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COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: MALAWI

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JSI RESEARCH & TRAINING INSTITUTE, INC.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@advancingpartners.org
Web: advancingpartners.org

ACRONYMS

ADC	area development committee
AEDO	agriculture extension development officer
APC	Advancing Partners & Communities
CBDA	community-based distribution agent
CDA	community development agent
CHBCV	community home-based care volunteer
CHS	community health system
CLAN	community leader for action on nutrition
CLTS	community-led total sanitation
DA	district assembly
DEC	district executive committee
DHO	district health office
EHP	essential health package
FP	family planning
HCMC	health center management committee
HSA	health surveillance agent
HSSP	Malawi Health Sector Strategic Plan 2011-2016
HSWG	health sector working group
IUD	intrauterine device
MOAIWD	Ministry of Agriculture, Irrigation, and Water Development
MOH	Ministry of Health
MOLGRD	Ministry of Local Government and Rural Development
MWK	Malawian Kwacha
NL	natural leader
ODF	open defecation-free
PE	peer educator
PHC	primary health care
TB	tuberculosis

TWG	technical working group
USAID	Unites States Agency for International Development
VDC	village development committee
VHC	village health committee
WASH	water, sanitation, and hygiene
ZHSO	zonal health support office

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

MALAWI COMMUNITY HEALTH OVERVIEW

There is no specific community health policy in Malawi, however, a vast array of policies guides community health in the country, including overarching health strategies and those pertaining to specific health areas, such as malaria and reproductive health. The following is an overview of various policies, strategies, plans, and initiatives that provide policy direction to community health programs in Malawi.

The *Malawi Health Sector Strategic Plan 2011–2016 (HSSP)* is the overarching framework that guides the Ministry of Health (MOH) and its stakeholders in health service delivery, governance, resource mobilization, financing, and monitoring and evaluation for improved health outcomes. Community health is a large component of the *HSSP*, with emphasis on community participation and the essential roles of certain community health provider cadres. The *Handbook and Guide for Health Providers on the Essential Health Package in Malawi (EHP)*, developed in 2004 and updated in 2010, guides health service delivery at multiple levels, including in communities.

Table 1. Community Health Quick Stats

Main community health policies/strategies[1]	*Guidelines for the District Implementation Plans for 2012/13*	*Handbook and Guide for Health Providers on the Essential Health Package in Malawi*	*Health Promotion Policy*	*Malawi Growth and Development Strategy 2011–2016*	*Malawi Health Sector Strategic Plan 2011–2016*	*National Health Surveillance Assistant Programme of Malawi*
Last updated	2011	2004	2013	2011	2011	2013
Number of community health provider cadres	7 main cadres Community-based distribution agents (CBDAs) Community home-based care providers (CHBCVs) Community leaders for action on nutrition (CLANs) Health surveillance agents (HSAs) Natural leaders (NLs) Peer educators (PEs) Village health committee (VHC) members					
Recommended number of community health providers[1]	4,500 CBDAs 80,000 CLANs 13,500 HSAs					
Estimated number of community health providers[1]	10,073 HSAs					
Recommended ratio of community health providers to beneficiaries[1]	1 CLAN: 10–15 households 1 HSA: 1,000 people 1 VHC: 1 village development committee (VDC)[2]					
Community-level data collection	Yes					
Levels of management of community-level service delivery	National, zonal, district, community					
Key community health program(s)	National Health Surveillance Agent (HSA) Program; various national health programs in multiple health areas (e.g., immunization, HIV and AIDS, TB)					

[1] Information is not available in policy for the other cadres.
[2] VDCs typically cover a 'grouping' of villages, but policy neither specifies the exact number of villages nor the total population a VDC covers.

Malawi is highly decentralized with planning, coordination, and budgeting of health activities managed at the district level. The district assembly (DA) oversees the planning process in conjunction with the district health office (DHO), NGOs, other private sector groups, and civil society. The *Guidelines for the District Implementation Plans for 2012/13,* directed by the *HSSP* and the *EHP*, provides guidance for implementing activities at the district level. In addition to these documents, the *Malawi Growth and Development Strategy II 2011–2016* and the *Health Promotion Policy* both include community participation as an important component. Finally, the *National Health Surveillance Assistant Programme of Malawi* is a roadmap for scaling up and strengthening the national program that supports health surveillance agents (HSAs), the country's flagship group of community health providers and extension workers who have been active since 1992.

