Associate Award Brief—Malawi

Selected Health and Demographic Data for Malawi	
GDP per capita (USD)	309.73
Total population	15,263,417
Maternal mortality ratio (deaths/100,000 live births)	675
Skilled birth attendant coverage	72
Antenatal care, 4+ visits	45.5
Neonatal mortality rate (deaths/1,000 live births)	31
Infant mortality rate (deaths/1,000 live births)	66
Under-five mortality (deaths/1,000 live births)	112 [30]*
Treatment for acute respiratory infection	65.7
Oral rehydration therapy for treatment of diarrhea	70.1
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	93
Modern contraceptive prevalence rate	42.2
Total fertility rate	5.7
Total health expenditure per capita (USD)	19.07

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

Program Activities

1. Strengthen National and District Level VMMC Quality Assurance System using Continuous Quality Improvement Model
2. Access to and availability of VMMC services increased
   a. Health worker capacity to deliver VMMC increased
   b. Access to quality VMMC services improved
3. Increase demand for VMMC in focus districts
4. Strengthen the capacity to monitor, evaluate and research VMMC

Program Dates	July 2013 – July 2017					
Total Mission Funding (ceiling)	Redacted					
Geographic Coverage	No. (%) of provinces	5	No. of districts	28	No. of facilities	30
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Partners	• Partners: Jhpiego is the prime and there are no subs on the award. Jhpiego will work closely with the Ministry of Health (MOH), Christian Health Association of Malawi (CHAM), village leadership and communities, the National AIDS Commission (NAC), HIV Unit and District Health Management Teams (DHMTs), along with other donors.					

Acronyms and Abbreviations

AE	Adverse Event
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CHAM	Christian Health Association of Malawi
DHMT	District Health Management Team
EIMC	Early Infant Male Circumcision
GOM	Government of Malawi
HBB	Helping Babies Breathe
HTC	HIV Testing and Counseling
IR	Intermediate Result
M&E	Monitoring and Evaluation
MC	Male Circumcision
MOH	Ministry of Health
MOVE	Models for Optimizing Volume and Efficiency
NGO	Nongovernmental Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
QA	Quality Assurance
STI	Sexually Transmitted Infection
TOT	Training of Trainers
USAID	United States Agency for International Development
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Overview

The agreement period for Sankhani VMMC project is 4 years (31 July 2013 to 30 July 2017), during which it will work with the Malawi MOH to establish and strengthen VMMC services in MOH and CHAM - supported facilities. In the first year, three districts (Thyolo, Chikwawa and Zomba), were targeted. In year 2, Sankhani will focus on 1 district for high impact VMMC service delivery.

The total estimated USAID amount of this cooperative agreement is Redacted with the recipient (Jhpiego) agreeing to expend Redacted of the total as a cost sharing measure.

The goal of the SANKHANI program is to scale up VMMC services targeting males 15- 49 in five districts by providing 150,000 circumcisions by 2017. The expected program results to reach this goal are:

1. Access to and availability of VMMC services increased
   - Health worker capacity to deliver VMMC increased
   - Access to quality VMMC services improved
2. Increase demand for VMMC in focus districts
3. Strengthen the capacity to monitor, evaluate and research VMMC

In program year 1, Sankhani focused on rapidly increasing the availability of services in the three focus districts of Thyolo. Chikwawa and Zomba. In addition, Sankhani supported the capacity building of MOH, CHAM and Jhpiego staff in key areas of VMMC implementation. Sankhani also made progress in the development and harmonization of key VMMC monitoring and evaluation tools, leading the process to eventual national tool harmonization. Finally, Sankhani has developed revolutionary demand creation strategies to sensitize communities on VMMC; used primarily in the Zomba campaign, the strategy is innovative, responsive and grounded within the community.

