ADVANCING PARTNERS & COMMUNITIES

COUNTRY PROFILE: MALAWI

MALAWI COMMUNITY HEALTH PROGRAMS
APRIL 2014

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COUNTRY PROFILE*

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* Adapted from the Health Care Improvement Project's *Assessment and Improvement Matrix* for community health worker programs, and PATH's Country Assessments of Community-based Distribution programs.

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ACRONYMS

AEHO	Assistant Environmental Health Officer
AIDS	acquired immunodeficiency syndrome
APC	Advancing Partners & Communities
ARI	acute respiratory infection
CBDA	Community-Based Distribution Agents
CBFP	community-based family planning
CG	Community Group
CHBC	Community Home Based Care Provider
CHW	community health worker
DMPA (IM)	Intramuscular Depo-Provera
EHP	Essential Health Package
FAM	fertility awareness methods
FP	family planning
FPAM	Family Planning Association of Malawi
GMV	Growth Monitoring Visitors
HIV	human immunodeficiency virus
HSA	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
IEC	information, education, and communication
IMCI	integrated management of child illnesses
IPT	intermittent preventive treatment for pregnant women
IRS	indoor residual spraying
IUD	intrauterine devices
LLIN	long lasting insecticide-treated net
MCH	maternal and child health
MOH	Ministry of Health
NCD	non-communicable disease
NGO	nongovernmental organizations
NTD	neglected tropical disease
ORS	oral rehydration solution
PE	Peer Educator
PLC	primary level of care
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
SDM	standard days method
SP	Sanitation Promoters

SRH	sexual and reproductive health
TB	tuberculosis
TBA	Traditional Birth Attendant
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
VHC	Village Health Committee
VDC	Village Development Committee

I. INTRODUCTION

This Country Profile is the outcome of a landscape assessment conducted by Advancing Partners & Communities (APC) staff and colleagues. The landscape assessment focused on the United States Agency for International Development (USAID) Population and Reproductive Health priority countries, and includes specific attention to family planning as that is the core focus of the APC project. The purpose of the landscape assessment was to collect the most up to date information available on the community health system, community health workers, and community health services in each country. This profile is intended to reflect the information collected. Where possible, the information presented is supported by national policies and other relevant documents; however, much of the information is the result of institutional knowledge and personal interviews due to the relative lack of publicly available information on national community health systems. As a result, gaps and inconsistencies may exist in this profile. If you have information to contribute, please submit comments to info@advancingpartners.org. APC intends to update these profiles regularly, and welcomes input from our colleagues.

II. GENERAL INFORMATION

1	What is the name of this program* and who supervises it (government, nongovernmental organizations (NGOs), combination, etc.)? *Please list all that you are aware of.* **If there are multiple programs, please add columns to the right to answer the following questions according to each community health program.*	At this time, Malawi does not have a stand-alone community health program. Rather, community health services are considered the primary level of care within the national health system. Primary health care services are delivered at the community through various Ministry of Health (MOH) intervention-specific programs, including: • Environmental health • Family planning • Maternal and child health • AIDS treatment, care, and support • Village-level operations and maintenance of water point • National growth monitoring and promotion • National youth-friendly health services • Integrated management of childhood illnesses • Sanitation marketing The delivery of primary health services across all program areas is coordinated at the village level by Health Surveillance Assistants (HSAs). For the purpose of this assessment, Malawi's community health system will be referred to as the primary level of care (PLC), a singular program that incorporates all community-level programs as indicated in the national Health