Malawi has seven main cadres of community health providers who work across various health areas, like HIV and AIDS, nutrition, sanitation, and family planning.

As a whole, these and many other strategies that incorporate service delivery at the community level provide guidance across many health areas and multiple cadres of community-level providers. However, because information guiding community health is spread across many policy documents, information is not always clear and at times is contradictory. Information is sometimes incomplete; for example, there are few details about some community health providers, like community home-based care volunteers (CHBCVs) and peer educators (PEs). Thus, while policy guiding community health in Malawi is widely available, it is not clear or comprehensive.

All of Malawi's main health policies emphasize the role of civil society and community groups in implementing health activities and conducting health promotion. Many also acknowledge a need for greater gender equity and equality in health service delivery and offer ways to facilitate this, such as promoting women's entrepreneurship and involvement in cooperatives and strengthening service delivery systems related to the prevention of gender-based violence.

There are multiple national health programs and initiatives in Malawi that operate at the community level and involve community health providers, such as the HSA program and other national programs for reproductive health, nutrition, integrated management of childhood illness, HIV and AIDS, tuberculosis (TB), malaria, and immunization. Most of these programs have been operating in the country for more than a decade and are updated approximately every five years. While they are distinct programs, the MOH coordinates them at the national level, often with the involvement of other ministries such as the Ministry of Local Government and Rural Development (MOLGRD), the Ministry of Agriculture, Irrigation, and Water Development (MOAIWD), the Ministry of Gender, Children, and Community Development, and the Ministry of Education. The programs also collaborate with the private sector, including international and national for-profit and nonprofit organizations, most notably the Christian Health Association of Malawi, a key partner and provider of health services across the country. Private sector partners provide financial and technical support, mobilize resources, support program implementation, and conduct advocacy.

Table 2. Key Health Indicators, Malawi

Total population[1]	17.2 m
Rural population[1]	84%
Total expenditure on health per capita (current US$)[2]	$24
Total fertility rate[3]	4.4
Unmet need for contraception[3]	39.8%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	43.2%
Maternal mortality ratio[4]	634
Neonatal, infant, and under 5 mortality rates[3]	27 / 42 / 64
Percentage of births delivered by a skilled provider[3]	89.8%
Percentage of children under 5 years moderately or severely stunted[3]	37.1%
HIV prevalence rate[5]	9.1%

[1] PRB 2016; [2] World Bank DataBank 2014; [3] NSO [Malawi] and ICF International 2016; [4] WHO 2015; [5] UNAIDS 2015.

Malawi has many cadres of community health providers, totaling anywhere between an estimated 100,000 and 200,000 individual workers. They vary considerably in terms of the health areas they address, their scope of practice, and the degree to which they are formally recognized. As health professionals employed by the MOH, HSAs are among the most critical community health providers. They comprise the largest cadre of health workers in Malawi across all levels, providing a range of primary health care (PHC) services at facilities and in communities. They are also responsible for coordinating and supervising several other cadres of community health providers.

Other community health providers include community-based distribution agents (CBDAs), CBHCVs, community leaders for action on nutrition (CLANs), natural leaders (NLs), PEs, and village health committee (VHC) members. The Human Resources for Health section provides further details about these cadres.

