Support for Service Delivery Integration-Services (SSDI-Services)

End of Project Report
(November 8, 2011–March 7, 2017)
This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Jhpiego and do not necessarily reflect the views of USAID or the United States Government.
# Table of Contents

Illustrations ........................................................................................................................................................................... ii  
Abbreviations ..................................................................................................................................................................... iii  
Support for Service Delivery Integration-Services (SSDI-Services) Impact in Numbers ........................................ iv  

Project Description ........................................................................................................................................................... 1  
  Background ..................................................................................................................................................................... 1  
  Linkages with SSDI-Systems and SSDI-Communication ....................................................................................... 1  
  Partnership with the Community .............................................................................................................................. 5  

Overall Project Progress in the Key Technical Areas ........................................................................................................ 5  
  Maternal and Newborn Health (MNH) ................................................................................................................... 5  
  Newborn and Child Health ........................................................................................................................................ 6  
  Family Planning (FP) and Reproductive Health (RH) ............................................................................................ 9  
  Malaria ....................................................................................................................................................................... 10  
  Nutrition .................................................................................................................................................................... 11  
  Household-to-Hospital Continuum ........................................................................................................................ 13  

Quality of Care ................................................................................................................................................................. 16  
  Strengthening the Enabling Environment ............................................................................................................... 16  
  Incentivizing Health Workers to Deliver Improved Services ........................................................................... 21  

HIV ...................................................................................................................................................................................... 25  
  Core Phase ................................................................................................................................................................. 25  
  Expansion Phase .......................................................................................................................................................... 25  
  Infrastructure Improvements ................................................................................................................................... 27  

Monitoring and Evaluation (M&E) ................................................................................................................................ 28  
  Strengthening HMISs .................................................................................................................................................. 28  
  Piloting and Scaling Up Digital Health Innovations .............................................................................................. 30  
  Strengthening Facility-Level M&E Capacity and Data Management ................................................................ 30  
  Improving Data Use for Decision-Making ............................................................................................................. 31  

Best Practices Resulting in SSDI-Services Successes ............................................................................................... 31  
Lessons Learned ............................................................................................................................................................... 34  

Appendix A: Performance Monitoring Plan (PMP) ......................................................................................................... 36
List of Illustrations

Figures

Figure 1. Districts served by the SSDI program......................................................................................................... 1
Figure 2. SSDI’s model of integration............................................................................................................................ 4
Figure 3. Trend of maternal deaths at facilities supported by SSDI-Services.......................................................... 6
Figure 4. Trend of newborn deaths at facilities supported by SSDI-Services........................................................ 8
Figure 5. Cumulative couple-years of protection delivered in the 15 SSDI districts, 2012–2016 .................... 10
Figure 6. Percentage of women receiving intermittent preventive treatment of malaria in pregnancy (IPTp) doses 1 and 2 with antenatal care in all 304 SSDI facilities................................................................. 11
Figure 7. Community action cycle for community mobilization............................................................................. 14
Figure 8. Facilities in performance-based incentive pilot earning at least 70% score in quality of care.................. 21
Figure 9. Trend in maternal sepsis at facilities supported by SSDI-Services..................................................... 22
Figure 10. Pregnant women receiving HIV testing services from SSDI-Services, 2012–2016...................... 26
Figure 11. Pregnant women initiated on antiretroviral therapy at SSDI-Services sites, 2012–2016 ............. 27
Figure 12. DHIS2 Reporting Rates in SSDI Districts.............................................................................................. 30

Table

Table 1. Facilities achieving at least 80% in performance standards................................................................. 23
Abbreviations

ANC  antenatal care
ART  antiretroviral therapy
BEmONC  basic emergency obstetric and newborn care
CBMNH  community-based maternal and newborn health
CCM  community case management
CM  community mobilization
CYP  couple-years of protection
DHMT  district health management team
DHO  district health officer
DQA  data quality assessment
EHP  Essential Health Package
EID  early infant diagnosis (for HIV)
ETAT  Emergency Triage Assessment and Treatment
FP  family planning
FY  fiscal year
HBB  Helping Babies Breathe
HDA  HIV diagnostic assistant
HMIS  health management information system
HSA  health surveillance assistant
HTC  HIV testing and counseling
IP  infection prevention
IPTp  intermittent preventive treatment of malaria in pregnancy
KMC  kangaroo mother care
M&E  monitoring and evaluation
MNCH  maternal, newborn, and child health
MNH  maternal and newborn health
MoH  Ministry of Health
PBI  performance-based incentive
PMTCT  prevention of mother-to-child transmission of HIV
PQI  performance quality improvement
RH  reproductive health
RHD  Reproductive Health Directorate
SBM-R®  Standards-Based Management and Recognition
SSDI  Support for Service Delivery Integration
SSDI-Communication  Support for Service Delivery Integration-Communication
SSDI-Services  Support for Service Delivery Integration-Services
SSDI-Systems  Support for Service Delivery Integration-Systems
USAID  United States Agency for International Development
Support for Service Delivery Integration-Services (SSDI-Services) Impact in Numbers

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 out of 304 SSDI-supported facilities are basic emergency obstetric and newborn care (BEmONC) centers</td>
<td>108 out of 304 SSDI-supported facilities are BEmONC centers</td>
</tr>
<tr>
<td>60% of pregnant women are tested for HIV at antenatal clinics</td>
<td>90% of pregnant women are tested for HIV at antenatal clinics</td>
</tr>
<tr>
<td>14% of pregnant women take second dose of antimalarial drugs during antenatal clinics</td>
<td>64% of pregnant women take second dose of antimalarial drugs during antenatal clinics</td>
</tr>
<tr>
<td>52% of asphyxiated babies are resuscitated successfully at birth</td>
<td>88% of asphyxiated babies are resuscitated successfully at birth</td>
</tr>
<tr>
<td>20 facilities offer kangaroo mother care services</td>
<td>194 facilities offer kangaroo mother care services</td>
</tr>
<tr>
<td>204 village clinics provide treatment for malaria, pneumonia, and diarrhea and follow-up of malnourished children in hard-to-reach areas</td>
<td>1820 village clinics provide treatment for malaria, pneumonia, and diarrhea and follow-up of malnourished children in hard-to-reach areas</td>
</tr>
<tr>
<td>10% of HIV-exposed infants are tested for HIV within 12 months of birth</td>
<td>95% of HIV-exposed infants are tested for HIV within 12 months of birth</td>
</tr>
<tr>
<td>145 health facilities are able to manage acute undernutrition</td>
<td>304 health facilities are able to manage acute undernutrition</td>
</tr>
<tr>
<td>DHIS 2 reporting rate averages 7%</td>
<td>DHIS 2 reporting rate averages 83%</td>
</tr>
<tr>
<td>Provided over 2,000,000 couple-years of protection</td>
<td></td>
</tr>
<tr>
<td>Reached 5,626,821 children with nutrition-related activities</td>
<td></td>
</tr>
</tbody>
</table>

18 health facilities are recognized as Centers of Excellence in infection prevention and reproductive health standards
## Project Name: Support for Service Delivery Integration-Services (SSDI-Services)

### Reporting Period:
November 8, 2011–March 7, 2017

### Obligation Funding Amount:
USD 89,268,254.00

### Project Duration:
November 8, 2011—March 7, 2017 (5 years)

### Evaluation Dates:
Midterm: August–October 2014; end of project: September–October 2016

### Persons Responsible for Drafting this Report:
Dan Wendo, Chief of Party; Deliwe Malema, Deputy Chief of Party; Lolade Oseni, Monitoring & Evaluation Director; Tambudzai Rashidi, Reproductive, Maternal and Newborn Health Director; David Amoruso, Project Management Officer; Naomi Kalemba, Communication and Knowledge Management Specialist

### Project Objectives:

1. Increase access to and utilization of EHP [Essential Health Package] services for women and children that can make a difference in their health and engage men in care.
2. Enhance quality of health services at community and facility levels in the 15 target districts.
3. Improve health-seeking behavior by individuals, families, and communities.
4. Strengthen health care delivery system through development, testing, and scale-up of innovative, sustainable community-based service delivery approaches.
5. Facilitate coordinated, coherent, harmonized, and mutually supportive activities with the Government of Malawi (GOM), SSDI-Systems, SSDI-Communication, private sector and social marketing (PSSM) partners, and other national stakeholders to ensure integration and leveraging of program inputs to scale up service delivery.

* See “Linkages with SSDI-Systems and SSDI-Communication” section for details on these inter-related projects. Together, the three projects made up the United States Agency for International Development (USAID)/Malawi SSDI program.
SSDI-Services was the flagship project for USAID/Malawi’s health office. The project was implemented from November 8, 2011 to March 7, 2017 under a cooperative agreement, valued at USD 89 million. Active project implementation occurred over a 4.5-year period from April 2012 to December 2016, with the preceding and following months focused on startup and closeout activities respectively.

The objectives of the project were to:

1. Increase access to and utilization of EHP services for women and children that can make a difference in their health and engage men in care.
2. Enhance quality of health services at the community and facility levels in the 15 target districts.
3. Improve health-seeking behavior by individuals, families, and communities.
4. Strengthen health care delivery system through development, testing, and scale-up of innovative, sustainable community-based service delivery approaches.
5. Facilitate coordinated, coherent, harmonized, and mutually supportive activities with the Government of Malawi (GOM), SSDI-Systems, SSDI-Communication, private sector and social marketing (PSSM) partners, and other national stakeholders to ensure integration and leveraging of program inputs to scale up service delivery.

SSDI-Services provided financial and technical assistance to the Malawian Ministry of Health (MoH) to deliver, refine, and scale up high-impact interventions contained in the Essential Health Package (EHP). The EHP includes globally proven and cost-effective interventions to address key causes of illness and death in Malawi. SSDI-Services implemented interventions under the following program areas: maternal, newborn, and child health (MNCH); family planning (FP); malaria; nutrition; HIV/AIDS; and sanitation and hygiene.

SSDI-Services was implemented by a consortium comprising Jhpiego as lead, CARE, Plan International, and Save the Children. The project focused on increasing access to, and strengthening the delivery of, EHP services both at the health facility and in the community. It leveraged the work of both SSDI-Communication and SSDI-Systems to improve health-seeking behavior and the quality of health services by addressing the informational needs of both service providers and their clients. It also addressed systems issues that may hinder the provision of high-quality health services.

Geographically, the larger SSDI program, of which SSDI-Services was one project, served 15 districts in all five of Malawi’s health zones, as shown in Figure 1. The districts were Balaka, Chikwawa, Chitipa, Dowa, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Nkhotakota, Nsanje, Phalombe, Salima, and Zomba.

**Linkages with SSDI-Systems and SSDI-Communication**

SSDI-Services was one in a trio of projects that made up USAID/Malawi’s SSDI program. The other two projects were SSDI-Communication and SSDI-Systems. SSDI-Services integrated service delivery by improving access to and quality of priority EHP services at the community and facility levels. SSDI-Communication used social and behavior change communication to promote normative and individual behavior change in the priority areas of HIV and AIDS, maternal and child health, malaria,
nutrition, water and sanitation, and FP. SSDI-Systems assisted MoH in improving policies, management and leadership, and fiscal responsibility to advance Malawi’s health system and the sustainable impact of the EHP.

The three SSDI projects were designed to be inter-related and to strengthen synergies and coordination between actors in the Policy Development Unit, Clinical Services Directorate, and Preventive Health Directorate of MoH. Integration of the three projects was based on criteria defined by USAID/Malawi’s Country Development Cooperation Strategy 3-C Approach: co-location, coordination, and collaboration.

SSDI harnessed the 3-C approach through the following design and implementation elements:

**Co-Locating Interventions**

- At the service delivery level, all EHP services were provided under one roof (i.e., one-stop shop for service provision).
- At the district and zonal levels, all three SSDI projects targeted the same 15 districts, thereby co-locating Services, Communication, and Systems interventions.

