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CONDOM DISTRIBUTION AND REPORTING ASSESSMENT

Strengthening Linkages at National, District, Facility, and Community Levels in Malawi

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HP+ HEALTH POLICY PLUS

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Acronyms

BLM	Banja la Mtsogolo
CBO	community-based organization
CCP	comprehensive condom program
CMST	Central Medical Stores Trust
DAC	district AIDS coordinator
DHA	Ministry of Health's Division of HIV/AIDS
GHSC-PSM	Global Health Supply Chain Procurement and Supply Management
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOM	Government of Malawi
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HP+	Health Policy Plus
HSA	health surveillance assistant
HTSS	Health Technical Support Services
LMIS	Logistics Management Information System
MBCA	Malawi Business Coalition Against AIDS
MOH	Ministry of Health
NAC	National AIDS Commission
NCCC	National Condom Coordination Committee
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PSI	Population Services International
RIV	requisition and issue voucher
SMS	short messaging service
USAID	U.S. Agency for International Development
UNFPA	United Nations Population Fund

Introduction

Malawi has made significant progress over the last decade in battling the HIV epidemic, averting over 275,000 deaths and gaining 1.4 million life-years since the early 2000s, thanks to scale-up of antiretroviral therapy and prevention programs (GOM, 2016). But there is still much work to be done. In 2016, Malawi's HIV prevalence remained high—close to 10 percent among those ages 15-19 (GOM, 2016). Although the number of new infections declined from 55,000 in 2011 to 33,000 in 2015 across all age groups, reaching the government's goal of reducing the incidence of new infections in adults to 0.2 per 100 person-years by 2020 will require heightened awareness and use of primary preventative methods. Condom use is an important biomedical intervention for preventing HIV and sexually transmitted infections, as well as for family planning. In 2014, Malawians used 55.9 million condoms; the actual estimated need for this timeframe was 363 million (GOM, 2017).

Malawi's *National Strategic Plan for HIV (2015-2020)* and *National HIV Prevention Strategy (2015–2020)* recognize that access to and use of condoms is essential to family planning efforts as well as the prevention of HIV and other sexually transmitted infections. Malawi's Ministry of Health, through its Department of HIV/AIDS, leads development and implementation of a comprehensive condom program (CCP) by providing strategic oversight and leadership. The CCP outlines five priority objectives and activities designed to ensure a coordinated, multi-sectoral approach for HIV prevention. The Ministry's Reproductive Health Department also provides strategic support, as part of the National Condom Coordination Committee (NCCC), to ensure harmonization of activities and integration of family planning/reproductive health and condom services within the overall health system.

The National AIDS Commission (NAC) provides leadership and acts as a secretariat in coordinating and managing the national response to HIV; this includes coordinating CCP implementation, capacity building, and monitoring. The NAC ensures that partner activities are in line with the CCP, organizing quarterly meetings to address implementation progress and challenges, and annual review meetings to review and refine the strategic objectives of the *Malawi National Condom Strategy (2015-2020)*. The NAC also organizes an HIV prevention technical working group and national response review meetings to enable experts to provide technical guidance and recommendations for successful HIV prevention programming.

To ensure multi-sector coordination is consistent with total market approach principles, as outlined in the *National Strategic Plan for HIV*, coordination among key public and private sector stakeholders is managed by the NCCC. Stakeholders are comprised of representatives from the government, development partners, implementing partners, local nongovernmental organizations, social marketing organizations, and the commercial sector. The private sector, both non- and for-profit, plays an important role in the CCP. In addition to providing healthcare services, social marketing, and commercial condoms, the sector supports condom programs in the workplace and functions as distributors and marketers. However, the perspectives, scope, and scale of private sector actors are often unclear, as enforcement of policies and regulations related to reporting are limited. To effectively grow the market through a total market approach, the private sector must be fully engaged.

In Malawi, gaps in information exist that affect CCP efforts—a need exists to better understand the total condom market, condom availability, and the systems for accessing condoms at district and facility levels so that opportunities for scaling-up condom distribution beyond public sector health facilities can be identified. Furthermore, public sector condom stockouts are a critical concern.

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR),

supports the Ministry of Health and the NCCC in coordinating and implementing the CCP using a total market approach. USAID requested that Population Services International (PSI) support distribution of condoms to priority districts while the public sector system is being improved. To address the aforementioned information gaps, the NCCC requested that HP+ implement a national-, district-, and community-level assessment of condom distribution and reporting across public and private sectors and document how data is being used to inform programming and resupply of both male and female condoms. This report, the result of HP+'s assessment, is intended to identify key public and private stakeholders and establish initial estimates for the total condom market, describe the systems in place for condom distribution and access, and identify current gaps and opportunities for scaling up condom distribution.

Objectives

Stakeholders recognize that to improve access to male and female condoms, strengths and weaknesses in distribution and reporting must be understood and addressed. During an NCCC strategy development workshop in Kasungu in June of 2016, stakeholders identified a need to assess barriers at the district level, linkages between public and private facilities, and both nongovernmental (NGO) and community-based organizations' (CBO) systems for accessing commodities in order to improve condom distribution and use. As a result of this discussion, HP+ was tasked with conducting this condom distribution and reporting assessment. Its objectives are to:

- Identify data related to total market size, procurement trends, market segments, and market inequities to support programming and strategic decisions for comprehensive condom programming
- Document public sector supply channels to identify the actors involved in distribution and how multiple supply chain partners coordinate on procurement, warehousing, and distribution patterns
- Document private sector supply channels and opportunities to improve data and segmentation efforts
- Assess major challenges and gaps in distribution and reporting faced by stakeholders at district and community levels
- Review condom management information systems to better understand data gaps and opportunities for improved data analysis
- Identify opportunities for improved coordination among stakeholders

Methodology

HP+ conducted in-depth interviews among a wide variety of government and private sector stakeholders to assess condom distribution and reporting patterns at national, district, facility, and community levels. These interviews included representatives from public and private sectors in four different districts: Salima (Central), Mzimba (Northern), Mangochi (Southern), and Thyolo (Southern). District-level stakeholders included district councils, district hospitals, lower-level district health facilities, and NGOs and CBOs working in the district (Annex A).

HP+ developed an interview guide outlining key research questions for stakeholders at all levels (Annex B). The interview guide was pre-tested in Salima district by HP+ staff; minor adjustments were made to further refine the questionnaire in subsequent field visits. Semi-structured interviews were conducted with district-level stakeholders. Interviews were documented, and stocking and reporting forms were collected. The findings, which were

compared across districts to better understand commonalities, gaps, and opportunities for better coordination, are summarized in this report.

