GOVERNMENT OF MALAWI

MALAWI COSTED IMPLEMENTATION PLAN FOR FAMILY PLANNING, 2016–2020

September 2015

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Malawi Costed Implementation Plan for Family Planning, 2016–2020

SEPTEMBER 2015

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FOREWORD

The Government of Malawi accords high priority to the promotion and practice of family planning (FP) as one of the ways of improving the quality of life of its people. Malawi, among several countries in Africa, made commitments during the Family Planning London Summit (FP2020) in July 2012 to achieve a modern contraceptive prevalence rate (mCPR) of 60 percent by 2020 from 33 percent for married and sexually active women, with a focus on reaching the 15–24 age group.

The Malawi Demographic and Health Survey (MDHS, 2010) indicated that 42 percent of married women used FP methods, while only 33 percent of all women of childbearing age use contraceptives. This shows that contraceptives in Malawi are mostly used by married women, resulting in a high fertility rate of 4.0 in urban areas and 6.1 in the rural areas, with an average of 5.7. There is a need therefore, to raise awareness of family planning among all women of childbearing age.

To ensure that the FP2020 commitments are met, there was a need to develop a national plan to provide direction to Malawi's FP programme, ensuring that all components of a successful programme are addressed and budgeted for government and partner buy-in. The Malawi Family Planning Costed Implementation Plan (FP-CIP), 2016–2020 has detailed plans to achieve Malawi's vision and goals to improve the health and well-being of the country's population.

The FP-CIP has therefore been developed for FP programming for the government across all sectors, development partners, and implementing partners.

M.P. Magwira PhD

SECRETARY FOR HEALTH

ACKNOWLEDGMENTS

The Malawi Family Planning Costed Implementation Plan, 2016–2020, reflects the input and participation of a large number of partners and stakeholders, over nearly six months. The plan was prepared under the leadership of the Reproductive Health Directorate in the Ministry of Health, with additional support from other sectoral ministries:

- Ministry of Agriculture
- Ministry of Education, Science and Technology
- Ministry of Gender and Social Welfare
- Ministry of Health
    - Department of Planning and Policy Development
    - Health Education Unit
    - Reproductive Health Directorate

Support for the plan's development was provided by Palladium, through funding from the United Nations Foundation, and by the United Nations Population Fund and the U.S. Agency for International Development.

In addition to the above, numerous donors and partners provided valuable input through the Costed Implementation Plan Task Force and the Strategic Advisory Groups:

- Abt Associates
- Adventist Health Services
- Banja La Mtsogolo
- Central Medical Stores Trust
- Christian AID
- Churches Health Association of Malawi
- Department for International Development
- Family Planning Association of Malawi
- Federation of Disability Organizations in Malawi
- Futures Group
- JHPIEGO
- Johns Hopkins Center for Communications Programs
- John Snow, Inc.
- Malawi Council for the Handicapped
- Malawi Interfaith AIDS Association
- Malawi Red Cross
- Medical Council of Malawi
- National Organization of Nurses and Midwives of Malawi
- National Paramedical Private Practitioners of Malawi
- National Youth Council
- Nurses Council of Malawi
- Population Research Bureau
- Population Services International
- Synod of Livingstonia
- United Nations Population Fund
- United States Agency for International Development
- World Health Organization
- Members of the Family Planning Technical Working Group and Safe Motherhood Technical Working Group

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BLM	Banja La Mtsogolo
CBDA	community-based distribution agent
CHAM	Christian Health Association of Malawi
CHW	community health worker
CIP	Costed Implementation Plan
CMST	Central Medical Stores Trust
COC	combined oral contraceptive
CPC	Child Protection Committee
CPR	contraceptive prevalence rate
CS	contraceptive security (thematic area)
CSA	Central Statistical Agency
CSO	civil society organisation
CYP	couple-years of protection
DC	demand creation (thematic area)
DEHO	District Environmental Health Officer
DHMT	District Health Management Team
DHO	District Health Office
DHS	Demographic and Health Survey
EC	emergency contraceptive
FBO	faith-based organisation
F	financing (thematic area)
FP	family planning
FP-CIP	Family Planning Costed Implementation Plan
FP2020	Family Planning 2020
FPAM	Family Planning Association of Malawi
GOM	Government of Malawi
HEU	Health Education Unit
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
HTSS	Health Technical Service and Support unit
ICT	information and communication technology
IEC	information, education, and communication
IUD	intrauterine device
IYCF	infant and young child feeding

LAM	long-acting method
LARC	long-acting reversible contraceptives
LMIS	Logistics Management Information System
LS&SRH	Life Skills and Sexual and Reproductive Health
mCPR	modern contraceptive prevalence rate
MDG	Millennium Development Goal
MDHS	Malawi Demographic and Health Survey
MOA	Ministry of Agriculture
MOEST	Ministry of Education, Science and Technology
MOGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MOH	Ministry of Health
MWK	Malawian Kwacha
NAPPPAM	National Paramedical and Private Providers Association of Malawi
NGO	nongovernmental organisation
PA	policy and advocacy (thematic area)
PMA2020	Performance, Monitoring and Accountability 2020
POC	progestin-only oral contraceptives
PSI	Population Services International
RHD	Reproductive Health Directorate
RMNCH	reproductive, maternal, newborn, and child health
SBCC	social and behaviour change communication
SDA	service delivery and access (thematic area)
SDG	Sustainable Development Goal
SG	stewardship and governance (thematic area)
SMC	supervision, monitoring, and coordination (thematic area)
SMS	short message service
SOP	standard operating procedure
SP	strategic priority
SRH	sexual and reproductive health
SRHR	sexual and reproductive health rights
TFR	total fertility rate
THE	total health expenditure
TMA	total market approach
TOR	terms of reference
TOT	training-of-trainers
TWG	technical working group
USAID	United States Agency for International Development

USD	United States dollar
YFHS	youth-friendly health services
YUNECO	Youth Net and Counselling

SECTION 1: INTRODUCTION

This document serves as the blueprint for Malawi to achieve its family planning (FP) objective of **reaching a modern contraceptive prevalence rate (mCPR) of 60 percent by 2020, with a focus on reaching the 15–24 age group.**[1] This objective is a critical component of achieving Malawi's broader development agenda and supports the shared aspiration described in Malawi's Vision 2020:

> *"By the year 2020, Malawi as a God-fearing nation will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income economy."*[2]

The Malawi Family Planning Costed Implementation Plan, 2016–2020 (FP-CIP) details the country's plans to achieve its vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based FP information and services.

Access to family planning and contraception is a fundamental dimension of sexual and reproductive health and reproductive rights. However, many Malawians are still unable to enjoy these rights. This, in turn, has an unintended impact on the lives and productivity of women and girls who cannot fulfill their rights to education, health, and employment due to the lack of information and means that would enable them to delay motherhood and plan their family size (should they decide to have children). These human rights issues are intrinsic to a life of dignity and well-being, thus meriting the government's protection. Further, the non-fulfillment of these rights impedes the country's economic and social development for current and future generations.

1.1 Rationale for and Use of the FP-CIP

Malawi's FP-CIP will guide FP programming for the government across all sectors, donors, and implementing partners. It details the necessary programme activities and costs associated with achieving national goals, providing clear programme-level information on the resources the country must raise domestically and from partners. The plan gives crucial direction to Malawi's FP programme, ensuring that all components of a successful programme are addressed and budgeted for in government and partner programming.

More specifically, the FP-CIP will be used to

- **Ensure one, unified country strategy for family planning is followed:** The FP-CIP articulates Malawi's consensus-driven priorities for family planning—derived through a consultative process—and thus becomes a social contract for donors and implementing partners. The plan will help ensure that all FP activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their FP investments and programmes. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the Ministry of Health (MOH) must hold development and implementing partners accountable for their planned activities and must realign funding to the country's needs identified as priorities. At the same time, the FP-CIP details commitments, targets, actions, and indicators to make the MOH ultimately accountable for their achievement. All other sectoral ministries should work in tandem with the MOH to implement the FP-CIP and coordinate efforts, and the FP-CIP should be consulted in the development of broader policies and strategies.
- **Define key activities and an implementation roadmap:** The FP-CIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's publically committed FP goals by 2020.

- **Determine impact:** The FP-CIP includes estimates of the demographic, health, and economic impacts of the FP programme, providing clear evidence for advocates to use to mobilise resources.
- **Define a national budget:** The FP-CIP determines detailed commodity costs and public-sector programme activity costs associated with the entire FP programme. It provides concrete activity and budget information to inform the MOH budget requests for FP programmes aligned with national goals between 2016 and 2020. It also provides guidance to the MOH and partners to prioritise the funding and implementation of strategic priorities.
- **Mobilise resources:** The FP-CIP should also be used by the Government of Malawi (GOM) and partners to mobilise needed resources. The plan details the activities and budget required to implement a comprehensive FP programme, and as such, the MOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP and conduct advocacy to mobilise funds from development partners to support any remaining funding gaps.
- **Monitor progress:** The FP-CIP's performance management mechanisms measure the extent of activity implementation and help ensure that the country's FP programme is meeting its objectives, ensuring coordination, and guiding any necessary course corrections.
- **Provide a framework for inclusive participation:** The FP-CIP and its monitoring system provide a clear framework for broad-based participation of stakeholders within and outside of the GOM and are inclusive of relevant groups and representatives from key populations in the implementation and monitoring of the plan.

Figure 1: Commitments made by the GOM at the London Summit on Family Planning (June 11, 2012)

1. Increase all women mCPR to 60% by 2020 with focus on 15–24 age group
2. Develop a comprehensive sexual and reproductive health programme for young people starting FY 2013–14
3. Increase coverage of services through the expansion of public/private partnerships, starting FY2013–14
4. Increase community participation in family planning services through initiatives like the Traditional Chiefs Committee
5. Strengthen forecasting and data management for effective supply chain operation
6. Create a family planning budget line in the main drugs budget by 2013–2014
7. Demonstrate accountability in utilization of available resources
8. Increase financial allocation for health systems supporting family planning
9. Raise the legal age for marriage to 18 by 2014
10. Strengthen policy leadership by elevating the Reproductive Health Unit to a full Directorate
11. Approve the National Population Policy by December 31, 2012

1.2 The Global Context

Scaling up the use of family planning is one of the most cost-effective ways of preventing maternal and newborn deaths. Modern contraceptive use prevents 188 million unintended pregnancies, 1.2 million newborn deaths, and 230,000 maternal deaths annually.[3] Medical care related to unintended pregnancies currently costs $2.5 billion USD annually, and would more than double to $6.9 billion USD if each of those pregnancies received the recommended prenatal and neonatal care. Extending FP services to every woman in need would cost $3.6 billion USD more than what is currently spent and result in a cost saving of $1.40 USD for every dollar spent on family planning.[4] The cost savings related to family planning would also cascade to other areas dependent on population trends, such as education.[5]

FP2020

Family Planning 2020 (FP2020) is a global partnership that promotes the rights of girls and

women to decide, freely and for themselves, whether and when they want to have children and how many, without coercion or discrimination. FP2020's goal is to enable 120 million additional girls and women to access voluntary family planning by 2020. The partnership was formed as an outcome of the 2012 London Summit on Family Planning, during which global leaders gathered to renew their commitment to reproductive rights and recognise family planning as a fundamental part of the global health agenda.[6] To date, more than 80 countries, civil society, private sector, donors, and multi-lateral organizations have made commitments in support of this goal.

As a participant in the summit, the GOM made 11 significant commitments to FP2020 (see Figure 1) and has already made significant progress in achieving them. Since 2012, the government has shown leadership in successfully[7]

- Creating an FP line item in the main national drugs budget
- Raising the legal age for marriage to 18
- Elevating the Reproductive Health Unit to a full directorate

In addition to the policy and financial commitments made at the London Summit, the GOM has also set an ambitious objective of increasing the mCPR from a baseline of 42 percent in 2010 to 60 percent in 2020. When this commitment was made at the summit, it was originally intended as an objective for all women in union, but has since been modified to represent the objective for women of reproductive age (WRA).

1.3 The Regional Context

Sub-Saharan Africa accounts for 59 percent of the global unmet need for family planning. Regionally, a significant number of women report the desire to space or limit child-bearing but are not currently using any method of contraception (see Figure 2).[8] Common contributing factors include misconceptions about contraceptive use, limited knowledge of available methods, lack of access to services, and poorly trained or unavailable staff.[9,10] The use of modern contraceptives for all WRA varies significantly within the region, ranging from a low of 12.1 percent in Mozambique to a high of 32.6 percent in Malawi (see Figure 3). The most popular contraceptive methods across all countries in the region are injectables, condoms, and pills.[11]

Figure 2: Unmet need for family planning, currently married women of reproductive age

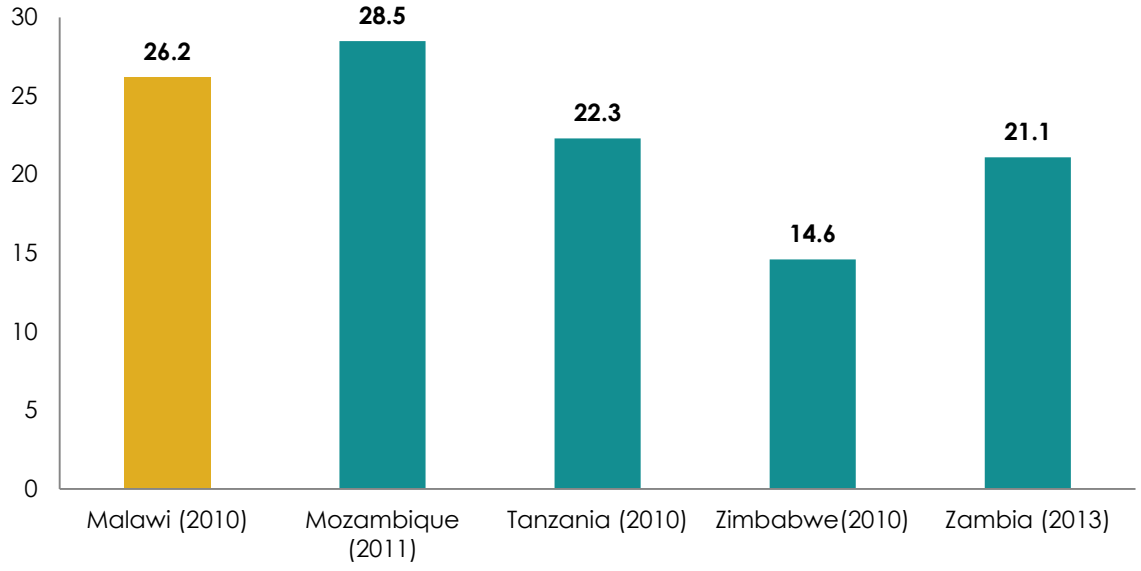
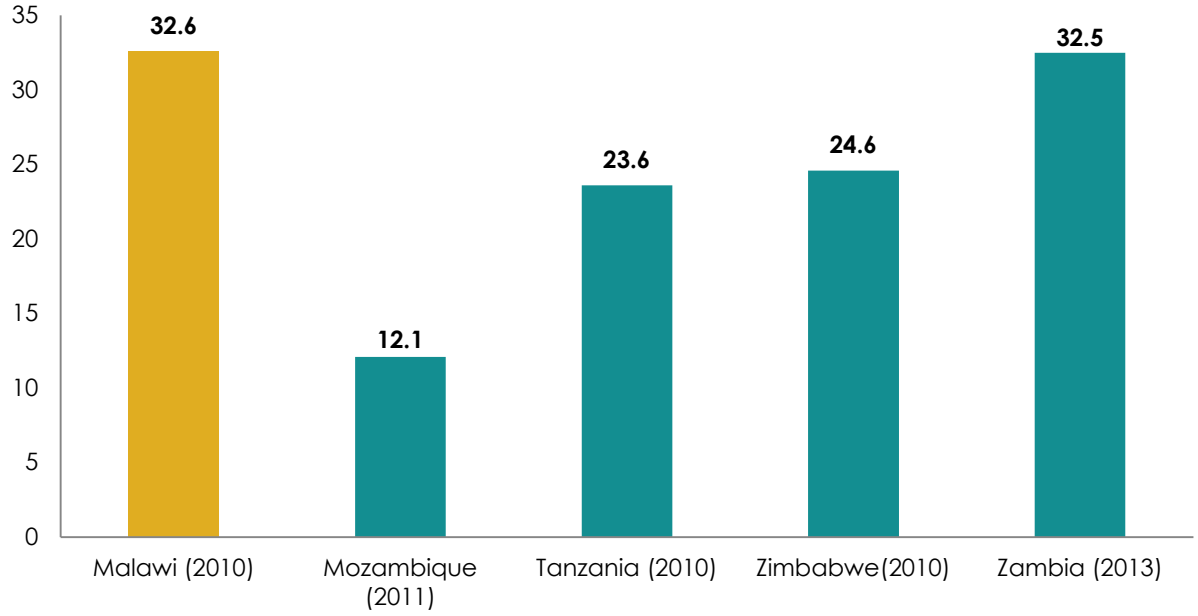


Figure 3: Modern contraceptive use, all women of reproductive age



The total fertility rate (TFR) remains relatively high among the countries (Malawi: 5.7, Mozambique: 5.9, Tanzania: 5.4, Zimbabwe: 4.1, Zambia: 5.3). High fertility rates have contributed to an increase in population growth in the past decade, with an average growth rate of about 2.7 regionally. The increasing population puts additional strains on public resources including health, education, food security, and the environment, requiring billions of additional dollars in spending.[12]

1.4 The Malawian Context

Five indicators provide a framework for understanding family planning in Malawi: fertility, maternal and child mortality, unmet need, and contraceptive use. Figure 4 shows the current status of indicators, and the targets Malawi has set for each one. As discussed below, Malawi has made significant strides towards achieving these targets, including meeting Millennium Development Goal (MDG) 4: reducing under-five mortality by two-thirds by 2015. However, high unmet need for family planning and low contraceptive use continue to contribute to high fertility rates and unwanted pregnancies—both of which have significant consequences on the health of the population and Malawi's spending.

Figure 4: Malawi development indicators

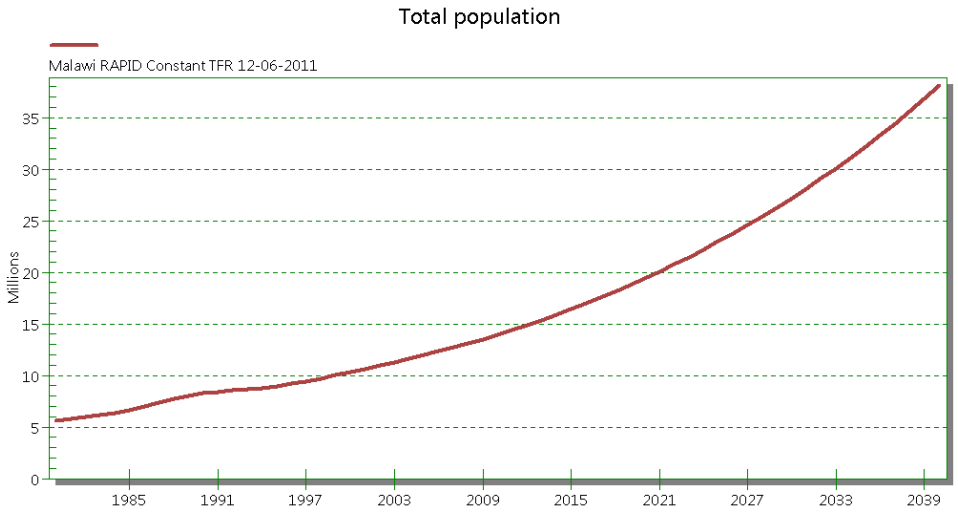
	Baseline	Target
Maternal mortality ratio per 100,000 live births	510 (MDG)	155 (MDG)
Newborn death rate per 1,000 live births	44.3 (MICS)	78 (MDG)
Total fertility rate	5.7 (DHS)	4 (National Sexual and Reproductive Health Strategy, 2011–2016)
Unmet need (married women)	26.1% (DHS)	20% (National Sexual and Reproductive Health Strategy, 2011–2016)
Modern contraceptive prevalence rate (married WRA)	42.2%	60% (FP2020)

Demographics

Malawi's population is currently estimated at 16.4 million people, based on the last estimate of 13.1 million people in the 2008 census.[13] At the current population growth rate of 2.8,[14] Malawi is expected to have 45 million people by 2050, triple the 2008 population size (see Figure 5);[15] this will further strain already limited resources.[16] With a high TFR and low life expectancy, the majority of Malawi's population are young dependents, with 54 percent of the population under age 18. This population structure puts an extra burden on the country's working-age population to provide food and education for dependents and requires significant job creation to accommodate the number of youth who will soon enter the workforce. At the same time, the growing population threatens the sustainability of existing natural resources, including land and water. Family planning can play a significant role in slowing the population growth rate and ensuring that Malawi has the opportunity to grow economically.[17]

The GOM is extremely concerned about the rapid population growth and released the national Population Policy in 2012 aimed at addressing development challenges that emenate from unmanaged population growth and high levels of fertility and mortality.[18] Additionally, in the National Sexual and Reproductive Health Strategy, 2011–2016, Malawi committed to lowering the TFR from 5.7 to 4. Adolescent pregnancy in Malawi has reached 26 percent; therefore, targeting pregnancy prevention efforts to adolescent girls will help the country reach a 60 percent mCPR among all WRA by 2020.

Figure 5: Total population of Malawi, 1985–2040



Malawi can create a valuable demographic dividend if the government follows the "Asian Tigers" example of utilizing the bulge in working population to stimulate economic growth. A demographic dividend refers to the economic and social benefits that come when a country experiences a decline in high fertility and mortality so that the working-adult population grows to a rate that is significantly larger than the number of dependents. The result is increased funding for health and schools, increased family wealth and savings, and a higher gross domestic product. With Malawi's current population trends, about 200,000 new jobs will need to be created each year to accommodate the number of young adults entering the workforce. For the country to achieve a demographic dividend, the TFR will need to fall to three children per woman.[19] To do so will require significant financial investments in education, economic policy, and family planning; and it will take 30 years for Malawi to see the benefits.[20]

Maternal and child mortality

Malawi has made significant strides in achieving MDG #4 (reducing child mortality) and #5 (improving maternal health). The country has already met its goal of reducing under-five mortality (surpassing the goal of 78 deaths per 1,000 live births in 2012), but it is still working towards the goal

of reducing maternal mortality to 155 deaths per 100,000 live births by 2015 (currently at 510 deaths per 100,000 live births).[21] High fertility rates and teenage pregnancy in Malawi are contributing factors to maternal mortality, with adolescent pregnancies accounting for 20 percent of maternal deaths.

While the median age at first birth in Malawi has increased to 18.9, 60 percent of youth ages 18–24 have had sexual intercourse before age 18, and 26 percent of adolescents ages 15–19 have begun childbearing (20% have had their first child and 6% pregnant with their first child).[22] While some of these pregnancies are wanted, many are not. A study in 2011 on abortion in Malawi found that nearly 50 percent of women presenting for postabortion care were under age 25, demonstrating the need for improving access to high-quality FP services for youth.[23]

Teenage pregnancy contributes significantly to maternal morbidity and mortality, because pregnancies in physically immature bodies are more likely to result in obstetric complications. Girls ages 10–14 are five times more likely than women ages 20–24 to die in pregnancy and childbirth, while those ages 15–19 are twice as likely as older women to die from childbirth and pregnancy, making pregnancy the leading cause of death in low-income countries for girls in this age group.[24] In Malawi, use of modern contraception among married adolescents ages 15–19 is just 26 percent, and 24 percent among unmarried, sexually active women.[25] There is also high unmet need for family planning among 15–19 year olds, with 27 percent of adolescents desiring to delay or space their pregnancies.[26] In the most recent Demographic and Health Survey (DHS), 25.6 percent of women ages 15–19 are either currently pregnant or mothers.[27] Child bearing during the teenage years frequently has adverse social consequences, particularly in terms of education, with girls who become a mother in their teenage years more likely to drop out of school. Addressing FP needs among youth has been globally recognised as a vital intervention for addressing maternal mortality.[28]

Unmet need

Unmet need represents the number of women who want to limit, space, or prevent births but are not currently using any modern method of contraception.[29] Malawi has seen some success in reducing unmet need, with a drop of 4.2 percent in six years, even as overall demand for family planning has increased. Unmet need among married WRA is currently 26.1 percent, down from 30.3 percent in 2004 (see Figure 6).[30] Despite the drop in unmet need, women in rural Malawi are still less likely to access family planning, with unmet need among rural women 3.5 percent higher than unmet need among women in urban areas (see Figure 7)[31]. Unmet need among poorer women is even higher, with women in the lowest wealth quintile reporting the highest unmet need at 30 percent—eight percent higher than women in the wealthiest quintile (Figure 8)[32]. Among all women in Malawi, there continues to be a significant desire to limit or have no more children (36.3% and 37.1%, respectfully). Currently, 25 percent of pregnancies in Malawi are unintended, highlighting the impact of unmet need for family planning. Fear of side effects, poor information, and distance to clinics are the most common reasons why women are not accessing FP services.[33]

Figure 6: Satisfied demand and unmet need for contraception, married women of reproductive age

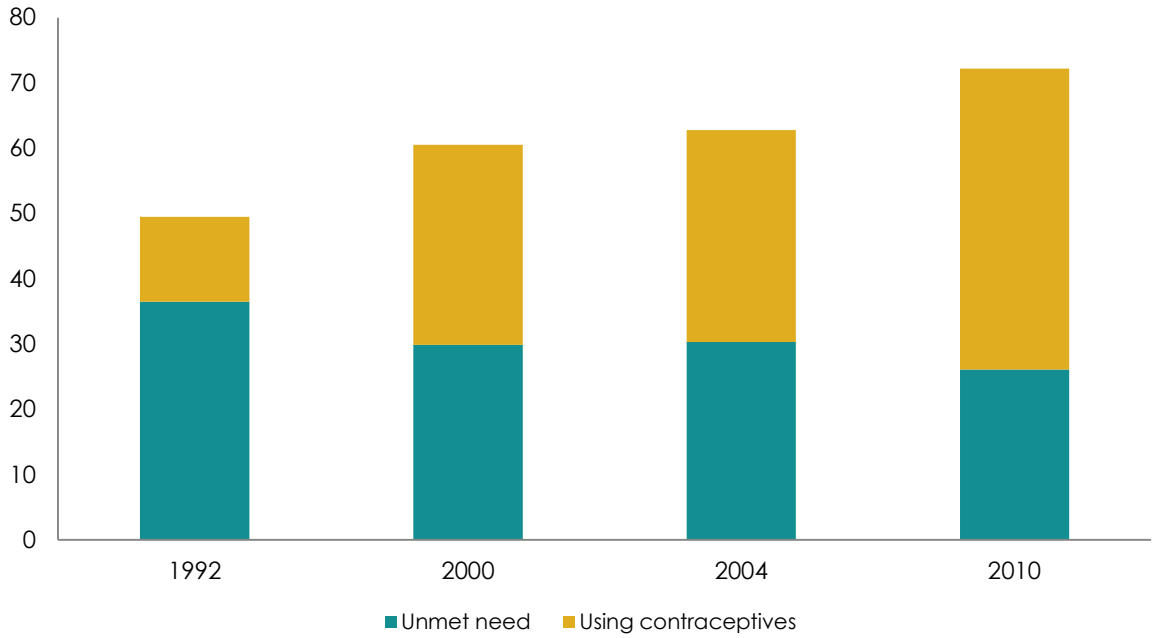


Figure 7: Unmet need by residence

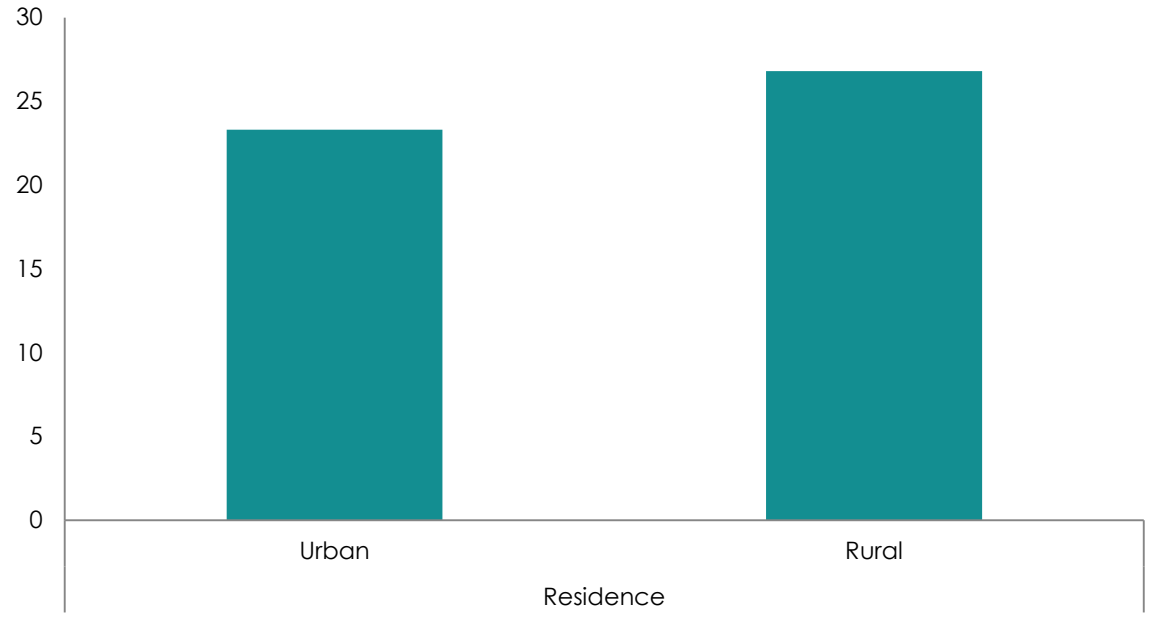
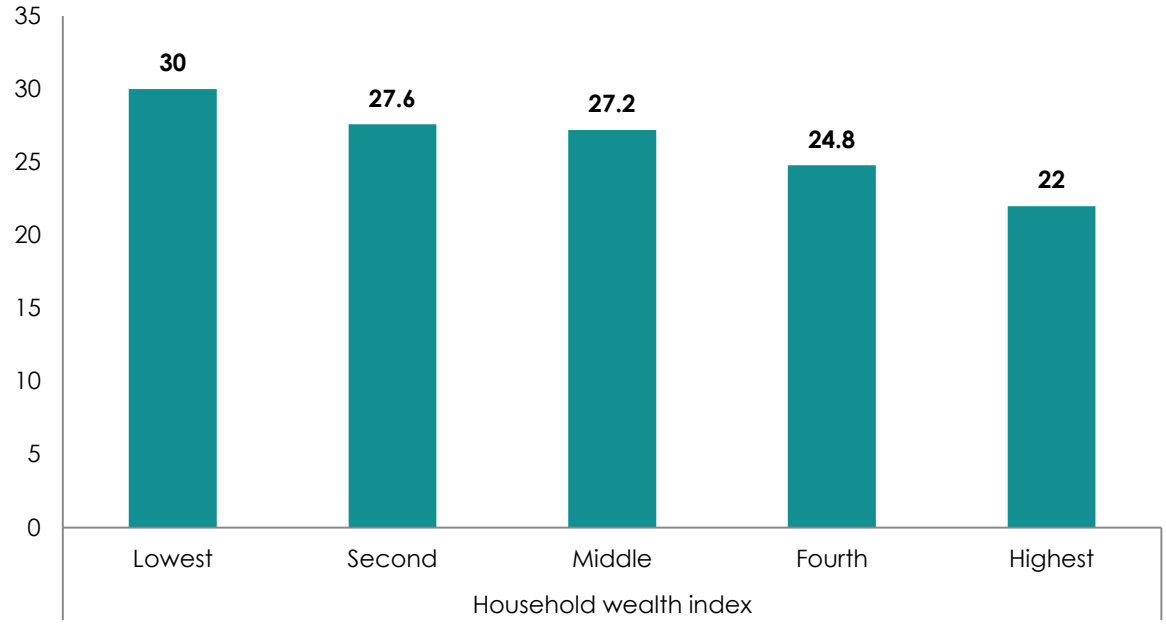


Figure 8: Unmet need by wealth quintile



Contraceptive Use

The 2010 Malawi DHS revealed that tremendous progress has been made to improve several key FP indicators, including mCPR. Malawi has also worked to generate local ownership for increasing contraceptive prevalence, including helping districts to set their own mCPR goals for 2020 using the Reality Check tool.[34] Despite these improvements, much work remains, particularly to reduce inequities that exist between and within regions and districts in accessing FP services.