LEADERSHIP AND GOVERNANCE

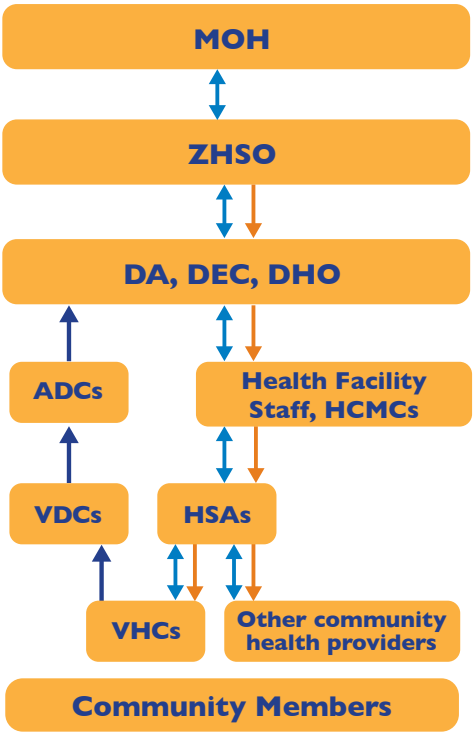
Community service delivery in Malawi is managed and coordinated across the national, zonal, district, and community levels. At the national level, the MOH and other related ministries like the MOAIWD are responsible for policy guidance and oversight, while the MOLGRD oversees implementation at the district and community levels. The zonal level, comprising five health zones, links the national and district levels and supports districts.

- At the **national level**, several health management bodies linked to the MOH contribute to Malawi's overall health strategies. These include a cabinet committee on health that comprises cabinet ministers and defines the health sector's political and policy direction; the health sector working group (HSWG), a multi-sectoral coordinating body that endorses and oversees strategy implementation; and 11 health sector technical working groups (TWGs) that provide policy guidance within their respective technical areas.
- The **zonal level** comprises the zonal health support office (ZHSO), which provides direct technical and supervision support to the DHO for facilitating inter-district collaboration; mobilizing resources; coordinating in-service training for district staff; and ensuring alignment and clarity in the planning and delivery of essential health package services across districts.
- At the **district level**, the DA is the administrative body responsible for the health as well as other sectors. It oversees the DHO, which is responsible for health planning and decision making, implementation of the EHP and other key strategies determined by national and district priorities, financial management, and data collection and monitoring. The district executive committee (DEC) develops district-level policies, including those in the health sector. The DHO and the DA have representatives on the DEC.
- At the **community level**, HSAs manage health services and supervise the activities of other cadres of community health providers, including VHC members, who provide health services in communities. VHCs also have operational roles, reporting local health matters to village development committees (VDCs), which oversee the overall development-related activities within a group of villages. VDCs report health and other development issues to area development committees (ADCs), which function at an intermediary level between villages and districts, and in turn convey information to the DEC. Health center management committees (HCMCs) oversee health service planning and implementation in line with district and national strategies, like the *HSSP*.

Figure 1 summarizes Malawi's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	Cabinet Committee on Health HSWG TWGs	–	
Zonal	ZHSO	Central Hospital	
District	DA DEC DHO	District Hospital	
Community	ADC HCMC HSA VHC	Rural Hospital Health Center Health Post Dispensary Maternity Facility	



Supervision
Flow of community-level data
Flow of information on community needs

HUMAN RESOURCES FOR HEALTH

A multitude of community health providers are active in Malawi. Table 3 provides a snapshot of the five more formalized cadres for which policy information is available:

- CBDAs provide education and counseling on FP methods and distribution of condoms and oral contraceptive pills.
- CLANs conduct nutrition-related activities with caregivers, like parents, in communities, with an emphasis on education, prevention, and monitoring of nutrition interventions.
- HSAs provide an array of promotive, preventive, and curative PHC services, maintain village registers, and conduct community mobilization through VHC members.
- NLs lead communities in becoming open defecation-free (ODF) through community-led total sanitation (CLTS) efforts.
- VHC members conduct promotive, preventive, and curative services related to PHC and disease surveillance under the guidance of HSAs.

Two other main cadres of community health providers who are not included in Table 3 due to a lack of consistent information in policy but who play integral roles in community health interventions are:

- CHBCVs, who offer services for people living with HIV and their families. Policy does not delineate a singular group of these providers; rather, their specific role varies across the organizations and programs with which they are affiliated.
- PEs, who work with key populations (youth, men who have sex with men, female sex workers, etc.) and provide education about preventive sexual and reproductive health behaviors and offer selected services, including counseling and testing for HIV and other sexually transmitted infections.

HSAs and other extension workers, such as agriculture extension development officers (AEDOs) and community development assistants (CDAs), oversee community activities that other cadres lead but policy is not clear about how they should balance their responsibilities and roles as supervisors.