Findings from the Condom Distribution and Reporting Assessment

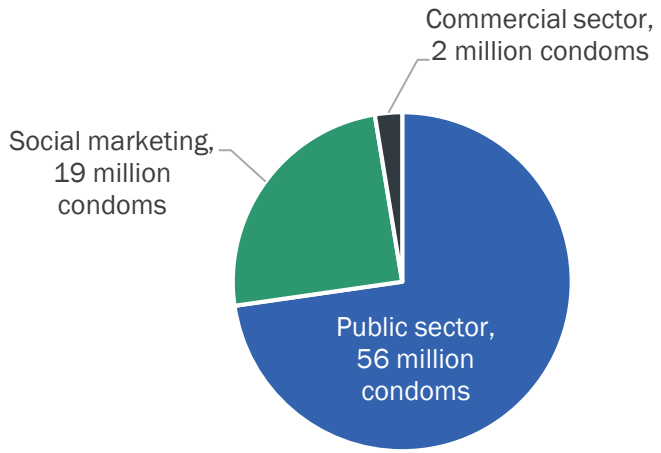
Understanding the Total Market

Government stakeholders are acutely aware of the valuable roles that the varied organizations involved in distributing male and female condoms in public and private sectors play, and the need for a comprehensive, coordinated approach among these actors. The quantification process for health commodities is the first step in understanding the public health need for a specific product, and considers expected demand for commodities, unit costs, existing stock, expiration, freight, logistics, lead times, and buffer stocks. In Malawi, the quantification process for health commodities is led by the Ministry of Health's Health Technical Support Services (HTSS) in conjunction with the Department of HIV/AIDS and the Directorate of Reproductive Health. USAID's Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) provides support to the national quantification exercise for all essential medicines. The quantification process for public sector supply includes representatives from multiple sectors, including national- and district-level representatives from the Ministry of Health, NGOs, and social marketing organizations—an important first step in developing multi-sectoral coordination.

Based on the *Quantification of Health Commodities in Malawi* report (GOM, 2017), public sector condom requirements are estimated to be 56 million male condoms and 964,000 female condoms. It should be noted that private sector condom needs have not been presented in the quantification report, which makes accurate determination of the current condom gap difficult.

In Malawi, as in many countries, the contribution of the for-profit commercial sector is difficult to quantify; initial estimates by PSI suggest that the commercial market is approximately 2 million condoms. For the social marketing sector, PSI estimates an additional 19 million condoms are needed.[1] Based on these data, initial estimates for the total condom market for 2017 are 77 million male condoms, as seen in Figure 1.

Figure 1. 2017 Estimated Male Condom Market, by Sector



Source: GOM, 2017 and PSI interviews

[1] Figure represents sales objective as actual need is unknown.

The 2015/2016 Demographic and Health Survey estimates that public sector facilities distribute 53 percent of male condoms, private facilities including the Christian Health Association of Malawi distribute 9 percent, Banja La Mtsogolo (BLM) distributes 2 percent, and the remaining 35 percent are distributed through the private sector (NSO and ICF, 2017). While this information is a good starting point, more detailed information is needed on how the public and private condom markets are segmented, including urban versus rural trends, sourcing based on geographic and/or wealth quintiles, and distribution of social marketing versus commercial brands.

In contrast, the total market for female condoms is estimated to be significantly smaller, with only public sector and social marketing sectors involved in distribution. Future efforts toward increasing the overall condom market and improving market segmentation will need to integrate total market metrics, including total market size, equity, access, and sustainability.

Government and Donor Procurement

The procurement of male and female condoms for distribution via the public sector and social marketing programs in Malawi is largely supported by international donors; in the last few years, these have primarily been the United Nations Population Fund (UNFPA), USAID, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). The Malawian government has also procured condoms in previous years, but in relatively small quantities.

For several years, UNFPA has been the primary donor for male and female condoms for public sector distribution, although their future commitment to condom procurement is unclear. Email exchanges with UNFPA indicate that in 2015 and 2016, UNFPA procured 28 and 52 million male condoms, respectively, and 1.2 million female condoms in both years—though in 2017, no condoms were procured by UNFPA.[2]

According to the Ministry of Health's Division of HIV/AIDS (DHA) supply chain officers, the Global Fund procured 20,160,000 male condoms in 2015 and 40,320,000 in 2016; in 2017, the fund procured the bulk of male condoms (70,560,000), in addition to other HIV/AIDS commodities. Communication with GHSC-PSM informed the authors of this report that USAID procured 500,000 female condoms in 2017. These data suggest a shortage of approximately 16 million male condoms and 464,000 female condoms still exists in Malawi.

Other NGOs bring condoms into Malawi in smaller quantities, such as Médecins Sans Frontières and the Center for the Development of People with the support of the Elton John AIDS Foundation.

In terms of government intervention in condom procurement, the Central Medical Stores Trust (CMST) is not directly involved in procurement for family planning/HIV commodities except when the Ministry of Health has allocated funds specifically for these programs. The process for estimating commodity shortages is complicated by each donor's funding timelines and delayed responses, meaning that it is often difficult to discern whether donor commitments will be confirmed and/or honored. Several stakeholders suggested in interviews that addressing this issue is crucial to improving overall coordination of family planning and HIV programs in Malawi. Despite the volatility of donor funding for male and female condoms in recent years, advocacy for the Ministry of Health to increase its condom funding is not a national priority.

[2] In 2017, UNFPA resources were redirected as the Global Fund procured the bulk of condoms in Malawi.

National Level Public Sector Supply Channels

The Health Technical Support Services (HTSS) in the Ministry of Health oversees the overall logistics system as well as Logistics Management Information System (LMIS) reporting. HTSS coordinates distribution of condom commodities across the supply channels. There are currently four organizations providing supply channels for condom distribution: CMST, the Global Fund through Bollore Transport and Logistics Malawi, GHSC-PSM (funded by USAID), and PSI (funded by USAID).