In 2010, 42.2 percent of married women in Malawi were using a modern contraceptive method (up from 28.1% in 2004). The most popular methods among all women include injectables, female sterilization, and condoms (see Figures 10 and 11). Contraceptive use varies significantly by location, with rural residents less likely to use modern contraception than their urban counterparts (40.7% and 49.6%, respectively). Regionally, the lowest modern contraceptive use is found among women living in the Northern region (39%), and the highest modern contraceptive use is found in the Central region (44.6%). Poorer citizens are the least likely to use modern contraception, with use gradually rising as wealth increases.[35]

Figure 9: Modern CPR among married women, by district

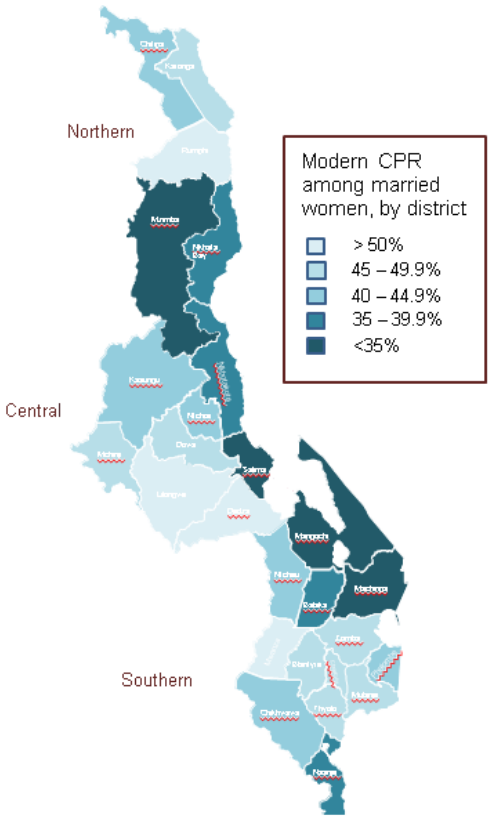


Figure 10: Contraceptive use, unmarried sexually active women

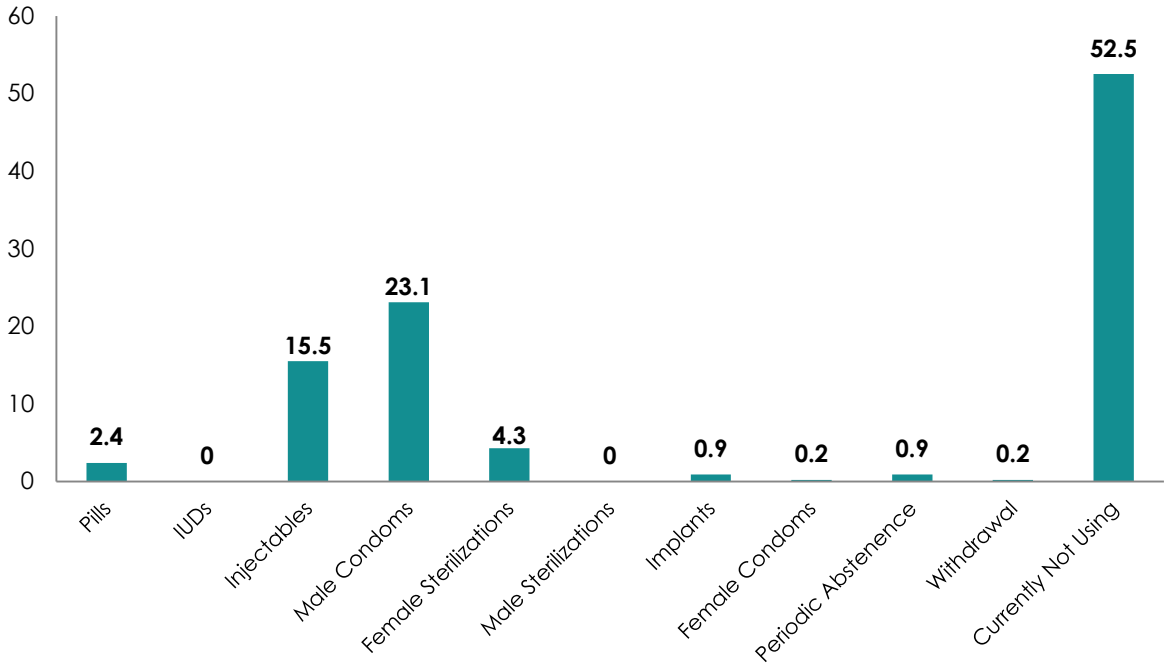
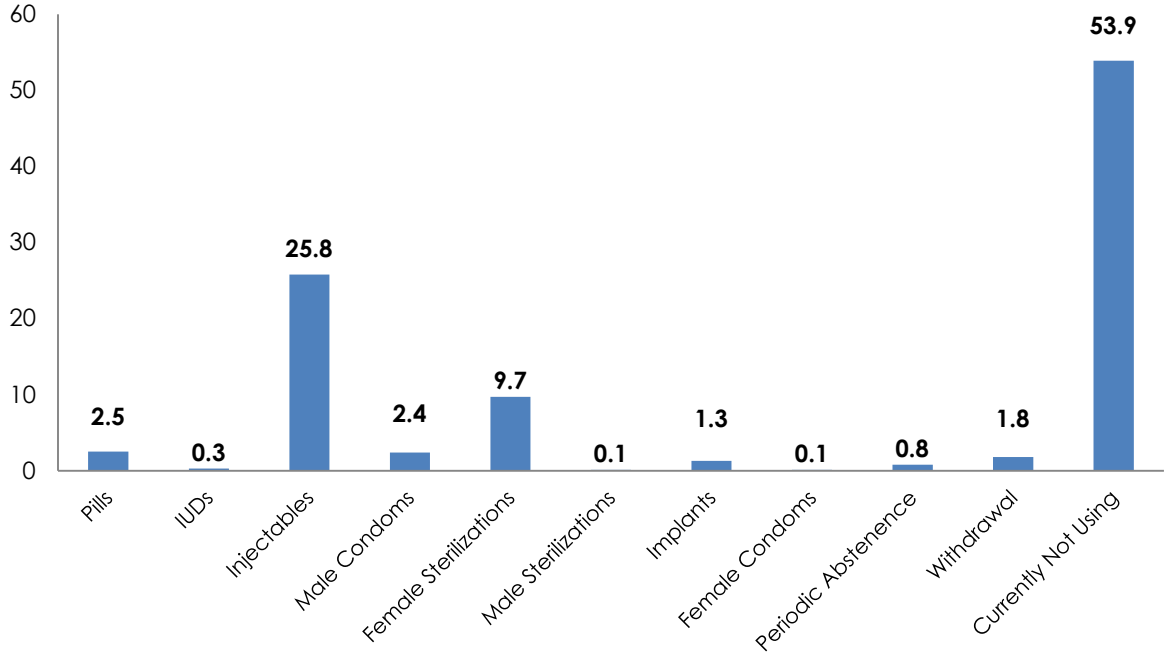


Figure 11: Contraceptive use, currently married women



1.5 Key Issues and Challenges

Demand

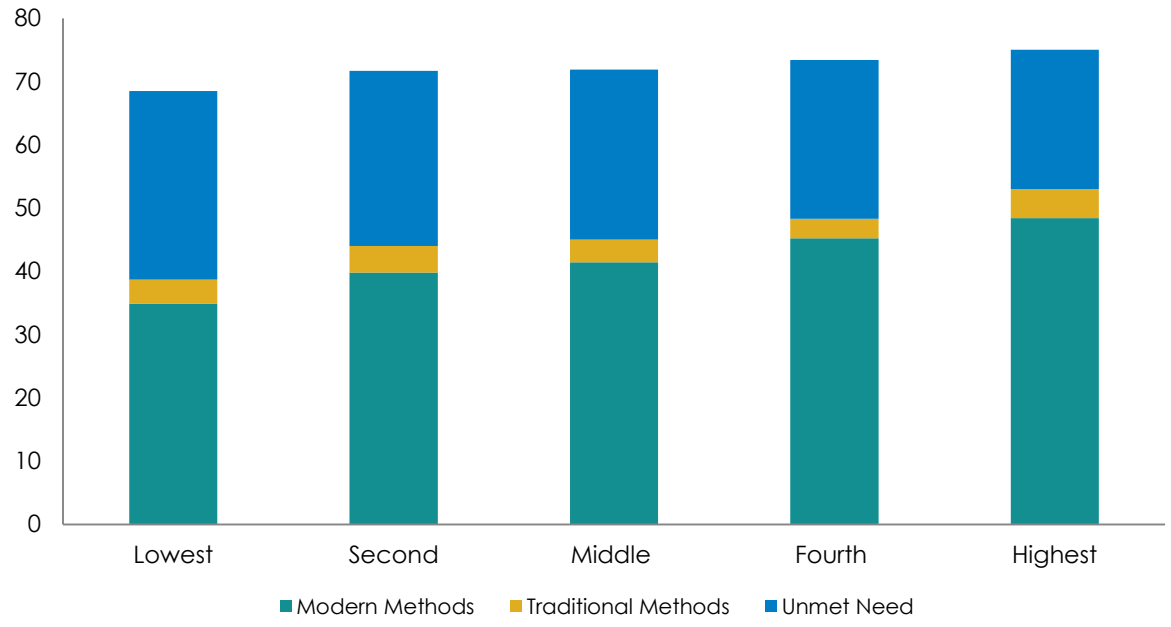
Malawi has identified demand creation as a priority strategy for addressing population growth and FP concerns.[36,37] The majority of Malawians (72.3%) have demand for FP services. Demand for family planning rises as the wealth of Malawians rises; and is more likely to be satisfied among wealthier people, with the poorest having only about 56 percent of their demand for family planning satisfied (see Figure 12).[38] Increasing knowledge about family planning is a significant part of generating and satisfying demand.[39] Almost all Malawians are aware of at least one method of family planning, with pills and condoms being the most commonly known method. Demand is also less likely to be satisfied among youth ages 15–19; this group is less likely to have accurate knowledge about family planning.

Key Issues Identified in Demand

- Fear of side effects is the most common reason why women do not access contraceptives
- Religious and cultural barriers prevent women from fully understanding and accessing FP services
- Youth lack information about family planning
- Parents do not discuss reproductive and sexual health with their children

Lack of information and knowledge among youth is believed to stem from a lack of support and sharing of information by parents and teachers and incorrect information from peers. Malawi has made some progress in addressing this situation by introducing life skills and sexual and reproductive health education into schools in 2002. Age-appropriate, comprehensive sexuality education, with links to sexual and reproductive health (SRH) services has been identified as a best practice to prevent early pregnancy.[40] While the Ministry of Education, Science and Technology (MOEST) has permitted the teaching of life skills education in schools, sexuality and sexual behaviour topics remain absent from the Malawi Life Skills and Sexual and Reproductive Health curriculum. Development partners are working with the MOEST to revise the existing curricula.

Figure 12: Demand by wealth quintile



Lack of adequate information about family planning has led to persistent misconceptions and myths about the side effects of contraceptives. Common beliefs about side effects in Malawi include the following: contraceptives cause cancer; intrauterine devices (IUDs) drift to your heart; and pills lump into a mass in the uterus. These myths have prevented women from accessing FP services.[41] While some of these myths could be addressed by health workers, 31 percent of women do not receive any information about family planning when they visit a health centre; this is fairly consistent for both urban and rural women.

Cultural beliefs also generate substantial barriers to meeting demand among women of reproductive age. Cultural and religious leaders are prominent figures in the communities they serve and remain key influencers of social norms and behaviours. More than 80 percent of Malawian citizens are Christian, and a large portion of those are Catholic; the Catholic Church in Malawi does not support the use of modern contraceptives for family planning, leading many Catholic women to rely on traditional methods.[42] Religious prohibition on family planning is one of the leading reasons for the lack of demand for contraceptives in Malawi.[43]

Service delivery and access

The number one priority of Malawi's National Sexual and Reproductive Health Strategy, 2011–2016, is to "increase access to, and utilization of, FP services at health facility and community level."[44] Despite this priority, there continue to be obstacles to free and equitable access to family planning, not least of which is the distance to clinics. The Ministry of Health recommends a travel distance to clinics of 5–8 km; the average distance is currently 10–15 km, while some women have been known to travel as far as 40 km.[45] Only 46 percent of the population lives within 5 km of a health facility, and 20 percent lives within 25 km of a hospital. Even when at a reasonable distance, clients can experience poor service due to stock-outs caused by poor supply chain management, lack of human resources for health, poor integration with other health services (mainly HIV), and lack of youth-friendly health care. Family planning is not considered an urgent health need; and therefore, many women are unwilling to travel long distances to access services that are not perceived to be an immediate necessity. An additional barrier is that when women do travel to the health centres, services are only provided on specific days in the most rural areas. Having specific service delivery days may result in missed opportunities to reach women who wish to access FP services and lead to more women being lost to follow-up—women may sometimes visit a health clinic on another day of the week for a different health need.[46] Additionally, specific days for family planning are also often known by the larger community, making it more difficult for women to keep her reproductive health choices confidential.[47]

Key Issues Identified in Service Delivery and Access

- Distance to clinics is too great
- Specific health services are only provided on certain days
- Providers are not trained to deliver FP services
- Providers are ill-equipped to deliver long-acting reversible methods
- Only one-third of providers reported receiving FP training in the last 24 months*
- Facilities are understaffed
- Staff are poorly trained on youth-friendly health services (YFHS)
- Stigma exists surrounding contraceptive use
- There is denial that premarital sex occurs

* Source: MOH and ICF International. 2014. *Malawi Service Provision Assessment (MSPA) 2013–14*. Lilongwe: MOH; and Rockville, Maryland, USA: ICF International.

The public sector is the largest provider of health services in Malawi, with 74 percent of women accessing contraceptives from public facilities.[48] In addition to the public sector, there are two not-for-profit, private sector organizations providing free or low-cost FP services: the Christian Health Association of Malawi (CHAM) provides 9 percent of FP services, and Banja La Mtsogolo (BLM), a

Marie Stopes affiliate, also provides 9 percent of services, notably long-acting reversible contraception and permanent methods (33% of all female sterilizations and 20% of all IUD insertions in Malawi). Population Services International's (PSI) supports contraceptive social marketing through its Tunza Network, which also includes 28 youth-friendly service providers in the Central Region, with plans to expand to the Northern Region.

Public health care services in Malawi are delivered at primary, secondary, and tertiary levels. Primary-level services are largely community initiatives that include community-based distributing agents (CBDAs), health surveillance assistants, village health committees, health posts, dispensaries, and health centres. CBDAs can only provide condoms, pills, and counselling on the standard days method. Health centres, clinics, and dispensaries can also provide injectables and implants; in Malawi, there are 328 health centres and 62 dispensaries. The secondary-level includes 24 district hospitals and four tertiary (central) hospitals (see Figure 13).[49] Hospitals can provide IUDs and some provide female and male sterilization. Among all the health facilities that provide services, only half have service providers trained on family planning present.[50] Lack of well-trained staff creates a significant barrier to the delivery of high-quality FP services. Facilities are frequently understaffed, or staffed with health workers who do not have adequate training to provide the full method mix expected at that level. Even when facilities are adequately staffed, health workers are often overburdened and do not have sufficient time for providing long-acting methods, or even to fully counsel clients. Some of the impediments to staffing facilities include the late deployment of newly trained staff to health centres that ultimately results in recent students finding other jobs, as well as the difficulty of recruiting staff to positions in rural areas due to limited incentives.[51]

Figure 13: Health centre distribution

Districts	Central Hospital	District Hospital	Health Centre	Dispensary	Maternity	Rural Hospital	Hospital	Mental Hospital
Dedza		1	17	1	1	3		
Dowa		1	13	2		2	1	
Kasungu		1	10	3		1	1	
Lilongwe	1		30	2		4	4	
Mchinji		1	8	1		3		
Nkhotakota		1	9	2		1	1	
Ntcheu		1	15	6	3	2		
Ntchisi		1	9					
Salima		1	14	2			1	
Chitipa		1	7	2		1		
Karonga		1	9	2	1	2		
Likoma								
Mzimba	1	1	24	5		4	3	1
Nkhata Bay		1	12			2		
Rumphi		1	16			2	1	
Balaka		1	7	2				
Blantyre	1		11	10	1		1	
Chikwawa		1	11	2			1	
Chiradzulu		1	7	2		1	1	
Machinga		1	11	2		1		

Districts	Central Hospital	District Hospital	Health Centre	Dispensary	Maternity	Rural Hospital	Hospital	Mental Hospital
Mangochi		1	23	4			2	
Mulanje		1	17	7	4	1	2	
Mwanza		1	10			1		
Nsanje		1	13	2		2	1	
Thyolo		1						
Phalombe		1	12	4	5	2	1	
Zomba	1	1	13	5	1		1	1
Total	**4**	**24**	**328**	**68**	**16**	**35**	**22**	**2**

Available staff may also hold biases against providing family planning for youth; these biases include beliefs that contraceptives promote sexual activity and that youth should not access contraceptives until they have had one child.[52] Young girls who want to delay pregnancy often rely on incomplete or wrong information provided by youth clubs, radio, friends, and *anankhungwi* (traditional initiators), which lead to fear of real and misconceived side effects. Strong societal disapproval and denial of the existence of premarital sex (emphasis on abstinence), and the associated stigma, are barriers to access to services for youth.

The GOM developed a Youth Friendly Strategy and Implementation Framework in 2004; however, while YFHS have been established, the MOH acknowledged that inadequate coordination and low sensitization at the community level impede the scale-up of high-quality YFHS.[53] The policy also supports the training of youth as CBDAs, which has shown some project success, but as these programmes are often linked to international nongovernmental organization (NGO) funding cycles, they are often not sustained.

Contraceptive security

Ensuring that commodities are available at health centres is essential for ensuring that demand is met. Challenges with the logistics and distribution system leads to frequent stock-outs of FP commodities. In Malawi, contraceptives are pushed to the health centres based on reported usage from the districts. Reporting of usage is done by pharmacists and store managers, and the data move through the health system to the regional medical stores and eventually to the Health Technical Service and Support unit (HTSS) at the MOH.[54] Quantification is conducted annually, using data from all public and private non-profit facilities; and while private for-profit sector facilities are required to report their data on commodities dispensed to users, it is not incorporated in the national quantification. The quantification data are then reported to the Central Medical Stores Trust (CMST) for procurement.[55] The Reproductive Health Unit has a logistics officer that works with HTSS during the quantification process to develop a procurement plan specifically for FP commodities. Procurement and distribution differs between the CHAM facilities and the private not-for-profit facilities. Both report through the same system; however, there are parallel procurement and warehousing systems at

Key Issues Identified in Contraceptive Security

- The stock data coming from districts are not always accurate or of high quality
- There is no accountability mechanism to ensure CMST is accurately delivering contraceptives and commodities
- Communication between FP coordinators and store managers is poor
- Redistribution rarely happens in the district, largely due to lack of transportation

the central level, with CHAM and the private sector pulling commodities from CMST, while most private not-for-profit organizations use a USAID warehouse. The public sector, which distributes the majority of contraceptive commodities, receives supplies from both the CMST and USAID warehouses. The lack of a unified supply chain leads to poor coordination and communication between the two sectors about the procurement and distribution of commodities.[56]

While central-level stock-outs of FP commodities are rare, health facilities in Malawi face frequent selective stock-outs, during which they are unable to provide clients with the full method mix. Long-acting methods are most commonly unavailable, with IUDs and implants out of stock (see Figure 14).[57] Accurate and timely data reporting is necessary for ensuring that the correct quantity of contraceptives is procured and that stock-outs are limited. However, data from health centres are frequently not reported, or reports are of poor quality.[58] Poor-quality data for family planning is particularly persistent, largely due to overworked pharmacy technicians. Poor-data reporting is partially due to the lack of communication between FP coordinators (responsible for ensuring that commodities are available and collecting health centre reports) and the pharmacy technicians (responsible for handling the stock of all essential medicines, including FP commodities). In addition to the lack of adequate data, there is a lack of accountability for how many contraceptives have been distributed, leading to limited knowledge of and preparedness for where and when stock-outs will occur. When stock-outs occur in facilities, redistribution within the district rarely occurs due to the absence of a budget line for fuel and transportation.[59]

Figure 14: Contraceptive availability

	Hospital	Health Centre	Dispensary	Clinic	Health Post
Combination oral contraceptives (COCs)	88	90	80	79	100
Progestin-only oral contraceptives (POCs)	81	73	66	56	51
Injectables	78	60	22	58	0
Male condoms	76	76	80	81	54
Female condoms	68	79	77	71	56
IUDs	69	42	0	80	N/A
Implants	92	91	94	84	100
Cyclebeads	74	56	N/A	52	N/A
Emergency contraceptives (ECs)	79	82	84	74	100

International donors finance the majority of the costs associated with procurement, storage, and distribution of contraceptives. Donor organizations currently pay the cost of handling and distribution that districts would normally be required to pay out of their district health budgets, but this arrangement will expire at the end of 2015. While the GOM has introduced a budget line to support the procurement of contraceptive commodities, there is still heavy reliance on donor funding to meet the existing demand for contraceptives—the national contribution constitutes just 20 percent of the total procurement budget for public facilities. Contraceptive security for Malawi will require more sustainable financing sources not just for commodities, but for the quantification, procurement, and distribution of contraceptives and supplies.[60]

Policy and enabling environment

While the area of population falls under the Ministry of Finance, Economic Planning and Development, family planning falls under the jurisdiction of the MOH. High fertility and rapid population growth have significant impacts on land, the environment, and education. Currently, there are no regular coordination meetings or shared policies amongst the relevant ministries (i.e., between the MOH; Ministry of Youth; Ministry of Gender, Children, Disability and Social Welfare—MOGCDSW; MOEST; or Ministry of Agriculture—MOA), despite their seemingly interconnected

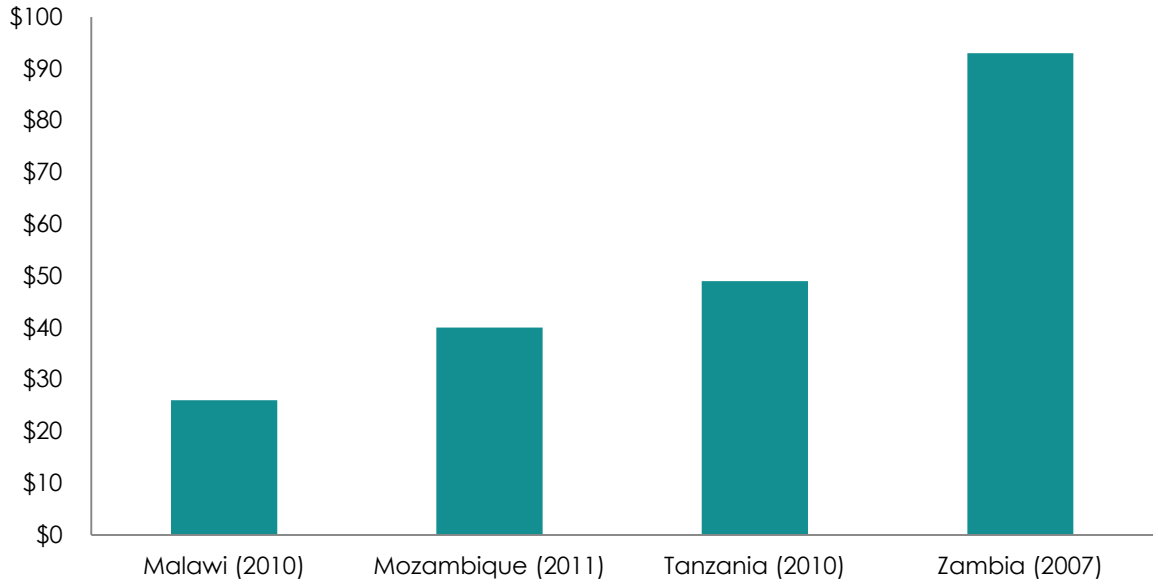
interests. In fact, many of these government ministries feel they should be engaged more in FP decisions and coordination.[61] Limited involvement from the non-health sector has prevented Malawi from experiencing the full benefits of family planning. Engaging and working with other ministries is considered a cost-effective way of reaching a wider population and generating greater demand.[62] Multisectoral engagement with the MOEST; MOA; and the MOGCDSW can have a significant impact on the community's knowledge and awareness of reproductive rights and FP options. While the MOEST has adopted a comprehensive Life Skills and Sexual and Reproductive Health curriculum for secondary school students, in practice, many schools do not provide any information on family planning due to teachers' lack of comfort discussing sexual health issues and push-back from local communities and parents.[63] The MOA has agriculture extension workers that work with farmers on myriad issues, including loss of productivity due to frequent pregnancies. Additionally, the MOGCDSW had previously been responsible for family planning in the 1990s and continues to contribute to FP policies.

To date, there has been limited engagement with the private sector in the development and implementation of FP policies and guidelines, leading to a poor understanding of its role in the larger issue of family planning and what activities would best compliment the government's plans.[64]

Financing

Among sub-Saharan Africa countries, Malawi spends the least amount of money on health at $26 USD per person, per year (see Figure 15).[65] However, this amount accounts for the highest regional expenditure on health as a percentage of gross domestic product,[66] indicating that the total resource ceiling for health broadly, and for family planning more specifically, is limited. Malawi is committed to increasing government financing for family planning; a line item for contraceptive commodities was first introduced in the 2013/2014 budget, and there are plans to increase it in the 2015/2016 budget.[67] Despite this progress, Malawi continues to rely heavily on donor funding to finance 80 percent of contraceptives.[68] It is difficult to track the overall contribution to family planning without a specific sub-account in the National Health Accounts. To achieve the ambitious goal of reaching a 60 percent mCPR among married and sexually active WRA, Malawi will need to also increase funding for family planning, and not just for contraceptives.

Figure 15: Health spending, per capita



Family planning funding, outside of contraceptives, is currently included as part of the maternal and child health budget, limiting the accessibility of FP-specific funds for national and district activities. This is reflected in the Malawi National Heath Accounts with subaccounts for HIV/AIDS, Malaria,

Reproductive Health, and Child Health for Financial Years 2009/10, 2010/11, and 2011/12, where reproductive health funding includes "family planning, maternal health, treatment and prevention of STDs and other RH conditions, infertility, abortion and post-abortion care, RH and sexuality counselling, information and education, and treatment and prevention for sexual abuse, gender-based violence and harmful practices, such as female genital cutting."[69] Without an individual funding area, family planning gets lost in and amongst other areas of reproductive health.

Stewardship and governance

There has been strong leadership from the GOM in addressing family planning as a critical development agenda item; however, there are still areas where further investment is vital to successfully achieve the GOM's objectives. In 2013, Malawi achieved its FP2020 goal of elevating the Reproductive Health Unit to a full directorate, giving the unit more power to influence policy.[70] The Reproductive Health Directorate (RHD) is responsible for all aspects of maternal and child health, including family planning, but the number of staff required to implement the full scope of activities that come along with such policy areas is not adequate, leading to overburdened and overworked staff, who are unable to invest sufficient time in overseeing and conducting adequate monitoring of FP policies and programmes. Additionally, RHD has only one full-time logistics officer, which leads to an unsustainable reliance on seconded staff.[71,72]

An effective performance management system helps to ensure that FP clients receive high-quality services from capable health care providers. Malawi created a performance monitoring plan for health care workers in 2008, but it has yet to be operationalised.[73] The plan established a system for non-financial recognition of exceptional providers and ensures that providers are following the national standards. However, the plan is yet to be implemented. As of May, 2015, supervisors have not been oriented in the new performance management system, and there is no monitoring system put in place to coordinate and supervise government and partner FP activities at either the national or district level, impeding the oversight and administration of FP programmes in Malawi.[74]

Coordination for family planning largely happens at the national level during FP technical working group meetings with government officials, their partners, and in-country donors. Currently, there is no set meeting date for these meetings, making it difficult to track the results of action items developed during previous ones. At the district level, family planning is coordinated through the FP coordinator that sits within the District Health Office. The coordinator's role is to provide updates and information regarding family planning to the district health officer to help plan and implement FP programmes. However, outside of that role, there appears to be no clear coordination mechanism for the implementing partners and donors on the ground to track their efforts and limit duplication.[75] Additionally, private for-profit organizations have no requirement to report to the FP coordinator, making it more difficult for the district to effectively monitor all FP programmes.[76]

SECTION 2. COSTED IMPLEMENTATION PLAN

The GOM has developed the FP-CIP to clearly define the country vision, goal, and strategic priorities and to provide a framework and timeline for the interventions required to achieve them. The FP-CIP estimates the cost of all activity inputs to serve as a tool for resource mobilization. The FP-CIP details the strategic priorities that will drive the government and nongovernment sector in achieving its mCPR goal and reducing unmet need by 2020. It will also generally guide efforts to increase knowledge of and access to family planning without discrimination, coercion, or violence.

The FP-CIP aligns with related strategic plans and policies of the MOH—such as the National Sexual Reproductive Health and Rights Strategy[77]—to make FP accessible, acceptable, and affordable. Family planning is seen as a key policy component for improving the health and well-being of Malawians, with sexual reproductive health and rights (SRHR) and family planning included in many health and national strategies and plans, such as the National HIV and AIDS Policy,[78] National Youth Policy,[79] and the Malawi National Plan for the Elimination of Mother-to-Child Transmission.[80] Family planning is also a key strategy in the 2012 National Population Policy.[81] The FP-CIP complements these policies by specifying the interventions and activities to be implemented and itemizing the financial and human resources needed to help women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing; and to support the achievement of gender equality. More broadly, voluntary family planning reduces preventable maternal mortality and morbidity, decreases unwanted teenage pregnancies, improves child health, facilitates educational advances, reduces poverty, and is a foundational element to the economic development of a nation.

The FP-CIP also (1) provides a foundation for the FP strategy that will be incorporated into other documents, such as the upcoming Health Sector Strategic Plan and Sexual and Reproductive Health Strategy 2016; (2) builds on the work being done by the GOM and its partners in Malawi to increase demand for and access to high-quality FP information and services; and (3) incorporates best practices identified from other countries.

2.1 Operational Goals

To increase the mCPR for married and unmarried sexually active women to 60 percent by 2020, with a focus on the 15–24 age group.

2.2 Strategic Priorities

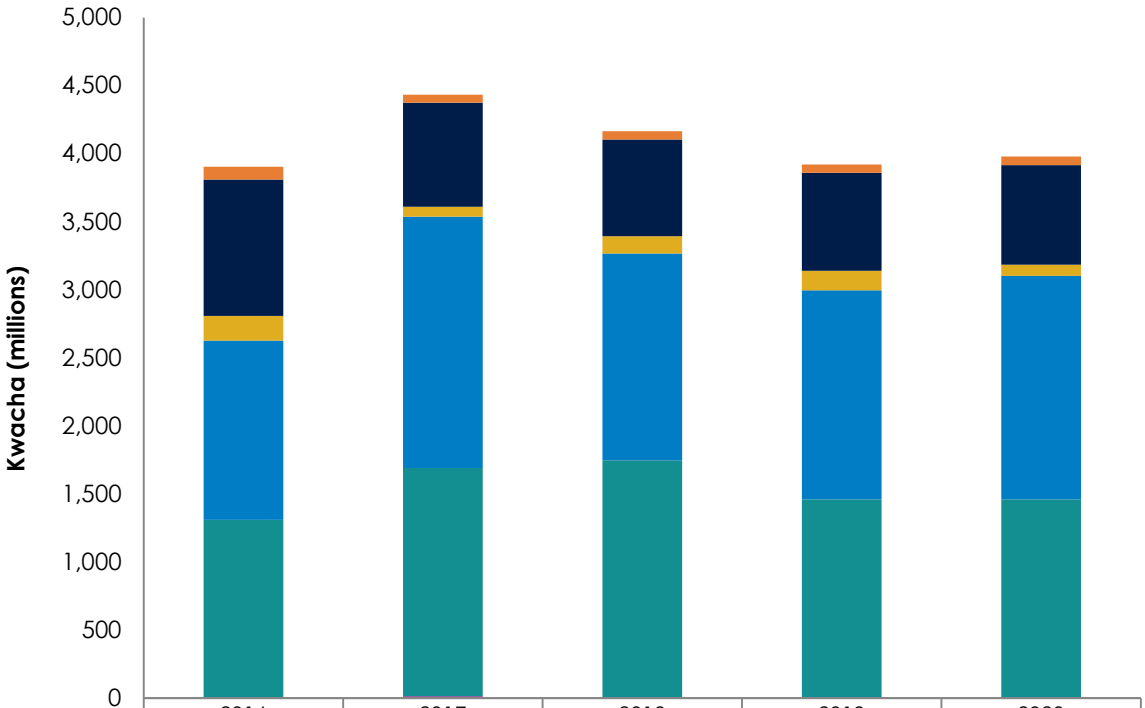
The strategic priorities detailed in the FP-CIP represent key areas for financial resource allocation and implementation performance. The priorities reflect issues and/or interventions that must be acted on to reach the country goals; they include outreach to specific population groups, especially adolescents, and cut across core components of an FP programme (i.e., supply, demand, and an enabling environment).

Focusing on these priorities will ensure that limited available resources are directed to areas that have the highest potential to reduce the unmet need for family planning in Malawi. In the case of a funding gap between resources required and those available, the priority activities should be given precedence to ensure maximum impact and progress towards achieving the plan's objectives. Having priority activities identified enables the MOH to focus resources and time on effectively coordinating and leading FP-CIP execution. However, all the components necessary for a comprehensive FP programme (all those that support, complement, and complete the FP programme) have been detailed with activities and costed; the strategic priorities highlighted here have been costed to help guide national priorities for additional and new funding and programme development (see Figure 16).