		Sector Strategic Plan (HSSP). The PLC is supervised by the MOH and various supporting agencies; however, at the village level, some services in the PLC are supervised and supported by village development committees (VDCs) and other implementing nongovernmental organization (NGO) partners.
2	How long has this program been in operation? What is its current status (pilot, scaling up, nationalized, non-operational)?	PLC services began in the 1950s with the delivery of immunizations by HSAs. Additional services and community health worker (CHW) cadres include the provision of assisted births by Traditional Birth Attendants (TBAs) in the 1960s, the establishment of Village Health Committees (VHCs) in the 1960s to monitor small pox and cholera, and the provision of family planning (FP) services by Community-Based Distributing Agents (CBDAs) in 1999 in eight pilot districts. Additionally, community-based water, sanitation, and hygiene (WASH) services were added in the 1990s and community-based HIV services were introduced in 2001. While the PLC is implemented nationwide, the MOH is scaling-up the type of services offered and the number of CHWs providing services. HSA recruitment is a priority of the MOH. Additionally, youth, integrated management of childhood illnesses (IMCI), HIV, sanitation, and maternal and child health (MCH) services are being scaled-up and systemized across the country, as presently many of these services are only active in NGO-supported regions in 42/75 districts.
3	Where does this program operate? Please note whether these areas are urban, peri-urban, rural, or pastoral. Is there a focus on any particular region or setting? *Please note specific districts/regions, if known.* ☐	The PLC operates in both urban and rural areas; the PLC extends the reach of the health system to areas with little access to health facilities. However, different packages are offered based on the needs of the community as determined by the VDC and implementing partner NGOs.
4	If there are plans to scale up the community health program, please note the scope of the scale up (more districts, regional, national, etc.) as well as location(s) of the planned implementation sites.	The PLC is recruiting human resource staff to implement services. The MOH plans to train more than 2,000 HSAs by 2015 and revitalize and train VHCs in areas where they are not currently functioning. The FP activities implemented by CBDAs are also being scaled up from the current eight districts to all 28. The government of Malawi intends for all PLC activities to be implemented nationwide, and is currently scaling up the numbers and responsibilities of the various CHW cadres across all intervention areas.

5	Please list the health services delivered by CHWs[1] under this program. Are these services part of a defined package? Do these services vary by region?	The Essential Health Package (EHP) comprises the services that the Malawian health system is meant to provide at all levels (PLC, secondary, and tertiary). At the PLC level the package includes: • Malaria prevention through vector control including indoor residual spraying (IRS) in high-risk areas, drainage, provision of long lasting insecticide-treated nets (LLINs), and intermittent preventive treatment for pregnant women (IPT). • Health promotion activities including community mobilization; information and education, advocacy on early recognition and danger signs for HIV and AIDS, acute respiratory infections (ARI), malaria, diarrheal diseases, perinatal conditions, non-communicable diseases (NCDs), tuberculosis (TB), malnutrition, vaccines, cancers, mental health, and neglected tropical diseases (NTDs). • Environmental and personal hygiene in the community through safe water and sanitation, good nutrition, food service inspections, and border-post checks. • Community-based family planning (CBFP) including the provision of contraceptives, links to HIV test counseling, and promotion of safer sex negotiation. • Safe child birth through referrals to health facility for delivery, information, education and communication (IEC) about danger signs during childbirth, and provision of hygiene kits for mothers. • Immunization for children under five and pregnant women. The various cadres of CHWs delivering services through the PLC provide health services that fall within the EHP. However, as mentioned, the exact services provided in a community may vary based on the needs of that community as determined by the VDC and the implementing NGO partners in the region.
6	Are family planning (FP) services included in the defined package, if one exists?	Yes, FP services are included in the EHP.
7	Please list the family planning services and methods delivered by CHWs.	FP services include the provision of contraceptives and counseling and IEC messages about contraceptive methods and sexual and reproductive health (SRH). CHWs distribute condoms, oral pills, and injectable contraceptives.
8	What is the general service delivery system (e.g. how are services provided? Door-to-door, via health posts/other facilities, combination?)	The service delivery system varies by CHW cadre and health intervention type. Services are available through health posts and village clinics, outreach campaigns, and door-to-door visits.

[1]The term "CHW" is used as a generic reference for community health workers for the purpose of this landscaping exercise. Country-appropriate terminology for community health workers is noted in the response column.