Table 3.1. Community Health Provider Overview: CBDAs and CLANs

	CBDAs	CLANs
Number in country	*Information not available in policy*	*Information not available in policy*
Target number	4,500	80,000
Coverage ratios and areas	*Information not available in policy*	1 CLAN: 10–15 households Geographical coverage differs based on village size.
Health system linkage	HSAs, who are government workers, supervise CBDAs. CBDAs also refer clients to HSAs for FP methods they cannot provide.	CLANs work with and report to extension workers (HSAs, AEDOs, CDAs) on nutrition activities. The extension workers report to the nearest health facility. Extension workers help train CLANs. CLANs are also linked to VDCs and VHCs, who may be involved in their selection. CLANs share information with VDCs at monthly meetings for higher-level caregiver support groups.[1]
Supervision	HSAs supervise CBDAs	Extension workers supervise CLANs and report to the respective ministries (i.e., MOH, MOAIWD). CLANs are also linked to the DAs through VDCs.
Accessing clients	On foot Bicycle Clients travel to them	On foot
Selection criteria	Criteria may vary by community, but may include: Malawi School Certificate of Education A resident of the community Accepted by community Able to communicate in local language Male or female Able to keep information confidential Healthy, energetic, and smart Displays integrity Friendly, cooperative, and respectful to FP users	Familiar with the community A mother or father who is considered a 'model' by other parents Old enough to be respected by beneficiary households Able to learn and share new skills and information with other parents Willing to participate in caregiver support groups (1–2 hours every two weeks) Willing to spend some of his/her time every day sharing health and nutrition information Displays integrity, respected by the community, not addicted to drugs and alcohol Previous experience working as a volunteer (preferred)

Table 3.1. Community Health Provider Overview: CBDAs and CLANs

	CBDAs	CLANs
Selection process	Communities, led by community leaders, identify CBDAs by discussing selection criteria, which may vary by area, nominating candidates, and holding an election.	Selection follows a participatory process with the help of the local leaders, VDC, and VHC members. Local leaders may recommend individuals as volunteers but must not be involved in the actual selection to avoid favoritism. Extension workers should facilitate the process, which policy suggests as follows: 1. Register all households in the community, identifying those with children 0–24 months, children 25–59 months, and pregnant women. 2. Cluster10–15 households that are close together to work with one CLAN. 3. Explain to each cluster the responsibilities of the CLAN. 4. Encourage households to discuss who should represent them. 5. Decide upon a CLAN for each cluster and meet to confirm that s/he meets the selection criteria. S/he then signs an agreement.
Training	The CBDA training process is not clearly specified in one policy, but available guidance suggests that CBDAs should undergo a 4-week training and/or on-the-job refresher trainings in FP clinics. Plans in the *Malawi Costed Implementation Plan for Family Planning 2016–2020* include an initial training over two weeks in 2017 at the district level and 6 four-day refresher trainings in 2019.	Training occurs in phases during caregiver support group meetings, at which extension workers teach CLANs health and nutrition messages. CLANs also report disease incidence and malnutrition and support each other.
Curriculum	*CBDA Training Manual* (2012). Includes information on context and history of FP in Malawi; benefits of FP; adolescent reproductive needs; female reproductive system; oral contraceptive pills; male and female condoms; lactational amenorrhea method; injectable contraceptives; implants; intrauterine devices (IUDs); vasectomy/tubal ligation; prevention of sexually transmitted infections including HIV and AIDS. There are plans to update the training material in 2016.	*Scaling Up Nutrition in Malawi Training Manual* (2002). Outlines the topics that CLANs should be taught in phases, including Scaling Up Nutrition (key interventions); working with groups and households (group dynamics, communication, support, and counseling); infant and young child feeding (breast and complementary feeding); maternal nutrition (before, during, and after pregnancy); growth monitoring; sanitation and hygiene; management of acute malnutrition; food production, processing, and utilization; and community monitoring and evaluation.
Incentives and remuneration	CBDAs do not currently receive financial incentives. Nonfinancial incentives include umbrellas; bicycles; caps; and formal social recognition for their service. Policy mentions plans for developing standardized incentives for CBDAs.	CLANs do not receive financial or nonfinancial incentives.