Six strategic priorities

- **Priority # 1:** Improve the ability of individuals within the population as a whole, as well as specific groups (e.g., adolescents, rural populations, urban poor) to achieve their fertility desires by providing accurate information about sexual and reproductive health, information on how fertility is linked to general health and well-being, and where and how to access desired services
- **Priority # 2:** Expand youth access to accurate and actionable information and family planning services, and promote youth rights to make their own fertility choices
- **Priority # 3:** Ensure new and existing health care workers receive adequate practical training in the full FP method mix, and empower community health workers and frontline workers to provide counselling and referral services, as well as short-term methods
- **Priority # 4:** Promote multisectoral coordination at the national and district levels, and integrate FP policy, information, and services across sectors
- **Priority # 5:** Ensure commodity availability through strengthening logistics management systems and distribution of FP commodities
- **Priority # 6:** Increase the sustainability of family planning through government commitment, integration of the private sector, and diversification of funding sources for FP activities and commodities

Figure 16: Annual cost of activities supporting strategic priorities, in MWK



	2016	2017	2018	2019	2020
Priority 6	93,391,249	59,263,922	60,745,520	62,264,158	63,820,761
Priority 5	1,002,871,620	763,216,302	709,371,777	717,851,274	729,948,562
Priority 4	180,777,111	74,808,640	126,456,076	144,768,996	81,594,607
Priority 3	1,316,014,040	1,844,612,441	1,518,807,039	1,535,213,267	1,643,049,810
Priority 2	1,307,810,206	1,676,884,186	1,745,925,475	1,457,767,166	1,456,960,014
Priority 1	2,725,000	14,319,983	2,862,953	2,934,527	3,007,890

Intervention and activity mapping to strategic priorities

The activities in the FP-CIP are structured around seven components or Thematic Areas of an FP programme:

1. Demand creation
2. Service delivery and access
3. Contraceptive security
4. Policy and advocacy
5. Financing
6. Supervision, monitoring, and coordination
7. Stewardship and governance

The six strategic priorities are addressed through various activities within these seven areas.

2.3 Thematic Areas

Across the seven thematic areas, there are 33 total strategic outcomes anticipated as a result of fully implementing the FP strategy in Malawi. Each area is further detailed with expected results, activities, sub-activities, inputs, outputs, and timeline information (refer to Annex A). Many of the strategic outcomes listed in this section map to a strategic priority (SP) (see Annex B for details).

Demand creation (DC)

Strategy

There is already high demand for family planning in Malawi; however, FP use remains low due to lack of knowledge about different methods, fear of side effects and complications, and beliefs of gatekeepers (e.g., primary decisionmakers at home, school, or in the community) that married women should bear high numbers of children and that young people do not need contraceptives because they should not be engaging in sex. Youth are particularly susceptible to misinformation about side effects and complications from contraceptive use.

The wide gap between knowledge about and use of contraceptives indicates a clear need for refocusing the FP programme and revamping communications to promote more widespread usage. Therefore, key interventions proposed aim to sustain support for family planning from the highest policy levels and promote public dialogue at all levels—from the national to the community level and within all sectors of the government—about the important role of family planning in promoting health and supporting the economic and social development of individuals, families, communities, and the nation. By implementing national-level advocacy, along with on-the-ground community mobilisation, demand and use of services will increase as awareness and acceptability among all population groups increases. The design of social and behaviour change communication (SBCC) campaigns will be harmonised across interventions, so communications to the public about family planning use evidence-based slogans and messages that resonate with target segments of the population.[82] SBCC efforts will also clearly indicate the benefits of family planning for specific, targeted populations. This will help lower the percentage of unmet need. High-impact, demand creation activities are included to close the knowledge-use gap by addressing (1) cultural and religious beliefs that impact FP uptake and utilisation, (2) myths and misinformation, and (3) fear of side effects and health concerns that impede its adoption and continuous use. Innovative technology and multiple media outlets, such as mobile health platforms, will be integrated to maximise the success of the initiatives.

In addition, specific demand creation efforts will be targeted at men and youth. While men share responsibility for reproductive health, lack of focus on men's involvement can infer that family planning is not their concern. Male engagement is crucial to a successful demand creation campaign, as men are often identified decisionmakers as well as gatekeepers to their wives and daughters' reproductive health actions.[83] Dispelling myths and misconceptions amongst men, and educating them on the potential benefits of family planning is important to ensuring their support.[84] Social and

behaviour change communication (SBCC) strategies targeting youth will be age-specific to address their particular developmental issues throughout that key period of the lifecycle.

Overall, the SBCC campaign will use formative and assessment research to inform the appropriate community-based strategy and methodology, as well as monitor the effectiveness of messages as the socio-cultural environment shifts over time. It is important to create messages and campaigns that can be transformed to meet the needs of different audiences.[85] For example, for campaigns to speak to the needs of the population, they should likely be region- or even district-specific. Multiple media outlets—including mass media; information, education, and communication materials; interpersonal communications; advocacy campaigns; and champions—will increase demand and uptake of services.[86] The formative research will outline the knowledge, attitudes, and perceptions of the audience, so that the campaign addresses the actual needs of the target population.[87] Successful campaigns can result in increased demand, open acceptance of family planning in the home, increased knowledge and access to FP services, and advocacy amongst users for FP methods.[88] Further, the integration of services, included in Thematic Area # 2: Service Delivery and Access, is a strategy that is successful and sustainable to increase demand for family planning, particularly amongst hard-to-reach populations. Appropriate services for the integration of family planning include, but are not limited to, cervical cancer screening; antenatal care; postpartum, post abortion and postnatal care; sexually transmitted infection screening, treatment, and care; HIV services; infant and young child feeding and malnutrition programmes; and routine childhood vaccination.

Strategic outcomes

DC1. Access to accurate information about healthy timing and spacing of pregnancies is increased. To increase the percent of women ages 15–49 years with demand for family planning (met demand and unmet need), a communications strategy (including information packages for select media channels) will be developed to (1) ensure tailored honest, objective, non-judgmental, accurate, clear, and consistent messaging around family planning in a multisectoral dimension (i.e., family planning as a development intervention); and (2) target various audiences (in- and out-of-school youth, men, fathers, frontline community workers, parents of adolescents, mothers of young children, young mothers, people living with HIV, sex workers, etc.). A mass media campaign will be developed and implemented, including radio spots, TV soaps/drama, print media, and mobile technology. In addition, non-health sector cadres will be encouraged to expand the reach of FP messages by incorporating positive messages in their programmes.

DC2. Communities receive accurate information about birth spacing and limiting family size through contraceptive use. To improve attitudes towards family planning, the MOH will engage leadership in other government sectors to support the promotion of family planning as part of a broader development agenda, including using frontline workers in other sectors to promote family planning. At the national level, family planning champions will continue to be supported to carry out activities within their communities, and the RHD will work with religious mother bodies to improve support and promotion of reproductive rights as part of religious leaders' commitment to health and the well-being of their communities.

DC3. Both partners are involved in FP decisions for their family and are supportive of the use of modern contraceptive by their partners. A key strategy to improve demand for family planning will be to engage chiefs and community leaders to provide accurate information about family planning to men in their communities. Traditional leaders will engage men through "husband school" to educate them on the benefits of family planning and address their questions and concerns. Additionally, the number of men who support the use of modern contraception for themselves or their partners will be increased by conducting community outreach events to engage men in FP dialogue and services.

DC4. Myths and misconceptions around modern contraceptives are addressed. To improve accurate information about contraceptives, satisfied users will be trained to address myths and misconceptions about family planning. Additionally, a free text and call-in hotline will be

implemented to provide men, women, and youth a confidential information source to answer inquiries about contraceptives.

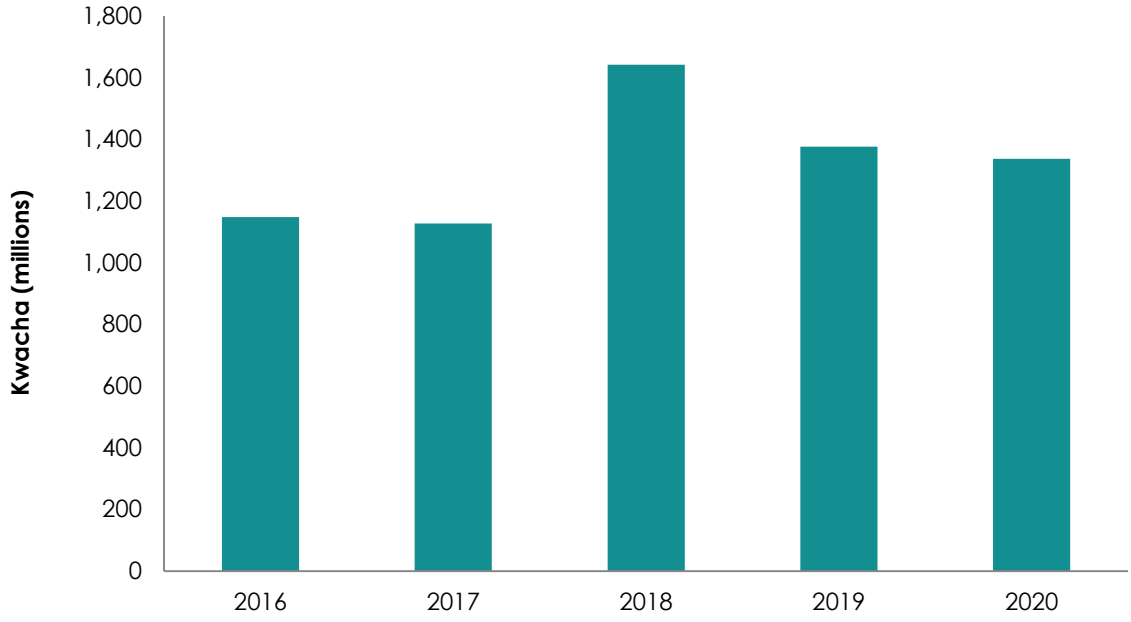
DC5. Youth are supported to access FP information or services by their parents. Parents will be engaged through media, health workers, religious groups, and local outreach groups, such as mothers' groups and child support committees, to have discussions about sexual and reproductive health rights and issues with their children.

DC6. Young people feel empowered to access FP services. Young people will be engaged through a variety channels that increase knowledge and acceptability of contraceptive use and will be empowered both as educators and consumers of FP services. Some specific strategies that will be used will include recruiting youth to act as peer educators, deploying targeted messages that address the issues that different youth populations face in regards to their sexual and reproductive health, and improving communication through new technologies such as blogs and cell phone applications.

DC7. Messages continue to evolve to respond to changes in perceptions around family planning. *To ensure that key messages and activities are responsive to the changing FP landscape and national priorities, an evaluation of the SBCC strategy will be conducted in 2020 to provide direction to the next strategic plan on how FP messages and communication can be improved.*

Costing summary

Figure 17: Annual demand creation costs, in MWK



Service delivery and access (SDA)

Strategy

Malawi employs a rights-based approach to family planning that includes voluntarism, informed choice, free and informed consent, respect to privacy and confidentiality without having to seek third party authorization, equality and non-discrimination, equity, quality, client-centered care, and participation and accountability. The approach also responds to community factors that impede access, such as distance to health facilities; inadequate human resources to provide primary health care services; provider bias; and limited support from community leaders for women and girls to delay, space, and limit their pregnancies. While 73.4 percent of married women of reproductive age in Malawi reported a desire to delay or completely stop bearing children, only 42.2 percent of married women are currently using modern contraceptives, indicating that there is still a significant barrier to

women achieving their reproductive health desires. To address barriers to access, a comprehensive approach will be implemented to make all methods more available and accessible and to improve the quality of service delivery.

To improve capacity for FP service delivery in Malawi's resource-constrained setting, several strategies will be employed. The integration of family planning into other health services is a critical strategy in enhancing the availability of FP services. At higher-level facilities with sufficient staff, FP services should be co-located with other services, providing a "one-stop shop" for women and men seeking other health care services; while at the community level, frontline workers in all sectors will be trained to discuss family planning with community members as part of family and community economic and social development. Following advocacy to change provider guidelines, task shifting will be instituted so that FP methods are available from the lower levels of the health system, including at the community level, relieving the burden at higher levels of care. Referral for FP services will be stressed in the training and supervision of all health care workers, so that providers trained in short-acting methods are empowered to refer clients who desire longer-acting methods to higher level services; and providers and educators who do not provide FP services are able to provide accurate information on FP methods and provide referral or linkages to where families can access contraceptive methods. In areas where distances to health facilities remain a significant barrier to access, or the existing health facilities are unable to provide modern contraceptives, mobile clinics will be established to meet the needs of the community, including the provision of long-acting methods.

Finally, in addition to continuing its partnership with the private not-for profit sector, the GOM will reach out to the private for-profit sector to discuss how to improve the quality of FP services, including through training for private sector providers and outreach to populations and areas where public FP services are limited.

Through these activities, the limited resources dedicated to family planning will be maximised to reach youth, rural, and other underserved populations. Although reaching these populations through a mix of mobile clinics and community-based distribution may in some cases prove difficult and is usually more expensive than stand-alone, clinic-based services, these initiatives will help ensure more equitable access to FP services.[89]

Strategic outcomes

SDA1. Health care workers are providing high-quality FP information and services and offering the full method mix to clients. In-service training will be reviewed to ensure training materials provide information on long-acting and reversible contraceptives (LARCs). Job aids will be updated, and supportive supervision will be conducted to ensure that health care providers are providing high-quality, rights-based information and services.

SDA2. Access and use of FP services at health facilities and at the community level is increased. To increase access to FP services, FP coordinators will review data on service availability and work with local and traditional leaders to identify areas where access to family planning is low. Access will be expanded in these areas through outreach from higher-level government facilities, as well as public-private partnerships to provide integrated mobile services in those areas.

SDA3. High-quality FP information and services are available at the community level. To strengthen service availability, the government will review the feasibility of task shifting to allow CBDAs to provide injectables and health surveillance assistants (HSAs) to provide implants. Refresher trainings will be held to ensure that these providers are counselling on all methods and on the rights of Malawians to access high-quality, voluntary services. Additionally, retired midwives will receiving training and support to provide FP services within their community.

SDA4. Private sector facilities are providing information on potential side effects to clients. To improve the information provided at private facilities, pamphlets on the potential side effects of

different FP methods will be printed and distributed to private facilities offering clients all FP services or commodities.

SDA5. Public-private partnerships for FP service provisions are implemented. A comprehensive landscape of the private sector will be conducted to identify the capacity and quality of FP service provision in both the private for-profit and not for-profit sectors. RHD will work with the private sector to explore opportunities to improve quality, as well as to expand services to more communities. Additionally, RHD will advocate with private sector employers to provide employees and their families with access to family planning, especially in more hard-to-reach areas such as tea and tobacco plantations.

SDA6. Access to family planning by young people is safe, rights-based, and confidential. To increase the availability of YFHS, health workers, children's corner patrons, and child representatives will be trained on these services. In addition, monitoring tools will be developed to track YFHS, and FP coordinators will be responsible for ensuring each facility in their district has staff providing the services.

SDA7. Health care providers entering the workforce are able to provide high-quality FP services. Pre-service training on family planning will be strengthened to include increased requirements for the practical application of FP skills, YFHS approaches, and internships to enhance the experience of graduates in providing family planning.

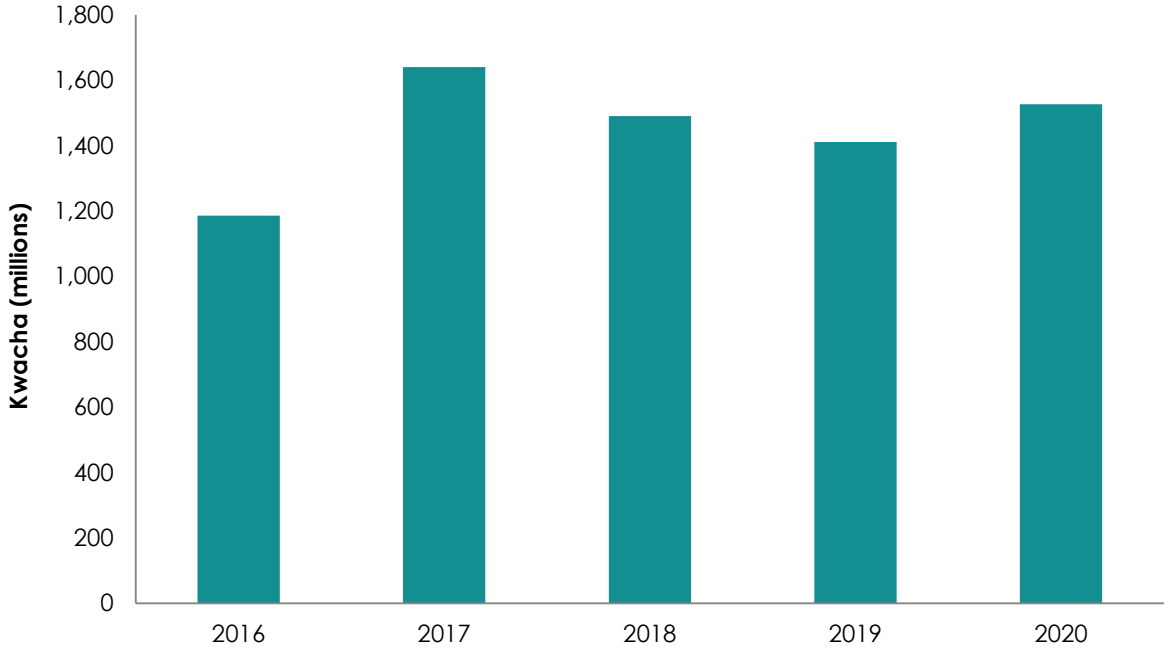
SDA8. Use of long-term methods is increased. To improve access to LARCs, the supervision of community health workers (CHWs) will be increased to ensure they are providing adequate counselling on the full method mix and referrals for LARCs. For those clients unable to access the method of their choice locally, a voucher system will be implemented to provide transportation refunds for clients to travel to facilities where LARCs are available.

SDA9. Family planning services are integrated into other health services. FP services will be integrated into cervical cancer screening; prenatal (information only), postnatal care, postpartum care; childhood immunization programmes; prevention and treatment of sexually transmitted infections, including HIV prevention, care, and treatment; and infant and young child feeding and immunisation programmes. Protocols will be developed, and service providers will be trained.

SDA10. Clients receive high-quality and respectful FP services. Health care workers will be educated on the rights of clients, and quality assurance teams will be strengthened to conduct annual visits to each district to ensure the high quality of information and services.

Costing summary

Figure 18: Annual service delivery and access costs, in MWK



Contraceptive security (CS)

Strategy

Maintaining a robust and reliable supply of contraceptive commodities to meet clients' needs, prevent stock-outs, and ensure contraceptive security is a priority for the programme to achieve its goal. This area also addresses the sustainable supply of contraceptive commodities and related consumables. It is aimed at ensuring that contraceptive commodities and supplies are adequate and available to meet the needs and choices of FP clients.[90] The activities of this strategic priority will be implemented in line with other commodity security plans of the MOH.

Because central-level supply is currently not a significant challenge for FP commodities, forecasting, quantification, and procurement will continue as in recent years, with capacity building targeted at improving the management and reporting at the district and facility levels. At the national level, the dual supply chains pose challenges to accurate data on commodities dispensed and lead to gaps in information about commodity availability at lower-level facilities. Currently, these facilities are receiving commodities on a push system, but the system will be modified and improved to better meet local needs. In addition, a plan will be put in place to move all facilities to a pull system, as capacity for forecasting commodity needs grows. The FP logistics management and information system (LMIS)/health management information system (HMIS) will also be improved to increase commodity security.

At the district level, redistribution of contraceptive commodities will be supported to ensure that one facility does not waste stock due to passed expiry dates, while another facility is unable to meet demand due to lack of commodities. Health care workers will continue to be trained to ensure stock management is conducted according to standard operating procedures (SOPs).

Providing a full mix of FP methods to meet the changing needs of clients throughout their reproductive lives not only increases overall levels of contraceptive use, it also ensures they are fully able to exercise their rights and meet their reproductive goals. Modern method use will increase, and traditional method use will decrease as an overall percentage of the total method mix—as shifting users from less effective to more effective methods while maintaining the widest possible range of

method choices allows women and families to best fulfill their reproductive intentions. The method mix available influences not only successful client use and satisfaction but also has implications for provider skills confidence and competence. In addition, specific activities will ensure that the contraceptives available in the country are of high quality. Currently, significant distribution challenges are a limiting factor in ensuring the availability of high-quality FP services at all levels of care. Specific activities will be undertaken to ensure that contraceptives are delivered through the "last mile" to the health facility to ensure reproductive health commodity security throughout the country.

Strategic outcomes

CS1. A comprehensive contraceptive forecasting and quantification system is implemented. FP commodities for the public, private for-profit, and private not-profit sectors will be jointly forecasted, quantified, and procured. Annual quantification, forecasting, and procurement workshops for FP commodities and consumables (for IUDs, implants, tubal ligations, etc.) will be held; the supply plan will be monitored; and the quarterly Family Planning/Reproductive Health Commodity Security Working Group meeting will review stock status.

CS2. Selective stock-outs of contraceptives at the district level are proactively addressed. FP coordinators and pharmacy assistants will coordinate within each district to proactively manage stock amongst facilities. A reporting system will be implemented to track the distribution and redistribution of contraceptive commodities.

CS3. The LMIS and HMIS are improved. The LMIS and HMIS will be improved to increase commodity security; for example, new technologies (e.g., the short message system or SMS via mobile phones) will be explored to improve real-time stock monitoring and re-supply planning.

CS4. District staff are able to report contraceptive forecasting data on time and accurately. Through sensitisation and training, staff will forecast FP commodities more accurately. Training and supportive supervision will facilitate appropriate forecasting and ensure that facilities are stocked more efficiently by integrating forecasting and quantification within routine facility, district, and procurement activities. At the district and zonal levels, FP coordinators will be trained to use commodity supply data for decision making, including forecasting potential stock-outs.

Costing summary

Figure 19: Annual contraceptive security costs, in MWK

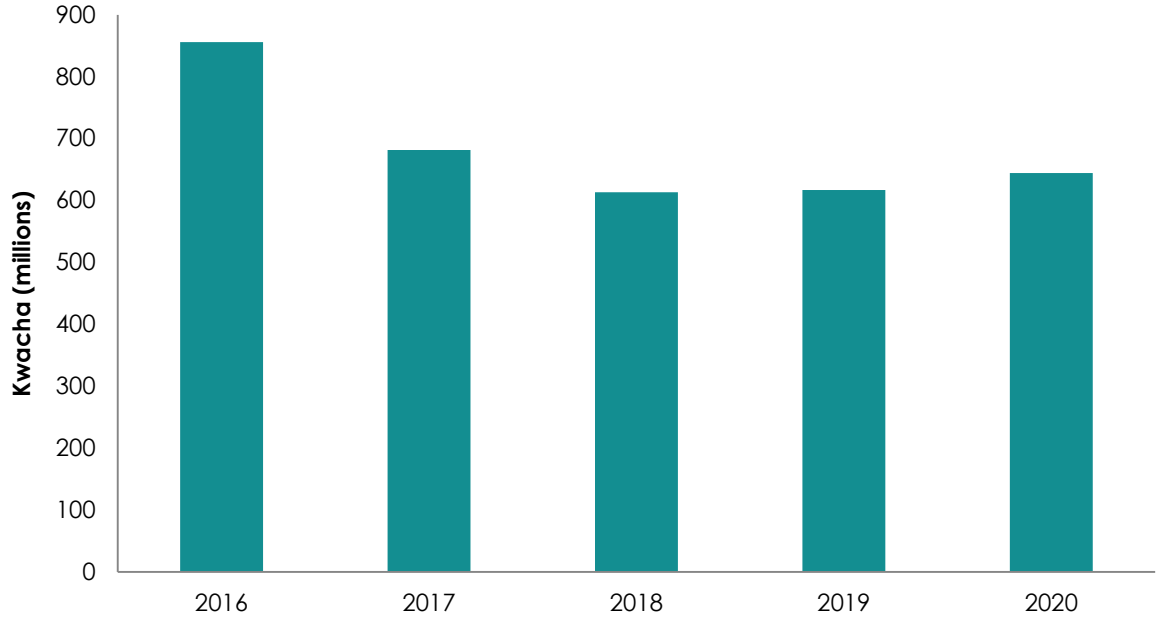


Figure 20: Annual contraceptive commodity and direct consumable costs, in MWK

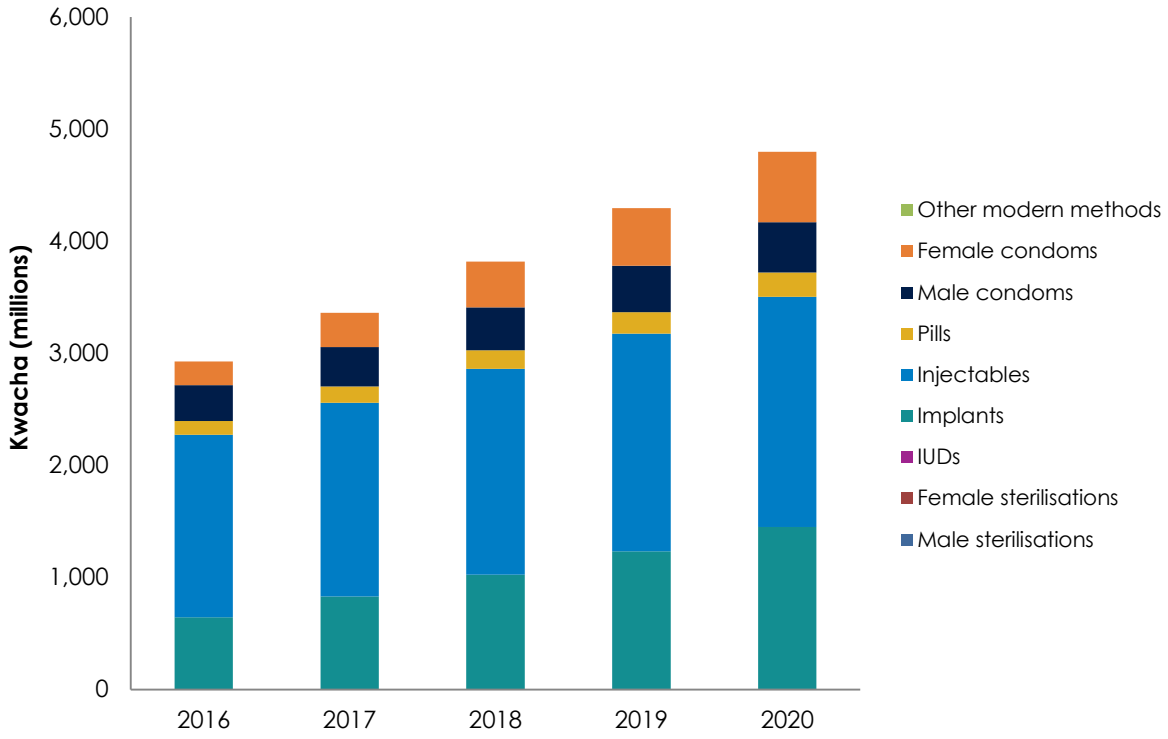
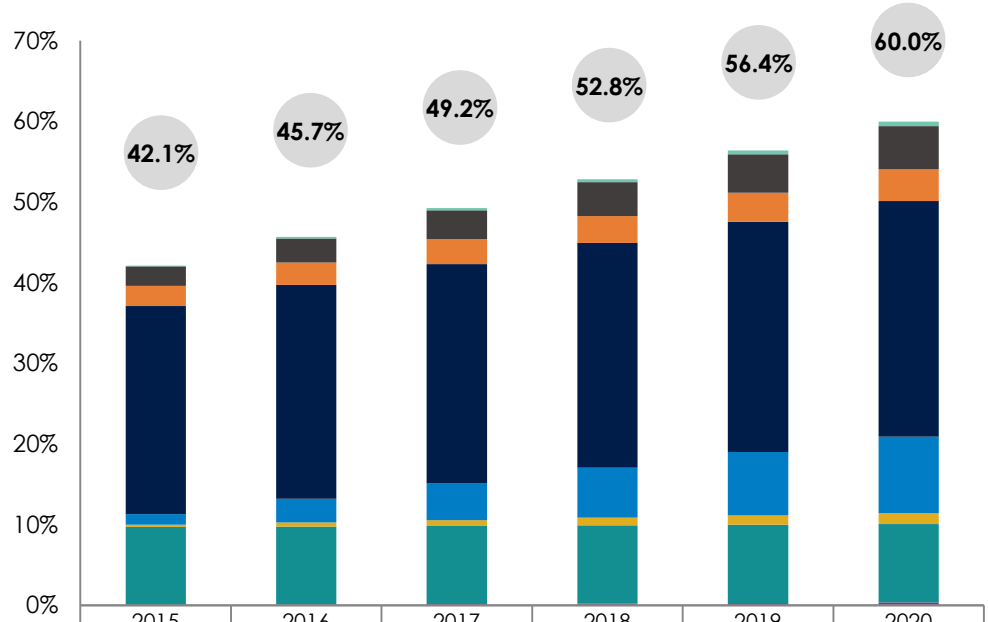
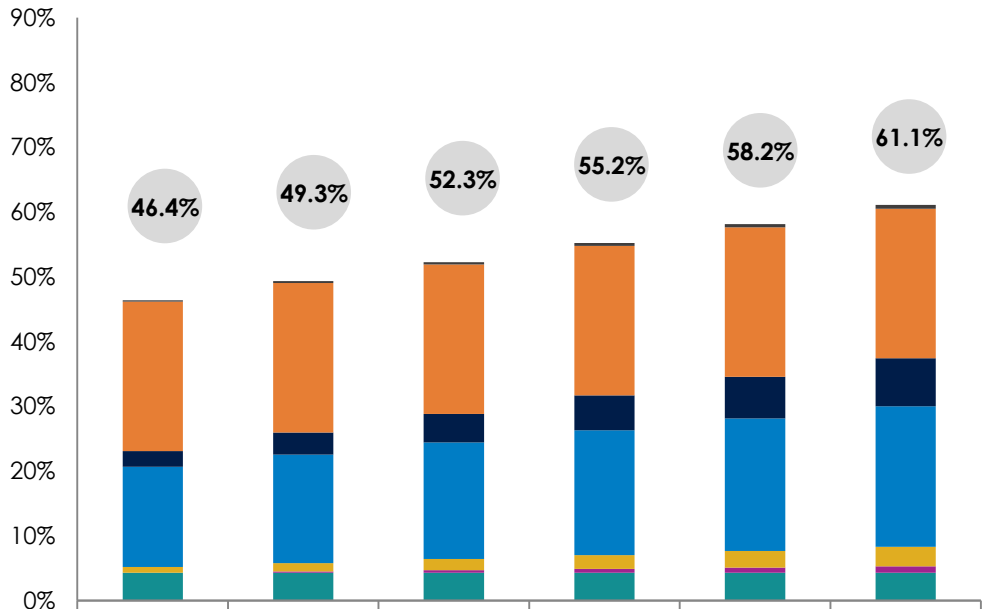


Figure 21: Projected method mix, married women and women in union, to reach 60% mCPR objective



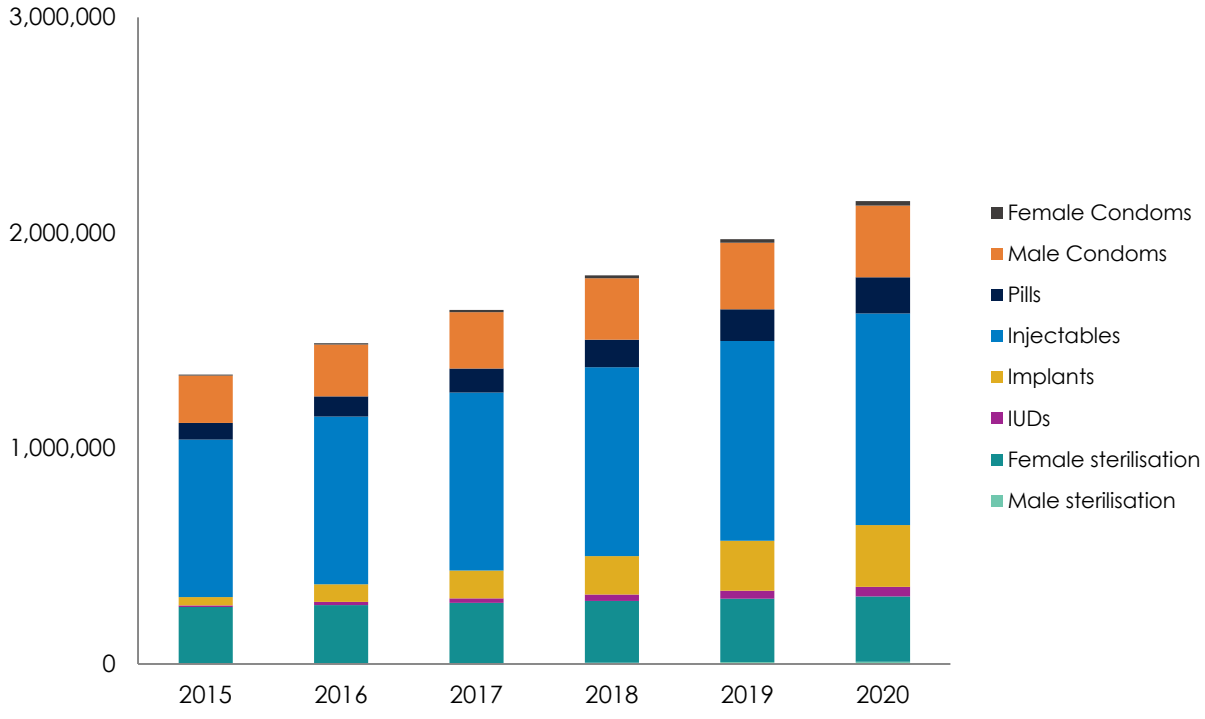
	2015	2016	2017	2018	2019	2020
Female condoms	0.10%	0.19%	0.29%	0.38%	0.48%	0.57%
Male condoms	2.40%	2.99%	3.59%	4.18%	4.77%	5.37%
Pills	2.50%	2.78%	3.06%	3.34%	3.62%	3.90%
Injectables	25.80%	26.48%	27.16%	27.84%	28.52%	29.20%
Implants	1.30%	2.94%	4.58%	6.22%	7.86%	9.50%
IUDs	0.30%	0.51%	0.72%	0.93%	1.15%	1.36%
Female sterilisations	9.70%	9.70%	9.70%	9.70%	9.70%	9.70%
Male sterilisations	0.00%	0.07%	0.15%	0.22%	0.29%	0.36%

Figure 22: Projected method mix, unmarried sexually active women, to reach 60% mCPR objective



	2015	2016	2017	2018	2019	2020
Female condoms	0.2%	0.27%	0.35%	0.42%	0.50%	0.57%
Male condoms	23.1%	23.10%	23.10%	23.10%	23.10%	23.10%
Pills	2.4%	3.40%	4.40%	5.40%	6.40%	7.40%
Injectables	15.5%	16.75%	17.99%	19.24%	20.48%	21.73%
Implants	0.9%	1.32%	1.74%	2.16%	2.58%	3.00%
IUDs	0.0%	0.20%	0.40%	0.60%	0.80%	1.00%
Female sterilisations	4.3%	4.30%	4.30%	4.30%	4.30%	4.30%
Male sterilisations	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%

Figure 23: Total contraceptive users, married and unmarried



Policy and advocacy (PA)

Strategy

To improve the policy environment for family planning, government policies and strategies will be reviewed to ensure that family planning is integrated appropriately and policies are not creating additional barriers to access. The MOH and its partners will ensure that FP-CIP strategies and activities are incorporated into the National Health Strategic Plan, as a cross-cutting intervention to promote a healthy population and national development. Specific advocacy will also be conducted to ensure that policies and guidelines for family planning promote access to FP services rather than hamper access for often marginalised groups, such as the rural population and youth, and to ensure the provision of FP services in accordance with human rights and quality of care standards.