III. COMMUNITY HEALTH WORKERS

<table>
<tr><td>9</td><td>Are there multiple cadre(s) of health workers providing services at the community level? If so, please list them by name and note hierarchy.</td><td colspan="4">There are many cadres of CHWs in Malawi, including HSAs, VHCs, CBDAs, TBAs, Community Home-Based Care Providers (CHBCs), Growth Monitoring Visitors (GMVs), Sanitation Promoters (SPs), Community Groups (CGs), and Peer Educators (PEs).

HSAs are the main connection point between the formal health system and communities. They supervise all CHWs working at the community level and provide services at health posts.

VHCs are a group of village members elected to oversee the type of health services being implemented in the community. VHCs ensure community participation in health service delivery and also provide health promotion services in the community. VHCs work with and are supervised by HSAs.

CBDAs provide CBFP services in community members' homes.

Other CHWs (including TBAs, CHBCs, GMVs, SPs, CGs, and PEs) provide a range of health services in various parts of the country. These CHWs supplement the services provided by HSAs, VHCs, and CBDAs based on the needs of the community (as they are determined by the VDC). All other CHWs are supervised by the VHC and HSAs.</td></tr>
<tr><td>10</td><td>Do tasks/responsibilities vary among CHWs? How so (by cadre, experience, age, etc.)?</td><td colspan="4">Yes; tasks differ by cadre.</td></tr>
<tr><td></td><td></td><td>HSAs

HSAs deliver a wide range of services at health posts and are the main implementers of the EHP at the community level.

Some HSAs receive additional training to provide specialized services in NGO-supported regions.</td><td>VHCs

VHCs provide promotion outreach services in the community. Their work compliments the preventive and curative services of the HSAs and any other CHWs working in the community.</td><td>CBDAs

CBDAs deliver door-to-door FP services in rural areas. After scale-up they will work in both urban and rural areas that do not have access to a health facility. Currently there is no way to define poor access to FP health services.</td><td>Other CHWs

TBAs work in rural areas only, providing MCH services, primarily referrals for skilled delivery.

CHBCs work in both urban and rural areas and provide palliative care to people living with HIV (PLHIV).

GMVs provide nutrition services in urban and rural areas and are most active in NGO-supported regions.

SPs sell sanitation products in rural areas, primarily in districts supported by NGOs active in sanitation marketing (15 districts making up 2/3 of the</td></tr>
</table>

					country). SPs also work in some district water offices.2 CGs provide C-IMCI services, including nutrition and breastfeeding promotion, in districts where NGOs are active. PEs provide youth-specific HIV outreach/education in rural & urban areas and are supported by partner NGOs.
11	Total number of CHWs in program *Break down by cadre, if known, and provide goal and estimated actual numbers. Please note how many are active/inactive, if known.*	**HSAs** As of 2013 there were 10,451 HSAs.	**VHCs** Information unavailable.	**CBDAs** There are approximately 1,003 CBDAs trained in the eight districts. By the end of 2015, there will be 3,360.	**Other CHWs** There are approximately 5,000 active TBAs; but only 3,000 TBAs have been formally trained by the MOH. Information is unavailable for the remaining cadres.
12	Criteria for CHWs (e.g. age, gender, education level, etc.) *Break down by cadre, if known.*	**HSAs** HSAs must have completed 12 years of education and a Malawi School Certificate of Education and be from the catchment area. Some HSAs have 10 years of education and a Junior Certificate of Education (the educational requirement prior to 2011). Some HSAs were placed in different districts than their own to increase recruitment.	**VHCs** VHCs must be gender balanced (50% male and 50% female).	**CBDAs** CBDAs must have completed 12 years of education and come from the communities they serve. Some CBDAs have 10 years of education due to previous requirements.	**Other CHWs** Other CHWs do not have specific criteria but are supposed to be gender balanced and come from the communities they serve.

[2] SPs are mainly supported by WaterAid and Water for the People.