**Coordinating among SSDI Partners and MoH**

- At the planning level, ensured work plans were well integrated and complementary with the district implementation plans of the focus districts.
- At the implementation level, ensured resources were leveraged and were maximizing each partner’s comparative advantage. For example, partners were invited to one another’s training sessions, partners sent trainees to partner-conducted trainings and shared the costs of running the sessions.
- At policy, guideline development, and—to the extent possible—implementation levels, served as the coordinating link connecting the MoH vertical programs.

**Collaborating with Nongovernmental Actors**

- With USAID’s Strengthening Health Outcomes through the Private Sector project: Trained health workers in Integrated Management of Childhood Illness. Built capacity in Emergency Triage Assessment and Treatment (ETAT) through pediatric case reviews and death audits as well as joint supervision and coaching visits to ensure functionality of ETAT services at select health facilities.
- With USAID’s Tiwalere OVC [orphans and vulnerable children] project: Conducted joint interventions to strengthen and scale up community-based delivery of nutrition services. Interventions included mass nutrition screening as well as training of care groups’ and community-based child centers.
- With University of North Carolina under Lilongwe Medical Relief Fund Trust: Conducted joint community mobilization (CM) events on FP methods, with a focus on postpartum intrauterine contraceptive device insertions.
- With World Vision International and Feed the Future: Provided technical and financial assistance to support the district nutrition coordinating committees.

* The care group model is a community structure utilizing mother-to-mother support groups to promote optimal feeding practices and other key care practices at household level. It was the platform for implementing the Scaling Up Nutrition global nutrition initiative.
• With Banja la Mtsogolo: Conducted integrated family health outreach clinics and mentored MoH health workers in bilateral tubal ligation.

Integration was operationalized at all levels of implementation: national, zonal, district, facility, and community. Figure 2 illustrates the model of integration and inter-relation between the three SSDI projects.
SSDI-Systems
Support the Ministry of Health with its use of:
- In-depth policy analysis
- Use of data in decision-making
- Integrated supportive supervision
- Strengthen management and leadership at national, zonal, and district levels
- Operationalize a health financing strategy

SSDI-Services
Define comprehensive service delivery package of services (community, health center, and hospital levels)
- Roll out mentoring packages for combined oral contraceptives
- Task shift/share using community-level health post health assistants
- Improve data quality improvement and use at community and facility levels

SSDI-Communication
Operationalize a unified platform, communication strategies, and subgrants
- Develop multimedia communication packages at different levels
- Support capacity-building of key national institutions’ social and behavior change communications
- Pilot innovative solutions for capacity building at community level

- Support to Health Education Unit
- Social and behavior change communication in district implementation plans
- Community cadres work together
- PBI at community levels
- Support to health surveillance assistants

- Advocate for district hospitals to be referral points
- Work on human resources and management at health center and hospital levels
- Provide continuing professional development in technical areas
- Develop supervision and mentoring systems
- Finalize performance-based incentive (PBI) design for Malawi (with Options*) and develop tools for PBI implementation
- Address gaps in logistics and supply chain management (with USAID | DELIVER†)
- Review policies on health surveillance assistants, community cadres, and task shifting

Partnership with the Community

SSDI-Services made a concerted effort to have direct interactions with beneficiaries at the community and household levels. This manifested in the scale-up of community-based service delivery points, increased frequency and number of outreach clinics, strengthening of community groupings, increased door-to-door service delivery, and improved engagement of communities in scorecard processes.

Overall Project Progress in the Key Technical Areas

Maternal and Newborn Health (MNH)

SSDI-Services supported MoH to expand the coverage and quality of key high-impact and cost-effective MNH interventions (see Box 1) at both the community and facility levels by building the capacity of facility- and community-based health workers using training, coaching, and supportive supervision and mentoring.

Key achievements in maternal health over the life of the project include:

- Reduction in maternal deaths at health facilities supported by SSDI-Services, from 120/100,000 recorded births to 46/100,000 (see Figure 3).
- Reduction in incidence of postpartum hemorrhage from 17.1/1,000 births to 11/1,000.
- Administered oxytocin to 1,001,239 women in the third stage of labor. Percentage of women receiving oxytocin in the third stage of labor increased from 15% to 93%.
- Supported 351,104 pregnant women to attend at least four antenatal clinic visits. Proportion of pregnant women attending at least four antenatal care (ANC) visits increased from 17% to 26%.

Box 1. Key Maternal and Newborn Health Interventions

- Community-based maternal newborn care
- Focused antenatal care
- Basic emergency obstetric and newborn care including active management of third stage of labor
- Comprehensive emergency obstetric care
- Postabortion care
- Helping Babies Breathe
- Kangaroo mother care

† See “Best Practices” section for more on the community scorecard process.
• Counseled and tested 1,334,173 pregnant women for HIV at antenatal clinics. Proportion of pregnant women with known HIV status in ANC increased from 66% to 95%.

• Administered intermittent preventive treatment of malaria in pregnancy second dose (IPTp2) to 897,291 women in ANC. Proportion of women receiving IPTp2 in ANC increased from 12% to 64%.

• Increased number of functional basic emergency obstetric and newborn care (BEmONC) sites in the 15 target districts from 50 to 108.

• Provided technical assistance to MoH to develop and institutionalize a postnatal register—the first of its kind for Malawi.

• Introduced and supported scale-up of the Misgav Ladach cesarean section technique, use of which has resulted in notable reduction in postcesarean infection at facilities that have adopted it.

• Supported MoH to revise, publish, and roll out community-based maternal and newborn health (CBMNH) training materials and reporting tools nationally.

Figure 3. Trend of maternal deaths at facilities supported by SSDI-Services

Newborn and Child Health
SSDI-Services supported MoH to institutionalize and scale up delivery of high-impact interventions proven to improve the survival and health of children under 5 years, with an emphasis on newborns and infants from day of birth to 2 months of life (see Box 2). The cascade of newborn and child health delivered preventive, diagnostic, and treatment services at both the health facility and community service delivery points. Child health interventions were deliberately designed to expand the continuum of care for children from the facility to the community through village clinics and customized outreach activities, such as integrated community case management and child health days.

Key achievements in newborn health over the life of the project (April 2012–December 2016) include:

- Incidence of newborn deaths has fallen from 15/1,000 births to 8/1,000 (see Figure 4).
- Successfully resuscitated 25,986 babies asphyxiated at birth. Proportion of babies successfully resuscitated increased from 53% to 87%.
- Established functional resuscitation stations at all 304 health facilities in the target districts. Each facility has at least one qualified Helping Babies Breathe (HBB) provider and was equipped to implement HBB.
- Scaled up and institutionalized novel high-impact methods of care for newborns, including Essential Care for Every Baby, application of chlorohexidine gel for cord care and prevention of newborn sepsis, and kangaroo mother care (KMC).
- Increased number of functional KMC sites from 20 to 194 in the target districts.
- Supported the revision, publication, and distribution of HBB and KMC registers, HBB Action Plan posters, KMC feeding guidelines, and KMC posters.

Box 2. Key Interventions for Newborns and Children Under-5 Years

- Essential Care for Every Baby
- Helping Babies Breathe
- Kangaroo mother care
- Chlorohexidine use for cord care
- Community case management
- Facility-based Integrated Management of Childhood Illness
- Emergency Triage Assessment and Treatment
- EPI+ including rotavirus and pneumococcal conjugate vaccines

Baby Praise was asphyxiated at birth and successfully resuscitated. She is seen here at 8 months old with her mother in Kasungu district.
Key achievements in child health over the life of the project include:

- Reached a total of 3,064,947 children with vitamin A, deworming, and immunization services through the child health days.

- Number of established and functional village clinics increased from 1,579 to 1,820. Through these clinics, a total of 894,830 sick children were assessed and received treatment.

- Number of village clinics offering integrated community case management services increased from 204 to 1,820.

- Reporting rates of commodity stocks at village clinics (using C-Stock) increased from 18% to 73%. Increased use of C-Stock led to improved commodity management and more consistent availability of services at village clinics.
• Increased number of fully functional ETAT facilities from 32 to 171.

• Established an ETAT observation room at each of the 304 facilities; observation rooms were equipped with the necessary equipment and supplies to fast-track delivery of care to children with emergency conditions.

**Family Planning (FP) and Reproductive Health (RH)**

SSDI-Services supported MoH to increase access to high-quality FP and RH services. SSDI-Services increased access to and uptake of FP services by expanding coverage of FP services through community-based distribution points, increasing uptake of long-acting FP methods, reducing missed opportunities by integrating FP into other services that are targeted to women of reproductive age, and scaling up youth-friendly health initiatives (see Box 3).

Key achievements in FP and RH over the life of the project include:

• Delivered cumulative 2,308,415 couple-years of protection (CYP) over 5 years (see Figure 5). Percentage of CYP attributable to long-acting and permanent methods increased from 26% to 47%. Quarterly uptake of CYP distributed through CBDAs increased from 8,298 in Fiscal Year (FY) 2012 Quarter 3 to 117,653 in FY 2017 Quarter 1.

• Increased number of health facilities that offer long-acting and permanent methods from 129 to 254.

• Increased average percentage of youths accessing FP health services from 10% to about 50%.

• Contributed to the increase in modern contraceptive prevalence rate in Malawi from 42% in 2010 to 58% in 2015–16, and to the use of implants from 1% in 2010 to 12% in 2015-16.

• Established routine FP compliance monitoring and reviews at all supported health facilities and community service delivery points.

• Supported MoH to revise, produce, and distribute the Reproductive Health Service Delivery Guidelines and Community-Based Family Planning Guidelines to FP service delivery points nationwide.

---

### Box 3. Key Family Planning (FP) Interventions

- Community-based FP
- Delivery of long-acting FP methods
- Integration of FP with HIV/AIDS and maternal, newborn, and child health services
- Strengthening and scale-up of youth-friendly health services

---

Peer educators from Mitundu Youth Club in Lilongwe.
Malaria

SSDI-Services supported MoH to scale up malaria prevention interventions (see Box 4) in pursuit of the national goal of achieving universal access to all malaria control interventions. Strategic approaches in this program area included: integrating malaria prevention and treatment into existing MNCH platforms at facility and community levels; intensified use of community action groups to foster community involvement in the prevention of malaria and early treatment-seeking behaviors; and support to MoH to revise and roll out guidelines for improved malaria service delivery.

Key achievements in malaria care over the life of the project include:

- Improved documentation of IPTp1 and 2 in ANC registers at health facilities.
- Provided IPTp1 to 1,287,935 women and IPTp2 to 856,957 women. Proportion of women receiving IPTp1 in ANC increased from 44% in FY 2012 to 88% in FY 2016 and proportion of women receiving IPTp2 increased from 12% to 64% in the same time period at the 304 SSDI-Services facilities. (See Figure 6.)
- Supported MoH to develop and publish Malawi’s inaugural malaria in pregnancy guidelines, including training manuals and supportive supervision tools. This achievement was a watershed moment in strengthening coordination and collaborative programming between several stakeholders.

Box 4. Key Malaria Interventions

- Malaria case management (facility and community levels)
- Prevention of malaria in pregnancy
- Behavior change communication to promote improved behaviors for malaria prevention and treatment (IPTp and use of long-lasting insecticide-treated nets)
MoH departments that target services to pregnant women (National Malaria Control Program, Reproductive Health Directorate [RHD], and HIV/AIDS and clinical services departments). Prior to these guidelines, services to pregnant women were delivered independently by each department.

- Distributed basic equipment to all health facilities nationwide to support direct observed therapy of IPTp.
- Trained over 5,000 health care providers and clinical instructors and Malawi’s pre-service training institutions to support rollout of the revised Malawi malaria case management guidelines. Rounds of mentorship and supportive supervision visits were conducted to reinforce skills and institutionalize the new guidelines.
- Instituted routine Malaria Data Reviews to facilitate improved use of data for decision-making and in response to MoH and donor concerns regarding malaria commodity security.