For example, the SRH guidelines will be revised to give health care providers clarity on how to counsel and provide services to adolescents younger than 16 years old. Advocacy will be conducted to allow peer educators to provide pills and condoms to youth, and policies will be developed to clarify the role of volunteers in the provision of health services. Across all of the policies reviewed, substantial focus will be on the visibility of family planning as a human rights and development issue for Malawi.

Strategic outcomes

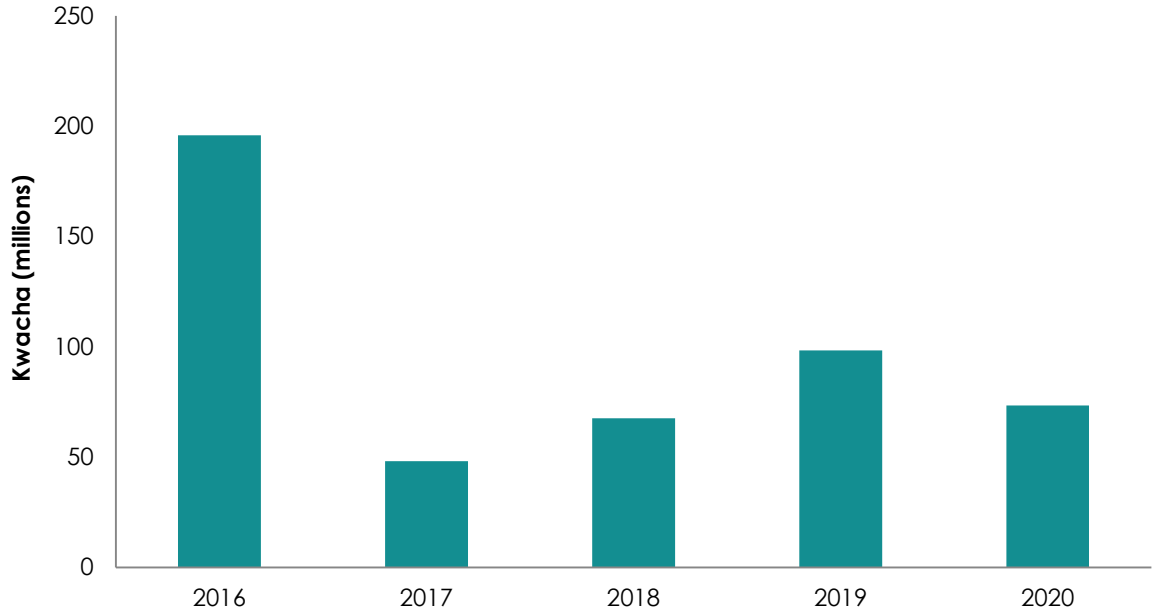
PA1. Government policies enable access to FP services. The political and legal framework for FP/SRH will be expanded to allow for the provision of FP information and services to any person requesting them.

PA2. Access to the full range of method mix is increased. The RHD will work with regulatory bodies to identify opportunities for task shifting and to revise guidelines and scopes of practice for CBDAs, HSAs, and community midwives. Increased regulation and oversight will include agreement on standardised incentives to be provided to volunteers and CHWs.

PA3 Policymakers have greater awareness of family planning as a human rights issue. Civil society will be engaged to work with the MOH and MOGCDSW to develop a women's reproductive health and human rights advocacy strategy, which will guide trainings of faith-based organisations, civil society, and other district structures to advocate for family planning as a human rights issue. Workshops for policymakers on how to advocate contentious bills on SRHR-related policies (e.g., approval of clinical officers to perform surgical contraceptive methods) will contribute to improvements in the policy environment for family planning and broader sexual and reproductive health and rights issues.

Costing summary

Figure 24: Annual policy and advocacy costs, in MWK



Financing (F)

Strategy

To address the limited financial commitment to family planning commensurate to need, the MOH and its partners will advocate for increased funding within national budgets, starting with the inclusion of FP activities within district improvement plans. In addition, advocacy will be conducted to increase FP funding from development partners and private corporations. The MOH will also cultivate FP advocates within Parliament to ensure that the national budget includes a line item for FP programming—which will be increased over time to meet the growing demand for FP services as SBCC and FP access activities are rolled out over the next five years. Advocacy for the creation of budget lines for family planning at the district level will support the prioritization and integration of family planning into district planning and budgeting processes.

As out-of-pocket expenditures on FP/RH services remain high in Malawi, the MOH and partners will conduct advocacy to ensure that the health insurance scheme includes coverage for all FP methods in all insurance packages.

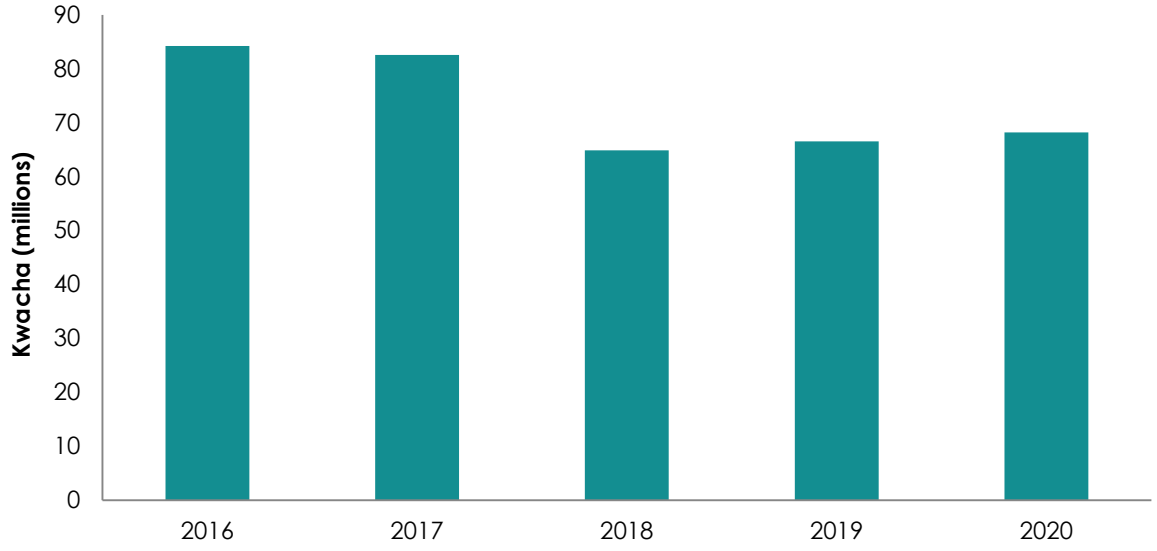
Strategic outcomes

F1. Adequate funding is available for FP commodities and activities, in line with the FP-CIP. The MOH and its partners will advocate with parliamentarians to endorse, maintain, and advocate increases in the FP line items in the MOH budget. At the district level, the MOH will develop advocacy plans to target local and traditional leaders, including ward councilors and district executive committees. Financial commitments will be tracked, and progress towards achieving commitments will be reported annually. Annual meetings with donors will be conducted to mobilise donor support for the priorities outlined in the FP-CIP.

F2. Family planning and contraceptives are more widely available and affordable at all health care centres. The RHD will conduct a cost-benefit analysis on including family planning as a part of private health insurance, as well as conduct advocacy with private insurers to provide all methods to their clients at no charge.

Costing summary

Figure 25: Annual financing costs, in MWK



Supervision, monitoring, and coordination (SMC)

Strategy

To meet the objectives outlined in the government's FP commitments, strong monitoring, management, leadership, and accountability are necessary. Effective management and coordination of FP activities at all levels, and within all sectors of government, is needed to ensure FP goals are reached. There are established forums for coordination; however, with numerous implementing partners and stakeholders involved, improved coordination and stronger accountability mechanisms are needed. Better systems are essential to improve collaboration amongst partners and the MOH and to ensure that activities are implemented under a harmonised national effort.

National coordination is essential, but coordination must also connect national efforts with the decentralised system, particularly at the district level. The role of FP coordinators in the district will be clarified and strengthened, and the capacity of district health management teams will be built to improve monitoring and supervision of FP programmes. The Family Planning Technical Working Group is a crucial body for coordinating partners and managing work at the central level. Efforts will be undertaken to duplicate this coordination mechanism at the district level.

Mentorship and supervision are key strategies for improving the quality of implementation. Revised supervision tools will include defined FP quality standards. Supervisors will receive training in conducting supportive supervision visits. Mentoring tools for family planning will be developed as part of the training curriculum for use in post-training mentorship sessions. These combined efforts will result in stronger management and accountability of the FP goals in Malawi.

Strategic outcomes

SMC1. Performance management systems effectively monitor and support FP service providers. The capacity at the MOH to coordinate the FP-CIP will be strengthened through the operationalising of the performance management system, and managers will be trained on implementation. Regular monitoring of the system will ensure it is effective in improving leadership and coordination of the FP programme.

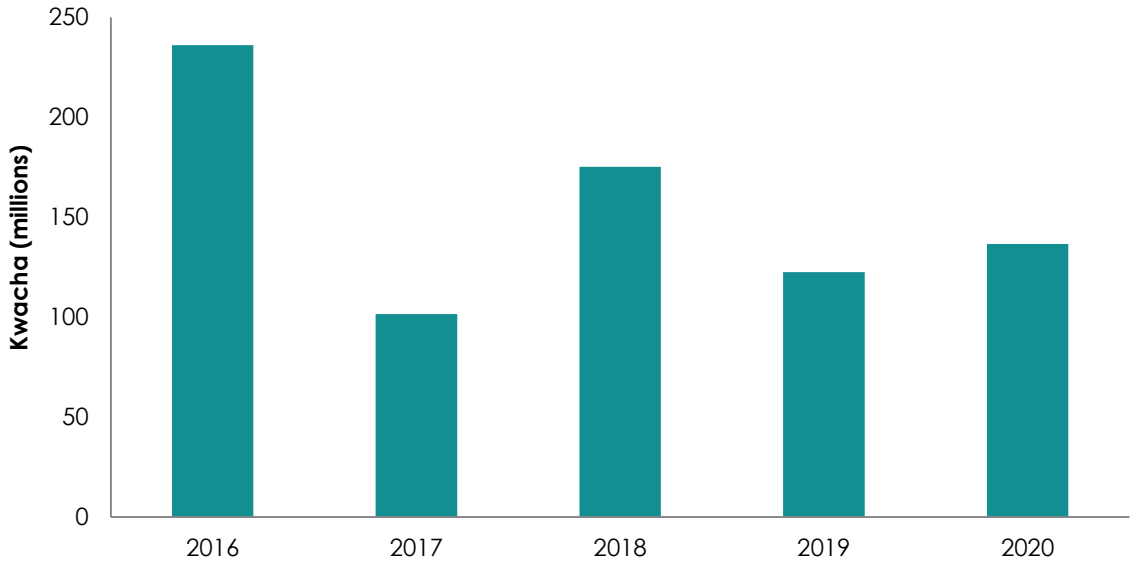
SMC2. Data are used to improve access to high-quality FP services. The capacity of district FP coordinators and HMIS officers to collect and analyse FP data will be improved. Transportation

support will be provided to FP coordinators to regularly monitor facilities, conduct supportive supervision, and ensure data quality.

SMC3. Coordination of FP activities is strengthened. At the national level, the FP TWG will continue to coordinate the FP partners; however, additional subcommittees will be convened to address inter-ministerial coordination and the private sector. The RHD will develop a training database to coordinate and monitor partner training activities. In the districts, FP coordinators will identify and engage partners at the district level—including other government ministries and workers, traditional and faith leaders, and civil society and development partners—and convene quarterly technical working groups to coordinate activities.

Costing summary

Figure 26: Annual supervision, monitoring, and coordination costs, in MWK



Stewardship and governance (SG)

Strategy

Effective management and governance of FP activities at all levels is needed to ensure FP goals are reached. The FP-CIP has been developed to guide the scale-up of family planning over the next five years; however, for it to make an impact, effective governance is required.

As the RHD supports implementation of the FP programme, coordination and management resources will be strengthened to ensure the efficient monitoring of FP-CIP activities. Designated RHD staff will monitor the activities semi-annually through an electronic database and track for performance and planning. At the district level, FP coordinators will monitor and track progress.

A mid-term and end-line evaluation of FP-CIP implementation will be conducted to identify how priorities in family planning have shifted and what activities need to be adjusted, revised, or reprioritised. Following the final evaluation of the plan, new FP objectives will be identified, and a new five-year plan will be developed to coordinate and guide Malawi towards its new goals.

SG1. RHD effectively tracks and monitors the FP-CIP. An FP-CIP dashboard will be created to monitor implementation of the plan. The MOH will track activities, including financial data outputs and timelines. The ministry will coordinate semi-annual data sharing amongst implementing partners and identify gaps through implementing partner feedback and annual refresher trainings on gap analyses. An outside evaluator will conduct a mid-term and end-line evaluation of the FP-CIP to recommend course corrections and develop a new plan at the end of the five years.

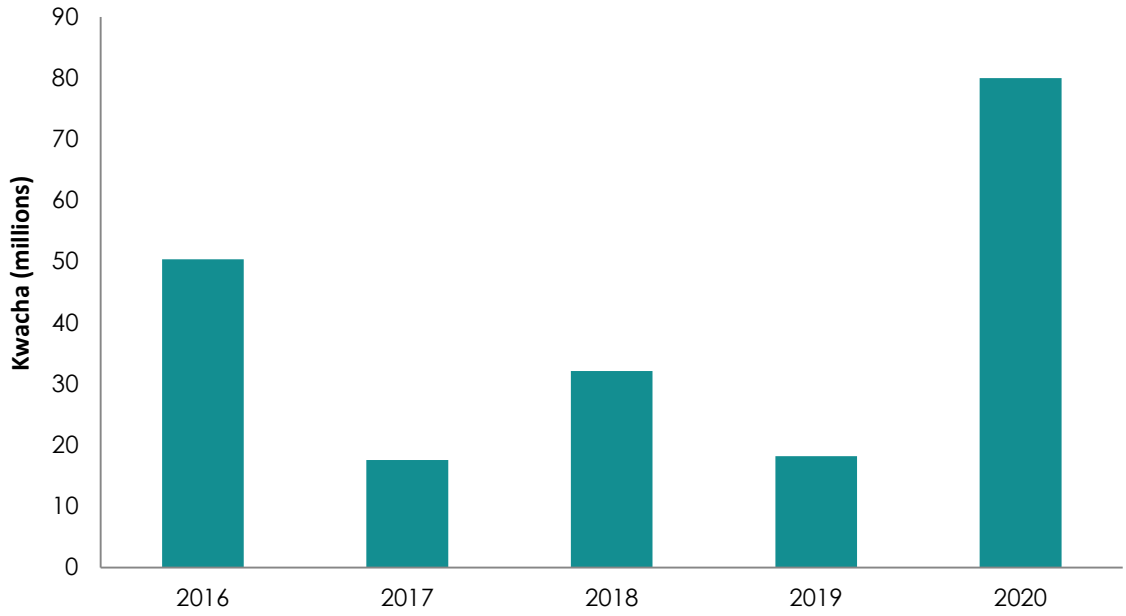
SG2. Capacity for the RHD to effectively lead, manage, and coordinate the FP programme is strengthened. The RHD will be strengthened to ensure effective management and coordination of the FP programme. A logistics coordinator will support the RHD at the national level, and an FP coordinator will be identified to track implementation of the FP-CIP. The RHD will also oversee review of the district FP coordinator's terms of reference to ensure that job expectations are clear and well-communicated.

SG3. The government is better able to track and review district FP efforts. FP coordinators and District Health Office (DHO) managers will be oriented on data management and advocacy for family planning, and a semi-annual meeting will be held nationally with all FP coordinators to monitor each district's implementation of the FP-CIP and progress towards achieving FP commitments.

SG4. The MOH supports continued FP2020 learning opportunities. An annual national conference will be held to share and disseminate new research and best practices in scaling up family planning.

Costing summary

Figure 27: Annual stewardship and governance costs, in MWK



SECTION 3: COSTING

3.1 Costing Assumptions

Costing elements are described and costed based on specific data from the MOH, implementing partners, and local suppliers. The source for each input is cited in the costing tool; all inputs are also editable in the costing tool. In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g., the specific input costs for producing a radio programme, the number of programmes to be produced, the cost of broadcasting the programme, and the number of times it will be broadcast, etc.).

Costing inputs have come from various sources and include standards provided by the RHD and Health Education Unit (HEU), the Central Medical Stores Trust (which produces standard cost lists for government commodity and consumable procurement), and implementing partners. Where specific costs for items were not available (e.g., if an activity has yet to be implemented in Malawi), the costing data were drawn from an Africa-regional or international source and noted as such in the costing tool.

Contraceptive costs are calculated from 2016 to 2020, using the 2010 Malawi Demographic and Health Survey's (MDHS) contraceptive prevalence rate (CPR) and method mix as a baseline assumption for the 2015 method mix.[91] The projections for 2020 were based on the national objective of reaching 60 percent mCPR among married women and sexually active unmarried users and the assumption that the method mix in each district would align with the district's own calculations using the Reality Check Tool.[92] The 2020 objective CPR for all women of reproductive age is then extrapolated for each intermediate year between 2015 and 2020.[93] These inputs can be updated when the next MDHS is published in 2016, and in intermediate years as new data become available. Additionally, the objectives should be updated if they are changed.

Unless otherwise noted, all consumable costs (e.g., salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of July 2015 and have been automatically adjusted for a base rate of inflation of 2.5 percent annually. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in Malawian Kwacha and have been converted to USD using the exchange rate of .0021 USD to 1 MWK, as of July 30, 2015. The conversion rate can be adjusted to accommodate market fluctuation.

The costing tool is available from the MOH for review, updating, or modification for other programmes.

3.2 Costing Summary

The costs have been calculated using a tool developed specifically for this purpose, with methodology borrowed from other FP plan costing activities regionally. The tool enables users to calculate the overall costs of the plan, as well as disaggregate the costs by activity area and year. It includes both initial (investment) costs and ongoing or sustainability costs for the plan's duration.

The total costs of the plan from 2016–2020 are 45.0 billion MWK (94.6 million USD).

Overall, 25.9 billion MWK or 58 percent of the overall costs are for commodities and consumables. These costs increase gradually over time as more women are reached. Of the activity-based costs, the two largest cost drivers are service delivery and access (16%) and demand creation (15%), followed by commodity security (8%) and supervision, monitoring, and coordination (2%). Financing, policy and advocacy, and stewardship and governance are all one percent or less of the total CIP cost.

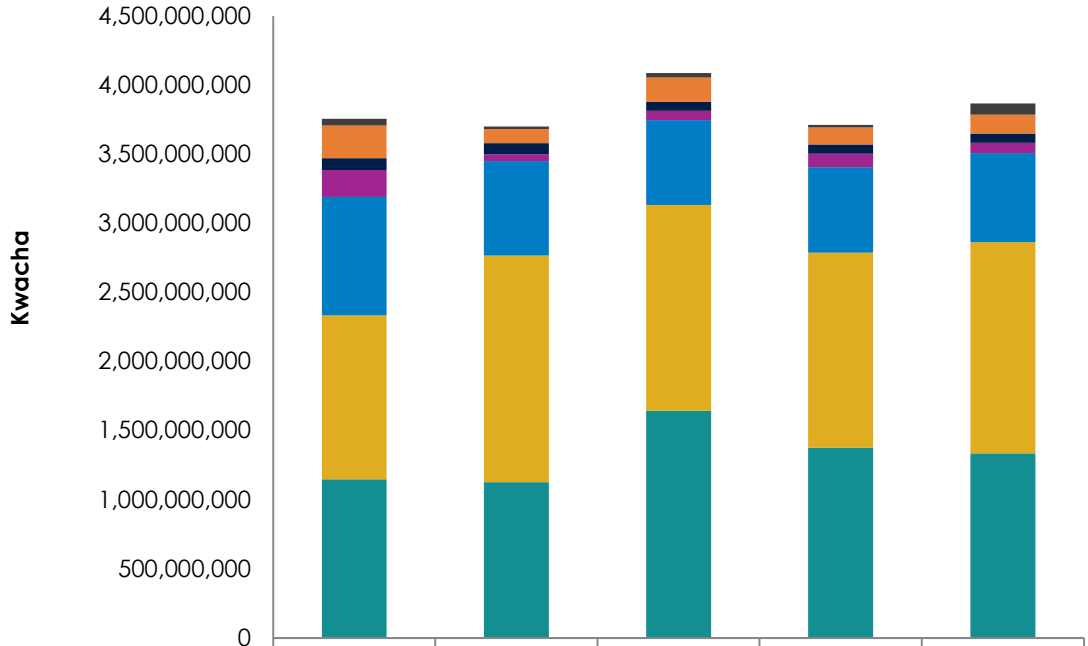
The costs of the plan are comparable to other countries' similar FP costed implementation plans. The cost per woman of reproductive age for activity costs is $1.84 USD per year, which is just below the

range of average costs in other countries of about $2–5 USD. The cost per user for FP commodities and consumables is $5.98 USD, above the costs of $4–4.20 USD seen in other countries.[94] However, this is likely due to the costs being derived from actual national costs obtained from Central Medical Stores Trust (CMST), rather than international estimate costs and the inclusion of various additional loaded costs for each commodity (e.g., pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight costs, insurance, storage fees, distribution fees/last mile costs), which were not included in the standard costing for commodities for some other CIPs.

Figure 28: Annual costs by thematic area, in millions of MWK (and millions of USD)

	2016	2017	2018	2019	2020	Total[95]
Demand creation	1,149 (2.4)	1,128 (2.4)	1,643 (3.4)	1,377 (2.9)	1,337 (2.8)	6,610 (13.9)
Service delivery and access	1,186 (2.5)	1,640 (3.4)	1,491 (3.1)	1,411 (3.0)	1,527 (3.2)	7,255 (15.2)
Contraceptive security (programmes)	856 (1.8)	682 (1.4)	613 (1.3)	618 (1.3)	644 (1.4)	3,412 (7.2)
Contraceptive security (commodities and consumables)	3,893 (8.1)	4,509 (9.5)	5,156 (10.8)	5,836 (12.3)	6,548 (13.8)	25,942 (54.5)
Policy and advocacy	196 (0.4)	48 (0.1)	68 (0.1)	98 (0.2)	73 (0.2)	483 (1.0)
Financing	84 (0.2)	83 (0.2)	65 (0.1)	67 (0.1)	68 (0.1)	366 (0.8)
Supervision, monitoring, and coordination	236 (0.5)	101 (.2)	175 (0.4)	122 (0.3)	137 (0.3)	771 (1.6)
Stewardship and governance	50 (0.1)	18 (<0.1)	32 (0.1)	18 (<0.1)	80 (0.2)	198 (0.4)
Total	**7,649 (16.1)**	**8,209 (17.2)**	**9,243 (19.4)**	**9,547 (20.0)**	**10,414 (21.9)**	**45,039 (94.6)**

Figure 29: Cost for strategic priorities, by area, in MWK



	2016	2017	2018	2019	2020
Stewardship and governance	50,355,808	17,572,705	32,093,978	18,178,024	80,014,260
Supervision, monitoring, and coordination	236,024,045	101,455,792	175,133,094	122,487,823	136,524,236
Financing	84,224,634	82,575,625	64,893,387	66,515,722	68,178,615
Policy and advocacy	195,840,120	48,132,780	67,585,456	98,388,906	73,435,358
Contraceptive security	855,734,140	681,841,470	613,162,180	617,172,037	644,203,515
Service delivery and access	1,185,827,575	1,640,400,898	1,490,827,398	1,411,134,464	1,526,822,502
Demand creation	1,148,560,002	1,127,542,033	1,642,779,357	1,377,077,626	1,336,617,462

Figure 30: Cost of strategic priorities, by area, in millions of MWK

	2016	2017	2018	2019	2020	Total
Priority # 1: Improve the ability of individuals within the population as a whole, as well as specific groups (e.g., adolescents, rural populations, urban poor) to achieve their fertility desires by providing accurate information about sexual and reproductive health, information on how fertility is linked to general health and well-being, and where and how to access desired services.	704	766	924	963	869	4,225
Priority # 2: Expand youth access to accurate and actionable information FP services, and promote youth rights to make their own fertility choices.	508	376	722	417	471	2,494
Priority # 3: Ensure new and existing health care workers receive adequate practical training in the full FP method mix, and empower community health workers and frontline workers to provide counselling and referral services, as well as short-term methods.	730	1167	992	832	807	4,529
Priority # 4: Promote multisectoral coordination at the national and district levels, and integrate FP policy, information, and services across sectors.	192	68	121	110	93	583
Priority # 5: Ensure commodity availability through strengthening logistics management systems and the distribution of family planning commodities.	971	740	693	699	717	3,820
Priority # 6: Increase the sustainability of family planning through government commitment, integration of the private sector, and diversification of funding sources for FP activities and commodities.	80	59	61	62	64	327
Total	**3,184**	**3,176**	**3,512**	**3,084**	**3,021**	**15,978**

SECTION 4. PROJECTED METHOD MIX AND CONTRACEPTIVE NEEDS

4.1 Assumptions

The FP-CIP interventions will lead to reaching a total mCPR of 60 percent for both married and unmarried sexually active WRA in 2020, which translates to an mCPR of 45.9 percent among all WRA.[96] This will lead to a total of 2.2 million women (1.7 million married women or women in union and 500,000 sexually active unmarried women) users of contraception in 2020.

The ImpactNow model[97] was used to calculate the impacts the GOM will benefit from by increasing mCPR to 60 percent by 2020. These demographic, health, and economic impacts include

- Unintended pregnancies averted
- Abortions averted
- Unsafe abortions averted
- Maternal deaths averted
- Child deaths averted (due to improved birth spacing)
- Health care costs saved

These calculations estimate that the FP interventions in Malawi will avert more than 2 million unintended pregnancies, more than a quarter million unsafe abortions, and more than 6,000 maternal deaths between 2016 and 2020. Additionally, the intervention will lead to an average savings of $10 million USD every year on just maternal and infant health care costs.[98]

These impacts were calculated by estimating the current mCPR for all women and inputting method mix assumptions for the baseline year 2015, based on 2010 MDHS data.[99] A target method mix for 2020 was projected for the FP-CIP and considers various factors, including the anticipated impact of the activities planned, availability of infrastructure, provider capacity, and historical trends. The method mix projections are to be understood as the best-guess projections for future method mix and are not to be interpreted as reducing user choice for any particular method. As such, the actual forecasting and procurement for FP commodities should be regularly reviewed and adjusted based on new and emerging data, including information on user preference and choice. The method mix projections are based on the following assumptions, which were guided by best practices and recommendations made by stakeholder expert groups:

1. The FP-CIP will be fully implemented by the MOH and its partners and will emphasise reaching underserved populations (e.g., youth, rural populations, and the urban poor) and creating demand and improving access for LARCs.
2. The method mix changes take into account the recommendations of the MOH and stakeholder groups to shift use, wherever feasible, from less effective to more effective methods, while maintaining the widest possible range of method choices.
3. Use of LARCs will rise at a similar rate to other countries in the region based on similar data for demand and access[100] once they are available at more service delivery points and demand creation activities for LARCs have begun, with the scale-up of training probable in project activities. The greatest rise in LARCs will be for implants, as task shifting increases their availability at the community level, but this will also be accompanied by an increased demand for IUDs, though at a lower rate. Male sterilisation will increase moderately as men become more active in reproductive decision making, while female sterilisation is likely to remain at a constant rate because it has already reached a plateau level.
4. Access and use of injectables will increase moderately in line with historical increases in injectable uptake in Malawi and regionally in Africa;[101] though, overall contribution to the mCPR will decrease as the accessibility and uptake of LARCs increases. However, if

advocacy for task shifting succeeds in allowing CBDAs to distribute injectables at the community level, the number of users and contribution to the method mix will likely intensify as they become more available.

5. The method mix quantification for the FP-CIP is based on variably adjusting CPR method mixes for married and unmarried women. In addition, for the FP-CIP, male and female condoms were only included in the method mix and costed for the amount required for FP usage alone—condoms used for the prevention of HIV and other sexually transmitted infections in addition to another method use by women are not included in this FP costing, although these costs are included in the larger RH commodity costs.
6. Emergency contraception is not included as a percentage of the method mix, as it is not promoted as a regular or consistent method of family planning. It will be procured for public and private sector use as a lifesaving commodity—a contraceptive method to be used when other primary methods are not used or fail.

The 2015 baseline method mix and the 2020 objective method mix assumptions, for all women, are outlined below.