13	How are CHWs trained? Note length, frequency, and requirements of training. *Break this down by cadre, if known.*	**HSAs** HSAs may receive up to three types of trainings: initial basic, specialized, and on-the-job. Basic training is 12 weeks and covers preventive health including primary health care, the EHP, community assessment and mobilization, the role of the VHC, CBHC, WASH, common diseases, patient follow up, and health education. The second portion of the training covers family health including safe motherhood, reproductive health, FP, antenatal and postnatal care, immunization, nutrition, growth monitoring, and infection prevention and universal precautions. HSAs may receive specialized trainings when new health interventions are added to the service delivery package by intervention-specific programs of the MOH. These trainings range in length from a few days to five weeks. HSAs also receive an initial one week orientation and on-the-job peer trainings led by HSAs who have attended specialized trainings.	**VHCs** VHCs receive a five-day basic training on health promotion and their specific roles. In regions where NGOs participate, VHCs may also receive specific trainings and orientation sessions in IMCI, MNCH, and postnatal care.	**CBDAs** CBDAs receive a two week basic training on their roles.	**Other CHWs** TBAs do not get standardized training except in areas where partner NGOs are active, in which they have a five day training. CHBCs receive a basic 10 day training. Additionally, they receive ongoing mentoring and additional specialized trainings on positive living, and ART adherence trainings. GMVs receive a basic five day training. SPs receive a one week training. CGs receive a one week standard training. PEs attend a one week standard training.

14	Do the CHWs receive comprehensive training for all responsibilities at once, or is training conducted over time? How does this impact their ability to deliver services?	**HSAs** HSA training is comprehensive based on the current scope of work. However, as the cadre is scaled up by the MOH and more specific interventions are added to the service package, additional specialized trainings will be conducted separately as needed.	**VHCs** Basic training is comprehensive. When additional health interventions are required by the MOH in a community, VHCs may need specialized training.	**CBDAs** Training is comprehensive.	**Other CHWs** Generally, the basic training is comprehensive and covers all responsibilities.
15	Please note the health services provided by the various cadres of CHW as applicable (e.g. who can provide what service).	**HSAs** Immunizations; village inspections of hygiene and sanitation; IEC; child growth monitoring and nutrition; antenatal care; WASH, including environmental hygiene and ensuring safe water supply at household and community levels, and chlorination; data collection and recording, including community assessment; facilitate VHCs; disease surveillance and response to outbreaks; family planning; vector and vermin control, including distribution of LLIN and spraying for vermin and larvae; and inspecting community facilities such as schools, restaurants, and other public buildings. HSAs who receive additional training provide	**VHCs** Community mobilization for health services; general monitoring and reporting of health issues to community members; IEC for behavior change.	**CBDAs** FP and HTC.	**Other CHWs** TBAs: Antenatal care; refer pregnant women to health facility for delivery; distribute condoms for dual protection. CHBCs: Psychosocial support for PLHIV; HIV medical support and counseling; nutrition; ART adherence counseling; family planning. GMVs: Nutrition counseling for mothers; growth monitoring for children under five; cooking demonstrations. SPs: Sanitation marketing. CGs: IMCI IEC on the recognized WHO and UNICEF 16 key family practices.

		the following services in program areas that the government has identified: therapeutic care nutrition programs for malnourished children at facilities; TB testing and treatment; additional FP services; HIV treatment and adherence counseling services; HTC for infants in PMTCT programs; and postnatal care.			PEs: HIV IEC for youth and family planning.

16	List family planning services provided by cadre(s) as applicable.	VHCs and most other CHWs do not provide FP services and are therefore not included below.			
			HSAs	**CBDAs**	**CHBCs and PEs**
		Information/ education	Condoms, oral pills, injectables, implants, IUDs, emergency contraception, and permanent methods.	Condoms, oral pills, injectables, implants, IUDs, and permanent methods.	Condoms
		Method counseling	Condoms, oral pills, injectables, implants, IUDs, emergency contraception, and permanent methods.	Condoms, oral pills, injectables, implants, IUDs, and permanent methods.	Condoms
		Method provision	Condoms, oral pills, and injectables (additional training required to provide pill and injectables).	Condoms and oral pills.	Condoms
		Referrals	Implants, IUDs, emergency contraception, and permanent methods.	Implants, IUDs, emergency contraception, and permanent methods.	Not applicable