**Figure 6. Percentage of women receiving intermittent preventive treatment of malaria in pregnancy (IPTp) doses 1 and 2 with antenatal care in all 304 SSDI facilities**

**Nutrition**

Left, men conduct a cooking demonstration at a care group in Chikwawa district. Right, men participate in a care group training session in Lilongwe district.
Malawi is one of the countries with the highest levels of chronic undernutrition globally, a situation that poses an overwhelming challenge to children’s survival, growth, and development. SSDI-Services supported MoH’s rollout and achievement targets under Scaling Up Nutrition, a global movement to improve maternal and child nutrition during the first 1,000 days of life, with intensified multisector efforts to reduce stunting.

SSDI-Services supported implementation of an evidence-based, integrated package of high-impact nutrition interventions (see Box 5) to prevent malnutrition and to have maximum impact on the child’s ability to grow and learn as well as capacity-building of health workers and health facilities to actively identify, manage, and treat children with acute malnutrition through community-based management of acute malnutrition services.

SSDI-Services’ primary strategy for supporting improved nutrition outcomes was delivery of high-impact nutrition interventions at the community level and with the direct involvement of the communities themselves. Door-to-door nutrition assessments; information, education, and communication distribution; and community case-finding of malnourished children were utilized to increase access to nutrition services. Capacity-building and direct support to community action groups and care groups were utilized to institutionalize improved preventive and health-seeking behaviors.

Key achievements in nutrition over the life of the project include:

- Reached 5,626,821 children with a nutrition program.
- Reached a total of 144,105 households with focused and contextualized nutrition assessment, counseling, and education during door-to-door visits by care groups.
- Reached 230,860 children aged 6–59 months with a community-level nutrition screening program in collaboration with UNICEF under the 2016-2017 Management of Severe and Moderate Acute Malnutrition in Lilongwe Rural Drought Affected Communities emergency response program. The partnership substantially increased the number of children who were identified early for treatment, before complications could set in.
- Achieved and maintained above 75% cure rates for severe or acute malnutrition at all supported facilities. Cure rates average as follows across service delivery wards—84% in outpatient therapeutic feeding programs; 90% in supplemental feeding programs; and 80% in nutrition rehabilitation units.
- Contributed to the reduction of stunting in Malawi from 47% in 2010 to 37% in 2015-16.
- Coordinated long-lasting and improved collaboration between actors in the nutrition sector through support to strengthen the role of the district nutrition coordinating committee.

Box 5. Key Nutrition Interventions

- Women’s nutrition during pregnancy and lactation
- Promoting optimal breastfeeding of children 0–6 months
- Complementary feeding for children 6–59 months
- Optimal feeding of the sick child
- Micronutrients: vitamin A, iron, iodine
- Prevention and treatment of moderate and severe acute malnutrition

---

Household-to-Hospital Continuum

SSDI-Services supported MoH to increase awareness of the communities on the availability of EHP services and increase uptake of EHP services both at facility and community levels in the 15 target districts. The project further aimed to improve the household-to-hospital continuum of care and build the capacity of community health workers and volunteers to scale up community-level interventions. Community-based approaches focused on:

- Building the capacity of existing community structures
- Mobilizing communities to:
  - Practice improved health behaviors
  - Proactively engage in health service delivery, including holding service providers accountable
  - Promote ownership of health resources and interventions in their communities

SSDI-Services engaged local nongovernmental organizations to implement CM activities in 13 focus districts to help promote the adoption of healthy behaviors in communities. CM is a process of building the capacity of communities to plan, carry out, and evaluate activities in a participatory and sustained way in order to improve their health. SSDI-Services CM interventions (see Box 6) aimed to facilitate positive and sustainable changes in social norms and attitudes and also in individual, household, and community practices. All CM activities were based on the community action cycle (see Figure 7). Communities were helped to go through each phase, from organizing the community for action through exploring health issues, planning for solutions, implementing the planned activities, and evaluating the achievements.

Box 6. Key Community Mobilization Interventions

- Create demand
- Empower communities to mobilize community resources for health
- Expand coverage of community-based service to enhance equitable access to health care
- Increase community awareness and education about cultural practices and beliefs that negatively affect health
- Develop systems to ensure ongoing community involvement in and ownership of the health services delivered
Key achievements in CM include:

- Established 557 community action groups (see Box 7), covering four traditional authorities in each of the 13 target districts for a total population of 3,142,252 in 729,839 households.

- Reached 647,150 households, representing 89% of the households served by the community action groups, with integrated EHP messages.

- 91% of community action groups were active at the end of the project, following direct support from SSDI-Services.

- 143 communities independently mobilized financial resources and invested in improved health service delivery or access to health services within their communities.
Box 7. Translation of Makowa Community Action Group’s By-Laws

- Any village that does not keep the borehole area clean will pay a penalty of MWK 3,000
- The family of a pregnant woman who delivers a baby at home or on the way to hospital will pay a goat to the group village head
- A husband that refuses to accompany the wife for antenatal care or family planning will be fined MWK 1,500
- Members of a family without a toilet will not be allowed to attend a funeral in the village
- Anybody found misusing mosquito nets will be charged MWK 2,000
- A family that refuses being tested for HIV will be charged MWK 1,000
- All village development committee members are expected to be united and abide by and reinforce the health living by-laws

Houses and toilets with “talking walls” and handwashing facilities in South East Zone.
Quality of Care

To improve quality of EHP services, SSDI-Services made significant investments to enhance health workers’ skill sets, create work environments more conducive to provision of improved-quality services, and incentivize preferred behaviors and practices among health workers. The Quality of Care section describes investments SSDI-Services made to strengthen the enabling environment and incentivize health workers to deliver improved services.

Strengthening the Enabling Environment

SSDI-Services implemented the following initiatives to strengthen the enabling environment for delivery of better-quality EHP services:

- Procured and distributed basic equipment and supplies
- Procured and distributed a fleet of ambulances
- Refurbished health facilities and commissioned minor construction of new structures
- Provided targeted health facilities with access to electricity through solar installations
- Piloted a performance-based incentives (PBIs) scheme.

Most of these initiatives were implemented under the MNH expansion phase, which was added to SSDI-Services in Year 4. The MNH expansion aimed to increase the project’s level of effort toward addressing systemic challenges which impact MNH in five districts. The five components of the MNH expansion phase were:

- Using training and mentoring to improve providers’ capacity to deliver basic as well as comprehensive emergency obstetric and newborn care
- Providing additional essential equipment
- Improving communication systems
- Improving transport systems
- Renovating infrastructure

However, mentorship was a core component of SSDI-Services’ capacity-building approach and was implemented throughout the life of the project and in all 15 districts.

**Equipment**

Lack of basic equipment and supplies had been identified as a significant contributing factor to the unavailability and poor quality of EHP services. SSDI-Services procured and distributed basic medical equipment and supplies to the 304 health facilities in the 15 districts (see Box 8). This substantial investment in basic equipment and supplies is meant to strengthen the enabling environment at health facilities by giving health workers access to the tools they need to do their jobs. The project’s internal endline assessment, conducted in March 2016, revealed an increase in availability of the majority of basic equipment at health facilities. This increase was observed in facilities supported by SSDI-Services and those supported by other partners. However, facilities supported by SSDI-Services were more likely to be equipped with a microscope, refrigerator, digital scale for newborn, and sterilizer. The positive change from 2012 to 2016 is a testament to MoH and its partners’ commitments to strengthening the enabling environment for improved delivery of EHP services.

**Box 8. Basic Equipment and Supplies Procured and Distributed 2012–2016**

<table>
<thead>
<tr>
<th>Blood pressure machines</th>
<th>X-ray machines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steethoscopes</td>
<td>Incubators</td>
</tr>
<tr>
<td>Fetoscopes</td>
<td>Oxygen systems</td>
</tr>
<tr>
<td>Microscopes</td>
<td>Sterilizers</td>
</tr>
<tr>
<td>Refrigerators</td>
<td>Decontaminants</td>
</tr>
<tr>
<td>Adult scales</td>
<td>Buckets for infection prevention</td>
</tr>
<tr>
<td>Under-5 weighing equipment</td>
<td>Disposable syringes</td>
</tr>
<tr>
<td>Digital scales for newborn</td>
<td>Safety boxes</td>
</tr>
<tr>
<td>Height boards</td>
<td>Surgical blades</td>
</tr>
<tr>
<td>Mid-upper arm circumference tapes</td>
<td>Local anesthetics</td>
</tr>
<tr>
<td>Tape measures</td>
<td>Delivery kits</td>
</tr>
<tr>
<td>Thermometers</td>
<td></td>
</tr>
</tbody>
</table>

Left, Nsanje, and right, Bwaila operating rooms, both now equipped with operating tables through SSDI-Services.
Transport and Referral Systems

To help district health offices alleviate chronic transportation challenges, SSDI-Services procured and distributed a fleet of ambulances (15 automotive ambulances, eight motorcycle ambulances, and 162 bicycle ambulances) to five districts, which were the focus of the MNH expansion phase in Year 4. The automotive ambulances were deployed to strategic points to cater to the transport needs of a cluster of health centers and facilitate health center–district hospital referrals; the motorcycle ambulances were deployed to hard-to-reach facilities; and the bicycle ambulances were distributed across traditional authorities to support community–facility referrals.

Infrastructure

The infrastructure renovations targeted five facilities in each of the three Country Development Cooperation Strategy districts of Lilongwe, Machinga, and Balaka and a total of five facilities in Mangochi and Nsanje districts. Site selection and type of refurbishment carried out at each facility was based on gaps identified during a needs assessment jointly conducted with MoH and Procurement and Maintenance Department. The refurbishments included construction of incinerators, placenta pits, and water and electricity supply systems. Through the refurbishments, SSDI-Services supported target health facilities to improve client flow, provide suitable shelter for waiting clients, gain access to potable water, and improve management of biohazardous waste materials.

After: Renovated shelter from inside (left) and outside (right).
Before: Women standing in a queue. Renovated shelter with benches provided for waiting clients.

Left: Incinerator and placenta pit constructed at Chikwawa District Hospital. Right: Incinerator renovated at Makhwira Health Center.

Left: Renovation of water supply at Karonga District Hospital, in 2009 and 2016. Right: Renovated water supply at Nsanje District Hospital.

Electricity/Solar
SSDI-Services, in partnership with We Care Solar, provided electricity to 43 maternity units that had previously not had access to electricity or a power source. In addition, SSDI-Services supported 34 health facilities to connect to the national power grid. With access to electrical power, these facilities gained better lighting as well as the ability to utilize medical devices and appliances to deliver better-quality care to mothers and their newborns.

You may not appreciate the impact this lighting has brought upon us, but the truth is it has been very hard for us, to an extent, asking patient guardians to buy candles, paraffin, or torches (flashlights) for us to work. These are very desperate people we have been asking. For now, at least, I have peace of mind because of this solar.

~Damien Makaka, facility in-charge, Ifumbo Health Center, Karonga

We had high staff turnover at Katimbira Health Center because it is a hard-to-reach area without electricity. Nurses were not motivated to work in such an environment, making it very tough for management to allocate other staff members when one got transferred. With the coming of solar electricity, all of the abovementioned problems are things of the past. It’s our hope that in the near future, the whole facility will have electricity.

~ Icily Medi, District Nursing Officer, Katimbira Health Center, Nkhotakota

I successfully and happily do suturing any time there is a tear during labor. It was very challenging before the solar. Candles were making the work terrible at night in the labor ward. I am also able to examine babies and their mothers in the postnatal ward. To those women who could not afford a candle, as a provider I was forced to use a torch from my phone as a source light, which was very difficult to work with, especially when a woman had a tear to be sutured.

~ Maggie Kafunda, nurse-midwife, Ifumbo Health Center, Karonga
Incentivizing Health Workers to Deliver Improved Services

Performance-Based Incentives (PBIs)

Deficiencies in quality of EHP service delivery in Malawi are due to a range of limiting factors, most prominent of which are resource gaps, poor infrastructure, and low motivation of health workers. To explore ways of alleviating these key constraints, SSDI-Services piloted a supply-side PBI scheme at 17 health facilities in Chitipa, Nkhotakota, and Mangochi districts over a period of 27 months (October 2014 to December 2016).