Sankhani spent quarter one implementing start up activities which included workplan development, office sourcing, staff hiring, procurements, and facilitating district stakeholders meetings. Sankhani used three modalities to expand access to VMMC services: static, outreach and campaigns. Sankhani opened two static sites and supported 2 existing static sites within the three districts; static sites offer continuous services throughout the year. In PY1, static sites completed 1,088 VMMCs. In line with the Ministry of Health campaign plans, Sankhani supported a total of 7 campaigns in program year 1. The first three were concurrent 2-week mini-campaigns in all focus districts in December and three mini-campaigns again in March conducting 11,081 VMMCs in all mini-campaigns combined. And in July/August/September Sankhani supported a major campaign in Zomba for 6 weeks conducted 5,468 VMMCs as of August 27, 2014. Throughout the year, Sankhani's rapid response team offered outreach services in areas where there was demand for services. While outreach services were hindered by delays in vehicle procurement, in PY2 Sankhani expects to build on this service and offer continual outreaches in the focal districts to ensure availability of services for the hard-to-reach. To date, Sankhani has conducted 17,637 VMMCs in program year 1, completing 73% of the 24,000 VMMC target. It is estimated that by the end of PY1 Sankhani will have reached 90% of the target.

Sankhani's key areas of focus in PY2 are to develop capacity in the districts and therefor sustainability in VMMC implementation in Malawi. Increasing access to services in order to

saturate the districts will be needed to reach the target of 16,000 VMMCs in PY2. Sankhani will utilize a 'hub and spoke' model in the primary district that allows for consistent service delivery year round through static site service delivery, with 'spoke' services through mobile and outreach services. The 'hub' static site will house a district level rapid response team inclusive of community mobilizers, rapid response vehicles and VMMC commodities. The rapid response teams will then be deployed to sites after the demand creation teams have generated interest in a geographic area. Sankhani envisions three static sites in the district that will host multiple outreaches and mobile services per month. Static sites are sustainable and will be able to be maintained past the Sankhani project with MOH or CHAM providers. This model will allow for more continuous services year round, and Sankhani will transition away from the campaign approaches through the life of the project. While ramped up services are expected during campaign times, consistent VMMC services will also be offered throughout the year.

In PY 2 the major expected outcomes are:

- Provide 16,000 VMMCs through outreach, campaign and static service delivery;
- Train 100 providers in VMMC surgical techniques, Infection Prevention Control, Refresher Trainings, and VMMC Site Management;
- Open 3 static sites in the focus district;
- Increase demand for VMMC in Sankhani focus districts through innovative and community driven activities;
- Strengthen district level capacity to monitor and evaluate VMMC through technical assistance, and support of district reporting structures;

Background

With an estimated adult HIV prevalence rate of 11.8%, approximately 920,000 Malawians are living with HIV/AIDS and an estimated 70,000 new infections occur annually. Malawi has made tremendous progress in its response to the HIV/AIDS epidemic; however, progress has slowed. The 2010 Demographic and Health Survey (DHS) findings show that there has been no statistically significant change in HIV prevalence in the past four years.

Three randomized controlled trials in sub-Saharan Africa have demonstrated that voluntary medical male circumcision (VMMC) reduces female-to-male HIV transmission by approximately 60%. Although the direct effect of VMMC on male-to-female transmission of HIV is not clear, reduced HIV incidence among men will lead to reduced HIV transmission among women, ultimately protecting the entire community. VMMC is not only cost-effective, but it is also cost-saving when compared with the costs of lifelong care and treatment, including antiretroviral treatment (ART) and opportunistic infection drugs, monitoring tests, and adherence counseling for people living with HIV/AIDS. In 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued guidance that strongly encouraged countries with high HIV prevalence, low male circumcision (MC) rates, and predominantly heterosexual epidemics, such as Malawi, to rapidly scale up safe VMMC services as part of a comprehensive HIV-prevention strategy. A 2009 statistical model based on Malawi's HIV epidemic suggested that by scaling up VMMC to 80% coverage of eligible men by 2015, the country would avert more than 265,000 adult HIV infections and would net cumulative savings of more than US$1.2 billion over the time period of 2009 to 2025.

In this context, in 2009, the government of Malawi (GOM) made its first strides toward the adoption of VMMC as a nationally endorsed HIV-prevention intervention by including it in the

National Action Framework and the National Prevention Strategy Operational Plan. Beginning in 2010, the MOH and its partners, including MCHIP, supported the development of the National VMMC Standard Operating Procedures for service provision, which was followed by the launch of the National Policy on VMMC in September 2012.