Figure 31: Baseline method mix from 2010 MDHS and projected method mix for 2020, married women

Contraceptive Method	Method Mix	
	MDHS 2010	2020 Projections
Pills	2.5%	3.9%
IUDs	0.3%	1.4%
Injectables	25.8%	29.2%
Male condoms	2.4%	5.4%
Female condoms	0.1%	0.6%
Female sterilisations	9.7%	9.7%
Male sterilisations	0.1%	0.4%
Implants	1.3%	9.5%
mCPR, married women	**42.2%**	**60.0%**[102]

Details of the annual method mix, services/commodities, contraceptive prevalence by method, and demographic and health impacts are shown in the following figures. Standard units needed for one year of use were used for these calculations.[103]

Figure 32: Projected mCPR by method, married women and women in union, 2015–2020

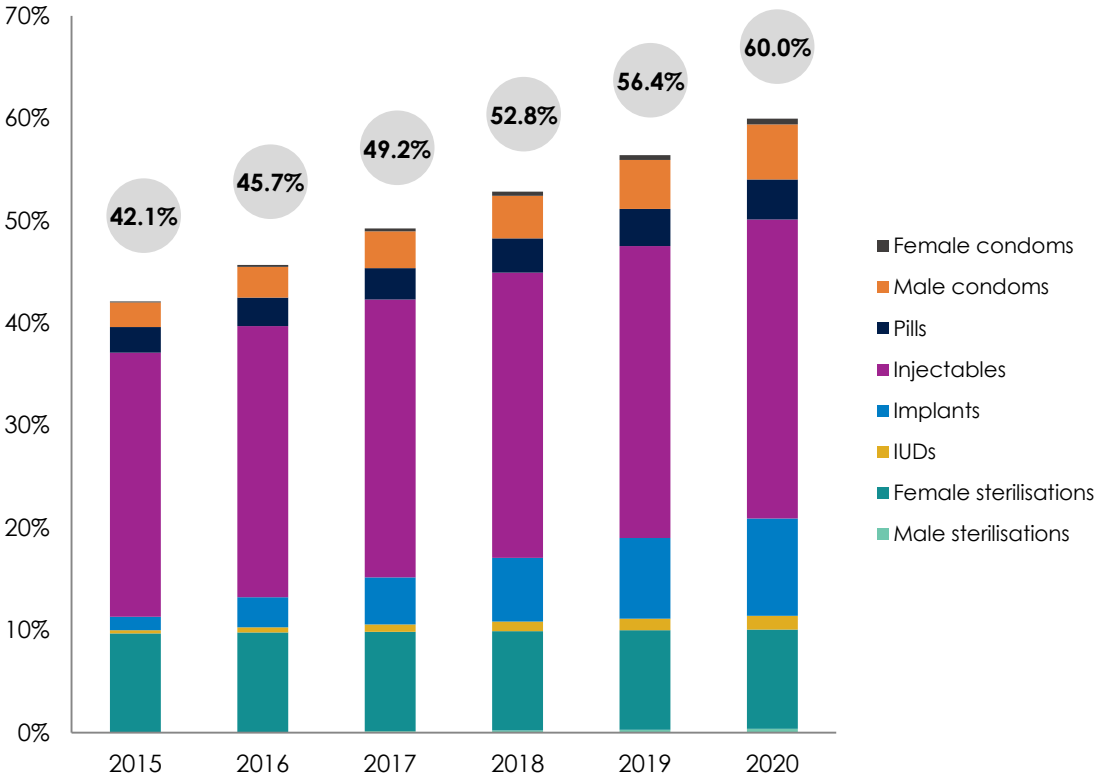


Figure 33: Projected mCPR by method, unmarried sexually active women, 2015–2020

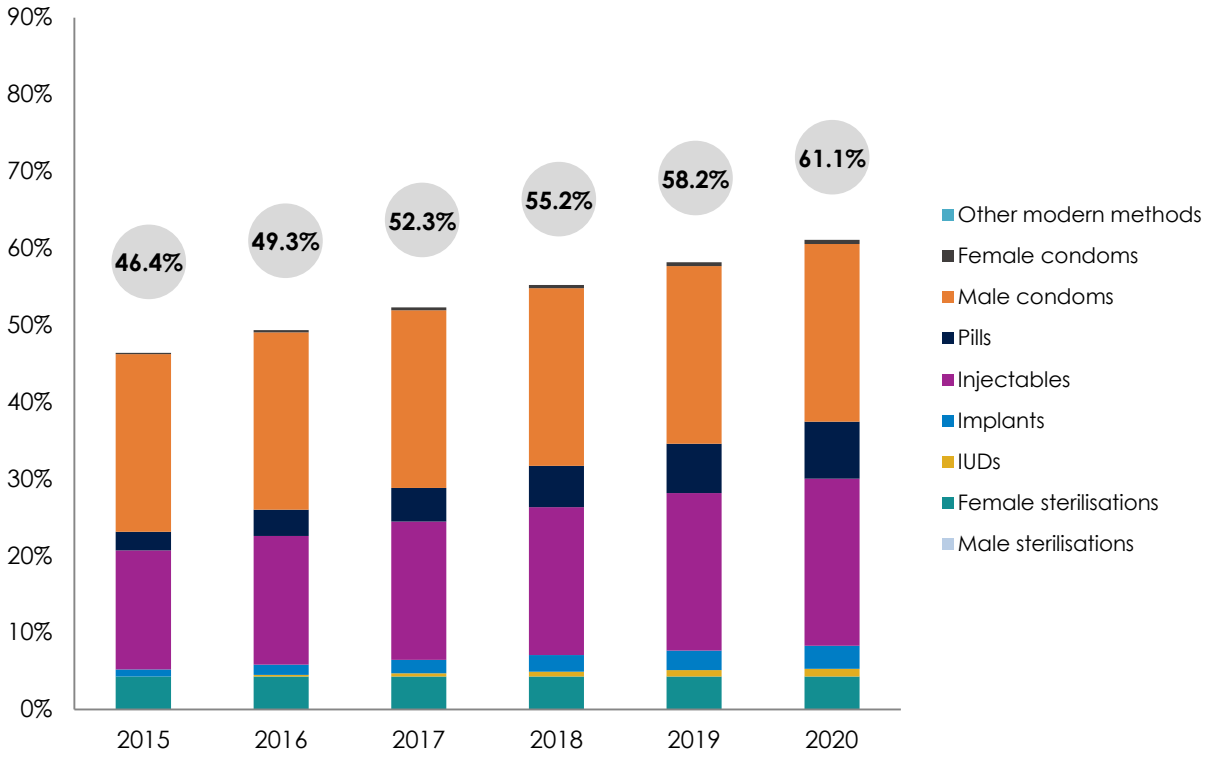


Figure 34: Projected number of FP users per year, 2015–2020

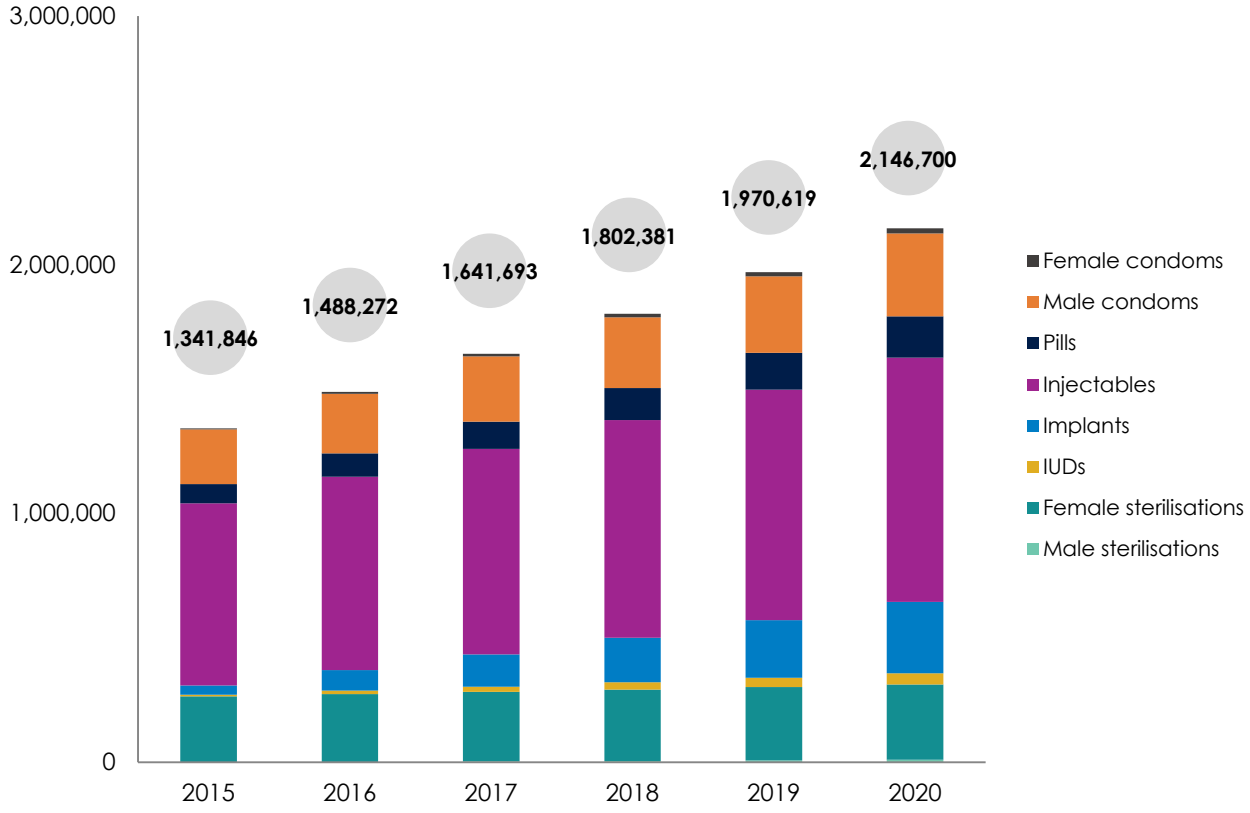


Figure 35: Number of FP users provided with services or commodities per year, projected 2016–2020

	2016	2017	2018	2019	2020
Pills	93,436	110,505	128,437	147,265	167,026
IUDs	8,456	10,323	12,284	14,345	16,510
Injectables	772,622	825,391	875,188	927,090	981,172
Male condoms	240,348	262,043	284,743	308,488	333,316
Female condoms	6,806	9,957	13,275	16,767	20,439
Female sterilisations	27,562	28,314	29,087	29,881	30,697
Male sterilisations	1,801	2,038	2,287	2,547	2,820
Implants	56,537	72,939	90,193	108,335	127,401
Total	**1,212,569**	**1,321,510**	**1,435,495**	**1,554,718**	**1,679,382**

Figure 36: Total FP user mix, projected 2016–2020

	2016	2017	2018	2019	2020
Pills	93,436	110,505	128,437	147,265	167,026
IUDs	14,129	21,380	29,016	37,054	45,508
Injectables	777,622	825,391	875,118	927,090	981,172
Male condoms	240,348	262,043	284,743	308,488	333,316
Female condoms	6,806	9,957	13,275	16,767	20,439
Female sterilisations	271,669	279,085	286,704	294,531	302,572
Male sterilisations	1,801	3,701	5,703	7,811	10,031
Implants	82,461	129,630	179,314	231,614	286,653
Total	**1,488,272**	**1,641,693**	**1,802,381**	**1,970,619**	**2,146,700**

SECTION 5. IMPACTS

Figure 37 presents the estimated impact of increases in FP demand, use, and priorities for 2016–2020 in Malawi. The numbers are drawn from MDHS 2010 data and projected outward based on full implementation of the FP-CIP; they show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health.

Demographic impacts. Unintended pregnancies averted refers to the number of births that will not occur, including live births, abortions, miscarriages, and stillbirths. The number of pregnancies, including abortions, averted also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions decline due to increased FP use and fewer unintended pregnancies, maternal deaths will also decline.[104]

Health impacts. As a result of full implementation of the FP-CIP, significant numbers of maternal and child deaths will be averted, as well as unsafe abortions, contributing to a healthier population.[105]

Economic impacts. Given the priority on the demographic dividend in Malawi, these numbers hold particular significance. With increased FP use, reduced unmet need for family planning, and increased contraceptive prevalence, a slower population growth rate will result in government savings and economic impacts throughout the country and across nearly all sectors of government. The below figure shows the specific impacts of the FP-CIP on maternal and infant health care costs only.

Figure 37: Impacts of Malawi's FP-CIP

	2016	2017	2018	2019	2020	Total
Unintended pregnancies averted	353,170	389,372	427,465	467,483	509,465	2,146,955
Abortions averted	109,483	120,705	132,514	144,920	157,934	665,556
Maternal deaths averted	1,298	1,410	1,524	1,640	1,759	7,631
Child deaths averted	6,702	7,389	8,112	8,872	9,669	40,744
Unsafe abortions averted	104,841	115,588	126,896	138,776	151,238	637,339
Maternal and infant health care costs saved (MWK)	6,233,615,714	6,901,175,714	7,544,953,810	8,251,304,286	8,992,297,143	37,923,346,667

SECTION 6. INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

The responsibility for governance and stewardship of the FP-CIP lies with the GOM. From an operational perspective, implementation of the FP-CIP will require the adoption of multisectoral and decentralised approaches in the coordination and management of the national effort. Such approaches create more opportunities for broad and diverse stakeholder involvement; however, managing multisectoral, decentralised coordination can be complex, challenging, and dynamic.

As described in the governance and stewardship section of this plan, the RHD will lead the FP programme and convene review meetings semi-annually to assess the progress of FP-CIP implementation against key Track20 indicators (see Figure 38). Based on these data, the review meeting will serve as an opportunity to agree on priorities for the upcoming period and identify activities that require budget advocacy. The district and zonal FP coordinators will also attend these review meetings to share best practices and challenges and discuss progress in their districts. The meetings will therefore serve to assess FP-CIP outputs/outcomes as a key accountability mechanism to assess implementation. The meetings will also involve reviewing the planning and programming process, in time to make recommendations for the next annual work planning cycle or long-term strategic planning.

Figure 38: Track 20 indicators to be reported during semi-annual review meetings

- **Indicator 1a**. Contraceptive prevalence rate, modern methods (mCPR), all women
- **Indicator 1b**. % distribution of users by modern method of contraception
- **Indicator 2**. Number of additional users of modern methods of contraception
- **Indicator 3**. Percentage of women with an unmet need for modern methods of contraception
- **Indicator 4**. Percentage of women whose demand is satisfied with a modern method of contraception
- **Indicator 5**. Annual expenditure on family planning from government domestic budget
- **Indicator 6**. Couple-years of protection (CYP)
- **Indicator 7**: Number of unintended pregnancies
- **Indicator 8**: Number of unintended pregnancies averted due to modern contraceptive use
- **Indicator 9**: Number of maternal deaths averted due to modern contraceptive use
- **Indicator 10**: Number of unsafe abortions averted due to modern contraceptive use

In addition to the more formal semi-annual review meetings, the existing FP TWG meetings will be leveraged to monitor progress in implementing the FP-CIP. A dashboard consisting of the input and output indicators of the plan will be developed in 2016 and be updated by the RHD; progress made will be reported on at quarterly national FP TWG meetings.

At the district level, a formal SRHR technical working group will be established to track and monitor progress towards implementing the district-level activities. This body will be convened by District Health Management Teams and comprise all district-level stakeholders, including other sectoral ministries, civil society, faith-based organizations, and government development partners.

Finally, a formal appraisal of FP-CIP implementation will be conducted mid-way through the plan period to assess progress and areas of preventive or corrective action.

ANNEX A: ACTIVITY MATRIX

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
DC1 Access to accurate information about healthy timing and spacing of pregnancies is increased	Communications strategy increases acceptability of family planning among potential users and gatekeepers	DC 1.1 Conduct formative research to inform the design of the SBCC strategy	1, 2, 4, 6	DC 1.1.1 Develop sub-committee under health research committee to oversee formative research • Task force to develop terms of reference for SBCC research consultant	No additional costs	2016 2017	FP SBCC task force meets quarterly	RHD, HEU
				DC 1.1.2 Consultant to undertake research survey to identify factors promoting and inhibiting family planning, and assess communication needs	Hire consulting firm (90 days)	2016	Factors promoting and inhibiting family planning assessed	HEU
				DC 1.1.3 Consultant to provide written report of situational analysis results to the task force	Printing: • 40 copies • 50 pages	2016	Task force meeting held to review results of consultant work	HEU

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
		DC 1.2 Design SBCC strategy	1, 2, 4, 6	DC 1.2.1 Conduct materials development and design workshops every five years to establish communication objectives with the HEU, RHD, and key FP stakeholders: • Establish communication objectives • Determine delivery channels • Draw up an implementation plan • Develop a monitoring and evaluation plan	5-day meeting • @ meeting space outside of Lilongwe • 25 people • Refreshments • Lunch • Transport refund	2017	SBCC strategy designed	HEU
				DC 1.2.2 Engage with human rights advocates to ensure communication materials include rights-based FP messages	2-day meeting with rights advocates • 10 people • Printing 20 pages per person • Refreshments • @ hotel in Lilongwe • Lunch	2017	SBCC strategy includes rights-based FP messages	RHD, HEU

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 1.2.3 Mid-year review of SBCC strategy	5-day meeting • @ meeting space outside of Lilongwe • 25 people • Refreshments • Lunch • Transport refund	2019	SBCC strategy reviewed	HEU
		DC 1.3 Develop and test FP communication messages	1, 2, 4, 6	DC 1.3.1 Based on design workshop, develop key messages and review messages with key partners and stakeholders	Meetings • 10 individual meetings • 10 people • Refreshments • Transport for 1 HEU and 1 RHD staff person • Printing: 5 pages per person	2017	Communication strategy developed	HEU Engaging: USAID, PSI, BLM, Family Planning Association of Malawi (FPAM)
				DC 1.3.2 Conduct focus group discussions to test key messages with target audiences, including • Youth—in-school (14–20) • Youth—out-of-school (14–20) • Men (15–50) • Fathers (15–50) • Frontline community workers • Parents of	5-day focus group discussion • 1 per zone for each target audience • @ meeting space in Lilongwe • Lunch • Refreshments • Transport allowance (3 from north, 3 from south, and 4 central target audiences) • 10 participants per focus group • Printing: 5 pages per person	2017	Number of focus group discussions held (target: 30)	HEU Engaging: USAID, PSI, BLM, Family Planning Association of Malawi (FPAM)

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				adolescents • Mothers of young children • Young mothers • Young people living with HIV • Women in sex work				
				DC 1.3.3 Review and revise communication messages based on feedback from focus group discussions	No additional costs	2017	Communication messages revised	HEU
				DC 1.3.4 Retest messages with focus groups: Conduct focus group discussions to test key messages with target audiences, including • Youth—in–school • Youth—out-of-school • Men • Frontline community workers • Parents of adolescents • Mothers of young children	5-day focus group discussion • 1 per zone for each target audience • @ meeting space in Lilongwe • Lunch • Refreshments • Transport allowance • 10 participants per focus group • Printing 5 pages per person	2017	Number of focus group discussions held (target: 30)	HEU

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
		DC 1.4 Implement communications strategy and monitor impact of communications messages	1, 2, 4, 6	DC 1.4.1 Disseminate communications strategy to stakeholders, FP coordinators, partner organizations, and frontline community workers	Print communications strategy in English Printing: • 300 copies of the 10-page key message document • 100 copies of the 50-page strategy Dissemination meeting: • @ hotel in Lilongwe • 50 people • Transport allowance (25) • Accommodation (25) • Refreshments • Lunch • Per diems (25)	2017	Number of copies of communication strategy printed and disseminated (target: 300)	HEU Engaging: USAID, PSI, BLM, FPAM
				DC 1.4.2 Produce FP creative briefs and reporting handbooks in line with the communications strategy that will inform media outlets (print, radio, TV, etc.) that target the following audiences: • Female youth ages 14–20 • Male youth ages 14–20 • Parents	Meetings: • 3 meetings • 3 days • 20 people • Transport allowance (5) • Per diem • Refreshments • Printing HEU to develop FP creative briefs with RHD from meeting notes • No additional costs	2017	Number of FP creative briefs developed (target: 1)	HEU, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				• Sexually active unmarried women and men • Sexually active married women and men				
				DC 1.4.3 Produce communication materials that fall in line with the communication strategy to be distributed to all stakeholders so that a common language is being used	• No additional cost, part of HEU's activities	2017 2018 2019 2020	Communication materials produced	HEU, RHD
				DC 1.4.4 Develop 5 different FP advertisements per year	Hire consultant (60 days)	2018 2019 2020	Number of FP advertisements produced (target: 5)	HEU, RHD
				DC 1.4.5 Purchase media space for FP messages, including • 60-second advertisements • Live panel discussions on TV and radio, featuring RHD staff, medical professionals, youth, parents, etc.	FP advertisements: • 60-second ad space • 3 times a day • 3 days a week • Throughout the year for 5 radio outlets • Purchase media space at 2 community radios per district (29) • Purchase media space at 5 national radio stations	2018 2019 2020	Number of media spots purchased (target: 2,340 advertisements, 20 panel discussions)	HEU, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
					Panel discussions: • 4 per year • 30 minutes TV time • 60 minutes radio time • Purchase film • Hire studio • 5 media outlets • Purchase media space at 2 community radio stations per district (29) and 5 national radio stations			
				DC 1.4.6 Conduct surveys in communities about the effectiveness of FP advertisements and panel discussions	Training of surveyors: • Zonal training (5 zones) • 3 days • Housing stipend • Per diem • 40 people per zone • @ meeting space in zone • Refreshments • Printing: 50 pages per person Support for surveyors: • 4 days quarterly • Per diem for 40 people per zone • Printing: 100 pages per surveyor • Transport allowance	2018 2019 2020	Number of surveys conducted (target: 4) Number of surveyors trained and supported (target: 40)	RHD, HEU, USAID

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
					Support 4 quality assurance staff in each zone: • Per diem (4) • Transport allowance (4)			
				DC 1.4.7 Host refresher training with journalists on how to best present FP topics and how to address and answer questions	Refresher training for media personnel on family planning: • 3 days • @ meeting space outside Lilongwe • 30 people • Per diems • Transport refunds • Printing: 5 pages per person	2018 2019 2020	Number of TV and radio producers and presenters oriented (target: 30)	USAID, HEU
				DC 1.4.8 Monitor implementation of the SBCC strategy; SBCC task force to meet 2 times per year to evaluate the effectiveness of key messages and delivery channels	No additional cost	2018 2019 2020	Number of meetings held (target: 2 per year)	HEU, RHD
		DC 1.5 Produce and implement soap episodes to be played on the radio in all 5 zones	1, 2, 3, 4, 5, 6	DC 1.5.1 Use formative research conducted in D 1.1 to inform soap episodes	No additional cost	2017	Evaluation of current FP environment completed	HEU, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 1.5.2 Research firm in D 1.1.2 to recruit and hire project director, 36 actors, 10 writers, and 6 producers to write, act, and produce the soap	Hire soap personnel for 6 months: • 1 project director • 36 actors • 10 writers • 6 producers	2017	Number of staff hired (target: 1 project director, 36 actors, 10 writers, 6 producers)	HEU, RHD
				DC 1.5.3 Research firm in D 1.1.2 to hold a series of trainings with the actors and writers	No additional costs	2017	Number of actors and writers trained (target: 36 actors, 10 writers)	HEU, RHD
				DC 1.5.4 Host advisory committee meetings to guide the soap episode development process	• 10 meetings • 10 people • 1 day • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person	2017	Number of advisory committee meetings held (target: 10)	USAID, PSI, BLM, FPAM
				DC 1.5.5 Promote the soap episodes in the community	Promotional material: • 100 30-second radio spots • 1,400 hats (50/district) • 1,400 shirts (50/district) • 29 banners (1/district)	2017	Soap episodes promoted in communities	HEU, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 1.5.6 Host listening teams to get feedback on the episodes	• 3 zones • 5 districts • @ district meeting room • 20 people • Refreshments • Journals	2017	Number of viewing teams held (target: 15)	PSI, BLM, FPAM, USAID
	SMS text messages are used to distribute accurate FP information	DC 1.6 Support the development of a mass mobile text campaign to communicate key FP messages and promote accurate information about FP services	1, 2	DC 1.6.2 Hire consultant to develop text messaging campaign	Hire consultant for 60 days Meetings: • 1 meeting • 15 people • Refreshments • @ meeting space in Lilongwe	2016	Text message campaign developed	PSI, BLM, Youth Net and Counselling (YONECO)
				DC 1.6.3 Host meetings with mobile companies to request reduced pricing for SMS based on quantity planned	One-on-one meetings @ mobile providers offices: • 15 people • Transport refund • Refreshments • Printing: 5 pages per person	2016	Number of meetings held (target: 15)	PSI, BLM, YONECO
				DC 1.6.4 Support staffing and running of SMS campaign	Staff salaries: • Salary—manager • Salary—information technology expert Equipment: • Server • Computers (5) • Office equipment: ○ 2 desks	2016 2017 2018 2019 2020	Number of staff hired and number of equipment procured (target: 2 staff people hired, 2 computers, 2 desks, 2 chairs, and 1 server)	PSI, BLM, UNECO

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
					○ 2 chairs			
				DC 1.6.5 Buy SMS space	Send mass SMS information • Once a quarter • Target: 1,000 people	2016 2017 2018 2019 2020	Number of SMS messages sent (target: 4)	PSI, BLM, UNECO
				DC 1.6.6 Coordinate with organisations that already have call/text centres to ensure that family planning is included	Meetings with partners: • 3 meetings • Printing: 3 pages	2016	Number of meetings with partners held (target: 3)	HEU
DC 2 Communities receive accurate information about birth spacing and limiting family size through FP contraceptive use	Cultural/religious leaders promote family planning in their communities	DC 2.1 Continue to sensitise and orient cultural and religious leaders in the community	1, 2, 6	DC 2.1.1 Hold national-level briefing meetings with religious leaders (6 religious mother bodies, 1 meeting each)	• One-on-one meetings with mother bodies • 6 meetings • Half-day • Refreshments • Printing: 5 pages per person • Transport allowance	2016 2017 2018 2019 2020	Number of national-level briefing meetings held (target: 6)	USAID, local governments, religious mother bodies
				DC 2.1.2 Hold joint planning meeting with representatives of religious mother bodies	• @ meeting space in Lilongwe • 1 day • Quarterly • 15 people • Refreshments • Printing: 5 pages per person • Transport allowance	2016 2017 2018 2019 2020	Number of districts selected for sensitisation work (target: 4)	USAID, local governments, religious mother bodies

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 2.1.3 Hold district sensitisation meeting and train selected traditional, religious leaders and marriage counsellors	• 18 people • Scale up to 29 districts over 4 years • @ meeting space in district • Technical stipend for 2 trainers • 6 days • Refreshments • Per diem • Transport allowance • Printing: 15 pages per person	2016 2017 2018 2019 2020	Number of district sensitisation meetings held and number of traditional leaders trained (target: 29 meetings and 18 people)	USAID, local governments, religious mother bodies
	Prominent Malawians support and promote family planning	DC 2.2 Continue to recruit and orient FP champions	1, 2	DC 2.2.1 Hold meeting with FP TWG to develop terms of reference for the FP champions training and select champions	• 15–20 people • Refreshments • At MOH • Printing: 5 pages per person	2016 2017 2018 2019 2020	Champions selected	USAID, HEU
				DC 2.2.2 Review training materials with key stakeholders	• 1 3-day meeting • 10 people • Refreshments • Lunch • @ meeting space in Lilongwe	2016 2018 2020	Training materials reviewed	USAID, HEU

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 2.2.3 Hold national training with proposed and invited champions	• @ hotel in Lilongwe • 3 days, 3 nights • 10 champions • 2 facilitators • Technical allowance for facilitators • Printing: 20 pages per person • Didactic material	2016 2017 2018 2019 2020	Number of champions trained (target: 20)	USAID, HEU
				DC 2.2.4 Provide support to follow up with champions	• Per diem for trainers to meet with champions and review what they learned • Per diem for champions to carry out activities within their communities	2016 2017 2018 2019 2020	Number of champions followed up with (target: 20)	USAID, HEU
				DC 2.2.5 Captains from each team of the Southern Region Football League, Central Region Football League, and Northern Region Football League are invited to participate in orientation on family planning, and how they can champion male involvement in family planning in their communities and teams	Conduct training in each region (3): • 10 players per training • 1 day • @ hotel in Lilongwe • refreshments • 1 night stay • Printing: 10 pages per person • Per diem	2016 2018 2020	Number of trainings held (target: 3)	PSI, Football Association League of Malawi

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 2.2.6 Engage musicians and artists on how they can make FP information a part of their performances	Conduct training in each region (3) • 10 artists • 1 day • @ hotel in region • Refreshments • 1 night stay • Printing: 10 pages per person • Per diem	2016 2018 2020	Number of musicians and artists engaged (target: 30)	PSI, FPAM, BLM, USAID
	Community workers across different development sectors promote family planning	DC 2.3 MOEST, MOA, and MOGCDSW coordinate with the MOH on their use of frontline workers for FP messages	1, 2, 3, 4, 5, 6	DC 2.3.1 Hold meeting with the MOEST, MOGCDSW, and MOA to agree on the terms of reference for the use of frontline workers for FP messages	• @ RHD • 5 people • Printing: 2–5 pages per person • Refreshments	2016	Terms of reference for frontline workers for FP messages agreed on	RHD, MOEST, MOA, MOGCDSW
		DC 2.4 Engage community extension workers and frontline workers to provide information on family planning and contraceptives to the community as FP motivators	1, 2, 3	DC 2.4.1 Create a job aid for the frontline workers	Meetings: • 2 meetings • 10 people • Refreshments • @ meeting space in Lilongwe Printing 1,000 job-aids for frontline workers	2016 2020	Job aid for frontline workers created	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 2.4.2 Work with the district agriculture officers to include family planning in existing agriculture extension workers training	Agriculture extension worker re-training • One meeting per zone • @ zonal meeting space • Supplies • Payment for trainers (1) • 50 agriculture extension workers	2016 2017 2018 2019 2020	Number of farm/ home extension workers re-trained (target: 50)	RHD, MOA
				DC 2.4.3 Work with the mother support groups, child protection committees (CPCs), and children's corner committees in the districts to incorporate FP information and psycho-social support into their existing trainings	CPC re-training • @ village training centres • In 5 districts in 5 zones • Supplies • Payment for trainers (1) • 50 participants trained from mother groups, children's corner committees, and CPCs	2016 2017 2018 2019 2020	Number of mothers groups re-trained (target: 50)	RHD, CPCs
				DC 2.4.4 Work with home craft workers groups and adult literacy instructors in the districts to incorporate family planning into their existing trainings	Home craft workers re-training • @ village training centres • In 5 districts in 5 zones • Supplies • Payment for trainers (1) • 50 craft workers and adult literacy instructors trained	2016 2017 2018 2019 2020	Number of home craft workers groups re-trained (target: 50)	RHD, home craft workers

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 2.4.5 Host half-day training with Banki M'khonde staff to incorporate family planning into training	Banki M'khonde workers re-training • @ village training centres • In 5 districts in 5 zones • Supplies • Payment for trainers (1) • 30 Banki M'khonde staff workers trained	2016 2017 2018 2019 2020	Number of Bank M'khonde staff trained (target: 30)	RHD, Banki M'khonde
				DC 2.4.6 Support 2 RHD staff to conduct supportive supervision trips with frontline workers	• Biannually • 5 MOH staff • 15 days • Transport allowance • Per diem • Lodging per diem	2016 2017 2018 2019 2020	Number of supportive supervision trips (target: 2)	RHD
	The community receives clear and consistent messages on family planning from the health and other development sectors	DC 2.5 FP coordinator and information, education, and communications (IEC) coordinator work together to identify opportunities to address low demand and barriers to family planning in each district within the zone	1, 2, 4, 6	DC 2.5.1 Support quarterly zonal meetings between FP coordinators and IEC coordinators	Coordination meetings between FP coordinators and IEC coordinators: • 4 meetings per year • @ meeting space at zone • 5 zones • 20 people per zone • Per diem per person • Writing material • Printing 10 pages per person • 2 national staff per diem	2016 2017 2018 2019 2020	Number of zonal meetings held with FP coordinators and IEC coordinators (target: 20)	RHD, FP coordinators, HEU, IEC coordinators

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				D 2.5.2 Conduct supportive supervision trips	• 5 people from MOH • Twice a year • Transport allowance • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supportive supervision trips conducted (target: 2)	RHD, HEU, MOH
DC 3 Both partners are involved in FP decisions for their family and are supportive of the use of modern contraception by their partners	Couples who support the use of modern contraception is increased	DC 3.1 Hold community engagement events	1, 2, 6	DC 3.1.1 Community-based artists and dance groups are supported to conduct interactive drama sessions in communities around antenatal care, family planning, male partner involvement, birth planning, and safe deliveries	Facilitate interactive drama sessions: • 10 sessions per district, per year • Every district • 2 staff per district • Per diem for staff • T-shirts • Hall hire • refreshments	2016 2017 2018 2019 2020	Number of drama sessions held (target: 1,400 drama sessions facilitated)	RHD, HEU, PSI, FPAM, USAID, BLM
				DC 3.1.2 Religious leaders and chiefs who are FP advocates conduct "husband schools," with a focus on family planning, facilitated by HSAs or nurses	• 1 per month, per traditional authority • @ chief's house • Every district (29) • 1 men's day per district • 20 men per meeting • Didactic material	2016 2017 2018 2019 2020	Number of husband schools held (target: 29)	Chiefs, RHD
				DC 3.1.3 Chiefs host village sensitisation meetings	• 2 times per year in each district • Develop promotional material (t-shirts) • Printing of handouts: 100 copies of 2-page document • @ meeting space in	2016 2017 2018 2019 2020	Number of sports days held (target: 58 per year)	Chiefs, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
					district • Per diem for chiefs • Didactic material			
				DC 3.1.4 Develop training material for FP coordinators and chiefs to engage male role models	• 5 meetings • Refreshments • Printing: 10 pages per person • 10 people • @ meeting space in Lilongwe	2016 2020	Training material for male role models developed	RHD
				DC 3.1.5 Engage male role models, particularly bus and taxi operators	• Branded hats and/or jackets (500) • Refreshments • Transport allowance for chiefs who are FP advocates and FP coordinators to talk to men • Training of male role models: o @ meeting space in district o Didactic material o Printing: 10 pages per person o 15 people	2016 2017 2018 2019 2020	Number of male role models engaged (target: 500)	RHD, PSI, USAID, USAID
DC 4 Myths and misconceptions around modern contraceptives are addressed	Percentage of people believing myths around modern contraceptives decreases	DC 4.1 Identify satisfied users to address myths and misconceptions and FP rights	1, 2	DC 4.1.1 Create training material for satisfied users on how to address myths and misconceptions and FP rights	Hire consultant for 30 days	2016 2020	Training material produced for satisfied users	RHD, USAID, PSI, USAID, BLM