The PBI scheme aimed to improve coverage and quality of EHP services and increase health workers’ motivation. Health facilities included in the PBI pilot were rewarded with financial incentives upon meeting or exceeding established performance standards for key EHP health services. The SSDI-Services PBI model was unique in that rewards were given to the health facility and not to individual health workers. Health facility staff would then determine how to invest the funds to improve their work environment and improve service delivery.

Routine assessments conducted over the life of the pilot revealed that the incentivized health facilities substantially improved coverage of specific EHP services and quality of care delivered. Key results include:

- Number of facilities achieving the acceptable level of quality of care (at least 70% score) increased from one at baseline to 12 in cycle 4 and 11 in cycle 5 (see Figure 8).^{15}

- Proportion of women attending antenatal clinic in the first trimester nearly doubled, from 8% at baseline to 15% at endline. Health facilities that were not incentivized demonstrated a more modest increase in women attending ANC in the first trimester, from 9% to 11% during the same time period.

- All 17 PBI health facilities were able to invest in infrastructure improvements. Improvements included installation of water tanks, construction of a new incinerator, construction of new toilets with accessibility ramp, laboratory renovation, electricity connectivity, and ambulance mobilization.

Figure 8. Facilities in performance-based incentive pilot earning at least 70% score in quality of care

^{15} One health facility in Mangochi district dropped out of the pilot between cycles 4 and 5.
SSDI-Services, in collaboration with the MoH Quality Assurance Secretariat and RHD, scaled up PQI/SBM-R for infection prevention (IP), RH, and child health to 215 health facilities—175 health centers and 40 hospitals—throughout the 15 target districts. Through the PQI/SBM-R approach, SSDI-Services considerably improved health outcomes for mothers and newborns at supported health facilities over the life of the project (2012 to 2016). Most notably, incidence of maternal deaths reduced from 120/100,000 births to 46/100,000 births; newborn deaths reduced from 15/100,000 to 8/100,000; and maternal sepsis reduced from 128/100,000 births to 84/100,000 births (see Figure 9). Health facilities with written, facility-specific waste management plans substantially increased from 26 to 213.

Figure 9. Trend in maternal sepsis at facilities supported by SSDI-Services

PQI/SBM-R also contributed to demonstrable reductions in complications of labor (postpartum hemorrhage, pre-eclampsia and eclampsia, obstructed labor, and ruptured uterus) and health facilities’ improved utilization of waste management plans as a tool to facilitate IP.

The PQI/SBM-R approach aimed to improve infection prevention and control practices and enhance the quality of MNCH, FP, malaria, and HIV services by minimizing nosocomial infections and contributing to MoH’s goal of reducing maternal and newborn morbidity and mortality. The PQI/SBM-R approach comprised the following key components:

- **Performance standards**: The PQI/SBM-R process begins with health facilities establishing performance standards across service delivery areas/departments. The performance standards are used to measure progress in quality of services and serve as the criteria for determining facility recognition and awards.

- **Training**: Trainings equipped health workers with the requisite skills to deliver high-quality health services. In addition, refresher trainings provided the opportunity to reinforce the need to implement quality standards for IP and RH; address bottlenecks health workers faced in putting the standards into practice; and reinvigorate health workers’ desire to achieve the standards, ultimately supporting their facility to achieve Center of Excellence status.††

†† A Center of Excellence is a health facility that achieves 80% or better compliance with the established performance standards upon external assessment.
- **Routine assessments**: After establishing quality benchmarks at baseline, routine performance assessments were conducted to monitor progress of quality improvement initiatives across facilities and health service areas. SSDI-Services conducted internal assessments of all health facilities to support them in preparation for the external assessments conducted by MoH, which determined Center of Excellence status and awards to facilities. Table 1 lists the health facilities that achieved at least 80% in performance standards.

- **Mentorship**: Mentorship and coaching were used to provide on-the-job training of health workers, allow for skills transfer based on health workers’ individual competencies, and troubleshoot bottlenecks relevant to their work environment and context. Mentoring review meetings were conducted to facilitate cross-learning among health facilities across each district.

- **Computer tablets**: Computer tablets were introduced to boost institutionalization of PQI/SBM-R by streamlining the mentorship and assessment processes and greatly facilitating provision of feedback.

- **Provision of equipment**: The project supported health facilities with provision of IP equipment, supplies, and personal protective wear, including IP buckets, mackintoshes, sterile gloves, gumboots, goggles, heavy-duty aprons, chlorine, detergents, operating drapes and gowns, large movable linen drums, and guidelines.

### Table 1. Facilities achieving at least 80% in performance standards

<table>
<thead>
<tr>
<th>Facility</th>
<th>Recognition</th>
<th>Technical area of achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central East Zone</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Francisca Palau Mzengawantheenga Community Mission Hospital | Certified as Center of Excellence (COE) | • Infection prevention (IP)  
• Reproductive health (RH) |
| Ngala Health Center (H/C)        | Certified as COE                                 | Integrated IP/RH/prevention of mother-to-child transmission of HIV (PMTCT) |
| Nkhotakota District Hospital     | Certified as COE                                 | • IP  
• RH |
| Nkhunga H/C                      | Certified as COE                                 | Integrated IP/RH/PMTCT                                             |
| **Central West Zone**            |                                                  |                                                                     |
| Mlare Community Hospital         | Certified as COE                                 | IP                                                                  |
| Nkhotokota Mission Hospital      | Certified as COE                                 | IP                                                                  |
| St. Gabriel's Mission Hospital   | Certified as COE                                 | IP                                                                  |
| **Northern Zone**                |                                                  |                                                                     |
| Atupele Community Hospital       | Certified as COE                                 | IP                                                                  |
| Chitipa District Hospital        | • Certified as COE  
• Received recognition plaque | IP                                                                  |
| Nthalire H/C                     | Certified as COE                                 | • IP  
• RH |
| **South East Zone**              |                                                  |                                                                     |
| Balaka District Hospital          | Certified as COE                                 | • IP  
• RH |
| Chikwewo H/C                     | Achieved COE status, not recognized              | —                                                                  |
| Chipala H/C                      | Certified as COE                                 | Integrated IP/RH/PMTCT                                             |
| Holy Family Mission Hospital     | Certified as COE                                 | • IP  
• RH |
| Mbeli H/C                        | Certified as COE                                 | Integrated IP/RH/PMTCT                                             |
| Mulanje District Hospital        | Certified as COE                                 | IP                                                                  |
| Mulibwanji Community Hospital    | Certified as COE                                 | IP                                                                  |
| Nankhumba H/C                    | Certified as COE                                 | Integrated IP/RH/PMTCT                                             |
### South West Zone

<table>
<thead>
<tr>
<th>Facility</th>
<th>Recognition</th>
<th>Technical area of achievement</th>
</tr>
</thead>
</table>
| Sisters of Divine Providence Trinity Mission Hospital | • Certified as COE  
• Received recognition plaque | • IP  
• RH |

Handover ceremony awarding a plaque for excellence in infection prevention and reproductive health to Sisters of Divine Providence Trinity Mission Hospital.

Chisipa’s district health officer, left, receiving a plaque on behalf of Chisipa District Hospital for excellence in infection prevention from the minister of health.

Nkhoma Mission Hospital staff receiving a certificate for excellence in infection prevention.

Mlare Community Hospital staff receiving a certificate for excellence in infection prevention.
SSDI-Services implemented HIV interventions aimed to support MoH in reaching the 90-90-90 global HIV targets (see Box 9). SSDI-Services strived to build the capacity of district MoH staff to provide high-quality HIV/TB services through in-service training, clinical mentorship/coaching, supportive supervision, and infrastructure improvements. The project also supported development, printing, and distribution of guidelines, standard operating procedures, protocols, and information, education, and communication materials. Implementation occurred in two phases—the core phase and the expansion phase.

**Core Phase**

Key HIV interventions were integrated into the SSDI-Services core MNCH platform, enabling mothers and their infants to access HIV testing and counseling (HTC) services, prevention of mother-to-child transmission of HIV (PMTCT), and early infant diagnosis (EID).

**Expansion Phase**

Key interventions included strengthening capacity of MoH staff in provision of antiretroviral therapy (ART), PMTCT, and EID services; extending reach of HTC services from facility to households; expanding community interventions to ensure adherence and retention in care for individuals on ART; and strengthening lab services, including scaling up viral load testing. The HIV expansion phase was implemented in Years 4 and 5 and was limited to 54 facilities in four (Chikwawa, Lilongwe, Nsanje, Salima) of the 15 SSDI districts.

**First 90: Knowing Your Status**

- Prevention of mother-to-child transmission of HIV (PMTCT)—Option B+
- HIV testing and counseling, including provider-initiated and door-to-door testing and counseling
- Early infant diagnosis, including sample transportation
- Laboratory strengthening

**Second 90: Receiving Antiretroviral Therapy (ART)**

- Training and clinical mentorship in ART, PMTCT, and TB
- Deployment of community coordinators and expert clients* to retain ART clients in care or bring them back to care
- Integrated nutrition care support treatment
- TB screening

**Third 90: Suppressing the Virus**

- Viral load testing, including sample transportation
- Laboratory strengthening

* Expert clients have been stable and adherent on ART for at least 2 years. They are identified by facility staff to receive a 1-week training on HIV basics, HIV testing, ART, PMTCT, early infant diagnosis, viral load testing, adherence counseling, stigma and discrimination, retention, and tracing clients lost to follow-up. After training, expert clients assist in outreach several days a week.

Key achievements in HIV programming over the life of the project include:

- HTC was successfully integrated as part of routine service delivery at under-5, ANC, maternity, and FP units in all health facilities in the 15 target districts.
- Tested 1,251,467 males and nonpregnant females for HIV as part of routine HTC. 188,857 were found HIV-positive and enrolled in care and 113,683 were initiated on ART.
• Tested **1,386,599 pregnant women** for HIV in ANC, of which 111,955 (8%) tested HIV-positive and were referred for enrollment in PMTCT. Number of women tested for HIV in ANC represents 85% of the 1,622,422 that attended ANC at SSDI-supported health facilities. (See Figures 10 and 11.)

• Initiated **102,066 pregnant and breastfeeding women on ART**. This represents 91% of the total found HIV-positive in ANC.

• Enrolled **3,000 mothers and infants in mother–infant pair clinics**, established to strengthen adherence and retention of mothers and their babies in PMTCT.

• Increased number of **ART facilities** receiving certificates of excellence in the four expansion districts from 17 to 42 in 2 years. The total number of ART facilities was 54.

• Conducted **45,062 viral load tests** in the four districts of which 93% of the results were undetectable. All supported facilities in the HIV expansion districts were supported to routinely conduct viral load testing.

• Brought back to care **6,187 (69%)** of 8,929 clients lost to follow-up and reinitiated them on ART.

• Provided **youth-friendly health services and psychosocial support to 1,200 adolescents** at Teen Clubs supported by SSDI-Services.

• Screened **45,249 ART/PMTCT clients for TB**, 4,629 were found TB-infected and 4,356 (94%) were initiated on TB treatment.

**Figure 10. Pregnant women receiving HIV testing services from SSDI-Services, 2012–2016**
Infrastructure Improvements

SSDI-Services invested considerably in refurbishing health facilities to improve the customer experience and quality of care for clients of HIV services. In addition, SSDI-Services conducted several small-scale construction activities to improve waste management and other auxiliary services.

![Newly constructed toilets at Sorgin Health Center in Nsanje district.](image1)

![Newly constructed antiretroviral therapy area at Ngabu Rural Hospital in Chikwawa district.](image2)

Renovation of antiretroviral therapy area, left, and newly constructed incinerator, right, at Nyamithuthu Health Center in Nsanje district.