In early 2011, four years after the VMMC guidance was issued, the GOM, through the Office of President and Cabinet, made the landmark declaration that Malawi would adopt VMMC as one of its HIV-prevention strategies. In 2011, United States Government (USG) funding other than that for the President's Emergency Plan for AIDS Relief (PEPFAR) was utilized by MCHIP, in collaboration with the GOM, to provide VMMC service delivery training to 42 service providers in nine districts. MCHIP also spearheaded a successful four-week VMMC campaign in Mulanje district, resulting in 4,348 men being circumcised, with 98% uptake of HIV testing and counseling (HTC). This campaign was conducted with the support and close coordination of PEPFAR partners, the MOH, Population Services International, the BRIDGE II project, the Malawi Defense Force, and Banja La Mtsogolo.

In February 2012, the MOH convened a meeting of the country's VMMC stakeholders, with multiple U.S. Agency for International Development (USAID) partners in attendance. The forum provided an opportunity to initiate the national planning process and for partners of USAID to share their achievements and plans. During the meeting, it was clear that partners must quickly move forward with VMMC acceleration plans to take advantage of the current fertile environment. At another stakeholder meeting in February 2013, the MOH urged all partners and donors to treat VMMC scale-up as an emergency response to the epidemic and to consider innovations to maximize efficiency. Given Jhpiego's global leadership and expertise in VMMC, MCHIP is uniquely positioned to bring high-quality VMMC services to scale rapidly in five districts, in collaboration with USAID and the MOH.

Approach and Activities

APPROACH

The USG strategy for scaling up VMMC service delivery follows a three-pronged approach: service delivery, commodities, and communications. The prongs include work at the national level to build the necessary systems and capacity to plan, support, and monitor an effective and efficient national VMMC program while at the same time supporting achievement of VMMC targets with focused interventions at the service delivery level.

Our approach strengthens access to quality VMMC services and empowers providers and community agents to employ VMMC as a critical strategy in the prevention of HIV. The SANKHANI Moyonela program, or "Smart Choice," will also use a multi-pronged approach that targets VMMC program strengthening, quality service delivery, and demand generation at the district and community levels to ensure rapid scale-up in five focus districts.

Efficient and effective programming requires close collaboration with other USAID programs, with the World Bank's commodity support partners, and with the Centers for Disease Control and Prevention (CDC) I-TECH interventions in Lilongwe. SANKHANI will work closely with the Mission to forecast needed supplies of commodities using USAID's Supply Chain Management System—a central mechanism that provides VMMC kits, local anesthesia, HIV test kits, and drugs for sexually transmitted infections (STIs)—to ensure that sufficient commodities are available to conduct 150,000 VMMCs under the SANKHANI program.

SANKHANI will work with the MOH to establish VMMC services in MOH- and CHAM-supported facilities in three districts in Year 1 (Thyolo, Chikwawa, and Nsanje) with a focus on intensified service delivery in 1 district in Year 2.

Lessons learned from the MCHIP 2011 VMMC campaign in Mulanje and the current VMMC program in Thyolo, as well as Jhpiego's successful VMMC programs in Tanzania, Mozambique, Zambia, and Kenya, will be critical in ensuring that maximum efficiency strategies are adopted to support rapid scale-up.. This includes utilizing both surgical and nonsurgical efficiencies such as ensuring availability of skilled VMMC human resources, especially VMMC and HTC counselors, and conducting targeted community mobilization throughout the project life. To ensure continuity of VMMC demand generation activities, SANKHANI will closely liaise with the Health Education Unit of the MOH and USAID's BRIDGE II program, both currently engaged in behavior change communication interventions including rollout of a national VMMC communication strategy, while supporting district-level community mobilization efforts.

The MOH has ambitious national and district VMMC targets for the next three years (see table below for MOH targets in three focus districts starting from Year 1). In order to achieve approximately 50% coverage of youth and men ages 15 to 49 in selected districts, for a total of 150,000 circumcisions, SANKHANI will need to promote efficiencies that rely on the availability of skilled service providers, innovative methods of generating demand, and establishment of effective measurement systems to monitor progress.