17	Do CHWs distribute commodities in their communities (zinc tablets, FP methods, etc.)? Which programs/products?	**HSAs** HSAs distribute condoms and chlorine for water treatment. HSAs who receive training for FP	**VHCs** Some VHCs who have received additional training distribute condoms for HIV prevention. Otherwise,	**CBDAs** CBDAs distribute condoms and oral pills.	**Other CHWs** CHBCs distribute condoms for dual protection, paracetamol, and gentian violet mouth wash for

		provide oral pills and injectables. HSAs trained in CCM distribute zinc, oral rehydration solution (ORS), eye ointment, lumefantrineartemether for malaria treatment, and cotrimoxazole. HSAs trained in additional nutrition services distribute vitamin A.	VHCs do not distribute any commodities.		treatment of oral candidiasis. PEs distribute condoms for dual protection.
18	Are CHWs paid, are incentives provided, or are they volunteers? *Please differentiate by cadre, as applicable.*	**HSAs** HSAs are salaried workers. They are paid approximately $100 per month.	**VHCs** VHCs are volunteers.	**CBDAs** CBDAs are unpaid but some partner NGOs provide a monthly stipend.	**Other CHWs** TBAs are paid by clients at an average of MK 1500-4000 (USD 3.50- 9.50). CHBCs, GMVs, CGs, and PEs are volunteers. SPs are self-financing based on their sales of WASH commodities.
19	Who is responsible for these incentives (MOH, NGO, municipality, combination?	**HSAs** The Government of Malawi is responsible for HSA salaries.	**VHCs** Not applicable	**CBDAs** If CBDAs receive incentives, they are provided by partner NGOs.	**Other CHWs** Both TBAs and SPs receive incentives from clients.
20	Do CHWs work in urban and/or rural areas?	**HSAs** HSAs work in urban and rural communities that are located five kilometers or more from a health center.	**VHCs** VHCs work in rural areas.	**CBDAs** CBDAs work in rural and urban areas. CBDAs primarily work in areas that are underserved by FP services.	**Other CHWs** TBAs work in rural areas. CHBCs work in rural and urban areas. GMVs work in rural and urban areas. SPs work in rural and urban areas. CGs work in rural areas. PEs work in rural and urban

					areas.
21	Are CHWs residents of the communities they serve? Were they residents before becoming CHWs (i.e. are they required to be a member of the community they serve)?	**HSAs** Residency is not required. Some HSAs may serve the communities they are from; others live in the community they serve but are not originally from that community; and some live in and are from different communities than the one they are currently serving.	**VHCs** VHCs must be members of the communities they serve.	**CBDAs** CBDAs must be members of the communities they serve.	**Other CHWs** All other CHWs must be members of the communities they serve.
22	Describe the geographic coverage/catchment area for each CHW.	**HSAs** The target ratio is one HSA per 1,000 people but the current ratio is one HSA per 1,200 people. Malawi intends to scale-up the number of HSAs to a total of 13,500 in order to meet the set catchment population.	**VHCs** VHCs serve a group village head (GVH) area, which is approximately 10-20 villages.	**CBDAs** One CBDA serves 1,000 to 1,200 people.	**Other CHWs** TBAs: Information unavailable CHBC: One CHBC group serves a GVH area. There is no specified size for a CHBC group but the ratio of CHBC member to patient is one to five. GMVs: Two GMVs serve one village SPs: Each village has one trained SP. CGs: One CG is comprised of 10 lead mothers. Each lead mother promotes IMCI in 10 households that have children under five. PEs: Each GVH area has at least 10 PEs.