**Figure 11. Pregnant women initiated on antiretroviral therapy at SSDI-Services sites, 2012–2016**

<table>
<thead>
<tr>
<th></th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV +</td>
<td>18,084</td>
<td>15,176</td>
<td>24,470</td>
<td>28,177</td>
<td>27,649</td>
</tr>
<tr>
<td>Initiated on ART</td>
<td>13,575</td>
<td>12,484</td>
<td>22,290</td>
<td>25,987</td>
<td>26,129</td>
</tr>
<tr>
<td>Initiated before ANC</td>
<td>5,000</td>
<td>10,000</td>
<td>15,000</td>
<td>20,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Initiated during ANC</td>
<td>20,000</td>
<td>30,000</td>
<td>40,000</td>
<td>50,000</td>
<td>60,000</td>
</tr>
<tr>
<td>Initiated during labour</td>
<td>20,000</td>
<td>30,000</td>
<td>40,000</td>
<td>50,000</td>
<td>60,000</td>
</tr>
</tbody>
</table>
At the onset of SSDI-Services implementation in 2011, the national M&E systems for the health sector faced considerable challenges that limited collection of high-quality data and impeded access to and use of performance data to inform decision-making by program managers and policymakers. Key gaps in the M&E landscape included: lack of a harmonized national data collection, management, and reporting system; a proliferation of nonstandardized data collection tools and reporting forms developed independently by MoH health programs; health facility registers and reporting forms were either unavailable at most health facilities or frequently out of stock; health care providers had limited knowledge and skills in capture, management, and reporting of service delivery data; and use of empirical data to improve service delivery and inform programming was limited.

In response to these challenges, SSDI-Services’ investment strategy in M&E focused on establishing and strengthening core elements of a harmonized health management information system (HMIS). The strategy sets its priorities to: 1) strengthen HMISs, 2) pilot and scale up digital health innovations, 3) strengthen facility-level M&E capacity and data management, and 4) improve data use for decision-making.

In the last 2 years of the project, SSDI-Services further strengthened core HMIS activities at national, district, and zonal levels while facilitating MoH leadership and ownership of these activities to ensure sustainability of the HMIS system after the closeout of the SSDI program.

Strengthening HMISs

SSDI-Services invested in supporting the MoH transition from primarily paper-based systems for managing and reporting service delivery data to electronic systems. The core components of this approach were the adaptation and scale-up of the DHIS 2 and TrainSMART systems.

DHIS 2

Though MoH had established DHIS 2 as the platform for managing service delivery data in the health sector prior to startup of SSDI-Services, utilization and functionality of the system remained minimal and uncoordinated. Initially, SSDI-Services adopted the DHIS 2 platform to collect, manage, and facilitate reporting of project-specific data solely in the 15 target districts. The approach included provision of computer equipment, accessories, and Internet connectivity, complemented with intensive mentoring, coaching, and supervision at all levels in the health sector. Reporting rates in DHIS 2 from facilities in the 15 target districts increased considerably: reporting rates (for all MoH program reports on technical areas relevant to SSDI-Services) improved from 7% in 2012 to 83% in 2016.

In Year 3, SSDI-Services and MoH, through the Central Monitoring and Evaluation Division, began a collaboration to integrate SSDI-Services’ DHIS 2 database with the national DHIS 2 platform. SSDI-Services also intensified its mentoring, coaching, and supervision interventions nationwide—beyond the 15 target districts. This expansion to non-SSDI districts has contributed to increased reporting rates in those districts. In addition, the support SSDI-Services has provided to the Central Monitoring and Evaluation Division to
harmonize and standardize HMIS tools, guidelines, and procedures contributed to Malawi being designated as a pathfinder country by the Global Health Collaborative at the 2015 Global Health Measurement Summit.

**TrainSMART**

In-service capacity-building was a key strategic approach for SSDI-Services’ implementation model. SSDI-Services trained over 32,000 health care workers, many of who received multiple instances of training by participating in more than one training course and refresher courses. At the onset of the project, documentation of individuals trained was paper-based. This made monitoring and tracking the training beneficiaries a significant challenge.

In 2012, SSDI-Services collaborated with MoH and I-TECH (the International Training and Education Center for Health, an affiliate of University of Washington) to modify Malawi’s version of TrainSMART. At the time, TrainSMART was being used to effectively manage beneficiaries of training under the HIV program, to capture training data for all program areas under the EHP. Through these efforts, SSDI-Services spurred the establishment of a country-owned harmonized database to track the various trainings attended by health workers in Malawi. SSDI-Services also supported MoH to roll out TrainSMART to all health zones and districts nationwide, allowing subnational managers to more effectively monitor the needs and progress of their staff. During the life of the project, SSDI-Services registered over 48,000 beneficiaries of its training programs.

**Revision, Printing, and Distribution of Health Facility M&E Tools**

Though data management and reporting have transitioned to electronic systems, data collection at the point of service delivery remains paper-based. This is manifested by the abundance of registers and reporting forms at all health facilities and at each point of care within the facility. SSDI-Services, in collaboration with other partners and MoH, facilitated the revision of key MoH service delivery registers and reporting forms. SSDI-Services also supported MoH by periodically printing and distributing registers and reporting forms to mitigate stock-outs at health facilities and community clinics.

SSDI-Services introduced self-carbonated reporting booklets that produce health facility reports in triplicate. This innovation has resulted in improved availability, completeness, timeliness, and efficiency of report compilation at health facilities. Each health facility now has the capacity to retain copies of all reports it produces, thus enhancing data verification and use of data at facility level. Prior to this intervention, the majority of health facilities only had enough paper to produce one report, which was submitted to the district hospital.

---

9 Jhpiego’s Training Systems Monitoring and Reporting Tool for tracking, monitoring, and managing in-service training events, trainees, and trainers.
Piloting and Scaling Up Digital Health Innovations

Through the M&E and health informatics platforms, Jhpiego piloted several digital health innovations to strengthen capture of service delivery data by frontline health workers in both facility and community settings. The innovations aimed to improve both quantity and quality of data collected and catalyze increased demand for and use of service statistics by individuals who are responsible for collecting the data.

Tablet-Based SBM-R/Mentoring

SSDI-Services piloted and rolled out use of Android tablets to facilitate implementation of the PQI initiative. Automation of the analysis and report production components of the PQI mentoring visits and assessments has resulted in substantially improved efficiency of and customer satisfaction with the PQI process at SSDI-supported facilities.

Community Case Management (CCM)/CBMNH Application for Health Surveillance Assistant (HSA) Decision-Making (in Collaboration with D-tree)

In Years 3 and 4, SSDI-Services, in collaboration with D-tree International, developed an integrated mobile application that supports clinical decision-making by HSAs at the village clinics when providing CCM and CBMNH services. The key feature of the pilot was distribution to HSAs of mobile phones preloaded with the CCM/CBMNH application. The phones helped guide HSAs through the CCM and CBMNH protocols to support improved decision-making while HSAs attend to clients. Since being piloted by six HSAs in Dowa district, this initiative has grown to be utilized by over 500 HSAs in Dowa and Machinga districts.

Strengthening Facility-Level M&E Capacity and Data Management

Printing of M&E Tools and Products

SSDI-Services built the M&E and data management capacity of SSDI-supported facilities through a range of interventions, including quality assurance of routine data, monthly data collection and validation, program
review meetings, trainings, and printing and distribution of data collection and reporting tools. Printing and distribution of M&E guidance documents, standard operating procedures, registers, reporting forms, flow-charts, graphs, and other data visualization tools improved availability of data at health facilities and catalyzed revitalization of facility-level data reviews.

Training, Mentorship, and Supervision

Over the life of the project, SSDI-Services trained 1,479 health workers and HMIS staff in documentation using health facility registers, recording and report preparation using the health facility summary forms, and basic data analysis, interpretation, and chart development. Routine visits to verify and validate the data reinforced the classroom training and provided onsite technical assistance and supportive supervision to 241 M&E focal persons. The technical support focused on service providers’ appropriate use of facility service registers and reporting tools, facilities’ institutionalization of routine data reviews, and facilitating feedback from prior training, reporting, supervision, or mentorship activity.

Routine Data Quality Assessment

SSDI-Services utilized a modified version of the MEASURE Evaluation Routine Data Quality Assessment Tool to facilitate data quality assessments (DQAs). The project routinely conducted DQAs to ensure compliance with M&E standard operating procedures and validate service delivery data. In 2014, SSDI-Services supported MoH to adapt the Routine Data Quality Assessment Tool to the purpose of ascertaining data quality at all health facilities nationwide. Since the tool was institutionalized as a national tool by MoH, there has been demonstrable improvement in compliance to recommended M&E practices at health facilities in all 28 districts. Improved practices include the display of data (via graphs, charts, and tables) in facilities and facility-based data reviews. Institutionalizing the DQA system has also resulted in facility-specific problem-solving through development of facility-specific action plans to address the data quality issues identified during the DQA exercises.

Improving Data Use for Decision-Making

Data Review Meetings

Data review meetings—held at both district and health facility levels—consisted of reviewing past performance data and discussing trends in key performance indicators for the SSDI-Services project as well as the district implementation plans. The review meetings gave teams the opportunity to utilize empirical data to inform decisions about future investments and programming, provided opportunities to address data challenges and other M&E-specific needs in health facilities, and reinforced the need for data use in health facility and district decision-making. Friendly competition between facilities and district health offices raised awareness and appreciation of service data and facilitated increased demand for and incorporation of data in routine planning and management processes.

Documentation of Successes, Lessons, and Best Practices

Throughout the life of the project, SSDI-Services routinely implemented knowledge management activities to ensure appropriate documentation and dissemination of project achievements, lessons learned, and deliverables. As the project closes, it has documented and disseminated all key products produced, which may be accessed at the USAID Development Experience Clearinghouse.

Best Practices Resulting in SSDI-Services Successes

Using performance review meetings for implementation teams to successfully plan and implement multilevel projects: The SSDI-Services project intensively invested time and guidance in performance review meetings. These meetings were conducted monthly with central-level project staff and semiannually with all project staff (including zone and district teams). The meetings were highly beneficial in enabling all project staff to understand and internalize the project, review progress, refocus project implementation plans, and

utilize data for restrategizing and ongoing programming. The meetings also resulted in standardization of project implementation modalities and strategies; prioritization of high-impact interventions; strengthened capacity of district and zonal project staff to perform critical analyses of project activities through a results-oriented lens; and strategic monitoring of project achievements.

**Integrating health service delivery:** Delivery of integrated health services to clients increased access to and coverage of multiple essential health services at each client visit. SSDI-Services exploited opportunities to integrate health services at all points that served mothers and children, primarily, as well as spouses. Integration allowed clients presenting at the health facility for a specific service access to other essential EHP services based on the results of triage or counseling. Integrated family health outreach clinics allowed community health workers to deliver multiple EHP services from one place at one time. HIV services were also integrated into maternal and child health, TB, sexually transmitted infection, and FP services. Integration of services greatly improved efficiency of service delivery, providing one-stop shopping for clients, as opposed to the previous model: specific services only available on certain days or in specific facility wards.

**Designating a program coordinator at MoH, helping to guarantee successful program implementation:** MoH designated a senior official from the ministry to serve as the program coordinator, providing government oversight to the three SSDI projects. The coordinator routinely participated in planning and review cycles for all three projects to ensure implementation aligned with government priorities and adequately leveraged synergy between the three program areas—service delivery, policy, and behavior change communication. The involvement of the program coordinator provided a platform for the SSDI projects to directly dialogue with MoH, fostering a cordial working relationship and government ownership of interventions and expediting decision-making at key moments. Being conversant with the projects’ plans and progress made the coordinator an important liaison between SSDI-Services, USAID, and MoH leadership.