To accomplish its goal of reaching 50% of the targeted population, SANKHANI will focus on task shifting (shifting of some surgical roles, HTC, and group education from clinical officers to trained professional nurses and nurse assistants, counselors, and lay counselors when possible); task sharing (assigning less complex tasks to lower credentialed but highly trained health care cadres); allocation of more than one surgical bed per surgeon; time-saving surgical techniques (e.g., forceps-guided method of circumcision); pre-bundled VMMC "kits" of instruments (reusable or disposable) with commodities; and electrocautery to quickly achieve hemostasis.[1]

ACTIVITIES

Year 1 activities by results area:

- National VMMC quality assurance (QA) system strengthened:
  - Conduct quality assurance assessments in all VMMC sites of the focus districts
- Health worker capacity to deliver VMMC services in focus districts increased:
  - Develop a comprehensive VMMC training plan
  - Conduct VMMC surgical skills training
  - Conduct VMMC orientation for HTC counselors
  - Conduct training of Rapid Response-MOVE members
  - Orient facility staff to VMMC

- Access to quality VMMC services improved:

[1] This approach is based on WHO guidelines, *Male Circumcision: Models for Optimizing Volume and Efficiency (MOVE)*. Service delivery points that utilize the MOVE process report a 100–150% increase in the number of procedures conducted in one day.

- Provide routine VMMC services (fixed site, outreach, mobile) in the three focus districts
- Conduct outreach services
- Conduct VMMC mobile services
- Conduct VMMC campaigns at district level
- Strengthen the routine VMMC QA activities in the focus districts
- Reinforce VMMC demand creation at community level

- Monitoring and evaluation (M&E): Strengthen the capacity to monitor, evaluate, and research VMMC:
  - Support the MOH in integrating VMMC M&E into the national M&E framework
  - Strengthen capacity to monitor and evaluate VMMC in the focus districts (integrating VMMC into the district MOH M&E systems)
  - Conduct quarterly data quality assessments in the focus districts
  - Conduct VMMC quarterly review meetings at district level

Results

SANKHANI will implement a comprehensive M&E system that includes the following: operational review to inform the implementation of an effective VMMC strategy; monitoring of health care provider training using a training information monitoring system (TrainSMART) and VMMC client forms and registers to ensure complete and accurate recordkeeping on characteristics and number of clients circumcised; accurate recording and timely reporting of adverse events (AEs) using reporting forms; monitoring of linkages to other services by recording referrals from HTC sites and referrals to STI treatment and HIV care and treatment services for HIV-positive men; and midterm program evaluations to assess progress and quality of services.

Next Steps

Malawi's national Voluntary Medical Male Circumcision (VMMC) program is still in its formative phase and additional effort is needed to bring it to a point where a comprehensive national plan supported by service delivery standards effectively guide delivery of VMMC services. SANKHANI will work closely with the VMMC technical working group, which is chaired by the MOH and includes various partners—National AIDS Commission (NAC), World Bank, UNICEF, USG, PSI, Banja La Mtsogolo CHAM, and Jhpiego—to facilitate adoption of national systems, particularly a VMMC Operational Plan and QA system, that will support and improve VMMC programming.

Output and Outcome Indicators and Targets

OUTPUT AND OUTCOME INDICATORS	DATA SOURCE	ANNUAL TARGET				TOTAL
		Year 1	Year 2	Year 3	Year 4	
Training						
Number of health workers who successfully completed an in-service training program by specific types*	TrainSMART, program reports	92	100	60	60	328