National

The supply chain for condom distribution and reporting (both male and female) involves a complex, multi-layered system of government and private-sector distribution channels. As stipulated by the Malawi Health Commodities Logistics Management System, the Central Medical Stores Trust (CMST) is the government's primary supply chain for government-procured drugs, contraceptives, HIV tests, laboratory reagents, consumables, and medical supplies. CMST currently has one central warehouse in Lilongwe and three regional warehouses for North, Central, and Southern regions. All Ministry of Health (MOH)-procured essential health commodities are received at the central warehouse and allocated to the regions based on population size. CMST uses a hybrid distribution model of direct and third-party distribution. CMST uses its own vehicles to directly distribute to the three Regional Medical Stores and to referral hospitals; distribution from the regional warehouse to the healthcare facility is managed by a third-party provider, Cargo Management Logistics. CMST also receives and distributes commodities procured by UNFPA.

Global Fund

The Global Fund, which primarily procures condoms and malaria and HIV medicines and supplies, distributes commodities via a third-party private sector partner, Bollore Transport and Logistics Malawi, Ltd. Bollore uses a modified push system, which includes quarterly visits to health facilities to check stock levels.

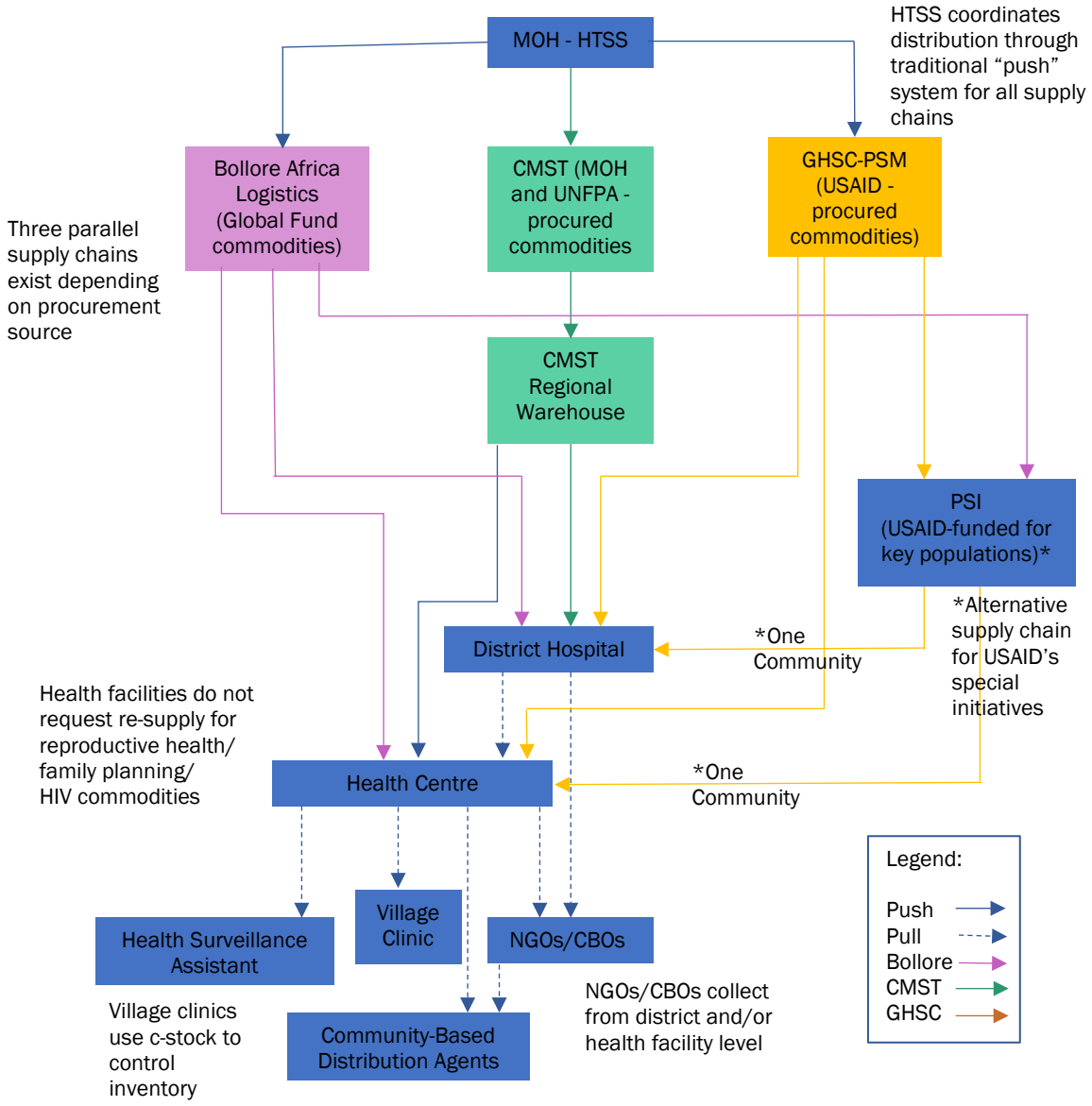
Global Health Supply Chain Procurement and Supply Management

USAID-funded commodities are also distributed using a modified push system via GHSC-PSM. As a modified push system, HTSS designates commodity distribution at the district and facility levels based on reporting as well as projections for upcoming activities that will affect commodity supply in a significant way. It is worth noting that condom supply is usually a pull system and becomes a push-pull hybrid when the push is applied—usually in response to emergencies or national stockouts. Stakeholders report that organizations and/or facilities often encounter problems receiving HTSS-designated amounts from CMST, and follow-up is complicated by the fact that CMST rarely provides delivery notes.

Key Populations

To address the unique requirements for key populations in the HIV response, USAID recently started supporting another distribution mechanism for community-level distribution of male condoms and lubricants to local NGOs and CBOs in 20 districts via HP+ for coordination and reporting and via PSI for distribution. HP+ has developed standard operating procedures for managing key population commodities of condoms and condom-compatible lubricant. In May and June 2016, HP+ helped to define the key population supply chain, working with USAID and others to designate PSI Malawi, through the Support for International Family Planning Organizations 2 project, as the agent for storage and distribution of condoms and lubricants to implementing partner organizations that provide direct services to key populations. In addition, PSI also supports distribution of condom commodities to specific facilities supported by USAID's One Community Project to ensure access to condom commodities at the district level.

Figure 2. Male and Female Condom Supply Chain for Distribution



The LMIS is the principal tool for managing movement of condoms from central warehouses to health facilities, utilizing a logistics software called Supply Chain Manager. Each month the LMIS produces national- and district-level reports that provide information on overall reporting rates by district; stock and consumption levels by program area, e.g., malaria, reproductive health, and neonatal and child health; as well as district-level stock and consumption levels. Both male and female condoms are included as part of the reproductive health program area. Other HIV commodities are reported under the national HIV program and do not include condom reporting.