[1] The *National Nutrition and Education and Communication Strategy* provides guidance for CLANs and also mentions caregiver support groups, which serve as intermediaries between CLANs and caregivers. Anecdotal information from implementation in Malawi suggests that caregiver support group members in reality may have heftier roles in health promotion, education, and service delivery than the CLANs. However, the official strategy, only describes caregiver support groups in brief. Thus, this profile provides more information on CLANs as described in the official strategy.

Table 3.2. Community Health Provider Overview: HSAs, NLs, and VHCs

	HSAs	NLs	VHCs
Number in country	10,073	*Information not available in policy*	*Information not available in policy*
Target number	13,500[1]	*Information not available in policy*	*Information not available in policy*
Coverage ratios and areas	1 HSA: 1,000 people (about 200 households)[1] Operate in rural, urban, and peri-urban areas. HSAs try to visit every household at least once a month.	*Information not available in policy*	1 VHC per VDC[2]
Health system linkage	Employed by the MOH and report to health facilities	NLs work with government extension staff, including HSAs and the VHC in monitoring the ODF status of a village.	HSAs supervise the health activities VHC members. VHCs also report health concerns and priorities to VDCs, which present them to the DEC along with other issues related to local development.
Supervision	Zonal officers, national program managers, DHOs, senior HSAs, environmental health officers, district program coordinators, and community health nurses may supervise HSAs. HSA supervisors monitor HSA activities, assess quality of activities through direct observation, provide support and feedback on performance, and record results of visit and ensure HSAs meet performance objectives by the next visit.	HSAs supervise NLs.	HSAs supervise VHC members during their health activities by observing performance, reviewing documents they submit, identifying areas for improvement, and offering encouragement and advice.
Accessing clients	On foot Bicycle Clients travel to them	*Information not available in policy*	On foot

Table 3.2. Community Health Provider Overview: HSAs, NLs and VHCs

	HSAs	NLs	VHCs
Selection criteria	Able to speak English and local language Mentally and physically able to serve the position Likely to serve in this role long-term Minimum of a Malawi School Certificate of Education Male or female Willing to work in the rural community 19 years of age or older	*Information not available in policy*	Male or female Community role models Trustworthy Literate Available at all times of need
Selection process	HSAs are recruited from the villages or areas where they will be deployed after training. District-level officials advertise advertises for the position, which is then followed by interviews and selection in conjunction with the MOH.	NLs are selected during the CLTS 'triggering' session to help lead implementation of village action plans for achieving ODF status.	The procedure of forming a VHC includes an initial consultation with the village headman, who calls a community election. The health worker (e.g., HSA) outlines the desired VHC member qualifications and appoints an election overseer.
Training	HSAs are trained for 12 weeks, the first 8 of which are classroom-based followed by a 4-week practical training. There is an initial pretest, continuous examination and field attachment assessments, and a final examination and end of course evaluation. There are also in-service refresher trainings based on local needs or priorities. HSA training occurs at 3 PHC training centers and selected districts according to MOH training policies and curricula. Curricula may be modified to include new activities.	NLs may be trained through working with CLTS triggering teams, but the details about their specific training are not specified.	HSAs train VHC members in a participatory, ongoing manner either during community visits or planned trainings.

Table 3.2. Community Health Provider Overview: HSAs, NLs and VHCs

	HSAs	NLs	VHCs
Curriculum	*Health Surveillance Assistant Course Curriculum*, updated in 2009. Includes four modules: preventive health (PHC, the EHP, VHCs, community home-based care, patient and client follow-up, and health education); family health (safe motherhood, FP, antenatal and postnatal care, immunizations, and growth monitoring); treatment care (diagnosis and treatment of malaria, diarrhea, and pneumonia); basic management and administration (village health registers, community-based health program management, bicycle and other equipment maintenance, and communication mobile technology).	No curriculum available.	There is no VHC curriculum, but general VHC member responsibilities are outlined in the *HSA Training Manual and Facilitator Guide* (2009). Includes improving sanitation, reporting health-related problems to health workers in the community, mobilizing community members in health promotional activities, helping health workers conduct health activities, and liaising between community and health workers.
Incentives and remuneration	Salaried as a civil servant at 34,000 Malawian Kwacha (MKW) plus a donor-funded top-up of 8,944 MKW for a total of 45,000 MWK annually, (about $63 US). Also receive per diems and salary top-ups. Nonfinancial incentives include bicycles. The MOH and NGOs finance all incentives.	No financial incentives. Nonfinancial incentives may include certificates, t-shirts, and caps, though policy does not specify the source of funding for these items.	VHC members do not receive financial or nonfinancial incentives.