23	How do CHWs get to their clients (walk, bike, public transport, etc.)?	**HSAs** HSAs are given bicycles by the MOH. However, when bicycles break down HSAs use public transport to visit their clients.	**VHCs** VHCs walk to visit their clients. In some NGO implemented areas, partner NGOs give VHC members bicycles.	**CBDAs** CBDAs walk or use public transport to visit their clients. Some CBDAs receive bicycles from partner NGOs.	**Other CHWs** All other CHWs walk to visit their clients. CHBCs, SPs, and PEs also receive bicycles in some NGO implemented areas.
24	Describe the CHW role in data collection and monitoring.	**HSAs** HSAs are responsible for collecting and aggregating all data on PLC community services. HSAs collect data using specific forms including the Village Health Register, TBA Card, CBDA card, and VHC forms. These forms collect data on disease outbreaks, low coverage of health services, and adverse environmental conditions. HSAs send these forms to the nearest health facility where an initial analysis is made. Data is analyzed quarterly by the District Health Officer and disseminated to the different MOH and NGO health programs in the district. A report on community-level indicators is also sent back to the HSAs.	**VHCs** VHCs complete a VHC form with the support of the HSA of that area.	**CBDAs** CBDAs complete the CBDA card at the end of each month and forward it to the HSA who sends it to the FP coordinator at the district-level.	**Other CHWs** All other CHWs are responsible for proper documentation, collecting and analyzing data, and submitting relevant data to their supervising HSA.

IV. MANAGEMENT AND ORGANIZATION

25	Does the community health program have a decentralized management system? If so, what are the levels (state government, local government, etc.)?	The PHC is semi-decentralized. The MOH is involved in the development of policies, standards, and guidelines, and oversight via the HSAs. Implementation directed at the district and local levels based on the needs of each community. In some areas, other CHWs (including CHBCs and PEs) are managed from the district level due to the high workload of the HSAs. Management levels include: • National ° Ministry of Health, including the Environmental Health, Reproductive Health, and HIV/AIDS sections • District ° District Council ° District Development Committee ° District Health Management Team • Health facilities ° Health Center Management Committee • Village ° Area Development Committee ° HSAs ° VHCs The service delivery system includes: • Central Hospital • District Hospital • Health Center • Health Post/Village Clinic (HSAs) • Community Outreach (all other CHW cadres)
26	Is the MOH responsible for the program overall?	Yes. MOH provides leadership and responsibility for the PLC. Some other CHWs (CGs, PEs, and SPs) are implemented by partner NGOs under the policy guidance of the MOH.

27	What level of responsibility do regional, state, or local governments have for the program, if any? *Note responsibility by level of municipality.*	At the national level, the MOH is responsible for policy formulation, enforcement, and regulation. The MOH also establishes service delivery standards and training and curriculum development. The Regional Zonal Offices offer technical support and monitoring. Community-specific planning, implementation, supervision, and reporting occur at the district and local levels.
28	What level of responsibility do international and local NGOs have for the program, if any?	NGOs and INGOs do not have any responsibility for the PLC but are actively involved in implementation. They provide supportive supervision, assist in training curriculum development, provide incentives in line with MOH policy, provide commodities, and train the HSAs, VHCs, CBDAs, and other CHWs in any specialized services in line with MOH policies. Additionally, partner NGOs in some districts share responsibility with the MOH for the management of CGs, PEs, and SPs.
29	Are CHWs linked to health system? Describe the mechanism.	Yes. CHWs in the PLC are linked to the formal health system. HSAs are employees of the MOH who work at HPs/VCs and are considered the lowest level of the health system. VHCs, TBAs, CHBCs, GMVs, CGs, PEs, and SPs are directly linked to the formal health system by HSAs who supervise their activities. Level of HSA supervision varies for each cadre. Additionally, all their activities are reported to the district level by HSAs.
30	Who supervises CHWs? What is the supervision process? Does the government share supervision with an NGO(s)? If so, describe how they share supervision responsibilities.	HSAs are formally supervised by the Assistant Environmental Health Officer (AEHO), an employee of the Department of Environmental Health at the district level. However, senior HSAs (a new position created to solely supervise HSAs) now provide the majority of direct supervision to HSAs in the communities where they work. Supervision is shared by NGOs when HSAs have been trained in additional specialized service packages. HSAs receive supportive supervision by both AEHOs and senior HSAs. VHCs are supervised by HSAs at least once a month. In areas where NGOs are active, they take part in such visits and in some cases finance supervision trips. CBDAs are supervised by the HSAs and community health nurses. Routine supervision is jointly conducted by NGOs active in FP and the community. All other CHWs receive immediate supervision by HSAs and are also supervised by MOH staff at various levels, depending on the health service offered. Some NGOs provide technical assistance and financing for supervisory visits.
31	Where do CHWs refer clients for the next tier of services? Do lower-level cadres refer to the next cadre up (of CHW) at all?	CHWs refer clients to the nearest health facility for services that are not provided at the community level. VHCs, CBDAs, and all other CHWs refer clients to HSAs for services they are able to provide.