The HTSS generates the initial distribution lists, which are shared with relevant programs for review and finalization. Final allocation depends on the availability of commodities in the warehouse and other factors. The distribution list reviewed by the reproductive health program is sent to CMST and relevant parallel supply chains; the list reviewed by the HIV program (for HIV commodities) is sent to Bollore.

LMIS data is invaluable to the overall quantification exercise as it is the most reliable data that exists on condom distribution through public sector facilities. Currently, the MOH is

working hard to improve overall reporting rates among all districts and roll out Open LMIS, an open-source, cloud-based electronic LMIS built for managing health commodity supply chains that will report LMIS data to HTSS and manage ordering of essential medical commodities from the Central Medical Stores Trust. While the LMIS database represents a critical tool for understanding condom consumption at the district level, it has additional utility as a tool that can be used to analyze trends and assess strengths and weaknesses across districts.

National Level Private Sector Supply Channels

In Malawi, several private sector supply channels exist for both male and female condoms. The most significant private sector distribution of condoms is through Malawi's two social marketing programs, estimated to make up between 25 and 37 percent of the total condom market (NSO and ICF, 2017).[3] Some employers also offer condoms through workplace programs; these are procured through a variety of sources. In addition, a few commercial condom brands are available for purchase in pharmacies and other retail outlets.

Social Marketing Organizations

PSI manages a national-level social marketing program that distributes the Chishango male condom in Malawi. Chishango was introduced in 1994; sales have gradually increased from 4.6 million condoms in 2001 to 16.9 million in 2015 (DKT International, 2016). Initially, Chishango's market positioning was described as the general public, with special emphasis on attracting sexually active young people between the ages of 14 and 24 as well as truck drivers and "men in uniform" in both urban and rural areas (GOM, 2005). Chishango has been the leading private sector condom for many years. As indicated in interviews with the PSI team, for 2017 PSI set a sales target of 19 million Chishango condoms, which reflects a slight decrease over PSI's reported sales of 21 million in 2016. Chishango condoms are sold in more than 6,000 outlets across the country, including hotspots.

PSI also distributes two female condom brands, Whisper and Care, via the same outlets. The Care condom is positioned on the market with the motto "express your willpower and being in control" while the Whisper condom is presented as the "easy-to-use contraceptive choice." Condom commodities for PSI's social marketing program are procured by USAID. Male and female condom sales are reported to the Ministry of Health and USAID, and presumably are then reviewed during national-level quantification exercises to track social marketing sales as part of the total market.

Banja La Mtsogolo, the local affiliate of Marie Stopes International, also implements a social marketing program in Malawi. In 2004, BLM launched a brand of condom called Manyuchi, originally designed to target young adults, a higher income bracket, individuals in the workplace, college students, and people "aspiring to a better lifestyle" (GOM, 2005). Over the years, sales have fluctuated, peaking at 3.4 million condoms in 2013; in 2015, condom sales were estimated at one million (DKT International, 2016). BLM shared sales reports data which suggest that the Manyuchi condom has a significantly smaller share of the private sector market than Chishango does.

Malawi's social marketing organizations have made important contributions to increase access to condoms. Future efforts to improve overall market segmentation and sustainability will require refining segmentation for social marketing brands, ensuring that subsidized products are reaching the intended target audiences; reducing product leakage to other regional markets; and creating greater awareness around cost-recovery levels for specific brands that tie into donor expectations for investment timelines and overall sustainability.

[3] The discrepancy in this estimate should be examined further through partner dialogue.

Workplace Condom Distribution

Private companies in Malawi often provide free condoms to their employees. For example, the Malawi Business Coalition Against Aids (MBCA), a membership organization for the private sector, advocates for a comprehensive HIV response among private sector employees. In 2016, MBCA consisted of 85 members that were actively supporting the organization. MBCA receives free condoms from the MOH and distributes them to their members. Other companies may also purchase condoms from social marketing programs. For example, an informational interview with Limbe Leaf Tobacco Company Ltd., a large tobacco processor in Malawi, revealed that Limbe Leaf receives free condoms from MBCA and district health officers and buys 20,000 Chishango condoms annually from PSI. Private sector employers distribute condoms anonymously (e.g., placing them in toilets or other well-patronized areas) and/or through on-site dispensaries or clinics. The number of condoms distributed by private companies is not reported to either MBCA or to the facilities from which they were collected. Given the lack of data, it is not possible to quantify how important the role is that private employers play in the overall supply chain, but it would be useful to advocate for MBCA to track and report these efforts.

Commercial Condom Brands

There are a number of commercial condom brands that are imported and distributed through private commercial channels. These male condom brands include Moods, Wet-n-Wild, Rough Rider, and Bareback, which are distributed through pharmacies as well as other non-traditional retail outlets, e.g., petrol stations, supermarkets, and drug shops. No commercial female condom brands are currently on the market. Estimates vary on the commercial sector's participation in the overall condom market; stakeholders recognize that a need exists for more precise data. Stakeholders reported that it may be feasible to collect data on commercial condom imports through the Malawi Revenue Authority—this would involve collecting data from the country's regional importation sites. Although HP+ did not meet with regulatory authorities, it is not uncommon to find commercial condom brands that are not officially registered being sold in the market—a practice that warrants further examination moving forward.

District Level Condom Distribution and Management

NCCC recognizes the importance of national- and district-level leadership and coordination for successful implementation of the CCP. HP+ interviewed district health officers, district council members, facility in-charges, pharmacy technicians, and department heads to identify barriers to condom distribution. District health officers acknowledged the existence of gaps in condom programming and reporting; while these officers acknowledged the important problem of condom stockouts at district and facility levels, several stated that they are not responsible for ordering condoms, which creates an issue of "accountability without responsibility." Most districts do not have condom program focal persons, primarily due to lack of human and financial resources. While condom data is captured through the LMIS, officers described gaps in the reporting systems, highlighting the fact that although condoms are distributed in HIV departments, this is not captured through Health Management Information System (HMIS) reporting.

The district council is also involved in HIV coordination through a district AIDS coordinator (DAC). The DAC works in conjunction with several committees, including the District Executive Committee, District AIDS Coordinating Committee, Community AIDS Coordinating Committee, Village AIDS Coordinating Committee, and CBOs. The DAC supports HIV prevention and condom distribution activities among CBOs. The DAC works in conjunction with the district health officer to solicit condom supplies and to refer CBOs to district facilities to receive condoms. CBOs are often registered with the district council. The DAC provides a reference letter to these organizations to facilitate access to condom commodities. Every quarter the DAC submits a consolidated report to NAC and the Ministry

of Local Government that reflects the number of condoms distributed in the district. However, given that most of these condoms are accessed through the district health office and are also included in LMIS reports, it is unclear how distribution reports are consolidated or whether overlap in reporting exists.