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 4.1.2 Train satisfied users in the 5 zones on how to address community myths and misconceptions and FP rights	Satisfied user training: • 50 satisfied users • @ meeting space in zone • 3 days, 4 nights • Printing of training material: 20 pages per person • Per-diem for training staff (2 per zone) • Hotel package for 3 nights • Lunch • Refreshments	2016 2017 2018 2019 2020	Number of satisfied users trained (target: 50 per zone)	RHD, USAID, PSI, USAID, BLM
				DC 4.1.3 Support satisfied users to conduct outreach and speak with the local community	• Transport allowance for 50 satisfied users • Didactic material for satisfied users (50)	2016 2017 2018 2019 2020	Number of satisfied users supported (target: 50)	RHD, USAID, PSI, BLM
		DC 4.2 Develop a national-level 12-hour hotline to answer questions about family planning		DC 4.2.1 Work with partner organisations to develop a 12-hour hotline to answer questions they have about family planning, including information about different methods, where they can be obtained, and the potential side effects	• Hire 5 part-time call centre staff • Purchase phone line • Use partner space Advertisements: • Hire consultant for 20 days to develop advertisements • 30-second advertisements • Purchase space at 5 national radio stations,	2016 2017 2018 2019 2020	12-hour hotline for side effects developed	RHD, USAID

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
					and 5 channels at each district (29) for 5 times each month			
DC 5 Youth are supported to access FP information or services by their parents	Parents are engaged in discussions about SRH rights and issues with their children	DC 5.1 Engage parents in discussing family planning with young people	1, 2	DC 5.1.1 Hold discussion forums on TV and radio about how parents can best talk to their children about family planning	• Buy 30 minutes per radio and TV station in every zone • 4 times annually • Develop and print presenter facilitation talking points	2016 2017 2018 2019 2020	Number of discussion forums held (target: 20)	RHD
				DC 5.1.2 Use mother groups, CPCs, church and religious leaders (identified and trained in D 2.1), and community leaders to hold local dialogues about how parents can discuss sexual education with their children	Orientation of mother groups, church and religious leaders, and community leaders: • 1 per district • 1-day orientation • 30 people • @ village training centre • Printing: 5 pages per person • Per diem • Lunch • Refreshments • Didactic material • Printing: 300 booklets	2016 2017 2018 2019 2020	Number of community dialogues held (target: 29)	RHD, mother groups, CPCs, chiefs
				DC 5.1.3 Use church and religious leaders (identified and trained in D 2.1) to provide information to parents about how to discuss sexual education with their children	• Per diem for 18 people per 29 districts	2016 2017 2018 2019 2020	Number of church and religious leaders facilitated to provide information to parents (target: 522)	RHD, BLM, PSI, FPAM

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 5.1.4 Train existing reproductive health assistants to engage parents in a discussion about sexual education	Re-training of existing BLM, PSI, and FPAM reproductive health advocates: • 1 per district • 1-day orientation • 20 people • @ village training centre • Printing: 5 pages per person • Per diem • Lunch • Refreshments • Didactic material	2016 2017 2018 2019 2020	Number of reproductive health advocates re-trained on discussing sexual education with parents (target: 580)	BLM, PSI, FPAM
				DC 5.1.5 Engage health workers to talk to parents about discussing family planning with their children and the use of contraceptives by their children	Orientation of health workers: • 1 per district • 1-day orientation • 20 people • @ village training centre • Printing: 5 pages per person • Per diem • Lunch • Refreshments • Didactic material	2016 2020	Number of health workers engaged to hold discussions with parents (target: 600)	RHD
DC 6 Young people feel empowered to access FP services	Young people are empowered to access FP information and services	DC 6.1 Engage youth to provide accurate and thorough information about family planning to their peers	1, 2	DC 6.1.1 Review and update current peer educators training material to strengthen the SRH components (including provision of short-term methods if implemented under	Review meetings: • 3 meetings • 10–15 people per meeting • @ meeting space outside of Lilongwe	2016 2020	Peer educators training manual updated	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				activity PA 1.2 and addresses the full FP rights)	• Refreshments • Printing: 50 pages per person			
				DC 6.1.2 Hold youth camps to recruit and orient peer educators and champions, including new FP communication strategy	1 camp per district, per year: • 50 youth • 3 days • Tent rental • 2 nights • Lunch • Refreshments • Transport • Artist stipend: 2 per zone • Technical allowance for 5 facilitators • 50 youth per region	2016 2017 2018 2019 2020	Number of youth camps held and number of youth attending (target: 140 camps, 7,000 youth)	RHD, PSI, USAID
		DC 6.2 Utilise current peer educator programmes in MOEST, MOGCDSW, and MOA to address FP methods	1, 2, 3, 4, 6	DC 6.2.1 Host meeting with MOEST, MOGCDSW, and MOA to discuss how to utilise their peer educators	Coordination meeting: • 1-day meeting • 10 people • @ meeting space in Lilongwe • Refreshments • Printing: 10 pages per person	2016	Meeting held with MOEST, MOGCDSW, and MOA	RHD
				DC 6.2.2 Training-of-trainers (TOTs) for peer educators	TOT for peer educators: • 25 trainers per region • @ hotel in region • Technical allowance for trainer • Printing: 200 pages per region	2016 2018 2020	Number of trainers trained (target: 25)	RHD, MOEST, MOGCDSW, MOA

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				DC 6.2.3 Train youth/peer educators from the clubs based on the outcomes of the coordination meeting held in D 6.2.1	Peer educator training: • 5 from each district (50 per region) • @ hotel in region • Every district represented • Per diem • Transport • Printing: 200 pages per person • Lunch • Refreshments	2016 2018 2020	Number of peer educators trained (target: 50)	RHD, MOEST, MOGCDS, MOA
				DC 6.2.4 Review and update existing job aids for peer educators	• Meetings: o 2 meetings o 10 people o Refreshments o @ meeting space in Lilongwe • Print 1,000 job aids	2016	Job aids reviewed and updated for peer educators	RHD
				DC 6.2.5 Support peer educators to provide information to the community	• Transport allowance for 50 satisfied users per region • Didactic material for satisfied users (50 per region)	2016 2017 2018 2019 2020	Number of peer educators supported (target: 50)	RHD, PSI, BLM, USAID
				DC 6.2.6 Conduct supportive supervision trips for peer educators	• 2 per year • 5 people from the MOH • Transport allowance • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supportive supervision trips conducted in a year (target: 2)	RHD, MOH

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
		DC 6.3 Train peer educators at tertiary institutions	1, 2	DC 6.3.1 Conduct trainings for 250 peer educators at tertiary institutions	10 5-day trainings: • 2 facilitator allowances • 25 participants • @ meeting space in universities • Accommodation • Printing: 250 manuals • Refreshments • Lunch	2016 2018 2020	Number of peer educators trained (target: 250)	RHD, PSI, BLM, USAID
				DC 6.3.2 Provide peer educators with job aids from D 6.2.4	• Printing: 300 job aids	2016 2018 2020	Number of job aids provided to peer educators at tertiary institutions (target: 300)	RHD, PSI, BLM, USAID
				DC 6.3.3 Conduct supportive supervision trips	• 2 supportive supervision trips held per year • 5 people from the MOH • Transport allowance • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supportive supervision trips conducted in a year (target: 2)	RHD, MOH, HEU
		DC 6.4 Develop a blog/Facebook page and phone app for youth to use to get and share information about family planning		DC 6.4.1 Hire a consultant to develop the BlogSpot and phone application with input from youth organisations	Hire messaging expert and information technology expert to develop BlogSpot and phone app: • 45 days Facilitate youth to manage the BlogSpot: • 4 youth • 20 days	2018	BlogSpot and phone app created	RHD, PSI, USAID, HEU

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
		DC 6.5 Develop age-appropriate FP information to be distributed at youth clubs, schools, and health centres		DC 6.5.1 Develop 3 age-appropriate FP handouts and posters for the following age groups: • 10–14 • 15–19 • 20–24	• Hire consultant to develop youth-specific FP information for 60 days	2016	Age-appropriate FP handouts developed	RHD, HEU
				DC 6.5.2 Print and disseminate handouts to youth clubs, schools, and health centres	• Print 13,200 copies of each pamphlet • Provide transport to IEC staff to distribute pamphlets to youth clubs (1 per district)	2016 2018 2020	Number of youth pamphlets distributed (target: 39,600)	RHD, HEU
DC 7 FP messages continue to evolve to respond to changes in perceptions around family planning	Evaluation of SBCC strategies implemented in the FP-CIP provide guidance for redesign in coming years	DC 7.1 Conduct evaluation of SBCC activities and initiate redesign based on outcomes		DC 7.1.1 Consultant to undertake research survey to identify factors promoting and inhibiting family planning, and assess how communication strategies have impacted demand and acceptability of family planning among key groups • Youth—in-school • Youth—out-of-school • Men • Frontline community workers • Parents of	Hire consulting firm for 90 days	2020	Evaluation conducted	HEU, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Demand Creation								
				adolescents • Mothers of young children				
				DC 7.1.2 Consultant to share outcome of SBCC evaluation with SBCC task force and FP TWG	No additional cost—to be conducted as part of existing regular meetings	2020	Evaluation shared with FP TWG	HEU, RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
SDA 1 Health care workers are providing high-quality FP information and services and offering the full method mix to clients	In-service training is improved to include the provision of appropriate information about methods and side effects and practical applications of the full FP method mix (appropriate to each cadre)	SDA 1.1 Current in-service training guidelines are reviewed and updated to ensure that they include a full and comprehensive FP section and capacity development for rights-based service provision		SDA 1.1.1 MOH to review and assess current in-service training material for facility health care workers to ensure that there is a comprehensive FP component and that the full information about patients RH rights and issues are addressed ; and to update training manuals to reflect additions or changes	• 3 meetings • @ MOH meeting space • 10–15 people • Printing: 50 pages per person • Refreshments	2016	Current training material for facility health care workers assessed	MOH
				SDA 1.1.2 TOT on updated training material for health centre staff	• National • 20 people • @ hotel in Lilongwe • 3 days, 4 nights • Printing: 50 pages per person • Per diem • Lunch • Refreshments	2017	Number of trainers trained (target: 20)	RHD
				SDA 1.1.3 Review and update existing FP job aids for facility health care workers	Meetings: • 2 meetings • 10 people • Refreshments • @ meeting space in Lilongwe • Print 3,000 job aids	2017	FP job aids for facility health care workers reviewed	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 1.1.4 Trainers are deployed to provide refresher trainings to health care workers on comprehensive family planning, including LARMs and emerging issues	29 trainings (1 per district): • Technical allowance for 2 trainers per training • Transport allowance for trainers • @ district venue • 5 days • Sitting allowances • Transport refund • Refreshments • Lunch • Didactic material • 2 staff per facility (800 facilities)	2017 2018	Number of staff trained and refreshed on FP emerging issues (target: 1,600)	RHD
				SDA 1.1.5 Conduct supportive supervision trips	• 2 per year • 10 people from the MOH • Transport allowance • Per diem • Lodging	2017 2018 2019 2020	Number of supportive supervision trips conducted (target: 2)	RHD, MOH
SDA 2 Access and use of FP services at health facilities and at community levels is increased	Access to FP services at facilities and community level increased	SDA 2.1 Target mobile and outreach clinic visits to locations with long distances between clinics and low access to LARMs		SDA 2.1.1 Host meeting with chiefs and traditional leaders to discuss where to establish mobile clinics and outreach* * For the purpose of this document, mobile clinics are considered to be temporary clinics set up on certain days	Regional meetings: • Total 30 participants • @ meeting space in region • Refreshments • Transport allowance	2016 2017 2018 2019 2020	Number of chiefs and traditional leaders consulted on mobile clinics (target: 30)	District Health Management Team (DHMT), with the support of implementing partners

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				in harder to reach areas. Mobile outreach is considered to be staff people travelling from the hospital or larger health centre to smaller health centres or posts to provide services not usually offered at that particular location (eg, IUDs).				
				SDA 2.1.2 FP coordinators to meet with implementing partners and map where current services are in the district and areas with low access to FP services, especially long-acting methods to determine where mobile clinics and outreach are most needed. Outreach areas could include • Mission hospitals where modern methods are not provided • Areas with long distances between facilities • Near secondary schools • Near fishing	Half-day meeting per district • @ DHMT • 15 people • Refreshments • Printing: 10 pages per person • Didactic material	2016	Assessment for where new mobile clinics are needed completed	DHMT, RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				villages, plantations, or other low access areas • On market days				
				SDA 2.1.3 FP coordinator to develop mobile outreach plans with stakeholders during the quarterly FP district stakeholders meeting	• 20 people • Refreshments • Printing: 10 pages per person • Didactic material	2016 2017 2018 2019 2020	Number of quarterly mobile outreach plans developed (target: 4)	RHD
				SDA 2.1.4 DHMTs to allocate vehicle to provide mobile outreach from health centres to health posts (identified in 2.1.2) in order to provide outreach services	• 10 people per region • Fuel reimbursement (50 litres of fuel)	2016 2017 2018 2019 2020	Vehicle allocated to provide mobile outreach	DHMT
				SDA 2.1.5 Increase mobile clinic visits to the high-priority areas identified in mapping	• Outreach once a week • 1 location per district • 10 service providers per region • Allowance for 10 service providers • 5 vehicles per region • 1 driver per vehicle • 5 equipment bags per region • 5 tents per region • 5 collapsible tables per	2016 2017 2018 2019 2020	Number of new mobile outreach sites (target: increase to all 29 districts, 25 additional districts from the original 4)	RHD, PSI, BLM

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
					region • 10 camping tents per district • Per diem for service providers to camp for 3 days			
				SDA 2.1.6 FP coordinator to report on impact of mobile outreach and re-assess frequency, locations, and services provided annually during FP TWG meeting	No additional cost	2016 2017 2018 2019 2020	Mid-term assessment of mobile outreach health services completed	RHD
SDA 3 High-quality FP information and services are available at the community level	Community workers are able to provide information on the full method mix and to provide clients with the FP method of their choice, within CBDA and HSA service provision guidelines	SDA 3.1 Revise guidelines for CBDAs and HSAs based on outcome of PA 2.1 to provide LARMs at the community level		SDA 3.1.1 Review terms of reference for consultant to produce feasibility study on CBDAs providing injectables and HSAs providing implants	Part of the agenda item on an FP TWG—no additional cost	2018	Consultant's terms of reference reviewed	FP TWG
				SDA 3.1.2 Consultant terms of reference approved by the RHD	No additional cost	2018	Consultant's terms of reference approved by the MOH	RHD
				SDA 3.1.3 Hire consultant to produce feasibility study on increasing the method mix offered by community health	Hire consultant (60 days)	2018	Assessment completed for where CBDAs and HSAs can Provide LAMs	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				workers, so that CBDAs are able to provide injectables and HSAs are able to provide implants				
				SDA 3.1.4 Review feasibility study with the MOH, policymakers, professional organisations, and other stakeholders	Review meeting • Half-day • 30 people • @ hotel in Lilongwe • Refreshments • Printing: 50 pages per person	2018	Assessment reviewed	RHD
				SDA 3.1.5 Based on the outcome of PA 2.1, develop guidelines for HSA service provision that includes identified best practices	Hire consultant (20 days) Meet with key stakeholders: • 2 meetings • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person	2018	Regulatory guidelines drafted	RHD, in coordination with professional associations
				SDA 3.1.6 Re-evaluate HSA training material to ensure it has the full FP method mix and revise to include implants if directed by the MOH (refer to PA 2.1)	• 3 meetings • 10 people • Refreshments • @ meeting space in Lilongwe • Printing: 5 pages per person	2018	HSA training material re-evaluated	RHD, in coordination with professional associations

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 3.1.7 Based on the recommendation from the MOH in PA 2.1, conduct a pilot programme in 3 districts in which HSAs provide implants	HSA trainings: • @ village training centres • 3 districts • 10 people per district • Transport allowance • Per diems (10) • Accommodation • Technical allowance for 1 trainer • Printing of 5 pages per person • Refreshments • 2 days, 3 nights • Lunch • Didactic material	2019	Number of districts piloted for the provision of implants by HSAs (target: 3)	RHD
				SDA 3.1.8 Assess pilot study results	Consultant to conduct assessment: 20 days Meeting to review results: • @ meeting space in Lilongwe • 15 people • Refreshments • Printing: 10 pages per person	2020	Pilot study results assessed	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 3.1.9 Based on results from 3.1.6, scale up training of HSAs on how to provide implants in addition to short-acting methods, with emphasis on training HSAs in hard-to-reach areas	HSA trainings: • @ village training centres • 50 people per zone in first year • 10 people per zone each year thereafter • Transport allowance • Per diems (50) • Accommodation • Technical allowance for 2 trainers • Printing of 5 pages per person • Refreshments • 2 days, 3 nights • Lunch • Didactic material	2020	Number of HSA staff trained (target: 250)	RHD
		SDA 3.2 Evaluate the CBDA training material to ensure that it includes comprehensive information on FP and rights-based information, and scale up training (based on the outcome of PA 3) to all 29 districts		SDA 3.2.1 MOH and partners to review current training materials to identify what CBDA training materials require updates and to ensure that full FP rights-based information is available	2 FP TWG sub-committee meetings: • Refreshments • @ meeting space in Lilongwe • Printing: 5 pages per person	2016	CBDA training material requiring updates identified	MOH, PSI, BLM

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 3.2.2 Conduct workshop to review and rewrite the CBDA training material—to include the provision of injectables if directed by the MOH in activity PA 3	5-day review meeting: • 25 people • @ hotel in Lilongwe • Per diem • Refreshments • Lunch • Lodging for 4 nights	2016	CBDA training material re-evaluated	MOH, PSI, BLM
				SDA 3.2.3 Host district CBDA training, including youth CBDAs and implementing partner organisations	6 trainings per district: • 2 week training • 25 people per training • @ village training centres • Transport allowance • Technical allowance for 2 trainers • Per diems • Printing: 5 pages per person • Refreshments • Lunch	2017	Number of CBDA staff trained (target: 4,200)	MOH, PSI, BLM
				SDA 3.2.4 Support CBDAs to provide FP services	• Purchase 15 bicycles for district for CBDAs • Purchase didactic material for every CBDA • 4,500 CBDAs	2017 2018 2019 2020	Number of CBDAs supported to provide FP services (target: 4,500 CBDAs)	MOH, PSI, BLM
				SDA 3.2.5 Host district CBDA refresher trainings	• @ village training centres • 6 trainings per district • 6 4-day trainings	2019	Number of CBDAs trained (target: 4,200)	MOH, PSI, BLM

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
					• 25 people • Transport allowance • Technical allowance for 2 trainers • Per diems • Printing: 5 pages per person • Refreshments • Lunch			
		SDA 3.3 Expand the work of the Nurses Association to train retired nurses in the community to provide skilled FP services		SDA 3.3.1 Nurses Association to train retired midwives (at least 1 for every facility) to provide FP information and services, including pills, condoms, implants, and injectables to the community	Midwife refresher training: • 5 days • Total of 800 retired nurses • @ village training centres • Transport allowance • Facilitator allowance • Printing: 10 pages per person	2016 2017 2018 2019 2020	Number of retired nurses oriented on family planning (target: 15 per zone)	Nurses Association
				SDA 3.3.2 Retired nurses to report monthly to their nearest health facility on service statistics and restock	• 6 monthly transport allowance	2016 2017 2018 2019 2020	Number of times data on service and commodity are reported to health facility (target: 12)	Nurses Association, RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
	All people have access to natural FP methods (including: cycle beads, standard days, periodic abstinence, etc.) and information on all modern methods at facilities where not all methods are distributed	SDA 3.4 Re-train faith-based organisations (FBOs) on the service provision of method mix, including natural methods		SDA 3.4.1 RHD to meet with Catholic mother body/head secretariat on what facilities have service providers that need to be re-trained in natural methods	No additional costs required	2016	Review of where to train FBO service providers completed	CHAM, RHD
				SDA 3.4.2 Use national training pool to train Catholic facility clinic staff on providing natural FP and referral services	Natural method training: • 2 days • @ district hotel • 20 people/district (29 districts) • Transport allowance • Printing: 10 pages per person • Provide 50 cycle beads to each trainee • Refreshments • Lodging • Lunch	2016	Number of FBO clinic staff trained (target: 580)	CHAM, RHD
SDA 4 Private sector facilities are providing information on potential side effects to clients	Private sector is able to counsel on side effects	SDA 4.1 Hold meetings with National Paramedical and Private Providers Association of Malawi (NAPPPAM) to discuss how to ensure that pharmacy personnel are providing		SDA 4.1.1 Host meeting with NAPPPAM to identify what additional information private sector pharmacy personnel need and how to convey it	Regional meetings: • @ teachers training colleges • 10 people per meeting • Meeting space • Transport allowance • Refreshments • 5 pages per person	2016	Decision made on information private sector pharmacy personnel need	NAPPPAM, RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
		comprehensive FP information and how to handle side effects		SDA 4.1.2 Develop leaflets for pharmacy personnel, which include the hotline number created in D 4.2	Hire consultant for 15 days to develop informative materials	2016	Leaflets for pharmacy personnel developed	RHD, NAPPPAM
				SDA 4.1.3 NAPPPAM to print and distribute leaflets to the private sector	• Printing: 10,000 leaflets • Distribute to private facilities (30) • Transport allowance	2017 2019 2019 2020	Number of leaflets distributed (target: 10,000)	NAPPPAM
SDA 5 Public-private partnerships for FP service provision are implemented	Increase coverage of services through the expansion of public-private partnerships	SDA 5.1 Conduct a baseline assessment of private sector capacity and coverage of providing FP services		SDA 5.1.1 Hire consultant to conduct assessment of the capacity and qualifications of the for-profit and not-for-profit private sectors to provide FP services according to National Standard Guidelines	Hire consultant for 45 days to conduct assessment	2016	Assessment on capacity of private sectors conducted	RHD
				SDA 5.1.2 Consultant to provide guidance to FP coordinators on which private for-profit and not-for-profit partners have the capacity and coverage to provide FP services	Hire consultant for 60 days : • 1-day meeting • @ meeting space in Lilongwe • All FP partners in 29 districts • Refreshments • Printing: 10 pages per district • Travel twice to each district (29) • 1 night lodging in each	2016 2018 2020	Partner FP activities mapped out	RHD, DHMT

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
					district, per trip • Airtime for communication with FP coordinators			
				SDA 5.1.3 FP coordinators to conduct outreach to partners identified in SDA 5.1.2 on FP service provision	• 1 FP coordinator per district (29) • Transport allowance • Per diem • About 5 outreach places	2016 2018 2020	Number of FP coordinators conducting outreach to partners about FP service provision (target: 29)	RHD
		SDA 5.2 Expand FP services through private the sector (e.g., SHOPS, PSI—Mtunza, Blue Star (social franchising) and social marketing with CBDAs		SDA 5.2.1 Host meeting with private sector providers to agree on where gaps can be filled by private sector service providers	1-day meeting with all FP partners: • 1 meeting per district (29) • @ DHMT office • Refreshments • Printing: 10 pages per person	2016 2017	Agreement reached on service provision gaps and partner organisations assigned to cover	RHD
				SDA 5.2.2 Host bi-annual meetings to review private sector service delivery	1-day meeting with all FP partners in each district: • 2 meetings per district, per year • 20 attendees • Refreshments • Printing: 10 pages per person • @ meeting space in district	2017 2018 2019 2020	Number of private sector service delivery reviews completed (target: 2)	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 5.2.3 RHD staff to conduct follow-up on bi-annual reviews and ensure implementation of decisions/ recommendations made	Transport allowance and phone minutes for 2 RHD staff	2017 2018 2019 2020	Number of follow-ups to agreements conducted (target: 2)	RHD
		SDA 5.3 Engage companies with on-site health clinics (e.g., tea, tobacco, etc.) to train clinical staff on FP method mix		SDA 5.3.1 RHD to conduct one-on-one advocacy meetings with private companies to promote how family planning is beneficial for the company and to discuss when and where clinical staff could be trained and other modalities like procurement of commodities and minor renovations to improve FP services	One-on-one advocacy meetings: • 15 meetings • Transport allowance for 2 staff people • Printing: 5 pages per meeting	2016 2017	Agreement on clinical staff training reached	RHD
SDA 6 Access to family planning by young people is safe, rights-based, and confidential	YFHS are improved	SDA 6.1 Health workers are trained on how to provide YFHS	3,2	SDA 6.1.1 Review where staff need to be trained YFHS or where staff need to be re-trained based on the updated YFHS manual (ongoing)	• Airtime for 2 RHD staff people to contact each youth-friendly coordinator for information on where staff need to be re-trained	2016	Identification of where staff need to be re-trained	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
				SDA 6.1.2 TOT on YFHS to support training of health care providers, children's corner patrons, and child representatives	TOT: • 4 trainers per district (29 districts) • @ regional hotel • 5 days, 5 nights • Technical allowance for trainer • Printing: 200 pages per person	2016	Number of trainers trained (target: 116)	USAID, PSI, YONECO, BLM, United Nations Population Fund, Save the Children, United Nations Children's Fund, RHD, GIZ
				SDA 6.1.3 Support training of health care providers, children's corner patrons, and child representatives	YFHS trainings: • 1 health care provider from each health centre, and an additional 10 children's corner patrons and child representatives from districts (about 1,029) • @ district-level meeting space • Transport for all health care providers per district • Transport for service providers • Lunch • Refreshments	2016	Number of health care providers trained (target: 1,029people)	Same organisations responsible above

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
		SDA 6.2 Strengthen YFHS supervision at the district level		SDA 6.2.1 RHD to develop a quarterly supervision schedule	Meeting of partners: • 4 times a year • 1 day • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person • 10 people	2016 2017 2018 2019 2020	Number of supervision schedules developed (target: 4)	RHD
				SDA 6.2.2 FP coordinators and district youth officers to conduct quarterly supervision trips	• 5 people • Transport allowance • 2 per district • Every quarter • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supervision trips conducted(target: 4)	RHD
		SDA 6.3 Intensify quality improvement by using the YFHS quality standards		SDA 6.3.1 Review the YFHS monitoring tools	Meetings: • 2 meetings • 10 people • Refreshments • @ meeting space in Lilongwe • Printing: 10 pages per person	2016 2018	YFHS monitoring tools reviewed	RHD
				SDA 6.3.2 Disseminate the updated monitoring tools to the districts	Dissemination meeting: • @ meeting space in Lilongwe • 100 people • Transport allowance for 5 MOH staff, 40 field staff	2016 2018	Number of monitoring tools disseminated (target: 1,000)	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
					• Refreshments • Printing: 1,000 copies of 20 pages			
				SDA 6.3.3 Train FP coordinators and youth-friendly coordinators with new tools	Trainings: • Zonally • 2 people per district • 3 days • Refreshments • Lodging • Lunch • Refreshments • @ hotel in zone • Transport allowance	2016 2018	Number of staff trained on new YFHS tools (target: 58)	RHD
SDA 7 Health care providers entering the workforce are able to provide high-quality FP services	FP pre-service practical skills strengthened	SDA 7.1 Conduct meeting to introduce new FP methods and service provision		SDA 7.1.1 Brown bag sessions at training schools on FP updates every month	• @ meeting in training centres • Refreshments • Didactic material • 25 people • Zonally	2016 2017 2018 2019 2020	Number of brown bag sessions on FP methods and service provisions updates held (target: 12)	All training institutions and RHD
		SDA 7.2 Conduct advocacy with professional registration bodies to increase practical requirements for pre-service training	3, 6	SDA 7.2.1 Convene meeting to lobby professional registration bodies and agree on LARM registration requirements for initial registration, including number of practical insertions/surgeries required	• 2 meetings (2 hours) • @ RHD or medical council • Refreshments • 15 people • Printing: 5 pages per person	2016	Meeting with professional registration bodies held	RHD, nurses council

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
		SDA 7.3 MOH to revive internship for nurses with required on-the-job learning targets such as number of IUDs inserted, etc.	3	SDA 7.3.1 Host meeting with the MOH to review and advocate the introduction of FP internships for nurses	• @ MOH • 5 people • Refreshments • Printing: 5 pages per person	2016	Introduction of internships for nurses reviewed with the MOH	RHD, training institutions
				SDA 7.3.2 MOH to create mandate requiring every health service facility to create space for 2 interns in family planning per year	No additional inputs	2016	Internship mandate implemented	MOH
				SDA 7.3.3 Develop standard operating procedures (SOPs) for internships and agreement forms	• 1-day meeting • @ MOH meeting space • 10 people • Printing: 10 pages per person • Refreshments	2016	SOPs for internships and agreement forms created	MOH, training institutions
SDA 8 Utilization of long-term methods is increased	Access to long-term methods is improved	SDA 8.1 Supportive supervision is strengthened to ensure CHWs are counselling on long-acting methods		SDA 8.1.1 FP coordinators to coordinate with the district environmental health officers to conduct quarterly CHW supervision trips	• 5 people • Transport allowance • Two per district • Every quarter • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supervision trips to CHWs completed (target: 224)	RHD, district environmental health officers

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
		SDA 8.2 Implement voucher system to reimburse people who are referred to higher-level facilities for services not offered at their nearest health facility		SDA 8.2.1 Develop voucher system to provide transportation refunds for clients receiving referrals for long-acting methods, as well as service vouchers for clients accessing FP services at the community level	Meeting with MOH: • @ RHD • 30 people • Half-day • Refreshments Write SOP for voucher system: • Hire consultant for 20 days Meeting with 3 DHMTs: • 5 days per district • Transport to district • Accommodation • Per diem • Half-day formal meeting • @ DHMT • 15 people • Lunch • Refreshments	2019	Voucher system to provide transportation refunds to clients developed	MOH
				SDA 8.2.2 Scale up voucher programme to districts where current services and mobile outreach are not reaching all women	Salary for national system manager and voucher manager in each district: • Manager salary (29) Procure equipment to operate voucher programme: • 25 computers • 25 printers • 25 mobile phones	2020	Number of districts voucher programme scaled up to (target: 29)	MOH

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
					District voucher managers to develop terms of reference with private facilities: • Transport refund • One-on-one meetings • Per diems Train providers on voucher system: • 1 training per district (25) • 1 day • @ village training centre • 30 providers • 2 facilitators • Lunch • Facilitator allowance • Per diem			
SDA 9 FP services are integrated into other health services	FP services are integrated into • Cervical cancer screening • Antenatal care (FP counselling only) • Postnatal care • Postpartum care • Sexually transmitted infection	SDA 9.1 Develop and roll out FP integration protocol	4	SDA 9.1.1 Hold stakeholder meeting to harmonise findings from integration studies, and identify sub-committee to develop comprehensive integration protocol	One-day meeting • @ hotel in Lilongwe • Refreshments • Lunch • 50 people • Printing: 30 page per person	2016	Integration studies harmonised	RHD

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
	screening, treatment, and care • Immunisation • Infant and young child feeding and malnutrition programmes • Routine childhood vaccination • Cancer screening			SDA 9.1.2 Integration task force to be created by RH TWG	Sub-committee to present at FP TWG	2016	Integration task force created	RHD, RH TWG
				SDA 9.1.3 Integration task force to develop integration protocol and present to FP subcommittee	• @ meeting space in Lilongwe • Refreshments • Printing: 10 pages per person • 20 people	2017	Integration protocol developed	FP sub-committee
				SDA 9.1.4 Host zonal training with DHMT and FP coordinators on integration protocol	Zonal meetings • 2 days, 2 nights • @ zonal hotel • 15 people • Transport allowance for each participant	2017	Number of DHMT and FP coordinators trained (target: 15 people)	DHMT, RHD
				9.1.5 MOH to provide facilities with a directive to integrate family planning with other services, with FP coordinators providing oversight and supervision of implementation	No additional cost required	2017	MOH provides facilities with an integration directive	MOH