OUTPUT AND OUTCOME INDICATORS	DATA SOURCE	ANNUAL TARGET				TOTAL
		Year 1	Year 2	Year 3	Year 4	
Coverage						
Number of males circumcised as part of the minimum package of MC for HIV prevention services (PEPFAR), by age*: <1, 1–14, 15–24, 25–34, 35–49, 50+	VMMC Register; VMMC Facility Monthly Report Form; and VMMC electronic database	24,000	16,000	42,000	42,000	150,000
Number of individuals who received HIV counseling services as part of MC services	VMMC Register; VMMC Facility Monthly Report Form; and VMMC electronic database	24,000	16,000	42,000	42,000	150,000
Number of individuals who received HTC services as part of MC services and received their test results (by HIV status)	VMMC Register; VMMC Facility Monthly Report Form; and VMMC electronic database	21,600	14,400	37,800	37,800	135,000
Quality of Care						
Number and percentage of clients circumcised who experienced one or more moderate or severe AEs within the reporting period,* disaggregated by severity	VMMC Register; VMMC Facility Monthly Report Form; and VMMC electronic database	<480 (<2%)	<320 (<2%)	<840 (<2%)	<840 (<2%)	<2,480(<2%)
Number of boys and men circumcised within the reporting period who return at least once for postoperative follow-up care (routine or emergent) within 14 days of surgery	VMMC Register; VMMC Facility Monthly Report Form; and VMMC electronic database	19,200	12,800	33,600	33,600	99,200
Percentage of sites achieving at least 80% of VMMC QA standards	QA assessment reports	—	40	60	80	80% for Phase 1 districts; 60% for Phase 2 districts
Service Delivery						
Number of sites providing MC services, disaggregated by site (fixed or outreach)*	Program reports; VMMC Facility List database	27	27	45	45	Minimum of 45 sites (1 fixed site per district and 8 outreach sites per district)
Number of program sites with an established referral system to and from other services by service (HTC, STI treatment, HIV treatment and care)	Health facility records	27	27	45	45	Minimum of 45 sites (1 fixed site per district and 8 outreach sites per district)
Percentage of HIV-positive men circumcised who are linked to HIV care and treatment services	VMMC Register; VMMC Facility Monthly Report Form	100	100	100	100	100

* Denotes PEPFAR indicator, next generation guidance.