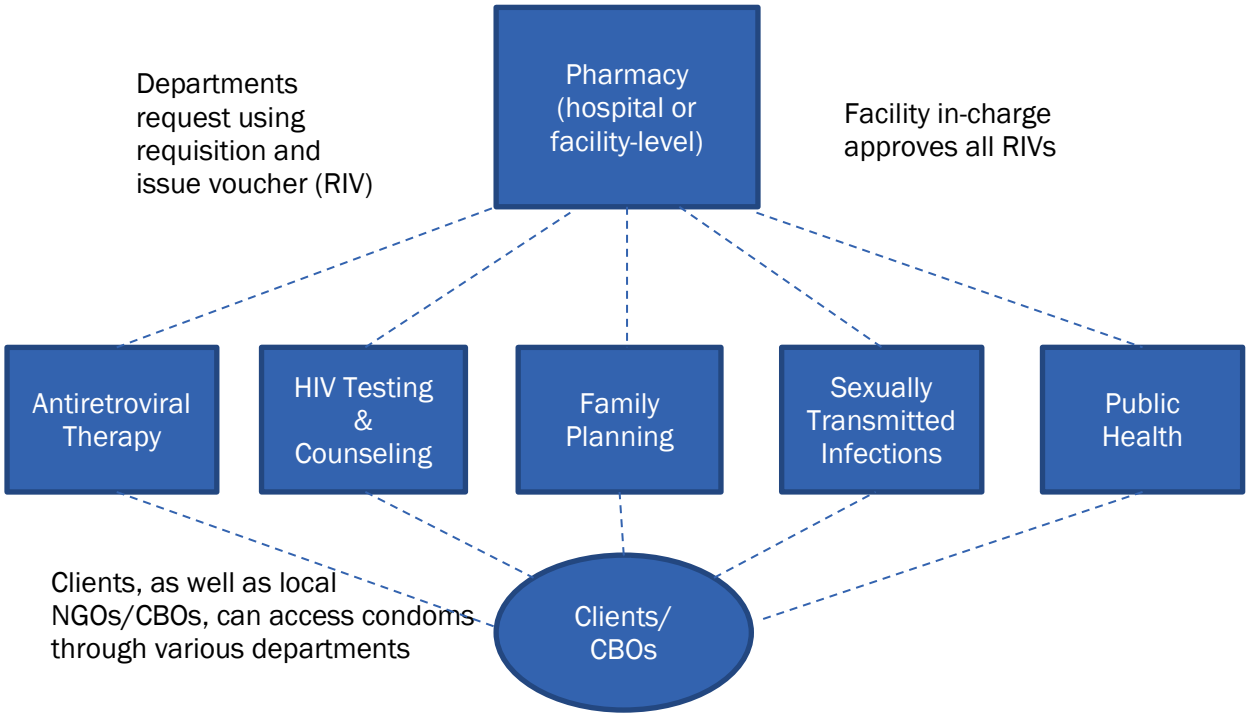
Pharmacy Level Condom Management and Distribution

All condoms distributed from central/regional warehouses to district and health facility pharmacies are received by pharmacists/pharmacy technicians/assistants or clerks, depending on the specific facility; the process is the same at all levels in the service delivery system. Condoms, like all pharmacy health commodities, are stored under lock and key. HP+ found that pharmacy-level personnel followed established protocols as described in the Malawi Health Commodities Logistics Management System Procedures Manual. When condoms are received, the quantity and date received are entered on the pharmacy stock cards and the accompanying delivery notes are filed. Records of male and female condoms are kept on different stock cards. As such, the stock cards and accompanying delivery notes clearly show the current available volume of condoms at the district- or facility-level pharmacy. Pharmacists, pharmacy technicians, and/or assistants are responsible for the management of health commodities, including condoms, in health facilities—although in smaller facilities, the in-charge or designated healthcare worker is responsible for these commodities. Pharmacy personnel conduct monthly physical inventory counting to identify discrepancies between actual quantities of condom supplies and the stock balances on the cards, and to detect damaged or expired items and adjust stock card records accordingly. These adjustments are all recorded on the stock cards, which are used to develop monthly LMIS reports. HP+ observed that the pharmacy management system is well-established throughout the public sector system; smaller, more remote pharmacies/facilities are also following the established procedures with only minor variations. As such, the LMIS reports provide a fairly accurate account of the volume of condoms that are being received and distributed. However, it is important to note that clients do not access condoms directly through district- or facility-level pharmacies; instead, they must queue for services through the various departments that provide condom commodities.

Department Level Condom Distribution

A number of service departments at the facility level distribute condoms directly to clients, including departments for family planning, antiretroviral therapy, HIV testing and counseling, sexually transmitted infections, and public health. As described in Figure 3, these various service delivery points request condoms from the pharmacy that are distributed based on client need (pull system). All departmental service delivery points use a requisition and issue voucher (RIV) to request condoms from the pharmacy. Each department has an RIV book with serial numbers, which is completed in triplicate and certified by the head of the department, usually a nurse-in-charge/matron, and approved by the facility. Once completed, the RIV is taken to the pharmacy to be checked and validated by pharmacy personnel prior to condoms being issued. Verification of condoms issued is completed by pharmacy staff in the presence of hospital attendant/user unit staff and security personnel, if available. At the department level, condoms are stored in cabinets or shelves with other health commodities and are directly distributed to clients.

