure 9. Improving percentage of febrile under-five children who received all the services at one area at Balaka District Old Hospital, Balaka (Aug 2016-July 2017)**

- **Improved the care of children under age five with severe malaria who are monitored for blood glucose, hemoglobin, Blantyre Coma Scale (BCS), and vital signs at Balaka District Hospital (in-patient department)** (Aug 2016 – Mar 2017). Evidence suggests that health workers fail to adhere to clinical guidelines in monitoring these tests, which are part of the evaluation of severe
malaria cases as to whether the child is improving or not while on treatment. For this reason, the Balaka in-patient QI team wanted to improve the clinical care of severe malaria cases admitted in the children’s ward by monitoring these four measures through proper documentation in the case notes. Change ideas tested in the children’s ward include:

1. The QI team leader developed a daily duty roster for one QI member to check the parameters as per guidelines on each patient. The duty roster is posted on the wall in the children’s ward.

2. The nurses in the children’s ward are advised every morning during handover meetings to admit all the patients with severe malaria into the emergency bay, close to the nurses’ station, until they improve.

3. QI clinicians and nurses made presentations once a week during morning clinical presentations to all the clinical and nursing staff on the importance of monitoring blood sugar, hemoglobin, BCS, and vital signs on children with severe malaria.

4. The laboratory provided a Haemacue machine to the children’s ward for the nurses to check hemoglobin at the patient’s bedside.

Overall, there was an improvement in monitoring severe malaria cases admitted at Balaka District Hospital – helping in the evaluation, and provision of the best clinical care to children under age five (see Figure 10).

Figure 10. Improving percentage of children under age five with severe malaria who are monitored for hemoglobin, blood glucose, Blantyre Coma Scale, and vital signs at Balaka District Hospital, Balaka (Aug 2016–July 2017)

- Conducted daily audit of dispensed artemisinin-based combination therapy (ACT) against confirmed uncomplicated malaria cases at Mkanda Health Centre (Oct 2016 – Mar 2017) (see Figure 11). Several reports within the country have suggested that the consumption of ACTs has been higher than the number of cases, for example in 2015 the country consumed about 12 million
courses of ACT versus 6 million cases reported. The Mkanda Health Centre wanted to ensure that
the consumption of ACTs is equal to the number of malaria cases. The changes ideas below were
tested:

1. QI team conducted daily audit of the dispensed ACTs vs confirmed malaria cases
2. The QI team sensitized all the health workers (HWs) on the entry of only authorized HWs into
   the pharmacy and drug store
3. Clinician to prescribe ACT to only children with positive malaria rapid diagnostic test (mRDT)
4. The QI team reviewed the data for malaria cases versus ACTs dispensed from the ACT, out-
   patient, and mRDT registers comparing with ACT stock cards every two weeks

When the teams started implementing the change ideas, within three months, each facility noted that
the consumption of ACTs was equal to the number of malaria cases. See Error! Reference source
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**Figure 11. Total number of ACT treatments consumed versus the total number of confirmed
uncomplicated malaria cases, Mkanda Health Centre, Mchinji (Oct 2016-Mar 2017)**

- **Improved percentage of under-five children with suspected severe malaria for whom
  microscopy was done at Mchinji District Hospital** (Jun 2016 – Mar 2017). According to the
  World Health Organization and Malawi NMCP guidelines, all suspected severe malaria cases
  should be confirmed with microscopy before initiation of treatment. One of the 14 intervention
  sites, Mchinji District Hospital, improved the percent of children under age five with suspected
  severe malaria for whom definitive diagnosis using microscopy was done, from 33% at the
  baseline in June 2016 to 85% by in June 2017 in Mchinji District. In Balaka District, the
  suspected severe malaria cases confirmed with microscopy before initiative of treatment moved
  from a baseline of 15% in March 2016 to 78% in June 2017. The two district hospitals have
  sustained performance above 75% in the past year (see Figure 12).
Figure 12. Percentage of children under age five with suspected severe malaria for whom microscopy was done, Mchinji and Balaka District Hospital, Mchinji (Jun 2016 – June 2017)