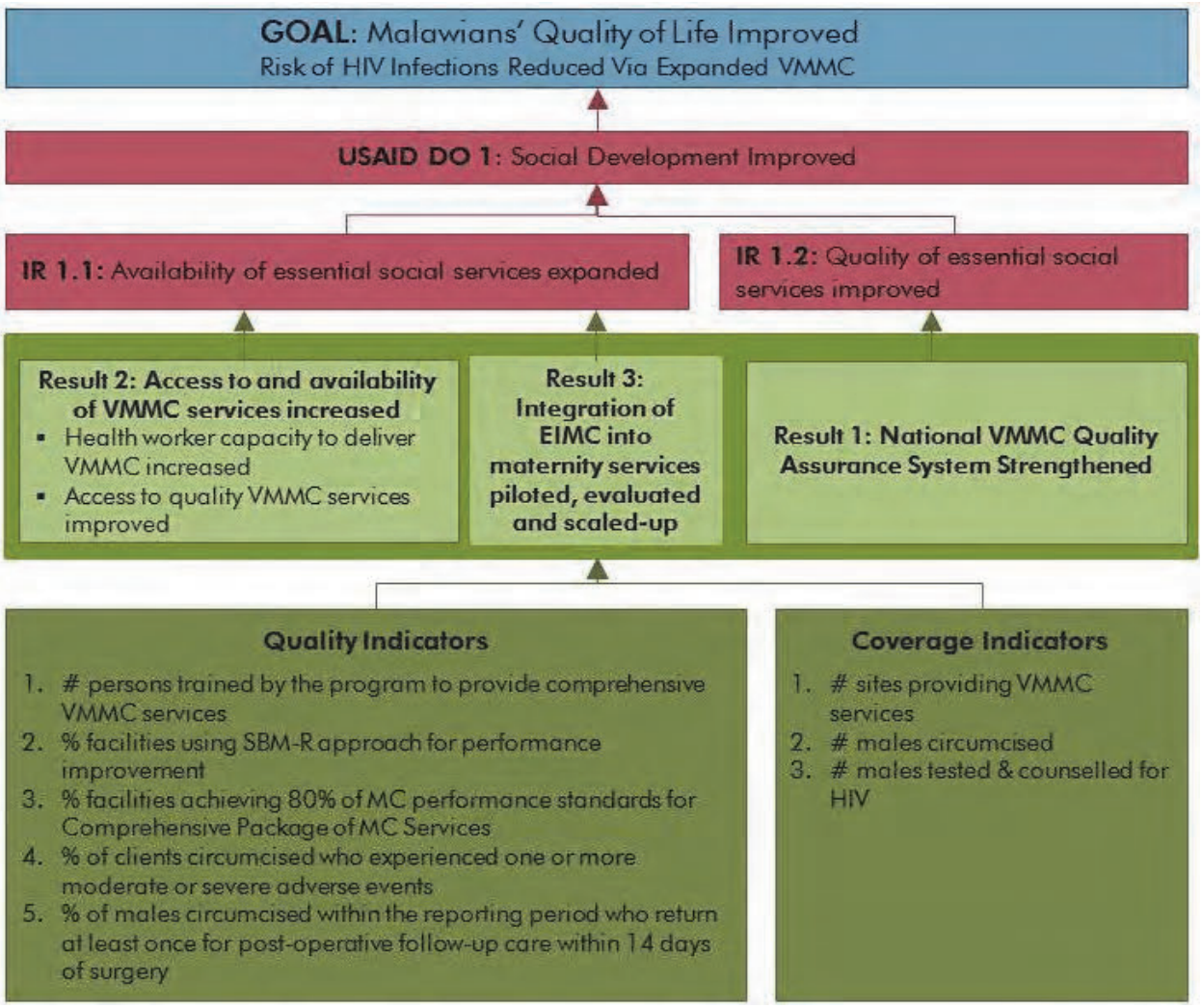
Progress toward Key Indicators

INDICATOR	FY 2014 TARGET	FY 2014 ACHIEVEMENT TO DATE	NOTES
1a. Number of health workers who successfully completed an in-service training program by specific type of VMMC skills training	92	0	All trainings involving national staff have been postponed to Year 2 because of the lack of participation by MOH staff due to the daily subsistence allowance (DSA) guidelines and financial challenges that SANKHANI is experiencing.
1b. VMMC skills TOT (clinical skills training)	12	0	
1c. Site management skills training	15	0	
1d. HTC counselors training in VMMC package	60	0	
2. Number of boys and men circumcised as part of a minimum package of MC for HIV prevention services	24,000	19, 272 (80.3%) Age group 1–9 = 318 10–14 = 7,136 15–19 = 6,986 20–24 = 2,526 25–49 = 2,198 50+ = 108 HIV status: HIV-positive = 166 (75 already known HIV-positive) HIV-negative = 19,047 Indeterminate = 59 Follow-up visit = 11,298 No follow-up visit = 7,974	318 circumcisions of boys below the age of 10 were done during the December 2013 campaign. The program circumcises only males 10 years old and above since January 2014 as recommended in PEPFAR VMMC programs and emphasized during PEPFAR M&E training.
3. Number of individuals who received HIV counseling services as part of MC services	24,000	19,272	All clients, including known HIV-positive, are counseled on HIV appropriately.

INDICATOR	FY 2014 TARGET	FY 2014 ACHIEVEMENT TO DATE	NOTES
4. Number of individuals who received HTC services for HIV as part of MC services and received their test results (by HIV status)	21,600 (90%)	19, 138 (99.3 %) HIV-positive = 91 HIV-negative = 19,047 Known HIV-positive = 75 (44 on ART) Not tested/ refused = 59	More than 99% of clients had HIV test and the remaining 1% includes those with known HIV-positive status and those who opted out of testing. 91 clients were found to be HIV-positive. HTC counselors linked these individuals to HIV care and treatment services and enrolled them into the care and treatment services. 75 clients had a known HIV-positive status at the time of circumcision and 44 of them were already on ART treatment, whereas 59 clients were not tested or had refused testing.
5. Number and percentage of clients circumcised who experience one or more moderate or severe AEs within the reporting period disaggregated by severity	<480 (<2%)	Intra-op: moderate = 15 (0.08 %) Severe = 4 (0.02 %) Post-op: moderate = 140 (1.2 %) Severe = 8 (0.07 %)	AEs during procedure were less than 1% while AEs at postop review were high, at 2.8%, beyond the 2% mark of the project. Most postop AEs are due to lack of good care of the wound at home, and there is need therefore for increased counseling about wound care at home.
6. Number of boys and men circumcised within the reporting period who return at least once for postoperative follow-up care (routine or emergent) within 14 days of surgery	19,200 (80%)	11, 298 (58.6 %)	The rate of postop follow-up care is below the target of 80%. The providers have therefore intensified postop counseling, with emphasis on the importance of postop follow-up care to clients.
7. Number and percentage of health facilities/sites achieving recommended minimum (80%) VMMC QA standards	—	—	QA assessments were not done to determine sites' achievements on VMMC QA standards. The project does not expect to have sites that will reach the minimum standard in this fiscal year.
8. Number of facilities/sites providing MC services, disaggregated by type of site	27	30 (4 static sites; 26 outreach sites)	The outreach sites were mainly utilized during campaign periods, although a few were utilized during routine service provision.
9. Number of program sites with an established referral system to and from other services by service (HTC, STI treatment, HIV treatment and care)	27	30 (4 static sites; 26 outreach sites)	All sites are set with referral system in place to offer VMMC as a package of care for HIV prevention.