Figure 3. Condom Distribution from Pharmacy to Department Level



Emergency Orders

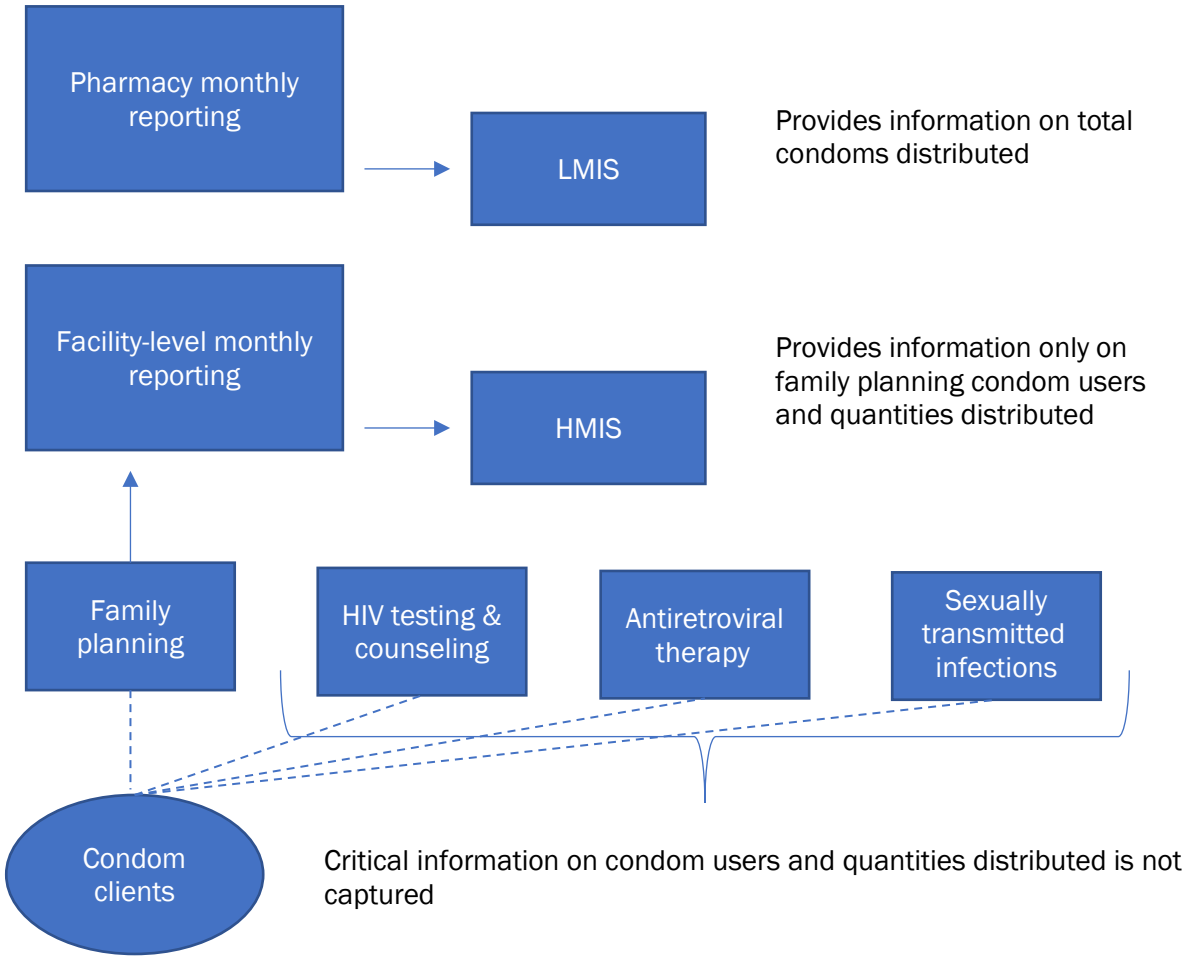
In addition to receiving condom commodities from the standard supply chain, health facilities may also receive condoms from the district hospital or other lower-level health facilities in the district. Facility-to-facility transfers normally occur when a facility has run out of condoms. The facility that is out of stock will place an emergency order with the district hospital using the requisition and issue voucher. The district hospital will supply the requested condoms if enough are in stock; if not, the condoms will be collected from another facility that will be subsequently restocked. Emergency orders can be challenging because in many cases the order is misplaced at the district hospital and/or no transport is available to deliver the condoms. HP+ encountered several facilities with condom stockouts that had not placed emergency orders because staff felt that the order would not be processed. They explained that normal procedure is to wait for the next condom shipment. This finding suggests that a need exists for increased advocacy and awareness regarding protocols for emergency orders.

Condom Reporting

As mentioned by several district health officers, monitoring condom distribution is inconsistent at district and facility levels, which means that not all distributed condoms are accurately captured in the HMIS. As seen in Figure 4, while the LMIS system consistently captures condom stock and distribution from pharmacies, service delivery data/distribution is not consistently captured. As described above, clients may access condoms through multiple departments, but not all departments report distribution. For example, the family planning register captures data on condom clients and number of condoms distributed; this information is aggregated into the monthly family planning service statistic summary form. The family planning coordinator then forwards this information to the district and/or facility HMIS office. The other major HIV departments that are involved in condom distribution capture condom distribution on individual patient registers, but this information is not included in monthly service delivery reports. Without this data, the HMIS significantly

underreports condom distribution; as a result, analysis of trends across different departments and data on condom distribution at the community level is not accurate.

Figure 4. Condom Reporting



Village Clinics

As reflected in Figure 2, requisition procedures are slightly different for village clinics at the community level, which are based on a pull system. Village clinics are operated by health surveillance assistants (HSAs) who provide basic services for vulnerable groups (e.g., women, children, and the elderly) that may find it difficult to reach health facilities. Village clinics are affiliated with specific health facilities. Typically, they maintain stocks for 5 to 12 essential health commodities, including male and female condoms. The clinics are resupplied using an automated system that transmits logistics information to appropriate facility authorities via a short messaging service (SMS) known as C-Stock.

To place an order, the HSA sends an SMS with stock-on-hand data for each of the health commodities being managed. The system computes reorder levels for each item and sends an SMS to the affiliated facility-in-charge to prepare the consignment for the HSA. Following confirmation, an SMS alerting the HSA that the consignment is ready for collection is sent. The HSA travels to the facility to request commodities using the requisition and issue voucher. The RIV is authorized by the senior HSA, who is based at the facility, and approved by the district health officer, matron, or facility in-charge. Following approval, the HSA goes to the pharmacy and collects condoms and other requisitioned health supplies. At the village clinic, the HSA stores the commodities in a drug box with a dual locking system. The HSA

keeps a key to one lock; another person, selected from the community, keeps the other key to ensure accountability.

One other service delivery point provides family planning and HIV testing services to the community: community-based distribution agents who are affiliated with village clinics and/or health facilities. Condoms distributed to clients of community-based distribution agents are recorded in a client contraceptive and HIV testing tally sheet.