- Improved percentage of mRDTs performed according to standard operating procedure (SOP) to above 90% (Aug 2016 – Mar 2017). Although Malawi rolled out mRDTs for confirmatory diagnosis of uncomplicated malaria to all facilities, mRDTs have not been conducted as per SOP. For example, in the baseline at Chiwoshya Health Center, we found that only 20% children under age five with fever were tested properly during the baseline in August 2016. Within three months of improvement work, mRDTs were conducted per SOP more than 90% of the time (Figure 13).

Change ideas tested:
1) Clinical presentation during morning handover meetings on severe malaria treatment
2) Good sample collection demonstration to nurses
3) Agreed on specific times for sample and results collection to/from lab
Figure 13. Percentage of patients with fever for which mRDT was performed according to SOP, Chiwoshya Health Center, Mchinji District (Aug 2016 – July 2017)

Change ideas tested:
- Posted the mRDT SOP on the wall in the lab for reference
- Twice per week, the team leader observed mRDTs being done

- Improved percentage of febrile children under five who return for the recommended follow-up visit within 72 hours of treatment (Apr 2016-July 2017). The Integrated Management of Childhood Illness (IMCI) guidelines recommend that all febrile children under age five should come for review within 72 hours after treatment at the village health clinic, whether or not the child is better. At Mozi Village Health Clinic, the facility has increased the percentage of all febrile children under age five returning for a follow-up visit within 72 hours of treatment from 56% in April 2016 to 97% in June 2017 (See Figure 14).
Figure 14. Percentage of febrile children under five who return for the follow-up visit within 72 hours of being treated with mRDT and treated appropriately, Mozi Village Health Clinic, Mchinji District (Apr 2016 – Jun 2017)

SPREAD OF IMPROVEMENT

Contingent upon the ASSIST extension, funding is available to support the scale-up of improved health care processes for managing patients with febrile illness developed in Mchinji and Balaka to four high-malaria burden districts: Machinga, Nkhotakota, and Phalombe as Phase III of this activity, proposed to be implemented in FY18.
## Improvement in Key Indicators

### Improve the quality of services for vulnerable children in Malawi

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>% of children 6-17 years Passing termly exams</td>
<td>54% (5,822) 15 schools</td>
<td>69% (10,862) 20 schools</td>
<td>61% (11,362) 20 schools</td>
<td>56% (7361) 14 schools</td>
<td>66% (6,496) 24 schools</td>
<td></td>
</tr>
<tr>
<td>No. of vulnerable children who are enrolled in school</td>
<td>--</td>
<td>1,565 (10 schools)</td>
<td>4,875 20 schools</td>
<td>2,949 14 schools (As of December 2016)</td>
<td>1,707 12 Schools</td>
<td></td>
</tr>
<tr>
<td>% of vulnerable children and caregivers tested for HIV and know their status</td>
<td>2% (74) 5 teams</td>
<td>14% (2,697) 10 teams</td>
<td>17% (3,228) 10 teams</td>
<td>28% (4,218) 10 teams</td>
<td>22% (5,513) 15 teams As of June 2017</td>
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### Improve the quality and safety of VMMC services, processes and systems in targeted facilities in 21 districts