INDICATOR	FY 2014 TARGET	FY 2014 ACHIEVEMENT TO DATE	NOTES
10. Percentage of circumcised HIV-positive men who are linked to HIV care and treatment services	100%	100%	All newly identified HIV-positive men are linked to HIV care and treatment services for further counseling, continuous support, and treatment by referring clients to HIV care and treatment units.
11. Number of targeted facilities implementing VMMC QA standards including infection prevention	27	30 (4 static sites; 26 outreach sites)	All sites established are made to implement VMMC QA standards in an effort to maintain quality services.
12. Number of facilities with a facility-specific written waste management plans	27	30 (4 static sites; 26 outreach sites)	The site-specific waste management plan will be written after identifying issues that might affect an ideal waste management plan in order to address the issues in the site waste management plans. However, each site offering VMMC services is assessed and a suitable waste management plan specific to the site's needs is recommended and put in place.
13. Number of facilities practicing appropriate waste segregation	27	30 (4 static sites; 26 outreach sites)	The established sites are well-supported to practice appropriate waste segregation.
14. Number of facilities with functional waste disposal site (incinerator and/or waste pit)	3	30 (4 static sites; 26 outreach sites)	2 static sites in Thyolo (Thyolo District Hospital and Malamulo Hospital), 1 static site in Chikhwawa (Chikhwawa District Hospital), and 1 static site in Zomba (Police College Clinic) have incinerators, while every outreach site providing VMMC services has at least a waste pit.
15. Number of demand creation activities conducted	>12	≥50	The demand creation activities included talking to district teams and traditional leaders, conducting public talks in communities using a PA system, holding sports bonanzas mixed with VMMC messages, and use of Health Surveillance Assistants and a door-to-door approach.

Note: Dash indicates information is not available.


GOAL: Malawians' Quality of Life Improved
Risk of HIV Infections Reduced Via Expanded VMMC
USAID DO 1: Social Development Improved
IR 1.1: Availability of essential social services expanded
IR 1.2: Quality of essential social services improved
Result 2: Access to and availability of VMMC services increased
Health worker capacity to deliver VMMC increased
Access to quality VMMC services improved
Result 3: Integration of EIMC into maternity services piloted, evaluated and scaled-up
Result 1: National VMMC Quality Assurance System Strengthened
Quality Indicators
1. # persons trained by the program to provide comprehensive VMMC services
2. % facilities using SBM-R approach for performance improvement
3. % facilities achieving 80% of MC performance standards for Comprehensive Package of MC Services
4. % of clients circumcised who experienced one or more moderate or severe adverse events
5. % of males circumcised within the reporting period who return at least once for post-operative follow-up care within 14 days of surgery
Coverage Indicators
1. # sites providing VMMC services
2. # males circumcised
3. # males tested & counselled for HIV


National Stakeholders
USAID ▪ Ministry of Health ▪ HIV Unit ▪ Implementing Partners
Project Offices—
Blantyre and Lilongwe
Serves as base of support for all program operations:
Engage DHMTs and Zonal Officials
Coordinate with Implementing Partner district-based project staff
Supportive supervision to service delivery sites
Deploy MOVE Team
Organize outreach visits and campaigns
Conduct M&E visits to site
Coordinate finance, administration and procurement
Focus District
District Health Management Team ▪ Static Service Delivery Sites
Mobile Service Delivery Sites
VMCC Community Stakeholders
Local NGOs ▪ Civil Societies ▪ Tea Estates ▪ Churches ▪ CBOs