Community-Based Organizations

Many community-based organizations in districts across the country are involved in HIV activities in Malawi. CBOs are often registered by the district councils in which they work, and coordinate with district AIDS coordinators. CBOs request condoms through their DACs, receive the condoms from the district hospital or nearby public health facilities, and distribute them to their clients. The requisition, tracking, and reporting of condoms varies from one CBO to another, as no systematic processes exist. CBOs access condoms through multiple departments, depending on ease-of-access, availability, and relationships with health staff. Some CBOs request condoms using a handwritten note; others solicit using a letter from the DAC.

The reporting process for CBOs also varies widely. Some CBOs use a register to record the number of condoms that are distributed and the person responsible for distributing them; others do not have any register or records. It seems that CBOs do not provide any distribution report to the facility from which condoms are received; however, they do submit periodic reports to the district council where they are registered using the local authority HIV/AIDS reporting form. DACs use this form to compile quarterly service coverage reports which are sent to the NAC, the Local Government Financing Committee, and the Ministry of Local Government and Rural Development. However, it is not clear how or where this information is analyzed to support comprehensive condom programming. An opportunity exists to improve coordination and reporting for CBOs who receive free and/or social marketing condoms.

Special Initiatives

USAID's One Community project focuses on a community-based response to Malawi's HIV epidemic by increasing the uptake of HIV prevention, care, and support services; increasing positive behaviors that reduce the impact of HIV on communities; and strengthening the capacity of Malawian partners to lead and implement this work. The project is currently working in seven districts (Blantyre, Chikwawa, Machinga, Mangochi, Mulanje, Phalombe, and Zomba) through approximately 100 public sector and Christian Health Association of Malawi health facilities. To ensure that all health facilities and surrounding communities have sufficient condoms, PSI provides targeted distribution of male condoms directly to designated facilities. Female condoms are not currently distributed by PSI to these targeted facilities because districts currently have sufficient supplies of female condoms, and there is concern that these female condoms may expire due to poor demand. The supported facility receives its condoms at the pharmacy and records them on stock cards according to standard procedure. These condoms are then issued to One Community project staff through requisition and issue vouchers.

One Community condoms are not kept separately from other condoms at the facility. Initially, facilities would receive One Community condoms and distribute them to other programs, creating condom shortages; these condom supply issues have been worked out over time. One Community's community engagement facilitators report occasional overlap between their catchment areas and PSI's community-level outreach activities that serve the same populations. Because One Community reports its condom distribution to PSI and the

district pharmacy reports condom distribution through the LMIS, it is possible that reports of distribution are doubled, and thereby inaccurate.

PSI currently supports warehousing and distribution of condoms and lubricants and HP+ supports reporting for key populations across eight NGOs/CBOs in 21 districts. Each of these organizations have different implementation models and are often funded by multiple donors. The Family Planning Association of Malawi, for example, receives support from the Global Fund through ActionAid and USAID support through the Linkages project. In some districts, district information centers distribute condoms to peer educators and peer navigators who in turn distribute them to sex workers. The district information centers have stock cards that capture condoms received and condoms issued. These condoms are usually requested verbally and not in writing. Each location working with key populations submits monthly reports on condom distribution, which informs HP+ on the quantifying number of condoms needed for resupply. Lubricants are distributed based on key populations and estimated number of sex acts, and reported accordingly. Over time, distribution of lubricants is adjusted based on consumption patterns. Coordination of lubricants is relatively simpler than condom coordination since only one main source of lubricants exists, except for Médecins Sans Frontières, which procures lubricants for their program.

Discussion and Recommendations

This assessment outlines several ways that multi-sector stakeholders in Malawi are committed to working together to strengthen the CCP. For example, key stakeholders recognize the importance of multi-sectoral engagement in strengthening implementation of the CCP using total market principles. The fact that the annual public sector quantification process is increasingly incorporating multi-sectoral representation is significant in its trajectory. Nonetheless, critical information gaps remain; this report focuses on opportunities and recommendations to strengthen condom data and reporting using a total market approach.

As discussed in detail in the previous section, while carrying out this assessment HP+ encountered several challenges with respect to estimating the total market size for condoms in Malawi. Of particular difficulty was collecting recent sales data from social marketing organizations as well as estimating the size of the for-profit/commercial sector. Future efforts aimed at increasing the condom market and improving market segmentation will need to integrate total market metrics, including indicators for assessing total market size, equity, access, and sustainability (Pallin, 2014). The planned market segmentation analysis, mentioned in the *Malawi National Condom Strategy 2015-2020*, will provide critical details on how the condom market is segmented, including urban versus rural trends, sourcing based on geographic and/or wealth quintiles, and use of social marketing versus commercial brands. This analysis will be an important first step in understanding market inequities and developing relevant total market indicators.

The procurement of male and female condoms in Malawi is largely donor-dependent and funding gaps remain. The process for estimating commodity shortages is complicated by each donor's funding timelines and delayed responses, meaning that it is often difficult to discern whether donor commitments will be confirmed and/or honored. Due to this volatility in funding, continued advocacy is needed for the Ministry of Health to transition from complete reliance on donor procurement to gradual financing from the government treasury. At the same time, international donors need to be transparent about their intended investment timelines while advocating for specific short- and long-term milestones for MOH procurement.

The private sector represents an important channel for increasing access to and use of male and female condoms in Malawi. Of particular note are condom social marketing programs, as these have played an important role in the market. Future efforts to improve market segmentation and sustainability will require better targeting of social marketing brands, ensuring that subsidies are reaching the intended market segments; reducing product leakage to other regional markets; creating greater awareness around cost-recovery levels for specific brands; as well as increasing transparency around donor investment timelines and expectations for overall sustainability. To start, social marketing programs should provide regular and updated information on sales, intended positioning (and the degree to which it is being achieved), geographic coverage, price, and cost-recovery levels. Another private sector channel for condom distribution is the workplace—some employers offer condoms through workplace programs; these are procured via several channels/sources. However, little data exists on the size of the for-profit commercial sector or distribution of condoms through private employers, which is needed to quantify the total private sector market for condoms.

Several information gaps related to existing reporting systems and use of data need to be addressed in order to better understand condom distribution and use patterns. The LMIS represents an invaluable tool for understanding condom consumption at the district level, although it is not clear if this data is being analyzed to assess strengths and weaknesses across districts. Likewise, a major gap in condom reporting exists in the HMIS, as most HIV departments do not include condom distribution data in monthly reporting. These practices

suggest that there is significant underreporting of condom distribution despite the fact that a functional system exists to collect and analyze such data. LMIS data should be examined to identify trends across districts and HMIS systems should integrate condom distribution for all HIV departments to better understand public sector supply channels.