32	Where do CHWs refer clients specifically for FP services? *Note method.*	VHCs and most other CHWs do not provide FP services and are therefore not included below.					
			HSAs	**VHCs**	**CBDAs**	**CHBCs**	**PEs**
		SDM/fertility awareness methods	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
		Condoms	Not applicable	HSAs, CBDAs	Not applicable	HSAs or nearest health facility (only if stocked out)	HSAs or nearest health facility (only if stocked out)
		Oral pills	Not applicable	HSAs	Not applicable	Not applicable	Not applicable
		DMPA (IM)	Not applicable	HSAs	HSAs	Not applicable	Not applicable
		Implants	District hospital, Banja la Mtsogolo (BLM) clinic, or the Family Planning Association of Malawi (FPAM) clinic.	District hospital, BLM clinic, or FPAM clinic.	District hospital, BLM clinic, or FPAM clinic.	Not applicable	Not applicable
		IUDs	District hospital, BLM clinic, or FPAM clinic.	District hospital, BLM clinic, or FPAM clinic.	District hospital, BLM clinic, or FPAM clinic.	Not applicable	Not applicable
		Permanent methods	Central hospital	District hospital, BLM clinic, or FPAM clinic.	District hospital, BLM clinic, or FPAM clinic.	Not applicable	Not applicable
		Emergency contraception	District hospital, BLM clinic, or FPAM clinic	District hospital, BLM clinic, or FPAM clinic.	District hospital, BLM clinic, or FPAM clinic.	Not applicable	Not applicable

33	Are CHWs linked to other community outreach programs?	Yes, HSAs, VHCs, CBDAs, and GMVs are linked to community outreach campaigns such as immunization campaigns and other community-wide outreach events sponsored by the MOH. The remaining other CHWs (TBAs, CHBCs, SPs, CGs, and PEs) are not linked to other community outreach programs.
34	What mechanisms exist for knowledge sharing between HEWs/supervisors?	There are no specified interventions for knowledge sharing among CHWs in the PLC. Some partner NGOs support knowledge sharing events among individual CHW cadres, but they are not required or routine.
35	What links exist to other institutions (schools, churches, associations, etc.)?	HSAs, VHCs, CHBCs, GMVs, SPs, CGs, and PEs are linked to other institutions. HSAs are mandated to work with communities as well as institutions within the communities to improve health so HSAs visit schools and churches. VHCs work with schools, churches, markets, and other institutions to provide IEC. CHBCs are linked to churches to provide psychosocial support. GMVs promote nutrition at schools and churches. SPs promote WASH technologies at schools and churches. CGs are linked to schools and churches. PEs provide HIV-prevention outreach at schools and churches.
36	Do vertical programs have separate CHWs or "shared/integrated"?	Overall, the PLC is an integrated program, with HSAs and VHCs providing integrated services and HSAs managing community level service delivery. However, in order to increase outcomes for specific health intervention areas, different departments of the MOH have created additional CHW cadres (CBDAs and other CHWs) to increase access to particular health services and uptake of specific healthy behaviors.
37	Do CHWs have data collection/reporting systems?	Yes, all CHWs complete data collection forms based on service delivery. These forms are collected by HSAs and aggregated at the health facility and sent to the DHO. In addition to the MOH forms, some CHWs must complete additional NGO forms that are sent to a health-specific office of the MOH. CGs and PEs complete these additional reporting requirements; data from PEs is submitted to the District AIDS Coordinator.
38	Describe any financing schemes that may be in place for the program (e.g. donor funding/MOH budget/municipal budget/health center user fees/direct user fees). ☐	The PLC is financed through the MOH budget and supplemented by donor and NGO funds.
39	How and where do CHWs access the supplies they provide to clients (medicines, FP products, etc.)?	Most commodities are collected by CHWs at the local health facility. HSAs distribute commodities to VHCs and other CHWs. Some NGOs provide certain commodities to CHWs such as HIV commodities, which are distributed by CBDAs and CHBCs.