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Oct 2016</th>
<th>Nov 2016</th>
<th>Dec 2016</th>
<th>Feb 2017</th>
<th>Last Value (June 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of VMMC clients who were circumcised</td>
<td>90.4% (2,133) 12 sites</td>
<td>98% (4,023) 12 sites</td>
<td>96% 12 sites</td>
<td>94.9% (505) 13 sites</td>
<td>98.1% (3713) 16 sites</td>
</tr>
<tr>
<td>% of VMMC clients who experienced moderate adverse events</td>
<td>0 (1) 12 sites</td>
<td>0.14% (3) 12 sites</td>
<td>0.0% (0) 12 sites</td>
<td>0% (1) 13 sites</td>
<td>0.2% (8) 16 sites</td>
</tr>
<tr>
<td>% of VMMC clients who experienced severe adverse events</td>
<td>0% (0) 12 sites</td>
<td>0% (0) 12 sites</td>
<td>0% (0) 12 sites</td>
<td>0% (0) 13 sites</td>
<td>0% (0) 16 sites</td>
</tr>
<tr>
<td>% of VMMC clients who reported for 48 hrs post-op care</td>
<td>99.3% (5,004) 12 sites</td>
<td>98.3% (2,183) 12 sites</td>
<td>99.0% (934) 12 sites</td>
<td>100% (505) 16 sites</td>
<td>83.6% (3104) 16 sites</td>
</tr>
<tr>
<td>% of VMMC clients who reported for the day 7 post-op care</td>
<td>85.1% (1,144) 12 sites</td>
<td>83.63% (1,993) 12 sites</td>
<td>44.6% (960)</td>
<td>78.1% (397) 13 sites</td>
<td>70.9% (1661) 16 sites</td>
</tr>
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</table>
Sustainability and Institutionalization

ASSIST’s sustainability strategy in Malawi relied on the following principles: 1) Enhancing the capacity of the MOGCD SW and MOH at the national, district, health center, and community levels to facilitate subsequent improvement in various service areas; 2) creating a conducive environment in health and social care services where care providers are able to identify their own priorities and seek necessary support from various stakeholders; and 3) facilitating further institutionalization of results through building
capacity of existing government structures such as District Executive Committees, Area Development Committees, Village Development Committees, and traditional leadership.

In FY17, ASSIST focused on building the capacity of the MOGCDSW at district level, focusing on district Social Welfare Officers and District Education, Health, and Agriculture Officers to establish district QI teams to sustainably follow up on the improvement activities in the seven districts. These multi-sectoral district QI teams would manage and provide oversight of all improvement work in the targeted seven districts with support from One Community and other OVC implementing partners in the district. This is being done to improve QI skills of the district coaches by intensely involving the coaches in facilitating QI coaching, learning sessions, exchange visits, and QI trainings. It is expected that once the coaches are empowered, they can mobilize resources within the districts to facilitate improvement activities with the support of other service delivery partners. To support the work of the district QI teams in facilitating improvement in the districts, ASSIST developed a change package consolidating all the effective changes in improving education performance in primary schools as well as one describing how vulnerable households can improve economic and food security status at the household level.

In FY17, ASSIST also built the capacity of the MOH at district and national levels focusing on District VMMC Coordinators and other District Health Officers. To sustain the improvement efforts established in the 27 VMMC QI teams, ASSIST supported the Ministry of Health to build the capacity of VMMC coordinators and other officers at national level to facilitate the establishment of multi-sectoral district QI teams to manage and provide oversight of all improvement work amongst the VMMC teams. This was done to improve QI skills of the coaches by intensely involving the coaches in facilitating QI coaching, trainings, learning sessions, and exchange visits. It is expected that once the coaches are empowered, they can mobilize resources within the VMMC program and other HIV programs to facilitate ongoing improvement.

6 Knowledge Management Products and Activities

- Developed one case study on improving education performance using QI approaches in Mangochi District, Malawi.

- Developed a change package on effective changes for improving education performance in primary schools and a second change package on household economic strengthening status in vulnerable households following the recent knowledge harvesting meeting. These products will be finalized in October 2017 with headquarters support.

- Developed two abstracts that highlighted how QI teams are improving access and utilization of health services for vulnerable beneficiaries through linkages, including improved HIV diagnosis and education performance using QI methods. These abstracts were accepted for presentation at the October 2017 International Society for Quality in Healthcare (ISQua) but could not be presented due to lack of funding and the pending ASSIST extension.