**Collaborating closely with district health management teams (DHMTs):** SSDI-Services invested in developing close working relationships with the DHMTs. As gatekeepers of health services at district level and below, it was critical that the project interventions and implementation plans get buy-in from DHMTs. SSDI-Services district staff were co-located with the district health officer’s (DHO’s) office, where possible, and the project’s district staff involved the DHMT and relevant district staff in all key activities: planning, review, supervision, mentoring, training, and service delivery. SSDI-Services staff were considered part of the extended DHMTs, which included MoH program coordinators, making the SSDI-Services staff an integral part of the district planning and decision-making process.

**Investing in DHMT leadership to enhance facility-level service delivery:** Investing in building capacity of district-level leaders, like the DHOs, district nursing officers, District Environmental Health Officers, and MoH program coordinators, facilitates government ownership and smooth implementation of project activities at facility level. Improvement in health outcomes and quality of health services was strongest in districts with highly engaged DHMTs.

**Coaching, mentoring, and supportive supervision jointly with MoH:** Coaching and mentorship are two strong strategies employed across the spectrum of technical areas within the SSDI-Services project. The use of joint coaching and mentorship was most evident in MNCH areas. SSDI-Services and MoH officials conducted joint coaching, mentorship, and supervision exercises at the different health facilities. Joint visits allowed MoH officials from central, zone, and district levels to verify that modes and service delivery complied with MoH standards as well as to routinely appraise progress of implementation and impediments to more effective service delivery as experienced on the frontlines. Health facilities attached a lot of significance to these joint exercises—the presence of high-ranking MoH officials facilitated participation and improved accountability of health workers. The HIV expansion phase of the project focused on strengthening the district clinical mentorship teams to provide onsite clinical mentorship and coaching to ensure provision of high-quality HIV services. The mentorship took mentees and facilities through three phases: intensive, maintenance, and—finally—graduation.

**Using outreach campaigns to substantially increase access to and uptake of FP services:** FP campaigns and open day events registered outstanding success across the 15 districts and contributed to the accelerated uptake of FP methods by women in target communities.
organized as a means to provide information on FP services, create demand, and increase access by providing an expanded method mix using community outreach clinics and community-based health workers.†††

Improving synergy among government directorates as a key to effectively addressing malaria in pregnancy: SSDI-Services facilitated a partnership between the RHD and National Malaria Control Program to jointly develop the inaugural guidelines, training manuals, and job aids addressing malaria in pregnancy. The partnership, and resulting guideline documents, contributed to resolving long-standing inefficiencies in delivering malaria prevention and treatment services to pregnant women. Furthermore, SSDI-Services supported the directorates to plan and conduct joint supportive supervision visits—which they are now doing—to monitor progress in implementation, assess provider adherence to the guidelines, identify gaps, and work with DHMTs to develop strategies to resolve the gaps identified.

Enlisting expert clients as a pathway to achieving the 90-90-90 HIV/TB targets: SSDI-Services recruited and deployed teams of expert clients to targeted health facilities and communities as a means of improving retention and return to care of clients on ART. Use of expert clients proved to be a very cost-effective mode of bringing clients back to care; clients were able to relate to the expert clients as peers in the same situation as themselves. Expert clients also effectively carried out additional programmatic and support functions (e.g., delivering health talks in the community, ensuring clients were tested for viral load, providing adherence support for clients on ART, and physically escorting HIV-positive clients to ensure linkage to care and treatment) that aided the ART providers in delivering services.

Employing HIV diagnostic assistants (HDAs) in HIV/TB care and treatment projects as an effective strategy for achieving the 90-90-90 global targets: In the HIV/TB expansion phase of the SSDI-Services project, which focused on HIV care and treatment, HDAs were utilized to increased access to and coverage of HIV diagnostic services. In addition to providing HIV testing, HDAs collected dried blood spot samples to test ART clients’ viral loads and carried out EID for HIV-exposed infants. Having a dedicated cadre focused on HIV testing services notably increased uptake of HTC and proved to be an effective way to accelerate achievement of the first 90 of the 90-90-90 HIV global targets.

Empowering communities to improve accountability in health facilities: Empowering communities with skills and knowledge increases their ability to identify health issues within their communities and resolve them on their own. Empowered communities are also more confident to demand better services at their catchment facilities and hold service providers accountable for optimal care. This was exemplified through the community action groups and community scorecard process under SSDI-Services.

Organizing care groups to effectively improve the adoption of health behaviors: Care groups provided a platform for engagement and collaboration between health workers, local leaders, and community members,


Box 10. Community Scorecard Empowers Communities to Demand Ambulance Services

After noting that the ambulance assigned to their health center was taken away to the district health office, community members of Malembo in Balaka, through a community scorecard interface meeting, inquired of the district health office why that was the case. They questioned why each time an ambulance was assigned to their health center, it was taken away within a few months. The DHO responded by reassigning the ambulance to the health center.

The same is true for Mbingwa community in Dowa and Chilipa in Mangochi, where communities, through the community scorecard interface meetings, demanded ambulances and their DHOs assigned them accordingly. For Mbingwa community, when the DHO indicated that their health center had no ambulance because of lack of resources to cover fuel costs, the community, in response, offered to pay for the cost of fueling the ambulance. Since then, the community has been fueling the ambulance for their facilities.

SSDI-Services End of Project Report 33
resulting in notably increased awareness and improved practice of specific health behaviors. Care groups extended the reach of health services and messages by advocating with and educating their peers on improved health behaviors. Increased awareness led communities to increasingly access and demand specific health services for their households and families.

Using community and facility staff interface meetings (community scorecard process) to fundamentally improve service delivery at the health center level: The community scorecard initiative was a key element of SSDI-Services’ PBI pilot. SSDI-Services rolled out use of community scorecards to increase community awareness and involvement in determining access to and quality of essential health services in their communities. The scorecard served as the tool to strengthen collaboration and foster productive interaction between health facility staff and members of the community—through their representatives to the health advisory council. Through this process, communities have become increasingly aware of the health services available to them and factors that facilitate and impede service delivery at their health facility.

Increased understanding of health facility operations has empowered communities to hold health providers accountable and advocate to the DHO for increased resources or specific attention to the health facility in their community (see Box 10). Understanding has also mitigated the tensions and negative perceptions health workers and clients had of each other.

Co-locating SSDI-Services and SSDI-Communication at district and zonal levels, leading to the successful implementation of CM activities: SSDI-Services and SSDI-Communication co-located staff at district and zonal offices to institutionalize joint planning and implementation of CM interventions. This arrangement allowed technical experts in behavior change communication and health service delivery to simultaneously weigh in on the operations of CM interventions and ensure that the messages as well as the services were reaching households in the most effective manner.

Institutionalizing quality as a contributing factor to achieving PQI: Institutionalizing quality standards at health facility level has proved to be a contributing factor toward achievement and sustainability of PQI. Three critical success factors for building a culture of PQI at health facilities are leadership, championship, and internal rewards. Commitment of the DHO and the DHO’s management team to PQI served as an example to the DHO’s staff, who directly affect performance and quality of services. Periodic rewards and recognition of facilities achieving established standards motivated staff to perform better and entrenched a culture of healthy competition, both among departments in a facility and across facilities and districts. Intensive coaching and mentorship on skills, especially the use of the performance standards, institutionalized PQI practices as part of routine service delivery.

Conducting M&E technical review meetings to strengthen M&E systems: SSDI-Services routinely brought together M&E and health information experts in each district for quarterly technical review meetings. Meetings often included participation from central- and zonal-level officials. The meetings provided a forum for peer-to-peer learning and development of standardized M&E practices across the 15 target districts. The reviews were also used to inform health facility staff of upcoming initiatives, such as national rollout of DHIS 2, and to troubleshoot any challenges specific facilities and/or districts were facing regarding M&E and HMIS.

Lessons Learned

Avoid mobile outreach clinics for HTC among the general population: Mobile outreach clinics that were designed to get 90% of those with HIV onto treatment were neither effective nor efficient in achieving this goal. Mobile outreach clinics required significant resources but produced low yield—the number of HIV-positive persons identified was notably low compared to the number of people who turned up for the test (even lower than the HIV prevalence). Mobile HTC services for the general population are unlikely to accelerate the achievement of the global 90-90-90 targets.

On the other hand, mobile outreach services targeting high-risk groups like armed personnel, fishermen, estate workers, and sex workers registered substantial yield.
Do not rely on capacity-building and equipment distribution alone to directly translate into improved service delivery: Capacity-building (training, orientation) of health facility staff and provision of basic equipment and supplies do not alone directly translate into improved service delivery, especially in the absence of strong accountability systems for delivery of high-quality health services. It is essential that district-level managers use follow-up supervision and coaching to ensure that trained providers are putting their skills into practice. Future projects should consider supporting MoH to institutionalize accountability mechanisms for ensuring health workers are utilizing the skills they have gained to the benefit of their constituent facilities and clients.

Prepare and procure materials well in advance for competency-based trainings: Competency-based trainings, such as those on BEmONC, HBB, and CBMNH, require advance planning for the training as well as advance procurement of materials to be used for the training and subsequent service provision. This ensures that the trainees are well-equipped with the materials that they need to put their skills to use once they go back to their duty stations. During Years 1 and 2 of the SSDI-Services project, procurements were done at the same time trainings were being planned; this resulted in preventable gaps in service provision despite skill acquisition. For example, HSAs were deployed to the field after training, but without the requisite CBMNH materials, such as weighing scales, timers, backpacks, and counseling cards.

Compensate for changes in donor policies to avoid disruptions in project implementation: Changes in the daily subsistence allowances negatively affected participants’ attendance in trainings, coaching, mentorship, and supervision exercises. Low attendance at these crucial activities affected service provision (at facility and community levels). Ultimately, this negatively affected project implementation and achievement of results. SSDI-Services managed the situation by ensuring that all partner organizations in the consortium applied a uniform policy on daily subsistence allowances to avoid confusion and minimize resentment among participants.

Plan technical update sessions as recurrent, not one-time, activities: Technical update sessions for both project and MoH staff must occur not only at the onset of the project but periodically throughout the life of the project. This would support project and MoH staff who join midproject to gain the requisite understanding of project implementation; and would promote maintenance of technical integrity of services provided and standardization of practices.

Roll out new and revised guidelines without delay: When projects support MoH to develop or change guidelines for service delivery, the projects should print and distribute new materials to service delivery points without delays. Because the dynamic nature of health programs sometimes necessitates frequent changes in guidelines, significant delays may result in the project being compelled to discard already-outdated guidelines (waste of invested resources).