40	How and where do CHWs dispose of medical waste generated through their services (used needles, etc.)?	HSAs and CBDAs use safety boxes to dispose any generated waste. VHCs and other CHWs do not generate medical waste.

V. POLICIES

41	Is there a stand-alone community health policy? If not, is one underway or under discussion? *Please provide a link if available online.*	There is no stand-alone community policy. All community programs are governed by the Public Health Act of 1948, the Health Sector Strategic Plan Pillar Number 10 on Public Health, and the Draft National Health Policy.
42	Is the community health program policy integrated in overall health policy?	Yes, the PLC is guided by the Health Sector Strategic Plan 2011-2016, which is based on the national health goals identified in the Draft National Health Policy 2012. The PLC is also supported by the Malawi Growth Development Strategy II 2011-2016.
43	When was the last time the community health program policy was updated (Months/years?)	The HSSP 2011-2106 was last updated in 2011. The Draft National Health Policy was last updated in 2012. The MGDS II was last updated in 2011.
44	What is the proposed geographic scope of the program, according to the policy? (Nation-wide? Select regions?)	The PLC is to be delivered nationwide as stated in the HSSP and the Draft National Health Policy.
45	Does the policy specify which services can be provided by CHWs, and which cannot?	The HSSP 2011-2016 outlines which services should be provided at the primary level, based on the EHP. The National Community Home Based Care Policy and Guidelines 2005 dictate which commodities CHBCs can distribute at the community level.
46	Are there any policies specific to FP service provision (e.g. CHWs allowed to inject contraceptives)?	Yes, the Community Based Injectable Contraceptive Services Guidelines 2008 allow HSAs to administer injectable contraceptives at the community level. Additionally, the CBDA Guidelines 2004 allow CBDAs to administer pills and condoms at the community level, and the National Condom Strategy 2005 allows for the provision of condoms for dual protection by CHBCs, PEs, and VHCs in communities where CBDAs are active.

VI. INFORMATION SOURCES

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VII. AT-A-GLANCE GUIDE TO MALAWI COMMUNITY HEALTH SERVICE PROVISION

Intervention		HSAs				CBDAs			
Family Planning	*Services/Products*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM								
	Condoms	X	X	X		X	X	X	
	Oral pills	X	X	X		X	X	X	
	DMPA (IM)	X	X	X		X	X		X
	Implants	X	X		X	X	X		X
	IUDs	X	X		X	X	X		X
	Permanent methods	X	X		X	X	X		X
	Emergency contraception	X	X		X	X	X		X
HIV and AIDS	VCT	X			X	X	X	X	X
	PMTCT	X			X	X	X		X

MCH	Misoprostol (for PPH)								
	Zinc	X	X	X					
	ORS	X	X	X					
	Immunizations	X	X	X					
Malaria	Bednets	X	X		X				
	IRS	X	X						
	SP	X	X	X					
Nutrition	Growth monitoring	X	X	X					
	Vitamin A	X		X					

Intervention		VHCs				Other CHWs			
Family Planning	*Services/Products*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM								
	Condoms	X	X	X		X	X	X	
	Oral pills								
	DMPA (IM)								
	Implants								
	IUDs								
	Emergency contraception								
	Permanent methods								
HIV and AIDS	VCT	X				X	X		
	PMTCT	X				X	X		
MCH	Misoprostol (for PPH)								
	Zinc					X	X		
	ORS					X	X		
	Immunizations								

Malaria	Bednets					X	X		
	IRS								
	SP					X	X		
Nutrition	Growth monitoring	X	X	X		X	X	X	
	Vitamin A	X		X					
WASH		X							

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