[1] There is conflicting information about the recommended number of HSAs in the country; the *HSSP* indicates there should be 13,500 with a ratio of 1 HSA: 1,000 people, but the National Health Surveillance Assistant Programme of Malawi recommends 27,000 to achieve the ideal ratio of 1 HSA: 500 people. The former is listed because the target ratio is expressed more explicitly in policy.
[2] VDCs typically cover a 'grouping' of villages; however, policy neither specifies the exact number of villages nor the total population a VDC covers.

HEALTH INFORMATION SYSTEMS

Community health providers routinely collect health data at the community level. HSAs, for instance, collect information on household coverage; mortality and other health outcomes; vital statistics; supervision indicators; and performance indicators, such as number of treated clients and referrals. They use community health diaries to record activities they plan and conduct to track trends, collecting data from key interviews, direct observations, minutes from VHC meetings, and vital registers, etc. In some areas, HSAs use mobile phones to collect and use data for supply chain management, an approach the MOH has successfully piloted in collaboration with development partners.

Community-level data flows from HSAs to health facilities to the DHO to the ZHSO and finally to the Director of Preventive Health Services at the MOH, as depicted in Figure 1. At each level, data is aggregated before sending upward. Data is fed back down the health management information system through reports and meetings to improve performance.

HEALTH SUPPLY MANAGEMENT

HSAs (and other community health providers) are provided with start-up kits that they restock at health facilities during management meetings as needed. Kits include items for water treatment, test materials like sputum collection boxes; thermometers; buckets; measuring tape; insecticides; job aids; and counseling cards. Plans for obtaining emergency back-up supplies are not outlined in policy.

If their scope of service requires it, community health providers are expected to dispose medical waste by assembling safety boxes before use, closing them when three-quarters full, and incinerating them. If there is no incinerator, they may burn safety boxes in designated pits and bury the ashes.

Table 4. Selected Medicines and Products Included in the *Malawi Standard Treatment Guidelines* (2015)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☑	Ready-to-use supplementary food
	☑	Ready-to-use therapeutic food
	☑	Vitamin A

The full list of commodities that all cadres of community health providers in Malawi is not available; however, Table 4 contains information about selected medicines and products included in the *Malawi Standard Treatment Guidelines* (2015).

SERVICE DELIVERY

The community health components of the EHP, last updated in 2010, comprise the main service delivery package at the community level. Table 5 summarizes how clinical services, health education, and community mobilization should be conducted.

Using FP as an example, community health providers may refer clients to:

- **HSAs** for condoms, oral contraceptive pills, injectable contraceptives.
- **Health centers** for implants, IUDs, emergency contraceptive pills, and postpartum family planning services, as well as contraceptives provided by HSAs.
- **District hospitals** for permanent methods as well as contraceptives available through health centers and HSAs.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Provided door-to-door
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Table 6 provides details about selected interventions that CBDAs, CBHCVs, CLANs, HSAs, NLs, and PEs may deliver in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH. Policy does not provide guidance on the specific interventions VHC members deliver.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP[1]	Condoms	CBDA, CHBCV, HSA, PE	CBDA, CHBCV, HSA, PE	CBDA, CHBCV, HSA, PE	CBDA, CHBCV, HSA, PE
	CycleBeads®	CBDA, HSA	CBDA, HSA	CBDA, HSA	CBDA, HSA
	Emergency contraceptive pills	CBDA, HSA	Unspecified	CBDA, HSA	CBDA, HSA
	Implants	CBDA, HSA	No[2]	CBDA, HSA	CBDA, HSA
	Injectable contraceptives	CBDA, HSA	HSA[3]	CBDA, HSA	CBDA, HSA
	IUDs	CBDA, HSA	No	CBDA, HSA	CBDA, HSA
	Lactational amenorrhea method	CBDA, HSA		CBDA, HSA	CBDA, HSA
	Oral contraceptive pills	CBDA, HSA	CBDA, HSA	CBDA, HSA	CBDA, HSA
	Other fertility awareness methods	CBDA, HSA		CBDA, HSA	CBDA, HSA
	Permanent methods	CBDA, HSA	No	CBDA, HSA	CBDA, HSA
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	HSA	HSA	HSA	HSA
	Iron/folate for pregnant women	HSA	Unspecified[4]	HSA	HSA
	Nutrition/dietary practices during pregnancy	HSA		HSA	HSA
	Oxytocin or misoprostol for postpartum hemorrhage	No	No	No	No
	Recognition of danger signs during pregnancy	HSA	HSA	HSA	HSA
	Recognition of danger signs in mothers during postnatal period	HSA	HSA	HSA	HSA
Newborn care	Care seeking based on signs of illness	HSA			HSA
	Chlorhexidine use	No	No	No	No
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	HSA		HSA	HSA
	Nutrition/dietary practices during lactation	HSA		HSA	HSA
	Postnatal care	HSA	HSA	HSA	HSA
	Recognition of danger signs in newborns	HSA	HSA	HSA	HSA

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	HSA	HSA	HSA	HSA
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	CLAN, HSA	HSA	CLAN, HSA	CLAN, HSA
	Exclusive breastfeeding for first 6 months	CLAN, HSA		CLAN, HSA	CLAN, HSA
	Immunization of children	CLAN, HSA	HSA[5]	CLAN, HSA	CLAN, HSA
	Vitamin A supplementation for children 6–59 months	CLAN, HSA	HSA	CLAN, HSA	CLAN, HSA
HIV and TB	Community treatment adherence support, including directly observed therapy	CHBCV, HSA	CHBCV, HSA	CHBCV, HSA	CHBCV, HSA
	Contact tracing of people suspected of being exposed to TB	HSA	HSA	HSA	HSA
	HIV testing	CHBCV, HSA, PE	HSA	CHBCV, HSA, PE	CHBCV, HSA, PE
	HIV treatment support	CHBCV, HSA, PE	CHBCV, HSA, PE	CHBCV, HSA, PE	CHBCV, HSA, PE
Malaria	Artemisinin combination therapy	HSA	HSA[6]	HSA	HSA
	Long-lasting insecticide-treated nets[7]	CHBCV, CLAN, HSA	HSA	HSA	CLAN, HSA
	Rapid diagnostic testing for malaria	HSA	HSA[6]	HSA	HSA
WASH	Community-led total sanitation	HSA, NL	HSA, NL		
	Hand washing with soap	CLAN, HSA, NL			
	Household point-of-use water treatment	CLAN, HSA, NL			
	Oral rehydration salts	HSA	HSA	HSA	HSA

[1] CLANs may 'mobilize' clients for family planning, but details about how are not provided.
[2] Currently, HSAs do not administer implants; however, the *Malawi Costed Implementation Plan for Family Planning, 2016-2020* indicates plans for HSAs to pilot the method.
[3] Currently, CBDAs do not administer injectable contraceptives; however, the *Malawi Costed Implementation Plan for Family Planning, 2016–2020* indicates plans for CBDAs to pilot the method.
[4] There is unclear information about whether HSAs may provide iron/folate to pregnant women. While it is a medicine included in their kits, policy says they must refer for this service.
[5] HSAs may immunize children with BCG, OPV, DPT, HepB, Hib 1, and PCV. Policy does not provide clear guidance about if they may vaccinate newborns.
[6] Policy only gives guidance for administration of this intervention for children under five years.
[7] CHBCVs can promote use of long-lasting insecticide-treated nets for people living with HIV and AIDS and chronically ill patients. CLANS may do so for pregnant women and children under five years.

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ADVANCING PARTNERS & COMMUNITIES
JSI RESEARCH & TRAINING INSTITUTE, INC.

1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: advancingpartners.org