Balance application of internal controls: There has to be a clear understanding and balance in the application of existing systems for administrative and financial internal control to ensure that systems work to support—and not impede—program implementation. This is especially important for finance and procurement systems, which are critical to program implementation.
## Appendix A: Performance Monitoring Plan (PMP)

<table>
<thead>
<tr>
<th>SSDI-Services PMP Indicators/Targets</th>
<th>Baseline</th>
<th>FY 12 (Results)</th>
<th>FY 13 (Results)</th>
<th>FY 14 (Results)</th>
<th>FY 15 (Results)</th>
<th>FY 16 (Results)</th>
<th>Extension (Oct-Dec 2016) (Results)</th>
<th>LOP Results</th>
<th>LOP Targets</th>
<th>% of LOP Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Element: Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Number of USG-assisted service delivery sites providing family planning (FP) counseling and/or services</td>
<td>102</td>
<td>144</td>
<td>213</td>
<td>282</td>
<td>278 of 304</td>
<td>277</td>
<td>273 of 304</td>
<td>273 of 304</td>
<td>291 of 304</td>
<td>94%</td>
</tr>
<tr>
<td>2. Number of service delivery sites that offer at least three modern methods of (and/or referral for) FP</td>
<td>102</td>
<td>144</td>
<td>223</td>
<td>272</td>
<td>267</td>
<td>264</td>
<td>265</td>
<td>265</td>
<td>276</td>
<td>96%</td>
</tr>
<tr>
<td>3. Number of service delivery sites that offer LAPM (disaggregated by targeted district)</td>
<td>77</td>
<td>129</td>
<td>215</td>
<td>245</td>
<td>251</td>
<td>253</td>
<td>253</td>
<td>253</td>
<td>251</td>
<td>101%</td>
</tr>
<tr>
<td>4. Percent of youth accessing family planning</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>51%</td>
<td>46%</td>
<td>53%</td>
<td>53%</td>
<td>53%</td>
<td>60%</td>
<td>88%</td>
</tr>
<tr>
<td>5. Number of counseling visits for FP/RH as a result of USG assistance</td>
<td>225,504</td>
<td>324,324</td>
<td>943,179</td>
<td>1,481,283</td>
<td>1,718,000</td>
<td>1,747,517</td>
<td>471,448</td>
<td>6,685,751</td>
<td>4,951,104</td>
<td>135%</td>
</tr>
<tr>
<td>6. Couple Years of Protection</td>
<td>60,548</td>
<td>41,383</td>
<td>293,938</td>
<td>508,238</td>
<td>723,296</td>
<td>595,107</td>
<td>117,653</td>
<td>2,308,421</td>
<td>1,638,166</td>
<td>141%</td>
</tr>
<tr>
<td>7. Percent of CYP provided through LAPM</td>
<td>-</td>
<td>26%</td>
<td>39%</td>
<td>47%</td>
<td>44%</td>
<td>46%</td>
<td>45%</td>
<td>45%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>8. Percent of FP services provided through Community-Based Distribution services</td>
<td>18%</td>
<td>62%</td>
<td>38%</td>
<td>30%</td>
<td>44%</td>
<td>36%</td>
<td>34%</td>
<td>34%</td>
<td>40%</td>
<td>85%</td>
</tr>
<tr>
<td>9. Number of health facilities providing GBV counseling and referral</td>
<td>40</td>
<td>49</td>
<td>114</td>
<td>128</td>
<td>204</td>
<td>221</td>
<td>225</td>
<td>225</td>
<td>220</td>
<td>102%</td>
</tr>
<tr>
<td>10. Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year</td>
<td>-</td>
<td>851 (M:565; F:286)</td>
<td>607</td>
<td>258</td>
<td>207</td>
<td>229</td>
<td>733</td>
<td>2,885</td>
<td>2,885</td>
<td>100%</td>
</tr>
<tr>
<td>11. Number of people trained in FP/RH with USG funds</td>
<td>981</td>
<td>1,172 (M:716; F:456)</td>
<td>791</td>
<td>283</td>
<td>301</td>
<td>421</td>
<td>733</td>
<td>3,701</td>
<td>3,652</td>
<td>101%</td>
</tr>
<tr>
<td>12. Number of service delivery points providing integrated counseling or RH/HIV/FP services</td>
<td>-</td>
<td>-</td>
<td>230</td>
<td>259</td>
<td>281</td>
<td>287</td>
<td>288</td>
<td>288</td>
<td>284</td>
<td>101%</td>
</tr>
<tr>
<td><strong>Program Element: Maternal, Neonatal and Child Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Number of sites that provide BEmONC</td>
<td>43</td>
<td>50</td>
<td>74</td>
<td>92</td>
<td>90</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>14. Number of women giving birth who received uterotonic in the third stage of labor through USG-supported programs</td>
<td>32,798</td>
<td>167,245</td>
<td>227,973</td>
<td>263,797</td>
<td>253710</td>
<td>55,716</td>
<td>1,001,239</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>SSDI -Services PMP Indicators/Targets</td>
<td>Baseline</td>
<td>FY 12 (Results)</td>
<td>FY 13 (Results)</td>
<td>FY 14 (Results)</td>
<td>FY 15 (Results)</td>
<td>FY 16 (Results)</td>
<td>Extension (Oct-Dec 2016) (Results)</td>
<td>LOP Results</td>
<td>LOP Targets</td>
<td>% of LOP Target Achieved</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>15. Percent of women giving birth who received oxytocin in the third stage of labor</td>
<td></td>
<td>35%</td>
<td>79%</td>
<td>80%</td>
<td>90%</td>
<td>90%</td>
<td>91%</td>
<td>91%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>16. Percent of pregnant women attending ANC receiving iron supplementation</td>
<td></td>
<td>10%</td>
<td>8%</td>
<td>20%</td>
<td>26%</td>
<td>21%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
<td>20%</td>
</tr>
<tr>
<td>17. Percent of births attended by a skilled doctor, nurse or midwife (skilled birth attendant) in the facility</td>
<td></td>
<td>71%</td>
<td>94% (75,592 of 80,119)</td>
<td>94%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>18. Percent of births conducted by Caesarian Section</td>
<td></td>
<td>-</td>
<td>-</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>19. Percent of newborns receiving postnatal health check within two days of birth</td>
<td></td>
<td>-</td>
<td>-</td>
<td>90%</td>
<td>94%</td>
<td>98%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>97%</td>
</tr>
<tr>
<td>20. Number of facilities with trained personnel in neonatal resuscitation</td>
<td>34</td>
<td>75</td>
<td>82% (207 of 253)</td>
<td>85% (249 of 293)</td>
<td>84% (258 of 304)</td>
<td>89% (271 of 304)</td>
<td>88% (267 of 304)</td>
<td>88% (267 of 304)</td>
<td>87.5% (266 of 304)</td>
<td>100%</td>
</tr>
<tr>
<td>21. Number of health workers trained in neonatal resuscitation (HBB)</td>
<td>285</td>
<td>236</td>
<td>368</td>
<td>76</td>
<td>0</td>
<td>41</td>
<td>0</td>
<td>721</td>
<td>814</td>
<td>89%</td>
</tr>
<tr>
<td>22. Number of facilities providing Kangaroo Mother Care (KMC)</td>
<td>71</td>
<td>87</td>
<td>117</td>
<td>144</td>
<td>170</td>
<td>194</td>
<td>194</td>
<td>194</td>
<td>194</td>
<td>100%</td>
</tr>
<tr>
<td>23. Number of facilities with trained personnel in ETAT</td>
<td>55</td>
<td>63</td>
<td>139</td>
<td>178</td>
<td>173</td>
<td>172</td>
<td>171</td>
<td>171</td>
<td>162</td>
<td>106%</td>
</tr>
<tr>
<td>24. Number of health workers trained in ETAT</td>
<td>294</td>
<td>395</td>
<td>511</td>
<td>174</td>
<td>0</td>
<td>0</td>
<td>34</td>
<td>1,114</td>
<td>612</td>
<td>182%</td>
</tr>
<tr>
<td>25. Percent of newborns not breathing at birth that were resuscitated successfully</td>
<td>57%</td>
<td>57%</td>
<td>82% (840 of 1,474)</td>
<td>83%</td>
<td>81%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>26. Per cent of ANC visits initiated during the first trimester</td>
<td>8%</td>
<td>5%</td>
<td>8%</td>
<td>9%</td>
<td>14%</td>
<td>11%</td>
<td>13%</td>
<td>13%</td>
<td>19%</td>
<td>68%</td>
</tr>
<tr>
<td>27. Percent of pregnant women attending 4 or more ANC visits</td>
<td>17%</td>
<td>18%</td>
<td>20%</td>
<td>22%</td>
<td>23%</td>
<td>23%</td>
<td>26%</td>
<td>26%</td>
<td>40%</td>
<td>65%</td>
</tr>
<tr>
<td>28. Per cent of pregnant women attending ANC that are tested for HIV</td>
<td>63%</td>
<td>70%</td>
<td>73%</td>
<td>82%</td>
<td>88%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>102%</td>
</tr>
<tr>
<td>29. Number of cases of child diarrhoea treated with ORT in USG assisted programs</td>
<td>74,497</td>
<td>76,497</td>
<td>130,979</td>
<td>138,706</td>
<td>151,923</td>
<td>104,577</td>
<td>23148</td>
<td>625,830</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>30. Number of cases of child pneumonia treated with antibiotics by trained facility or</td>
<td>192,399</td>
<td>192,399</td>
<td>307,879</td>
<td>362,613</td>
<td>424,785</td>
<td>657,487</td>
<td>189,495</td>
<td>2,134,658</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>SSDI-Services PMP Indicators/Targets</td>
<td>Baseline</td>
<td>FY 12 (Results)</td>
<td>FY 13 (Results)</td>
<td>FY 14 (Results)</td>
<td>FY 15 (Results)</td>
<td>FY 16 (Results)</td>
<td>Extension (Oct-Dec 2016) (Results)</td>
<td>LOP Results</td>
<td>LOP Targets</td>
<td>% of LOP Target Achieved</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>community health workers in USG-supported programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Number of children under one year who have been fully immunized</td>
<td>56,382</td>
<td>66,130</td>
<td>200,881</td>
<td>282,114</td>
<td>332,394</td>
<td>280,126</td>
<td>54,355</td>
<td>1,216,000</td>
<td>1,207,671</td>
<td>101%</td>
</tr>
<tr>
<td>32. Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs</td>
<td></td>
<td></td>
<td></td>
<td>2308</td>
<td>2332</td>
<td>1,761</td>
<td>1775</td>
<td>8,176</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Program Element: Nutrition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Number of under-5 children who are underweight (WAZ&lt;2)</td>
<td>29,771</td>
<td>37,295</td>
<td>121,286</td>
<td>174,687</td>
<td>161,593</td>
<td>128,466</td>
<td>29,417</td>
<td>652,744</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>34. Number of health facilities with established capacity to manage acute undernutrition (community-based management of acute malnutrition)</td>
<td>98</td>
<td>145</td>
<td>228</td>
<td>279</td>
<td>286</td>
<td>304</td>
<td>304</td>
<td>303</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>35. OTP Cure Rate</td>
<td>80%</td>
<td>84%</td>
<td>88%</td>
<td>90%</td>
<td>92%</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>89%</td>
<td>104%</td>
</tr>
<tr>
<td>36. NRU Cure Rate</td>
<td>82%</td>
<td>84%</td>
<td>83%</td>
<td>84%</td>
<td>85%</td>
<td>82%</td>
<td>81%</td>
<td>81%</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>37. Default Rates among children admitted to NRU</td>
<td>13%</td>
<td>8%</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
<td>8%</td>
<td>63%*</td>
</tr>
<tr>
<td>38. Default Rates among children admitted to OTP</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
<td>6%</td>
<td>33%*</td>
</tr>
<tr>
<td>39. Death Rates among children admitted to NRU</td>
<td>10%</td>
<td>9%</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
<td>100%*</td>
<td></td>
</tr>
<tr>
<td>40. Death Rates among children admitted to OTP</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>50%*</td>
</tr>
<tr>
<td>41. Number of children reached by USG-supported nutrition programs</td>
<td>-</td>
<td>102,660</td>
<td>1,487,491</td>
<td>1,653,856</td>
<td>1,254,751</td>
<td>871,201</td>
<td>256,862</td>
<td>5,626,821</td>
<td>3,064,906</td>
<td>184%</td>
</tr>
<tr>
<td>42. Number of children under five who received of Vitamin A from USG-supported programs</td>
<td>63,281</td>
<td>133,046</td>
<td>521,426</td>
<td>1,653,856</td>
<td>(Outreach: 1,374,426)</td>
<td>649,496</td>
<td>553,985</td>
<td>171,957</td>
<td>3,683,766</td>
<td>2,222,794</td>
</tr>
<tr>
<td>43. Number of people trained in child health and nutrition through USG-supported health area programs</td>
<td>544</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
<td>1,119</td>
</tr>
</tbody>
</table>

**Program Element: Malaria**
<table>
<thead>
<tr>
<th>Program Element: Mentoring and PQI</th>
<th>Baseline</th>
<th>FY 12 (Results)</th>
<th>FY 13 (Results)</th>
<th>FY 14 (Results)</th>
<th>FY 15 (Results)</th>
<th>FY 16 (Results)</th>
<th>Extension (Oct-Dec 2016) (Results)</th>
<th>LOP Results</th>
<th>LOP Targets</th>
<th>% of LOP Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>55. Number of health facilities in SSDI districts receiving 1 or more mentoring visits per quarter</td>
<td>0</td>
<td>-</td>
<td>74</td>
<td>81</td>
<td>71</td>
<td>100</td>
<td>94</td>
<td>94</td>
<td>170</td>
<td>55%</td>
</tr>
</tbody>
</table>