- Made two presentations on learning from ASSIST’s OVC improvement work in Malawi at the Regional Psychosocial Support Initiative’s Forum 2017 in Arushi, Tanzania (Sept 4-5, 2017): “A multi-sectoral approach to improve the quality of education for boys and girls in primary schools in rural Malawi” and “Stepping up to improved service delivery in psychosocial support and child protection – experiences from Malawi and Tanzania”.

- Developed for USAID a technical report consolidating findings of the baseline and first follow-on assessment of VMMC service quality at the 10 MOH district hospitals. This report was submitted to the MOH and USAID Mission in June 2017.

- A case study on improving malaria diagnosis using microscopy on all suspected under-five severe malaria cases in Balaka and Mchinji District Hospitals. The case study is currently being reviewed by PMI in Malawi.
• A comparison on baseline and endline assessment on febrile illness, Technical report. The report is being reviewed by PMI Malawi Mission

• A change package of effective changes in febrile illnesses is being reviewed by PMI Malawi Mission.

7 Gender Integration

In FY17, ASSIST continued to provide guidance and support to community QI teams to collect gender-sensitive and sex-disaggregated data and to use it to identify any existing gaps in service provision or improvement. The teams were given new data collection sheets with new age and sex categories following the new PEPFAR monitoring, evaluation, and reporting guidance from the Mission. In health, for example, teams focusing on increasing HIV testing among vulnerable beneficiaries were guided to consider promoting HIV testing among males because male HIV testing rates were previously found to lag behind those of females. The teams incorporated gender issues from root cause analysis of problems, developing change ideas to address identified gender issues, and reviewed and reported their data disaggregated by sex. In education, communities were encouraged to review their data by sex to identify performance disparities between boys and girls and then develop changes to close the identified gaps.

The teams were given new data collection sheets with gender-sensitive indicators to track in the VMMC data collection forms. The teams were also oriented on the importance of integrating gender to improve the quality of services provided to VMMC clients as well as continually using the gender-sensitive data for continuous improvement of VMMC services.

In April 2017, technical staff were trained remotely on gender considerations in VMMC and malaria improvement activities so that they could conduct a session on gender integration at the next learning sessions for VMMC and malaria improvement activities.

In July 2017, ASSIST staff received gender integration in QI training that included defining gender and related concepts; understanding the process of conducting a gender analysis; understanding how to develop, analyze, and report on sex-disaggregated data and gender-sensitive indicators; identifying and addressing gaps and issues related to gender in ASSIST activities; and gender-sensitive program planning. The training also included information about gender-based violence (GBV). Gender issues discussed in OVC activities included: how gender norms affect boys’ and girls’ access to and use of education; gaps identified through sex-disaggregated and age-disaggregated analysis of education outcomes, and the changes QI teams have tested to close those gaps; HIV testing and counselling for key populations (women caregivers of OVC, sex workers, truck drivers, motorcycle drivers); low HIV testing and counselling among adolescent boys; the gender make-up of QI teams and the gender imbalance of QI team member participation in learning sessions and team meetings; and sex-disaggregated analysis of outcomes for child-headed households. Gender issues discussed in VMMC activities included: female involvement in VMMC (female sexual partners as well as mothers, sisters, aunts, grandmothers, etc.); women’s influence on men’s decision to undergo VMMC or not; the gender knowledge gap about VMMC and how that affects demand, adverse events, the potential for violence, the potential for other sexual partners, and protection against HIV.

We discussed how some QI teams started working on female involvement after the learning session in May where gender integration was introduced, but these QI teams have had problems with data collection in that women come to the clinic but are ignored during group education sessions and are not tracked. After including a session on gender integration in VMMC at a learning session, QI teams from the Malawi Department of Defense and Malawi Defense Forces started talking with women’s groups and with groups of wives about VMMC.

ASSIST staff continued to provide guidance and support to the QI teams to collect gender-sensitive and sex-disaggregated data and use to identify any existing gaps in service provision. The teams continued collecting core indicators data which is dis-aggregated by sex to inform febrile illness programming.