Strategy Outcome	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/group/ organisation responsible
Service Delivery and Access								
SDA 10 Clients receive high-quality and respectful FP services	Quality of FP services for clients are improved	SDA 10.1 Reinforce quality assurance assessment from the MOH	6	SDA 10.1.1 Strengthen quality improvement support teams	• 5 people • Per district • Per diem • Transport allowance	2016 2017 2018 2019 2020	Number of district quality improvement support teams strengthened (target: 29)	MOH
				SDA 10.1.2 National quality assurance teams to conduct follow-up supervision trips to the district quality improvement teams	• 5 people • Travel to every district • Transport allowance • Per diem • 10 days • Lodging	2016 2017 2018 2019 2020	Number of quality assurance supervision trips conducted (target: 1)	MOH
		SDA 10.2 Health care workers are educated about client's rights to FP information and services, including availability, accessibility, quality, equity, and non-discrimination informed choice		SDA 10.2.1 Educate health care workers about the rights of clients	• Part of SDA 1.4—no additional costs	2016 2019	Number of staff trained and refreshed on clients rights (target: 1,600)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
CS 1 A comprehensive contraceptive forecasting and quantification system is implemented	Data are available on contraceptive commodity usage and used to accurately forecast commodity quantities for procurement	CS 1.1 Review contraceptive reporting system to incorporate data from the government, NGO, and private sectors and to ensure reporting requirements are streamlined	5	CS 1.1.1 Hold meetings with Reproductive Health Commodity Security (RHCS) technical working group about the feasibility of incorporating the NGO and private sectors into the public sector reporting system	• 3 meetings • @ MOH • Refreshments • 30 people • Printing: 10 pages per person	2016	Agreements on new reporting system reached	RHCS
				CS 1.1.2 Hire consultant to develop new reporting forms and database	Hire consultant for 20 days 3 meetings: • 10 people • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person	2016	New reporting system forms developed	RHD
				CS 1.1.3 Train store managers, FP coordinators, and data managers on the new system and supply chain management	Regional training: • 50 people per region • Technical allowance for 2 trainers • @ regional hotel • 2 days, 3 nights • Refreshments • Printing: 20 pages per person • Didactic material	2016	Number of store managers trained (target: 150)	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 1.14 Hold meetings with the RHSC TWG to see whether and where reporting forms can be streamlined	RHCS TWG meetings: • 3 meetings • @ MOH • Refreshments • 30 people • Printing: 10 pages per person	2016	Number of meetings held with RHSC TWG (target: 3)	HTSS unit, RHD
		CS 1.2 Develop comprehensive annual contraceptive forecast and procurement plan	5, 6	CS 1.2.1 Conduct annual quantification, forecasting, and procurement workshops for FP commodities and consumables	Quantification workshop: • 2 days • @ hotel in Lilongwe • 30 people • Refreshments • Printing: 100 documents of 50 pages	2016 2017 2018 2019 2020	Number of workshops held (target: 3)	HTSS unit
				CS 1.2.2 Review and update commodity pipeline and forecast data	• 30 people per meeting • @ MOH • Refreshments • Printing: 20 documents per person	2016 2017 2018 2019 2020	Reproductive commodity supply chain meetings held (target: 3 per year)	HTSS unit
				CS 1.2.3 Support HTSS unit to write a quantification report on the current FP stock status, short and mid-term forecast, and projected financial gap	Hire consultant for 60 days National consultative meetings: • 3 days • 40 people • @ meeting space in Lilongwe • Refreshments • Lunch • Printing: 30 pages per person	2016 2017 2018 2019 2020	Quantification report written	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 1.2.4 Print and disseminate report	• Printing: 150 copies, 35 pages	2016 2017 2018 2019 2020	Number of quantification reports disseminated (target: 150)	HTSS unit
		CS 1.3 Assess the compliance of facilities, FP coordinators, pharmacy assistants, MOH quantification staff, and CMST in following the logistics SOPs, and provide incentives based on performance	5	CS 1.3.1 Hire consultant to review the logistics SOPs developed in 2015	Hire a consultant for 60 days Host consultative meetings: • 3 meetings • 10 people • @ hotel in Lilongwe • Refreshments • Printing: 5 pages per person	2016	Research on logistics SOP compliance completed	HTSS unit
				CS 1.3.2 Distribute findings of logistics SOP review	Dissemination at RHCS: • @ MOH • Refreshments • Printing: 100 copies of 15–20 page document	2016	Number of logistics SOP research documents distributed (target: 100)	HTSS unit
				CS 1.3.3 Develop procedures and agreement on incentives for facilities within each zone that follow the SOPs most closely	• 3 meetings • 15 people • Refreshments • @ meeting space in Lilongwe • Printing: 5 pages per person	2016	Procedures and agreement on incentives developed	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 1.3.4 Provide non-financial incentives to top facilities based on a review of SOPs, such as plaques, opportunities to travel to other training centres, etc…	Zonal technical supervisor to review SOPs on a quarterly basis Provide non-financial incentives to 2 top health centres: • Certificates • Hats • Jackets • Trip to national FP meeting • Trip to other training sites	2016 2017 2018 2019 2020	Number of non-financial incentives provided (target: 10)	HTSS unit
				CS 1.3.5 Conduct supportive supervision trips occurring quarterly following the initial review of the commitment to SOPs	• 5 people from the DHO • Transport allowance • Per diem • Lodging	2016 2017 2018 2019 2020	Number of supportive supervision trips conducted (target: 4)	HTSS unit
CS 2 Selective stock-outs of contraceptives at the district level are proactively addressed	Stock-outs of contraceptives at the district level are limited	CS 2.1 Facilitate the redistribution of contraceptives within a district	5	CS 2.1.1 Host meeting with national MOH staff, DHOs, FP coordinators, pharmacy assistants, and key stakeholders to develop operating procedures for the redistribution of contraceptives	• 1-day meeting • @ meeting space in Lilongwe • 20 people • Printing: 10 pages per person • Refreshments	2016	Operating procedures for redistribution of contraceptives developed	RHD, HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 2.1.2 Distribute operating procedures	• Transport allowance for IEC coordinator to distribute (1 per district, 29 districts) • Printing: 1,000 copies of 10 pages	2016	Distribution meeting held	RHD, HTSS unit
				CS 2.1.3 Facilitate FP coordinators and pharmacy assistants to redistribute contraceptives	• Transport allowance for 29 districts	2016 2017 2018 2019 2020	Number of districts supported in the redistribution of contraceptives (target:29)	HTSS, RHD unit
				CS 2.1.4 Procure branded utility vehicles at zonal level to be used for the redistribution of commodities	Procure branded utility vehicles: • 1 per zone (5)	2016	Number of vehicles procured (target: 3)	RHD, FP partners
		CS 2.2 Develop a distribution reporting system	5	CS 2.2.1 Hold meetings with the RHSC TWG to develop new agreements and SOPs for which contraceptives are distributed and when	RHSC TWG meetings: • 2 meetings • @ MOH • Refreshments • 20 people • Printing: 10 pages per person	2016	Number of meetings held with the RHSC TWG (target: 2)	HTSS unit
				CS 2.2.2 Hire consultant to develop a reporting system for the distribution of contraceptives	Hire consultant for 20 days	2016	New reporting system for the distribution of contraceptives developed	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 2.2.3 Train the CMST, NGOs, and private sector on how to accurately review/use the form	National training: • @ hotel in Lilongwe • 30 people • Refreshments • 1 day • Printing: 10 pages per person • Per diem	2016	Number of people trained on the new distribution reporting forms (target: 30)	HTSS unit
				CS 2.2.4 CMST to report monthly on contraceptives distributed, using the reporting form	No additional costs	2016 2017 2018 2019 2020	Number of CMST reporting forms received (target: 12)	CMST
				CS 2.2.5 Conduct quarterly routine quality checks on the reported distribution of contraceptives	• 3 HTSS staff to travel to field • Per diem • Transport allowance • Lodging	2016 2017 2018 2019 2020	Number of routine quality checks conducted in a year (target: 4)	HTSS unit
		CS 2.3 Develop a performance measurement framework that coordinates with the distribution reporting system	5	CS 2.3.1 Host a meeting to develop a performance measurement system and discuss • How it will be developed • What will be measured • Incentives for meeting targets	• 4 meetings • 15 people • @ meeting space in Lilongwe • Refreshments • Printing: 10 pages per person	2016	Performance measurement framework system developed	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 2.3.2 Integrate performance monitoring into the commodity logistics system to track performance (e.g., on time reporting, number of emergency orders, etc.)	• Hire firm for 90 days to integrate the database	2016	Performance monitoring system integrated into the commodity logistics system	HTSS unit
				CS 2.3.3 Train CMST staff on the performance measurement framework	• About 20 people • @ meeting space in Lilongwe • 3 days • Refreshments • Per diem • Printing: 10 pages per person	2016 2018 2020	Number of CMST staff trained on the performance measurement framework (target: 20)	HTSS unit
		CS 2.4 Assess CMST's available equipment for distribution		CS 2.4.1 Hire consultant to conduct assessment and prioritise necessary equipment with CMST's reform committee	Hire consultant for 30 days to conduct the assessment	2016	Assessment of CMST's available equipment conducted	DELIVER Project, PSI
				CS 2.4.2 Based on the assessment, purchase necessary equipment that is not available	Procure equipment: • Based on the assessment	2016 2017 2018 2019 2020	Necessary equipment purchased for CMST	DELIVER Project, PSI

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
CS 3 LMIS and HMIS is improved	FP logistics management (LMIS/HMIS) is improved to increase commodity security	CS 3.1 Investigate whether new technologies (e.g., SMS) would improve real-time stock monitoring and re-supply planning	5	CS 3.1.1 Review current stock monitoring practices and assess practicality of using new technologies	Hire a consultant to conduct a desk review (30 days)	2016	Review of current stock monitoring practices completed	HTSS unit
				CS 3.1.2 Disseminate desk review	Dissemination: • @ MOH • Printing: 100 copies of 10–15 page document • Refreshments	2016	Number of desk reviews disseminated (target: 100)	HTSS unit
				CS 3.1.3 Based on the findings of CS 3.1.1, pilot the use of real time stock monitoring in hospitals and health centres in 2 districts per region	Procure mobile phones for all district hospitals: • 29 phones • Procure computers and software for district hospitals and DHO offices (58) • Hire technical assistant to communicate data to DHIS 2	2016	Number of information and communication technology (ICT) equipment procured (target: 29 phones, 58 computers)	HTSS unit, PSI, DELIVER Project
				CS 3.1.4 Hold meeting to assess where the pilots will be conducted	• 1 meeting • 10 people • @ MOH meeting space • Refreshments • Printing: 2–5 pages per person	2016	Meeting held to determine pilot of ICT material	HTSS unit

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 3.1.5 Train the information and communications technology (ICT) personnel in hospitals and select health centres in the six districts	District level trainings: • 6 districts • 4 day meeting • @ teacher training colleges • 15–20 people per district • Refreshments • Per diem • Hotel package • Transport allowance • Printing: 20 pages per person	2016 2017	Number of personnel trained on ICT material in pilot study (target: 500)	HTSS unit, PSI, DELIVER Project
				CS 3.1.6 Assess pilot study	• Meeting with ICT personnel • @ regional meeting space • Transport allowance • Refreshments • 1 day • 15–20 people • Transport allowance • Printing: 10 pages per person	2017	Pilot study assessed	HTSS unit
		CS 3.2 Conduct full scale implementation of the ICT programme based on outcome of CS 3.1	5	CS 3.2.1 TOT on the use of real time stock monitors	ICT TOT: • National level, 2 days • @ hotel in Lilongwe • 20 people • Per diem • Transport refund • Printing: 5 pages per	2017	Number of trainers trained (target: 30)	HTSS unit, DELIVER Project, PSI

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
					person			
				CS 3.2.2 Support trainers to conduct training on ICT material	Staff trainings on ICT: • @ 15 hospitals • @ 328 health centres • Refreshments: 3 people per facility • Transport refund: 10 people • Per diem: 10 people • Purchase ICT material (15 computers, 1,000 cell phones) • Purchase airtime for 3 people per facility	2017	Number of staff trained on ICT material (target: 1,029)	HTSS unit, PSI, DELIVER Project
CS 4 District staff are able to report contraceptive forecasting data on time and accurately	Staff are sensitised on forecasting contraceptive methods	CS 4.1 Support someone to specifically monitor stock at the zone	1–5	CS 4.1.1 MOH and HTSS travel to the zonal level to monitor stock availability and data reporting	Transport and per diem allowance: • 5 people • 10 days • Quarterly	2016 2017 2018 2019 2020	Number of stock monitoring people supported (target: 5)	HTSS unit, MOH
		CS 4.2 Support coordination between FP coordinators and store managers	5	CS 4.2.1 Host district meetings with FP coordinators and store managers	Host meetings in 29 districts: • @ DHO offices • 5 people • Refreshments • Writing material • Printing: 5 pages per person • Transport and per diem for 3 national HTSS staff to travel to the districts	2016 2017 2018 2019 2020	Number of district meetings between FP coordinators and store managers held (target: 29)	HTSS unit, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
		CS 4.3 Develop capacity of FP coordinators to analyse stock data and consumption trends	5	CS 4.3.1 Host zonal training with FP coordinators on how to use data for decision making	Hire consultant to conduct training: • 5 zones • About 10 FP coordinators per zone • 3 days • @ hotel in zone central • 4 nights • Per diem • Printing: 20 pages per person	2016 2018 2020	Number of FP coordinators trained on how to use data for decision making (target: 29)	HTSS unit, RHD
				CS 4.3.2 Conduct follow-up meetings with FP coordinator during data reporting	Hire consultant to go into the field for data assistance: • 29 districts • Quarterly	2016 2017 2018 2019 2020	Number of follow-up meetings with FP coordinators conducted (target: 112)	HTSS unit, RHD
		CS 4.4 Train pharmacy assistants, technicians, store managers, and pharmacists on logistics and supply-chain management	5, 3	CS 4.4.1 TOT to provide on-the-job training to pharmacy assistants and pharmacists	Zonal meeting: • @ zonal hotel • 20 people • 3 days, 4 nights • Transport refund • Technical allowance for 2 facilitators • Printing: 20 pages per person • Didactic material	2016 2017 2018 2019 2020	Number of trainers trained (target: 100)	HTSS unit, PSI, DELIVER Project

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Contraceptive Security								
				CS 4.4.2 Facilitate trainers to go to health facilities and provide training	3-year scale-up to all health facilities: • Supportive supervision by store managers and FP coordinators • 60 trainers • Per diem • Transport refund • 1,000 stationary books	2016 2017 2018 2019 2020	Number of trainers facilitated to train (target: 100)	HTSS unit, PSI, DELIVER Project
				CS 4.4.3 Monitor the trainers to provide on-the-job training with 5 zonal quality inspectors	• 6 people • 5 days travel • Per diem • Transport refund	2016 2017 2018 2019 2020	Number of monitors deployed (target: 6)	HTSS, PSI, DELIVER Project

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
PA 1 Government policies enable access to FP services	SRHR/FP policies and strategies increase access to FP information and services	PA 1.1 Update political/legal framework for SRHR/FP policy to expand the age allowance for FP services to include younger adolescents (under the age of 15)	2,3	PA 1.1.1 Review and identify gaps/discrepancies surrounding youth access to FP services in priority policy documents across ministry documents (MOH, MOE, MOGCDSW, Ministry of Youth and Sport, etc.)	Hire consultant to draft updated policy framework (60 days)	2016	Gaps in youth access to FP services in policy documents identified	RHD
				PA 1.1.2 Craft harmonised policy changes to address identified gaps in individual ministerial policy documents based on international best practices	Same consultant to create policy changes	2016	SRH/FP policy updated	RHD
				PA 1.1.3 Validate draft policy changes with key stakeholders and develop and implement SRH/FP advocacy strategy to deliver key messages to policymakers. Stakeholders include Law Commission; Ministry of Justice; Centre for Human Rights and Rehabilitation; Malawi Human Rights Commission; all line	Same consultant to host meetings (20 days) Hold stakeholder meeting to generate buy-in to strategy for policy change: • 8 CSO/advocacy groups • 30 policymakers (multi-ministerial representation) • 2 days at hotel • @ hotel in Lilongwe • Refreshments • Per diem • Transportation costs	2016	Key policy changes validated with key stakeholders	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
				ministries (education, gender, youth and sport, health, agriculture, local government); and regulatory bodies. Conduct regional meetings with FBOs and SCOs.	• Printing: 50 pages per person			
				PA 1.1.4 Update draft SRH/FP strategy to reflect policymakers concerns, and feed up through SRH TWG for approval	Policy consultant (30 days)	2016	SRH strategy draft updated	RHD
				PA 1.1.5 Disseminate finalised SRH/FP strategy	National launch • 100 people • 100 brochures • 100 copies of the policy (50 pages) • @ meeting space in Lilongwe • Refreshments • Per diem for 50 staff • Transportation costs District dissemination events (32) • 60 people • transport allowances for 5 zonal staff • Refreshments • Per Diem • @ district meeting space	2016	Disseminate SRH/FP strategy (target: 100 brochures, 100 policy copies)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
		PA 1.2 Advocacy is conducted on enabling peer educators to provide pills and condoms	2,3	PA 1.2.1 RHD to develop concept note on the provision of pills and condoms by peer educators and present to the FP TWG	Meeting to develop concept note: • 30 people • @ RHD • Refreshments • Printing: 5 pages per person	2016	Concept note developed	RHD
				PA 1.2.2 Concept note is shared with Safe Motherhood TWG for endorsement	• 30 people • @ RHD • Refreshments • Printing: 5 pages per person	2016	Concept note presented to safe motherhood TWG	RHD
				PA 1.2.3 RHD to present concept note to Senior Management Team to allow the SRHR Strategy to include provision of pills and condoms by peer educators	No additional costs required	2016	New SRH policy includes allowance for peer educators to provide pills and condoms	RHD
PA 2 Access to the full range of method mix is increased	Scopes of practice expanded for lower-skilled providers	PA 2.1 Revise scopes of practice for HSAs, community midwives, nurses, etc., and lobby the MOH to consider task shifting • Community midwives	3	PA 2.1.1 Identify gaps in health workforce's ability to provide adequate FP method mix • Review current scopes of practice related to FP • Identify best practices in the literature	Hire consultant for 15 days to review workforce guidelines for the provision of FP methods at each level of care.	2016	Gaps in health workforce's ability to provide full method mix identified	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
		provide implants, IUDs post-partum • HSAs provide implants • CBDAs provide injectables		PA 2.1.2 Convene an FP working group to review scopes of practice for HSAs, CBDAs, and community midwives and detail HSAs training and current scope of practice • Task force will include professional association representatives, MOH representatives, regulatory bodies, etc.	FP working group meeting: • 3 days • 15 participants • Travel/lodging costs • Per diem • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person	2016	Scopes of practice for HSAs, CBDAs, and community midwives reviewed	RHD
				PA 2.1.3 Revise scopes of practice for HSAs, CBDAs, community midwives, nurses, etc., based on technical working group meeting	Hire consultant (same as PA 3.1) to incorporate working group recommendations into existing scopes of work (15 days)	2016	Scopes of practice for HSAs, HSAs, and CBDAs developed	RHD
				PA 2.1.4 Present revised guidelines to regulatory bodies	Validation meeting: • 2-day meeting • 30 participants (working group and regulatory body representatives) • Lodging for two nights • Per diem • @ meeting space in Lilongwe • Refreshments	2016	Scopes of work approved by regulatory bodies	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
					• Printing (about 20 pages per person)			
				PA 2.1.5 Print and disseminate revised guidelines	Print guidelines: • 200 copies • 20 pages	2016	Number of guidelines disseminated to stakeholders (target: 200)	RHD
				PA 2.1.6 Lobby the MOH and regulatory bodies to regulate the HSA cadre	Meetings with regulatory bodies and professional associations: • 5 meetings • 10 people • Refreshments • @ meeting space in Lilongwe • Printing: 5 pages per person	2016	Number of meetings with regulatory bodies and professional associations meeting held (target: 5)	RHD
	Increased regulation of lower-skilled providers	PA 2.2 Implement guidelines and incentives for volunteers, CHWs, etc.	3	PA 2.2.1 Formalise and implement revised policy guidelines on volunteer incentives	Meetings: • 3 meetings • @ meeting space in Lilongwe • 15 people • Refreshments • Printing: 5 pages per person	2016	Policy guidelines on volunteer incentives formalised	Department of Preventive Health Services
				PA 2.2.2 Present volunteer guidelines to relevant stakeholders	Validation meeting: • Half-day meeting • 30 people expected • Printing: 10 pages per person	2016	Volunteer guidelines presented to stakeholders	Department of Preventive Health Services

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
					• Travel/lodging costs • Per diem • @ meeting space in Lilongwe • Refreshments			
PA 3 Policymakers have greater awareness of family planning as a human rights issue	Increased advocacy of family planning as a human rights and development issue	PA 3.1 Work with the MOGCDSW and CSOs to advocate for family planning as a human rights issue		PA 3.1.1 Develop a women's reproductive health and human rights advocacy strategy using the gender equity act, African protocol on gender, Maputo declarations, and the new marriage bill	Hire a consultant to develop an advocacy strategy and translate SRHR in Chichewa (30 days): • Printing: 100 copies in each language of a 100-page document	2016 2017 2018 2019 2020	Women's reproductive health and human rights advocacy strategy developed	Department of Preventive Health Services
				PA 3.1.2 Conduct orientation for district structures and extension workers on FP/SRH and as a human rights issue (i.e., meetings with the district executive committees, community victim support units, CPCs, community and religious leaders, community child protection workers, etc.)	Orientation meeting: • 30 participants • @ meeting space in district • Half-day • Refreshments • Printing: 10 pages per person • Transport allowance for team of 4 headquarters staff from Lilongwe (MOH and MOGCDSW)	2016 2018 2020	Orientations held	MOH, MOGCDSW

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
		PA 3.2 Organise and host FP advocacy coalition meetings	4	PA 3.2.1 Bi-annually coordinate relevant stakeholders from the MOGCDSW, CSOs, etc.	• 30 attendees • 1 days • Refreshment • @ meeting space in Lilongwe • Printing: 5 pages per person	2016	Number of FP advocacy coalition meetings held (target: 2)	RHD
				PA 3.2.2 Train CSOs, community-based organisations (CBOs), and FBOs to advocate for FP/SRHR at community levels in 29 districts	• 29 district training sessions (during CSOs meetings) • @ district meeting space • 2 days • 2 trainers from national level • Per diem • Lodging • Lunch • Refreshments • Transport allowance • 20 people • Printing: 20 pages per person	2016 2019	Number of CSOs trained (target: 29)	RHD
				PA 3.2.3 Conduct community advocacy forums with CBOs, FBOs, and CSOs on policies and laws related to FP/SRH. Invite youth and community members to attend.	29 district training sessions (during CSOs meetings): • 20 people • @ district meeting space • 2 days • 2 facilitators from the national level • Per diem • Lodging	2016 2017 2018 2019 2020	Number of advocacy forums conducted	MOH, MOGCDSW

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators (per year identified in timeline)	Person/ Organisation Responsible
Policy and Advocacy								
					• Lunch • Refreshments • Transport allowance • Per diem for 5 youth • Per diem for 5 community participants • Printing: 20 pages per person			
				PA 3.2.4 Dissemination of protocols, gender equity rights, and policies to the communities so that they are aware of rights to access FP services	• 15 people • @ meeting space in villages • Transport for 2 district staff • 2 district staff: travel 10 days • Refreshments • Didactic material	2016	Number of meetings conducted with CSOs, CBOs, and chiefs (target: 1000)	RHD
		PA 3.3 Train and orient policymakers on how to advocate for bills on sexual and reproductive health rights policies, including family planning		PA 3.3.1 Hold workshops to orient policymakers on how to advocate for bills	• @ hotel outside of Lilongwe • 2 days • 20 people • Per diem • Housing • Lunch • Refreshments • Printing: 10 pages per person • Consultant hired for 10 days to conduct training	2016 2019	Number of policymakers oriented on how to advocate for bills (target: 20)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
F1 Adequate funding is available for FP commodities and activities, in line with the FP-CIP	Increased budget allocation for family planning	F 1.1 Develop a national advocacy strategy, with a specific financing strategy for family planning, in line with the national RHCS strategy and the FP-CIP	6	F 1.1.1 Develop an FP commodity security advocacy strategy, with annual updates Identify: • 5 year objective for domestic and private resources available for family planning • Annual target for domestic and private resources available for family planning • Targets audiences for advocacy • Who will lead advocacy efforts • When will advocacy efforts be conducted	• 4 meetings (August–December), annually • @ MOH • Refreshments • 30 people • Printing: 10 pages per person	2016 2017 2018 2019 2020	FP commodity security advocacy strategy developed	MOH
				F 1.1.2 Disseminate FP advocacy strategy to the Health Donor Group	• 1 meeting, annually • @ meeting space in Lilongwe • Refreshments • 30 people • Printing: 10 pages per person • Printing strategy: o 50 pages, 300 copies	2016 2017 2018 2019 2020	Number of FP commodity security advocacy strategies disseminated (target: 300 copies)	MOH, RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
		F 1.2 RHD and CSOs to engage critical policy and planning departments to advocate increased funding for reproductive health (and family planning specifically)	4, 6	F 1.2.1 Director to meet individually with directors in other ministries; directorates to advocate increased funding for FP/RH	• 15 trips • 1 director • Transport refund • Per diem	2016 2017 2018 2019 2020	Number of meetings held with ministries (target: 15)	RHD
		F 1.3: Conduct advocacy with District Executive Committee, ward councillors, DHMTs, and traditional leaders to include family planning in district improvement plans and annual district budgets	4, 6	F 1.3.1 Develop a district FP financing guide, outlining the budget process and accountability and specifying roles and responsibilities for budget advocacy, development, and monitoring	• Hire consulting firm for 45 days to develop a guide for use by districts on how to advocate establishment of an earmarked budget for family planning • Print and disseminate to all districts (29) • 90 copies (3 copies per district) • 2 MOH staff • Transport refund for MOH staff travelling to regions • Per diem for MOH staff travelling to regions • @ district meeting space • 20 people per district • Refreshments	2016	FP financing guide produced	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
				F 1.3.2 Conduct budget advocacy workshop with ward councillors, DHMTs, and traditional leaders • Train on budget process to ensure family planning is given a priority in the budget at the area development committee and assembly level • Review annual FP activities, as detailed in the FP-CIP, and objectives, as identified through Reality Check; and identify what funding is required to implement activities at the district level • Supported by RHD in the first two years and then shifted to DHMT leadership	• 2 meetings annually in each district (29 total) • 40 people (ward councillors, DHMTs, and traditional leaders) • @ district meeting space • Lunch • Refreshments • Transport refunds • Per diems • Didactic material	2016 2017 2018 2019 2020	Number of district budget advocacy workshops held annually (target: 29)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
				F 1.3.3 Develop a policy brief for local leaders advocating an FP line item in the district budgets and district improvement plans, and update annually	Hire consultant for 20 days 1 technical working group meeting to validate brief: • 30 people • @ meeting space in Lilongwe • Refreshments • Printing: 4 pages per person	2016 2017 2018 2019 2020	Policy brief developed	RHD, USAID, PSI, BLM, FPAM, USAID, John Snow, Inc.
				F3.4: Policy briefs printed and disseminated	• Printing: 4 pages glossy, 1,000 copies • Per diem for IEC to distribute to ward councillors, DHMTs, and traditional leaders during budget advocacy workshop	2016 2017 2018 2019 2020	Number of briefs disseminated (target: 1,000)	RHD
		F 1.4 Conduct advocacy among district health officers and district health teams for an FP line item in the annual district health budgets	4, 6	F 1.4.1 Develop policy brief on the benefits of an FP line item in the annual district health budgets to be distributed to district health officers and the district health teams	Hire consultant to develop a guide for use by districts on how to advocate the establishment of an earmarked budget for family planning (45 days): • Print and disseminate to all districts • 29 copies • 2 MOH staff • Transport refund for MOH staff travelling to regions • Per diem for MOH staff travelling to regions	2016 2017 2018 2019 2020	Policy brief for parliament-arians developed	RHD, USAID, PSI, BLM, FPAM, USAID, John Snow, Inc.

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
				F 1.4.2 Policy briefs printed and disseminated	Printing: • 4 pages glossy, • 250 printed annually Personally distributed to MPs, health committee meetings • Transport refund for 2 MOH staff	2016 2017 2018 2019 2020	Number of briefs distributed (target: 250)	RHD
		F 1.5 Advocate with parliamentarians to increase funding for the FP contraceptive budget line	6	F 1.5.1 Create and disseminate 1-page print-outs about the benefits of increased funding for contraceptives to Members of Parliament (MPs) and the MOH	• Printing: 50 copies of 1-page document • Transport refund • 1 RHD staff to travel to ministry and MPs for advocacy	Every June–July 2016 2017 2018 2019 2020	Print-out about benefits of increased funding for contraceptives developed and number distributed (target: 50)	RHD
				F 1.5.2 Host meetings with the parliamentary committee on health during the seating session about the benefits of increased funding for contraceptives	2 District Implementation Plan budget-related meetings a year: • 1-day meeting • @ meeting space in Lilongwe • Refreshments • Transport allowance • 10 people • Printing: 3 pages per person	2016 2017 2018 2019 2020	Number of meetings with parliamentarian committees held per year (target: 2)	RHD, USAID, PSI, BLM, FPAM, USAID, John Snow, Inc.
		F 1.6: Review progress towards achieving FP2020 financial commitments	6	F 1.6.1 MOH produces report on progress towards the FP2020 financial commitment of increasing the budget for family planning	No additional cost—to be completed as part of the annual FP-CIP review	2016 2017 2018 2019 2020	Change in FP funding reported to TWG	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
	FP funding is tracked and analysed for efficiency	F 1.7 Track FP financial resources		F 1.7.1 Develop system to track FP financial data at the national and district levels	Hire consultant (40 days) Meetings: • 2 meetings • 10 people • @ meeting space in Lilongwe • Printing: 5 pages per person • Refreshments	2016	System to track FP financial data created	RHD
				F 1.7.2 Train RHD staff and FP coordinators to track FP financial data	• 3 days • 5 people • @ hotel outside of Lilongwe • Per diem • Lunch • Refreshments • Printing: 15 pages per person • Hiring above consultant for 2 days to train	2016	RHD staff trained in tracking FP financial data	RHD
				F 1.7.3 Analyse the data to find where improvements can be made in funding allocations	Report produced by RHD with assistance from consultant (15 days) Meetings: • 2 days • 15 people • @ meeting space in Lilongwe • Refreshments • Per diem • Printing: 5 pages per person	2016 2017 2018 2019 2020	Financial tracking data analysed	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
					• Lunch • Transport allowance			
		F 1.8 Conduct cost-effectiveness assessment analysis of FP activities in Malawi		F 1.8.1 Hire consultant to conduct cost-effectiveness assessment	Hire consultant (30 days)	2017	Cost-effectiveness assessment of FP activities conducted	RHD
				F 1.8.2 Disseminate findings of cost-effectiveness assessment	• 1 day • @ meeting space in Lilongwe • 50 people • Refreshments • Printing: 50 pages per participant • Lunch	2017	Number of findings disseminated (target: 50)	RHD
	FP funding from development partners is increased and reflects shared priorities and plans	F 1.9 Implement advocacy strategy developed in F1 targeting development partners	4	F 1.9.1 Host meeting with development partners to invite commitments using the advocacy strategy	• 20 people • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person • Transport allowance	2016 2017 2018 2019 2020	Number of meetings with development partners held per year (target: 1)	RHD
		F 1.10 Map and monitor donor financial commitments		F 1.10.1 Hold meeting with FP stakeholders to assess financial commitments and review new commitments	National level: • 1-day meeting • @ meeting space in Lilongwe • 30 people • Refreshments • Printing: 5 pages per person • Transport allowance	2016 2017 2018 2019 2020	Number of meetings with FP stakeholders held per year (target: 1)	RHD, with support of partners

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
					District level: • 1-day meeting • @ meeting space in districts (29) • 30 people • Refreshments • Printing: 5 pages per person			
F 2 FP and contraceptives are more widely available and affordable at all health care centres	Out-of-pocket expenditures for family planning are reduced	F 2.1 Conduct advocacy to ensure that any health insurance scheme includes full FP method coverage for all insurance packages	1, 6	F 2.1.1 Host a series of dialogues with the MOH and insurers, including private insurers, to advocate the addition of all methods as part of health insurance programmes	• 5 meetings • 1 day • @ meeting space in Lilongwe • 10 people • Refreshments • Transport allowance • Printing: 2–5 pages per person	2016 2017 2018 2019 2020	Number of discussions held with the MOH and insurers per year (target: 5)	RHD, MOH
				F 2.1.2 Conduct study on costs and benefits of including FP services in private health insurance	Hire consultant (45 days)	2017	Study conducted on costs and benefits of including FP services in private health insurance	RHD
				F 2.1.3 Print and disseminate study findings	Dissemination meeting: • @ hotel in Lilongwe • 100 people (including the Permanent Secretary Ministers of Parliament, and private sector insurers) • Refreshments	2017	Number of study findings disseminated (target: 50 copies of full study, 200 copies of brief)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Financing								
					Print full study: • 50 copies • 50 pages Print study brief with key findings: • 200 copies • 1 page, double-sided, glossy			