44. Number of health workers trained in IPTp with USG funds

Baseline: 182 (M:21; F:10)

FY 12 (Results): 31

FY 13 (Results): 134

FY 14 (Results): 801

FY 15 (Results): 3569

FY 16 (Results): 761

Extension (Oct-Dec 2016) (Results): 0

LOP Results: 5,296

LOP Targets: 1,190

% of LOP Target Achieved: 445%

45. Number of health workers trained in case management with ACTs with USG funds

Baseline: 806 (M:156; F:48)

FY 12 (Results): 204

FY 13 (Results): 540

FY 14 (Results): 825

FY 15 (Results): 3569

FY 16 (Results): 120

Extension (Oct-Dec 2016) (Results): 0

LOP Results: 5,258

LOP Targets: 5,055

% of LOP Target Achieved: 104%

46. Number of people trained in malaria treatment or prevention with USG funds

Baseline: 806 (M:303; F:131)

FY 12 (Results): 454

FY 13 (Results): 644

FY 14 (Results): 1,123

FY 15 (Results): 3569

FY 16 (Results): 120

Extension (Oct-Dec 2016) (Results): 0

LOP Results: 5,890

LOP Targets: 5,347

% of LOP Target Achieved: 110%

47. Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnostic Tests – RDTs) or microscopy with USG funds

Baseline: - (M:126; F:63)

FY 12 (Results): 199

FY 13 (Results): 30

FY 14 (Results): 834

FY 15 (Results): 3569

FY 16 (Results): 120

Extension (Oct-Dec 2016) (Results): 0

LOP Results: 4,752

LOP Targets: 3,288

% of LOP Target Achieved: 145%

48. Number of people reached through community outreach activities that promotes the correct and consistent use of insecticide-treated nets

Baseline: N/A

FY 12 (Results): 272,351

FY 13 (Results): 349,873 (Outreach: 349,873)

FY 14 (Results): 438,860 (Outreach: 69,781)

FY 15 (Results): 590,902

FY 16 (Results): 697,227

Extension (Oct-Dec 2016) (Results): 103,744

LOP Results: 2,452,957

LOP Targets: 2,091,490

% of LOP Target Achieved: 117%

49. Number of people reached through community outreach activities that promotes the treatment of malaria according to National Guidelines

Baseline: N/A

FY 12 (Results): 79,847

FY 13 (Results): 558,815

FY 14 (Results): 625,909

FY 15 (Results): 607,347

FY 16 (Results): 490,345

Extension (Oct-Dec 2016) (Results): 3270

LOP Results: 2,365,533

LOP Targets: 1,976,850

% of LOP Target Achieved: 120%

50. Number of children under 5 treated for fever via village clinic

Baseline: 302,784

FY 12 (Results): 136,101

FY 13 (Results): 529,833

FY 14 (Results): 625,909

FY 15 (Results): 662,132

FY 16 (Results): 457,519

Extension (Oct-Dec 2016) (Results): 106,083

LOP Results: 2,517,577

LOP Targets: NA

% of LOP Target Achieved: NA

51. Percentage of pregnant women attending antenatal care who receive a first dose of IPT (IPT1) under direct observation

Baseline: 35%

FY 12 (Results): 52% (58,677 of 113,683)

FY 13 (Results): 88%

FY 14 (Results): 88%

FY 15 (Results): 87%

FY 16 (Results): 88%

Extension (Oct-Dec 2016) (Results): 81%

LOP Results: 81%

LOP Targets: 91%

% of LOP Target Achieved: 89%

52. Percentage of pregnant women attending antenatal care who receive a second dose of IPT (IPT2) under direct observation

Baseline: 14%

FY 12 (Results): 17% (19,397 of 113,683)

FY 13 (Results): 56%

FY 14 (Results): 58%

FY 15 (Results): 60%

FY 16 (Results): 64%

Extension (Oct-Dec 2016) (Results): 53%

LOP Results: 53%

LOP Targets: 70%

% of LOP Target Achieved: 76%

53. Percent of suspected malaria cases tested for malaria

Baseline: 29%

FY 12 (Results): 24%

FY 13 (Results): -

FY 14 (Results): 24%

FY 15 (Results): 35%

FY 16 (Results): -

Extension (Oct-Dec 2016) (Results): 69%

LOP Results: 108%

LOP Targets: 100%

% of LOP Target Achieved: 100%

54. Percent of suspected malaria cases who tested positive for malaria and received ACTS

Baseline: 108%

FY 12 (Results): 100%

FY 13 (Results): -

FY 14 (Results): 100%

FY 15 (Results): 100%

FY 16 (Results): -

Extension (Oct-Dec 2016) (Results): 100%

LOP Results: 100%

LOP Targets: 100%

% of LOP Target Achieved: 100%
<table>
<thead>
<tr>
<th>SSDI –Services PMP Indicators/Targets</th>
<th>Baseline</th>
<th>FY 12 (Results)</th>
<th>FY 13 (Results)</th>
<th>FY 14 (Results)</th>
<th>FY 15 (Results)</th>
<th>FY 16 (Results)</th>
<th>Extension (Oct-Dec 2016) (Results)</th>
<th>LOP Results</th>
<th>LOP Targets</th>
<th>% of LOP Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. Number of services providers mentored on key EHP areas (disaggregated by facility/community)</td>
<td>0</td>
<td>93</td>
<td>801</td>
<td>Cumulative graduates: 753</td>
<td>Cumulative graduates: 1154</td>
<td>Cumulative graduates: 1154</td>
<td>2638 mentored (Cumulative graduates: 1154)</td>
<td>Cumulative graduates: 1500</td>
<td>Cumulative graduates:</td>
<td>77%</td>
</tr>
<tr>
<td>57. Number of health facilities in SSDI districts receiving 1 or more supervision visits per quarter</td>
<td>48</td>
<td>124</td>
<td>212</td>
<td>234</td>
<td>167</td>
<td>252</td>
<td>237</td>
<td>237</td>
<td>239</td>
<td>99%</td>
</tr>
<tr>
<td>58. Number of facilities achieving &gt;= 80% of performance and quality standards for key service delivery areas (disaggregated by program area)</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>12</td>
<td>15</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>30</td>
<td>70%</td>
</tr>
<tr>
<td>59. No of health workers trained in performance and quality improvement</td>
<td>-</td>
<td>1,396</td>
<td>1,397</td>
<td>148</td>
<td>49</td>
<td>135</td>
<td>49</td>
<td>3,174</td>
<td>1,280</td>
<td>248%</td>
</tr>
<tr>
<td>60. Number of service delivery sites renovated/or rehabilitated (disaggregated by program area)</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>13</td>
<td>31</td>
<td>55</td>
<td>58</td>
<td>58</td>
<td>55</td>
<td>105%</td>
</tr>
<tr>
<td>61. Number of facilities with complete and timely HMIS reports</td>
<td>-</td>
<td>172</td>
<td>226</td>
<td>279</td>
<td>283</td>
<td>282</td>
<td>265</td>
<td>265</td>
<td>304</td>
<td>87%</td>
</tr>
</tbody>
</table>

Program Element: LMIS

<p>| 62. Number of facilities with completed LMIS report                                                | -        | -              | 233            | 269            | 294            | 295            | 296                              | 296         | 304         | 97%          |
| 63. Number of facilities experienced stock out of Fe at any time during the reporting period      | 52%      | 52%            | 13             | 36             | 66             | 177            | 177                              | NA          | NA          | NA           |
| 64. Number of facilities experienced stock out of ARV (Tenofovir/Lamivudine/Efavirenz) at any time during the reporting period | 6%       | 6%             | 10             | 12             | 7              | 10             | 7                               | NA          | NA          | NA           |
| 65. Number of facilities experienced stock out of ARV- Triomune Baby (4FT/3TC/NVP) at any time during the reporting period | 15%      | 15%            | 51             | 47             | 42             | 39             | 35                              | NA          | NA          | NA           |
| 66. Number of facilities experienced stock out of Determine HIV Test kit at any time during the reporting period | 19%      | 19%            | 40             | 18             | 19             | 17             | 24                              | NA          | NA          | NA           |
| 67. Number of facilities experienced stock out of SP at any time during the reporting period       | 4%       | 4%             | 10             | 5              | 12             | 54             | 45                              | NA          | NA          | NA           |</p>
<table>
<thead>
<tr>
<th>SSDI -Services PMP Indicators/Targets</th>
<th>Baseline</th>
<th>FY 12 (Results)</th>
<th>FY 13 (Results)</th>
<th>FY 14 (Results)</th>
<th>FY 15 (Results)</th>
<th>FY 16 (Results)</th>
<th>Extension (Oct-Dec 2016) (Results)</th>
<th>LOP Results</th>
<th>LOP Targets</th>
<th>% of LOP Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>68. Number of facilities experienced stock out of LA at any time during the reporting period</td>
<td>2%</td>
<td>2%</td>
<td>22</td>
<td>21</td>
<td>94</td>
<td>125</td>
<td>91</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>69. Number of facilities experienced stock out of depot medroxyprogesterone acetate at any time during the reporting period</td>
<td>17%</td>
<td>17%</td>
<td>47</td>
<td>47</td>
<td>29</td>
<td>28</td>
<td>23</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>70. Number of facilities experienced stock out of Combined Oral Contraceptives (cycles) at any time during the reporting period</td>
<td>25%</td>
<td>25%</td>
<td>50</td>
<td>51</td>
<td>8</td>
<td>14</td>
<td>14</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>71. Number of facilities experienced stock out of Implants ( Jadelle/Implanon) at any time during the reporting period</td>
<td>23%</td>
<td>23%</td>
<td>53</td>
<td>45</td>
<td>44</td>
<td>42</td>
<td>39</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>72. Number of facilities experienced stock out of Male condoms at any time during the reporting period</td>
<td>8%</td>
<td>8%</td>
<td>82</td>
<td>37</td>
<td>49</td>
<td>33</td>
<td>28</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Environmental Impact Monitoring Indicators**

<table>
<thead>
<tr>
<th>SSDI -Services PMP Indicators/Targets</th>
<th>Baseline</th>
<th>FY 12 (Results)</th>
<th>FY 13 (Results)</th>
<th>FY 14 (Results)</th>
<th>FY 15 (Results)</th>
<th>FY 16 (Results)</th>
<th>Extension (Oct-Dec 2016) (Results)</th>
<th>LOP Results</th>
<th>LOP Targets</th>
<th>% of LOP Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>73. Number of targeted facilities implementing PQI with integrated standards including infection prevention and injection safety</td>
<td>-</td>
<td>-</td>
<td>148</td>
<td>165</td>
<td>173</td>
<td>201</td>
<td>201</td>
<td>201</td>
<td>238</td>
<td>84%</td>
</tr>
<tr>
<td>74. Number of facilities with a facility-specific written waste management plans</td>
<td>-</td>
<td>-</td>
<td>26</td>
<td>54</td>
<td>108</td>
<td>213</td>
<td>213</td>
<td>213</td>
<td>161</td>
<td>132%</td>
</tr>
<tr>
<td>75. Number of facilities practicing appropriate waste segregation</td>
<td>-</td>
<td>-</td>
<td>133</td>
<td>138</td>
<td>186</td>
<td>240</td>
<td>188</td>
<td>188</td>
<td>244</td>
<td>77%</td>
</tr>
<tr>
<td>76. Number of facilities with functional waste disposal site (incinerator, Placenta pit and/or waste pit)</td>
<td>-</td>
<td>-</td>
<td>175</td>
<td>216</td>
<td>226</td>
<td>244</td>
<td>229</td>
<td>229</td>
<td>267</td>
<td>86%</td>
</tr>
</tbody>
</table>

* Less than 100% indicates good performance