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
SMC 1 Performance management systems effectively monitor and support FP service providers	The performance management system is operationalised	SMC 1.1 Operationalise the performance management system for FP health care workers	3	SMC 1.1.1 Conduct evaluation of the current performance management system to identify gaps and challenges and the barriers to implementation	Hire consultant (30 days) to conduct evaluation at district and zone levels, in all 5 zones and 1 sample district per zone	2016	Current performance management system evaluated	RHD
				SMC 1.2 Review current supervision and monitoring tools	• 5 meetings • @ meeting space in Lilongwe • 10–15 people • Printing: 50 pages per person • Refreshments	2016	Supervision and monitoring tools reviewed	RHD
				SMC 1.3 Train DHOs and health centre managers on supervision and monitoring	• Zonal training • 20–30 people per zone • 3 days, 3 nights • Transport allowance • Technical stipend for 2–3 trainers • Didactic materials • Printing 10–20 pages per person • @ zonal meeting space • Lunch	2016 2018 2020	Number of DHOs and health centre managers trained on supervision and monitoring (target: 20–30 people)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				SMC 1.4 Conduct follow-up visits to assess supervision	• 2–3 trainers per zone • 7 days • Transport allowance • Per diem • Bi-annually • Lodging • Lunch	2016 2017 2018 2019 2020	Number of follow-up visits conducted (target: 10)	RHD
SMC 2 Data are used to improve access to high-quality FP services	Districts are able to monitor FP service provision	SMC 2.1 Support districts to conduct quality insurance/quality assurance activities in facilities		SMC 2.1.1 Review FP quality insurance/quality assurance tools	• National meeting • 5–10 people • @ meeting space in Lilongwe • Refreshments • Printing: 5 pages per person	2016	Evaluation document for FP coordinators developed	RHD
				SMC 2.1.2 Train FP coordinators on how to use the evaluation forms	• Zonal training • 10 people • Transport allowance • 2 days, 2 nights • Refreshments • Didactic material • @ zonal meeting space • Lodging • Lunch	2016 2018 2020	Number of FP coordinators trained on how to use the evaluation forms (target: 28)	RHD
				SMC 2.1.3 Support FP coordinators to travel to each facility within the district quarterly to conduct supportive supervision and data quality assurance	Transport to facilities • 29 fuel stipends for 20 km • 4 times per year • Per diem for 5 days	2016 2017 2018 2019 2020	Number of district managers supported to travel to review facilities (target: 29)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
		SMC 2.2 Collect HMIS data on FP indicators	3,4,5	SMC 2.2.1 DHIS 2 Mentorship and refresher trainings held for FP coordinators and HMIS officers and facilitated by central HMIS staff	3-day refresher trainings held annually: • 29 FP coordinators • 58 HMIS officers (2 from districts) • 4 facilitators from the central office • @ hotel in Lilongwe • Printing: 10 pages per person • Lunch • Per diem • Refreshments • Lodging	2016 (4 trainings) 2017 (2 trainings) 2018 (2 trainings) 2019 (2 trainings) 2020 (1 training)	Number of FP coordinators trained (target: 29); number of HMIS officers trained (target: 58)	MOH—Central Monitoring and Evaluation Division
				SMC 2.2.2 Conduct supervision of FP coordinators to ensure the high quality of HMIS reports, including data verification and back-entry of missing or incorrectly entered data	3-person team to visit each district twice annually during the 2nd and 4th quarters (except in 2017 when each district will receive only one visit): • Per diem • Transport allowance • 14 days	2016 2017 2018 2019 2020	Number of supervisory visits conducted (target: 58 per year)	MOH—Central Monitoring and Evaluation Division
				SMC 2.2.3 Procure laptops and dongles for FP coordinators	Procure 29 laptops and 29 dongles to be distributed to each district	2016	Number of laptops procured (target: 29); number of dongles procured (target: 29)	MOH—Central Monitoring and Evaluation Division

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				SMC 2.2.4 Dissemination of FP reports	1-day meeting in the 3rd quarter annually: • 60 people • @ hotel in Lilongwe • Transport allowance for 29 FP coordinators • Full board for 29 FP coordinators for 2 days • Lunch for 60 people • Refreshments for 60 people • Printing: 10 pages per person	2016 2017 2018 2019 2020	Number of FP reports disseminated (target: 1 per year)	MOH—Central Monitoring and Evaluation Division
SMC 3 Coordination of FP activities is strengthened	FP services are effectively coordinated	SMC 3.1 Facilitate coordination among the MOH, implementing partners, religious organisations, and community organisations for the implementation of FP services at the district level	4	SMC 3.1.1 FP coordinators to conduct an analysis of FP stakeholders to engage in their district	• No additional cost	2016	Number of FP stakeholder analyses conducted (target: 29)	RHD
				SMC 3.1.2 Strengthen the coordination of district youth officers, FP coordinators, agriculture extension officers, district education officers, district AIDS committees, district nutrition officers, and CBOs on how to train their frontline workers on family planning through a 1-day orientation on their	• Orientation session meeting with 84 district youth officers, agriculture extension officers, family planning coordinators • @ national meeting space • Accommodation • Allowances • Transport refund • Refreshments	2016	Number of orientations held (target: 1)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				roles and responsibilities				
				SMC 3.1.3 DHO to convene district- and traditional authority-level working groups on FP/SRH	District level: • Quarterly meetings • @ district meeting space • Refreshments • 10 people • Printing: 2–5 pages per person Traditional authority level: • Quarterly meetings • @ traditional authority meeting space • Refreshments • 5 people • Printing: 2–5 pages per person	2016 2017 2018 2019 2020	District and traditional authority level FP working group created	RHD, MOGCDSW
				SMC 3.1.4 Purchase software for FP coordinators to conduct electronic tracking	• Software for 28 FP coordinators	2018	Number of electronic tracking software purchased (target: 29)	RHD, DELIVER Project

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				SMC 3.1.5 Train implementing partners and FP coordinators on data implementation and tracking	• Zonal training • 50 people • 3 days, 4 nights • Printing: 20 pages per person • Didactic material • Transport allowance • Technical stipend for 2–3 trainers • @ zonal meeting space	2018	Number of implementing partners and FP coordinators trained on data implementation and tracking (target: 50 people)	RHD, DELIVER Project
		SMC 3.2 Facilitate coordination among the MOH, implementing partners, religious organisations, and community organisations for the implementation of FP services at the national level	4	SMC 3.2.1 Support the coordination sub-committee within the FP TWG	• 10 people • Refreshments • @ MOH • Printing: 2–5 pages per person	2016	Sub-committee within the FP TWG to address coordination of FP efforts strengthened	RHD
				SMC 3.2.2 Develop an interface for the districts planning/ performance system to feed into the RHD for review	Hire consultant for 20 days to develop interface	2017	Interface for the districts planning/performance system to feed into the RHD is created	RHD
				SMC 3.2.3 Train RHD staff person on data tracking and analysis	Hire training firm for 1 week: • 3 days • 2 people • Printing: 10 pages • @ meeting space in Lilongwe • Lodging • Refreshments • Lunch	2016	Number of RHD staff trained on data tracking and analysis (target: 2)	RHD, Deliver

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
					• Per diem			
		SMC 3.3 Coordinate with the private sector on the delivery of FP services	4, 6	SMC 3.3.1 Develop and support a private sector sub-committee under the FP TWG to meet quarterly	• Refreshments • 10 people • Printing: 2–5 pages per person	2016 2017 2018 2019 2020	Private sector committee created	RHD
		SMC 3.4 Support coordination among implementing partners and the MOH in training of service providers	3, 4	SMC 3.4.1 Develop a training database to track which facilities have providers trained to provide all methods and where trained providers are located	Hire consultant to a develop database with input from the RHD, partners, and each DHO (180 days), and update monthly (60 days per year)	2016 2017 2018 2019 2020	Training database to track facilities developed	PSI, BLM
				SMC 3.4.2 RHD to designate staff to update training database and identify facilities that need training for staff	• No additional cost	2016 2017 2018 2019 2020	Staff designated to update training database	RHD
				SMC 3.4.3 RHD to share training database with partners bi-annually and validate baseline data during an FP TWG meeting	• No additional cost	2016 2017 2018 2019 2020	Current training of service providers tracked	RHD
				SMC 3.4.4 RHD to coordinate with partners annually to designate who will cover the various areas where training has not yet occurred	• 1-day meeting • 15 people • Refreshments • Printing: 5 pages per person	2016 2017 2018 2019 2020	Meeting held to designate who will cover where service providers have not been trained	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				or where re-training is required				
	Family planning is viewed as an essential activity for sectors outside of health	SMC 3.5 Strengthen multisectoral engagement	4,6	SMC 3.5.1 Develop and support an inter-ministerial coordination group for RH, with a focus on family planning	• 10 people • Refreshments • @ meeting space at ministries • Printing: 2–5 pages per person	2016 2017 2018 2019 2020	Inter-ministerial coordination group developed	RHD, PSI, BLM, USAID, FPAM
				SMC 3.5.2 Train the MOH, MOEST, MOGCDSW, and Ministry of Finance, Economic Planning and Development bi-annually on how to incorporate /mainstream FP/RH into daily ministry workplans	Facilitate FP mainstreaming workshop: • Half-day workshop • @ meeting space at ministries • 2 times per year • Technical stipend for 1 trainer • Refreshments • Lunch • Per diem • Printing: 5 pages per person • 20 people	2016 2017 2018	MOH, MOEST, MOGCDSW, and Ministry of Finance, Economic Planning and Development trained on FP/RH integration into daily work	RHD, PSI, BLM, USAID, FPAM
				SMC 3.5.3 Develop training documents for how the non-health private sector can incorporate FP/RH into regular activities	Hire consultant for 20 days	2016	Training documents for how the non-health private sector can incorporate family planning into regular activities developed	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Supervision, Monitoring, and Coordination								
				SMC 3.5.4 Train the non-health private sector on how to incorporate FP/RH into regular activities, including • CBOs • Tea, sugar, coffee, and tobacco plantations	Zonal workshops: • 1 day • @ zonal meeting space • 25 people per zone • Transport allowance • 1 day per diem • Refreshments • Technical stipend for 1 trainer	2016 2018 2020	Number of non-health private sector staff trained on FP integration (target: 125)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Stewardship and Governance								
SG 1 RHD effectively tracks and monitors the FP-CIP	MOH tracks and monitors FP-CIP activities and financial data outputs and timelines	SG 1.1 Support monitoring of the FP-CIP		SG 1.1.1 Support the FP TWG to monitor the FP-CIP	• 20–30 people • Refreshments • Printing: 2–5 pages • Quarterly	2016 2017 2018 2019 2020	Working group is supported to host meetings	RHD
				SG 1.1.2 Develop an FP-CIP reporting dashboard to track progress towards implementing the FP-CIP (This may be Excel-based or exist online within the MOH intranet)	Hire 2 consultants for 80 days	2016	FP-CIP reporting component developed	RHD
				SG 1.1.3 Train staff on how to use the FP-CIP online reporting component	• 3–4 people • @ RHD • Technical stipend for trainer • Refreshments • Printing: 5 pages per person • 2 days • Lunch allowance	2016	Staff trained on how to use the FP-CIP reporting component (target: 3–4)	RHD
				SG 1.1.4 RHD staff report to FP TWG on progress in implementing the FP-CIP	• RHD staff to complete reporting dashboard monthly and report to FP TWG on progress	2016 2017 2018 2019 2020	Dashboard updated monthly	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Stewardship and Governance								
		SG 1.2 Monitor and supervise Track20 and FP-CIP output indicators for FP programme monitoring		SG 1.2.1 Conduct semi-annual national review of FP indicators and data validation	• 20–30 people • @ hotel in Lilongwe • Lodging • Lunch • Per diem • 2 days • Refreshments • Printing: 50 pages per person • Transport and per diem for 2 facilitators	2016 2018 2020	Semi-annual national-level monitoring and data validation for FP data are held	RHD, Track20
		SG 1.3 Conduct a mid-term assessment of FP-CIP implementation		SG 1.3.1 Hire a firm to conduct a mid-term review to assess implementation and recommend course corrections	Hire a consultant for 60 days: • 10 meetings with stakeholders • @ RHD • Refreshments • 10 people • Printing: 5 pages per person	2018	Mid-term assessment of FP-CIP conducted	RHD
				SG 1.3.2 Disseminate findings during the national FP meeting, where best practices and districts who have excelled are highlighted	Panel at national FP meeting: • Printing: 100 copies of 20 pages	2020	Assessment findings disseminated (target: 100 copies)	RHD
				SG 1.3.3 Hire a consultant to conduct a final evaluation to inform planning post-2020 and develop a new plan	Hire a consultant (60 days): • 10 meetings with stakeholders • @ RHD • Refreshments • 10 people	2020	Final evaluation of CIP conducted	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Stewardship and Governance								
				SG 1.3.4 Disseminate the evaluation	• 1-day meeting • @ hotel in Lilongwe • Printing: 1,000 copies of 50 pages • Refreshments • 40 people	2020	Final evaluation of FP-CIP disseminated (target: 1,000 copies)	RHD
SG 2 Capacity for the RHD to effectively lead, manage, and coordinate the FP programme is strengthened	RHD supports the coordination and implementation of the FP programme	SG 2.1 Hire additional staff as necessary to oversee monitoring and evaluation of FP–CIP implementation		SG 2.1.1 Host meetings at the RHD to develop a terms of reference for the FP coordinator and logistics staff	• 2 meetings • 5 people • Refreshments • Printing: 2 pages	2017	Terms of reference for coordinator developed	RHD
				SG 2.1.2 Designate an RHD staff member as an FP-CIP coordinator and adjust his/her terms of reference accordingly	• No extra cost	2017	Coordinator designated	RHD
				SG 2.1.3 Hire logistics staff person at RHD	• Salary for mid-level staff person	2017	Additional logistics staff person for RHD hired	RHD
				SG 2.1.4 Hire outside training firm to conduct training with RHD staff on monitoring, data analysis, and management	• @ hotel • 3 days, 3 nights • 6 people • Printing: 15 pages per person • Technical allowance for 1 trainer • Lunch allowance	2017	Number of RHD staff trained on monitoring, data analysis, and management (target: 6)	RHD

Strategic Outcomes	Expected Results	Activity	Strategic Priority	Sub-activity Details	Inputs	Timeline	Output Indicators	Person/ Organisation Responsible
Stewardship and Governance								
SG 3 The government is better able to track and review district FP efforts	RHD evaluates and supports districts to implement FP activities	SG 3.1 Evaluate implementation of FP activities at the district level		SG 3.1.1 Host bi-annual coordination meetings at the national level with all FP coordinators to review district efforts	• @ hotel in Lilongwe • 2 days, 3 nights • 35 people • Transport allowance • Refreshments • Didactic material • Printing: 5 pages per person	2016 2017 2018 2019 2020	Bi-annual national coordination meetings with FP coordinators held	RHD
		SG 3.2 FP-CIP coordinator to disseminate FP-CIP to each district and conduct consultative meetings with FP coordinators and DHOs to explain their role in implementing and managing the FP-CIP		SG 3.2.1 Host a consultative meeting on data management and advocacy for district FP coordinators and DHO managers	• Technical stipend for coordinator • Zonal • 20 people • Transport allowance • Printing: 10 pages per person • Didactic material	2016 2017 2018 2019 2020	Number of FP coordinators and DHOs trained on data management and advocacy (target: 56)	RHD
SG 4 The MOH supports continued FP2020 learning opportunities	FP2020 learning opportunities are supported	SG 4.1 Disseminate FP best practices during national FP2020 meeting		SG 4.1.1 Host national FP2020 meeting in Lilongwe	• Hire space • 100 people • Refreshments • Lunch • Transport allowance for 40 people • Printing: 100 pages; 3 banners	2017 2019	National FP2020 meeting held	MOH, RHD

ANNEX B: CODING LIST FOR ACTIVITIES

Strategic Priorities [SP.#]

- **Priority # 1:** Improve the ability of individuals within the population as a whole, as well as specific groups (e.g., adolescents, rural populations, urban poor) to achieve their fertility desires by providing accurate information about sexual and reproductive health, information on how fertility is linked to general health and well-being, and where and how to access desired services [SP.1]
- **Priority # 2:** Expand youth access to accurate and actionable information and FP services and promote youth rights to make their own fertility choices [SP.2]
- **Priority # 3:** Ensure new and existing health care workers receive adequate practical training in the full FP method mix, and empower community health workers and frontline workers to provide counselling and referral services, as well as short-term methods [SP.3]
- **Priority # 4:** Promote multisectoral coordination at the national and district levels, and integrate FP policy, information, and services across sectors [SP.4]
- **Priority # 5:** Ensure commodity availability through strengthening logistics management systems and the distribution of FP commodities [SP.5]
- **Priority # 6:** Increase the sustainability of family planning through government commitment, integration of the private sector, and diversification of funding sources for FP activities and commodities [SP.6]

ANNEX C: ACTIVITY COSTS, BY YEAR

Demand Creation

	SP	2016	2017	2018	2019	2020	Total
D1.1 Conduct formative research to inform the design of the SBCC strategy	2	20,783,230	0	0	0	0	20,783,230
D 1.2 Conduct SBCC strategy design	2	0	6,585,113	0	15,991,826	0	22,576,938
D 1.3 Develop and test FP communication messages	2	0	12,771,500	0	0	0	12,771,500
D 1.4 Implement the communications strategy and monitor the impact of communications messages	2	0	11,549,188	233,707,350	239,550,034	245,538,784	730,345,355
D 1.5 Produce and implement soap episodes to be played on the radio in all five zones	2	0	50,288,710	0	0	0	50,288,710
D 1.6 Support the development of a mass mobile text campaign to communicate key FP messages and promote accurate information about FP services	2	28,232,102	6,362,977	6,522,051	6,685,102	6,852,230	54,654,462
D 2.1 Continue to sensitise and orient cultural and religious leaders in the community	2	26,716,200	24,422,470	25,033,032	25,658,858	4,328,050	106,158,610
D 2.2 Continue to recruit and orient FP champions	2	9,317,000	9,549,925	9,788,673	10,033,390	10,284,225	48,973,213
D 2.3 MOEST, MOA, and MOGCDSW coordinate with the MOH on their use of frontline workers for FP messages	2	27,500	0	0	0	0	27,500

	SP	2016	2017	2018	2019	2020	Total
D 2.4 Engage community extension workers and frontline workers to provide information on family planning and contraceptives to the community as FP motivators	2	54,608,000	55,183,950	56,563,549	57,977,637	60,277,014	284,610,151
D 2.5 FP coordinator and IEC coordinator work together to identify opportunities to address low demand and barriers to family planning in each district within the zone	2	8,364,000	8,573,100	8,787,428	9,007,113	9,232,291	43,963,932
D 3.1 Hold community engagement events	2	380,423,150	389,472,479	399,209,291	409,189,523	316,164,243	1,894,458,686
D 4.1 Identify satisfied users to address myths and misconceptions and FP rights	2	42,513,500	43,576,338	44,665,746	45,782,390	46,926,949	223,464,922
D 4.2 Develop a 12-hour hotline to answer side effect questions	2	129,913,620	133,161,461	136,490,497	139,902,759	143,400,328	682,868,665
D 5.1 Engage parents in discussing family planning with young people	1	265,714,100	251,210,588	257,490,852	286,145,023	270,526,327	1,331,086,889
D 6.1 Engage youth to provide accurate and thorough information about family planning to their peers	1	113,784,500	114,784,113	117,653,715	120,595,058	125,348,440	592,165,826
D 6.2 Utilise current peer educator programmes in MOEST, MOGCDSW, and MOA to address FP methods	1	16,618,100	6,759,875	17,112,685	7,102,094	17,979,015	65,571,768
D 6.3 Train peer educators at tertiary institutions	1	38,285,000	3,290,250	40,223,178	3,456,819	42,259,477	127,514,724

	SP	2016	2017	2018	2019	2020	Total
D 6.4 Develop a blog/Facebook page and phone app for youth to use to get and share information about family planning	1	0	0	275,600,024	0	0	275,600,024
D 6.5 Develop age-appropriate FP information to be distributed at youth clubs, schools, and health centres	1	13,260,000	0	13,931,288	0	14,636,559	0
D 7.1 Conduct an evaluation of SBCC activities and initiate a redesign based on outcomes	2	0	0	0	0	22,863,530	41,827,846
Total		**1,148,560,002**	**1,127,542,033**	**1,642,779,357**	**1,377,077,626**	**1,336,617,462**	**6,609,712,950**

Service Delivery and Access

	SP	2016	2017	2018	2019	2020	Total
SDA 1.1 Current in-service training guidelines are reviewed and updated to ensure that they include a full and comprehensive FP section and capacity development for rights-based service provision	3	450,000	257,803,900	261,199,033	31,875,963	32,672,862	584,001,757
SDA 2.1 Target mobile and outreach clinic visits to locations with long distances between clinics and low access to LARMs		353,346,350	351,495,460	360,282,847	369,289,918	378,522,166	1,812,936,740
SDA 3.1 Revise guidelines for CBDAs and HSAs based on the outcome of PA 3 to provide	3	0	0	20,473,277	1,685,980	28,506,454	50,665,711

	SP	2016	2017	2018	2019	2020	Total
LARMs at the community level							
SDA 3.2 Evaluate the CBDA training material to ensure that it includes comprehensive and rights-based information on family planning and scale-up training (based on the outcome of PA 3) to all 29 districts	3	4,317,500	280,229,773	50,729,428	137,338,554	53,297,605	525,912,860
SDA 3.3 Expand the work of the Nurses Association to train retired nurses in the community to provide skilled FP services	3	539,776,600	553,271,015	567,102,790	581,280,360	595,812,369	2,837,243,135
SDA 3.4 Re-train FBOs on provision of the FP method mix, including natural methods	3	37,267,200	0	0	0	0	37,267,200
SDA 4.1 Hold meetings with NAPAM to discuss how to ensure that pharmacy personnel are providing comprehensive FP information and how to handle side effects		4,472,205	172,200	176,505	180,918	185,441	5,187,268
SDA 5.1 Conduct a baseline assessment of private sector capacity and coverage of providing FP services	3	16,035,720	15,470,551	16,847,528	16,253,747	17,700,434	82,307,980
SDA 5.2 Expand FP services through the private sector (e.g., SHOPS, PSI—Mtunza, Blue Star) and social franchising	3	174,000	12,695,650	12,830,233	13,150,988	13,479,763	52,330,634

	SP	2016	2017	2018	2019	2020	Total
SDA 5.3 Engage companies with on-site health clinics (e.g., tea, tobacco, etc.) to train clinical staff on the FP method mix	3	87,500	89,688	0	0	0	177,188
SDA 6.1 Train health workers on how to provide YFHS	3	37,966,000	0	0	0	0	37,966,000
SDA 6.2 Strengthen YFHS supervision at the district level	3	62,690,000	64,257,250	65,863,681	67,510,273	69,198,030	329,519,235
SDA 6.3 Intensify quality improvement by using the YFHS quality standards	3	31,987,500	0	33,606,867	0	0	65,594,367
SDA 7.1 Conduct updates on new FP methods and service provision	3	3,417,500	3,502,938	3,590,511	3,680,274	3,772,281	17,963,503
SDA 7.2 Conduct advocacy with professional registration bodies to increase practical requirements for pre-service training	3	82,500	0	0	0	0	82,500
SDA 7 .3 MOH to revive the internship for nurses, with required on-the-job learning targets such as number of IUDs inserted, etc.	3	87,500	0	0	0	0	87,500
SDA 8.1 Strengthen supportive supervision to ensure CHWs are counselling on long-acting methods	3	54,000,000	55,350,000	56,733,750	58,152,094	59,605,896	283,841,740

	SP	2016	2017	2018	2019	2020	Total
SDA 8.2 Implement a voucher system to reimburse people who are referred to higher-level facilities for services not offered at their nearest health facility		0	0	0	88,309,675	230,582,837	318,892,512
SDA 9.1 Develop and roll out an FP integration protocol		273,000	5,681,063	0	0	0	5,954,063
SDA 10.1 Reinforce quality assurance assessment from the MOH		39,396,500	40,381,413	41,390,948	42,425,722	43,486,365	0
SDA 10.2 Educate health care workers about clients' rights to FP information and services, including availability, accessibility, quality, equity, and non-discrimination informed choice	3	0	0	0	0	0	207,080,946
Total		**1,185,827,575**	**1,640,400,898**	**1,490,827,398**	**1,411,134,464**	**1,526,822,502**	**7,255,012,837**

Contraceptive Security

	SP	2016	2017	2018	2019	2020	Total
CS 1.1 Review the contraceptive reporting system to incorporate data from the government, NGO, and private sectors and to ensure reporting requirements are streamlined	5	34,626,966	0	0	0	0	34,626,966
CS 1.2 Develop a comprehensive annual contraceptive forecast and procurement plan	5	15,295,820	15,678,216	16,070,171	16,471,925	16,883,723	80,399,855

	SP	2016	2017	2018	2019	2020	Total
CS 1.3 Assess the compliance of facilities, FP coordinators, MOH quantification staff, and CMST in following the logistics SOPs, and provide incentives based on performance	5	71,787,460	30,338,463	31,096,924	31,874,347	32,671,206	197,768,400
CS 2.1 Facilitate the redistribution of contraceptives within a district	5	79,940,000	0	0	0	0	79,940,000
CS 2.2 Develop a distribution reporting system	5	5,181,940	0	0	0	0	5,181,940
CS 2.3 Develop a performance measurement framework that coordinates with the distribution reporting system	5	21,741,230	0	575,743	0	604,889	22,921,862
CS 2.4 Assess CMST's available equipment for distribution	5	0	0	0	0	0	0
CS 3.1 Investigate whether new technologies (e.g., SMS) would improve real-time stock monitoring and re-supply planning	5	88,986,454	14,766,150	0	0	0	103,752,604
CS 3.2 Conduct full scale implementation of an ICT programme based on the outcome of CS 3.1	5	0	79,642,090	0	0	0	79,642,090
CS 4.1 Support someone to specifically monitor stock at the zone	5	3,800,000	3,895,000	3,992,375	4,092,184	4,194,489	19,974,048
CS 4.2 Support coordination between FP coordinators and store managers	5	6,447,150	6,608,329	6,773,537	6,942,875	7,116,447	33,888,338
CS 4.3 Develop the capacity of FP coordinators to analyse stock data and consumption trends	5	48,922,520	39,933,508	51,399,223	41,955,142	54,001,308	236,211,701

	SP	2016	2017	2018	2019	2020	Total
CS 4.4 Train pharmacy assistants, technicians, store managers, and pharmacists on logistics and supply-chain management	5	479,004,600	490,979,715	503,254,208	515,835,563	528,731,452	2,517,805,538
Total		**855,734,140**	**681,841,470**	**613,162,180**	**617,172,037**	**644,203,515**	**3,412,113,342**

Policy and Advocacy

	SP	2016	2017	2018	2019	2020	Total
PA 1.1 Update the political/legal framework for FP/SRHR policy to expand the age allowance for FP services to include younger adolescents (under the age of 15)	2	59,790,880	0	0	0	0	59,790,880
PA 1.2 Conduct advocacy to enable peer educators to provide pills and condoms	2	330,000	0	0	0	0	330,000
PA 2.1 Revise scopes of practice for HSAs, community midwives, nurses, etc., and lobby MOH to consider task shifting • Community midwives provide implants and post-partum IUDs • HSAs provide implants • CBDAs provide injectables	3	10,932,910	0	0	0	0	10,932,910
PA 2.2 Implement guidelines and incentives for volunteers, CHWs, etc.	3	2,944,500	0	0	0	0	2,944,500
PA 3.1 Work with the MOGCDSW and CSOs to advocate for family planning as a human rights issue	4	24,624,410	7,435,770	25,871,021	7,812,206	27,180,741	92,924,148

	SP	2016	2017	2018	2019	2020	Total
PA 3.2 Organise and host FP advocacy coalition meetings	4	94,035,950	40,697,010	41,714,435	87,150,605	46,254,617	309,852,617
PA 3.3 Train and orient policymakers on how to advocate for bills on sexual and reproductive health and rights policies, including family planning		3,181,470	0	0	3,426,095	0	6,607,565
Total		**195,840,120**	**48,132,780**	**67,585,456**	**98,388,906**	**73,435,358**	**483,382,620**

Financing

	SP	2016	2017	2018	2019	2020	Total
F 1.1 Develop a national advocacy strategy, with a specific financing strategy for family planning, in line with the national RHCS strategy and the FP-CIP	6	1,035,000	1,060,875	1,087,397	1,114,582	1,142,446	5,440,300
F 1.2 RHD and CSOs to engage critical policy and planning departments to advocate increased funding for RH (and family planning specifically)	6	570,000	584,250	598,856	613,828	629,173	2,996,107
F 1.3 Conduct advocacy with district executive committees, ward councillors, DHMTs, and traditional leaders to include family planning in district improvement plans and annual district budgets	6	37,100,640	27,066,294	27,742,951	28,436,525	29,147,438	149,493,847
F 1.4 Conduct advocacy among district health officers and district health teams for an FP line item in annual district health budgets	6	16,990,615	17,415,380	17,850,765	18,297,034	18,754,460	89,308,254

	SP	2016	2017	2018	2019	2020	Total
F 1.5 Advocate with parliamentarians to increase funding for the FP contraceptive budget line	6	1,321,000	1,354,025	1,387,876	1,422,573	1,458,137	6,943,610
F 1.6 Review progress towards achieving FP2020 financial commitments	6	0	0	0	0	0	0
F 1.7 Track FP financial resources	6	16,192,379	4,539,423	4,652,908	4,769,231	4,888,462	35,042,402
F 1.8 Conduct a cost-effectiveness assessment of FP activities in Malawi		0	7,738,145	0	0	0	7,738,145
F 1.9 Implement the advocacy strategy developed in F1, targeting development partners		1,060,000	1,086,500	1,113,663	1,141,504	1,170,042	5,571,708
F 1.10 Map and monitor donor financial commitments	6	7,230,000	7,410,750	7,596,019	7,785,919	7,980,567	38,003,255
F 2.1 Conduct advocacy to ensure that any health insurance scheme includes full FP method coverage for all insurance packages	1	2,725,000	14,319,983	2,862,953	2,934,527	3,007,890	25,850,353
Total		**84,224,634**	**82,575,625**	**64,893,387**	**66,515,722**	**68,178,615**	**366,387,982**

Supervision, Monitoring, and Coordination

	SP	2016	2017	2018	2019	2020	Total
SMC 1.1 Operationalise the performance management system for FP health care workers	3	22,447,410	1,539,038	15,384,302	1,616,951	16,163,132	57,150,833
SMC 2.1 Support districts to conduct quality insurance/quality assurance activities in facilities		21,743,500	18,429,500	22,754,962	19,362,493	23,906,931	106,197,386

	SP	2016	2017	2018	2019	2020	Total
SMC 2.2 Collect HMIS data on FP indicators	5	118,607,600	61,963,095	84,030,879	86,131,651	77,370,550	428,103,775
SMC 3.1 Facilitate coordination among the MOH, implementing partners, religious organisations, and community organisations for the implementation of FP services at the district level	4	22,170,900	115,313	34,742,467	121,150	124,179	57,274,008
SMC 3.2 Facilitate coordination among the MOH, implementing partners, religious organisations, and community organisations for the implementation of FP services at the national level	4	1,491,535	4,718,014	0	0	0	6,209,549
SMC 3.3 Coordinate with the private sector for the delivery of FP services	4	220,000	225,500	231,138	236,916	242,839	1,156,392
SMC 3.4 Support coordination among implementing partners and the MOH for the training of service providers	4	41,508,960	14,238,603	14,594,568	14,959,432	15,333,418	100,634,981
SMC 3.5 Strengthen multisectoral engagement	4	7,834,140	226,730	3,394,780	59,229	3,383,187	14,898,065
Total		**236,024,045**	**101,455,792**	**175,133,094**	**122,487,823**	**136,524,236**	**771,624,989**

Stewardship and Governance

	SP	2016	2017	2018	2019	2020	Total
SG 1.1 Support monitoring of the FP-CIP		37,584,320	676,500	693,413	710,748	728,517	40,393,497
SG 1.2 Monitor and supervise Track20 and FP-CIP output indicators for FP programme monitoring		3,008,588	0	3,160,898	0	3,320,918	9,490,404
SG 1.3 Conduct a mid-term assessment of FP-CIP implementation		0	0	15,085,735	0	62,144,975	77,230,710
SG 2.1 Hire additional staff as necessary to oversee the monitoring and evaluation of FP–CIP implementation		52,000	3,150,032	2,951,418	3,025,203	3,100,833	12,279,487
SG 3.1 Evaluate the implementation of FP activities at the district level		7,952,900	8,151,723	8,355,516	8,564,403	8,778,514	41,803,055
SG 3.2 FP-CIP coordinator to disseminate the FP-CIP to each district and conduct consultative meetings with FP coordinators and district health officers to explain their role in implementing and managing the FP-CIP		1,758,000	1,801,950	1,846,999	1,893,174	1,940,503	9,240,626
SG 4.1 Disseminate FP best practices during the national FP2020 meeting		0	3,792,500	0	3,984,495	0	7,776,995
Total		**50,355,808**	**17,572,705**	**32,093,978**	**18,178,024**	**80,014,260**	**198,214,773**

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