In several facilities, condom stockouts were observed and/or reported in recent months. Facility personnel are aware of the provision for emergency orders, but several noted that these emergency orders are often not attended to due to lack of transport and/or paperwork misplacement. Because the system is defined by local stakeholders as a "push" system, facility staff often don't perceive themselves to be directly responsible for ordering supplies, and therefore are content to wait to receive the next regular resupply of condoms. Continued advocacy regarding the importance of and protocols for emergency orders is crucial to reduce the frequency and length of condom stockouts.

Based on field-level observations, the system for NGOs and CBOs to access condoms is inconsistent. No central department at the district level exists that is responsible for coordinating NGO/CBO activities; according to NGO representatives, condoms are procured from multiple departments based on where healthcare staff have proven to be most accessible/available. Requisitions are often submitted on handwritten notes or without documentation, and no effort is made to require NGOs/CBOs to provide information on how commodities are distributed. Standardized procedures for requisition and reporting for NGOs and CBOs receiving condom commodities at the district level need to be developed to better understand how effective these supply channels are.

Table 1 outlines several recommendations by programming area in both the short- and medium-term. Short-term recommendations are those that may be achieved within the next year; medium-term recommendations may require several years of follow-on support or may be continuously evolving.

Table 1. Summary of Recommendations by Area

Programming Area	Recommendations	Time Frame
Total Market Metrics	Discuss discrepancies in total market data with all stakeholders and achieve consensus on the total condom market for each sector (public, social marketing, and NGO).	Short-term
	Share results of the market segmentation analysis with key stakeholders to begin dialogue on comparative strengths of different sectors.	Short-term
	Develop indicators that reflect total market principles, including total market size, equity, access, and sustainability.	Medium-term
	Engage stakeholders in discussing specific market-shaping strategies across sectors to improve overall condom use and total market growth.	Medium-term
Procurement	Initiate dialogue with MOH and better coordination among donors to develop specific procurement milestones for MOH for male and female condoms and clarity around donor investment timelines.	Medium-term

Programming Area	Recommendations	Time Frame
Private Sector Engagement	Collect more detailed information from social marketing organizations on sales, positioning, geographic coverage, price, and cost-recovery levels for market segmentation analysis.	Medium-term
	Determine data collection tools/strategies for more precise information on commercial sector sales and other private sector channels, e.g., employer-based programs.	Short-term
	Initiate dialogue on defining and refining the intended role of social marketing vis-a-vis the total condom market and the role of the commercial sector.	Medium-term
Reporting Systems	Use OpenLMIS system to conduct a district-by-district analysis of public sector condom distribution, including frequency of reported stockouts.	Short-term
	Encourage MOH to integrate consistent condom reporting through HMIS to allow for better analysis of condom distribution patterns through existing service delivery as well as CBO and NGO distribution.	Medium-term
Stockouts/ Emergency Orders	Use LMIS data to conduct an analysis of the frequency of condom stockouts by district.	Short-term
	Engage district-level stakeholders in increasing awareness of importance of protocols related to condom reporting, stockouts, and emergency orders.	Short-term
	Address supply chain and district-level discrepancies around management of emergency orders for condoms.	Medium-term
CBOs/NGOs	Implement systems to improve requisition and reporting systems for CBOs and NGOs working at the community level.	Short-term
	Strengthen district coordination and planning between the Department of Health and DAC.	Medium-term

Conclusion

The condom distribution and reporting assessment is an important first step in understanding the strengths and weaknesses, information gaps, and opportunities for improved collaboration that exist in Malawi's condom market. The road to achieving total market impact is not an easy one and requires significant coordination to understand who is doing what and where; to achieve increased efficiency in resource utilization among all sectors and better targeting of donor and government subsidies for underserved and priority audiences; and to ensure better monitoring of total market metrics. The results of the assessment will be shared with relevant stakeholders to validate key findings, explore alternative solutions, and identify next steps, including the development of an action plan based on recommendations by the NCCC. This consensus-building process will require strong stewardship by the MOH to continuously move the CCP and its multiple actors toward a well-integrated program that achieves effective impact and stronger market sustainability.

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Annex A. Stakeholders Interviewed

Facilities and Institutions Visited at the District Level

Region/District	Name of Facility/Organization	Type of Facility/Organization
North: Mzimba	Mzuzu Urban	District Hospital
	Ekwendeni	Mission Hospital (CHAM)
	Engucwine	Health Center
	Mzimba (N) District	Council
	Family Planning Association of Malawi (FPAM)	NGO
	Malawi Aids Counselling & Resource Organization (MACRO)	NGO
	Ekwendeni Youth Counselling Organization	Local NGO
Centre: Salima	Salima	District Hospital
	Khombedza	Health Center
	Makioni	Health Center
	Lifeline	Health Center (CHAM)
	Katawa	Health Center (CHAM)
	FPAM	NGO
	SAMALA	CBO
	Madalitso	Private Clinic
Eastern: Mangochi	Mangochi	District Hospital
	Monkey bay	Community Hospital
	Malukula	Health Center
	Assalam	Private Clinic-Trust
	Billy Riordan Memorial	Private Clinic-Trust
	Chembe	Village Clinic
	Mangochi District	Council
	Mangochi Town	Council
	Community Initiative for Self Reliance (CISER)	Local NGO
South: Thyolo	Thyolo	District Hospital
	Chisoka	Health Center
	St Helen Oakly	Health Center (CHAM)
	Bvumbwe	Banja la Mtsogolo Clinic
	Thyolo District	Council
	Pakachere	NGO
	Ntambanyama	CBO
Blantyre	Chileka	Health Center

Institutions Visited at the National Level

	Name of Stakeholder	Type of Organization
1	Central Medical Stores Trust	National Supply Chain Management Institution
2	Population Services International	Social Marketing and Key Population Supply Chain
3	Department of HIV/AIDS	Malawi Government Department
4	Health Technical Support Services (HTSS)	MG Department-Health Commodities Supply Chain Coordinator
5	Linkages	Key Populations Financier
6	Global Fund-Project Implementation Unit	Parallel Supply Chain/Financier
7	One Community	NGO
7	UNFPA	Donor
8	Chemonics	Global Health Supply Chain Procurement and Supply Management
9	Bollore Transport & Logistics Malawi Limited	Parallel Supply Chain Company
10	Banja La Mtsogolo (BLM)	Social Marketing
11	Limbe Leaf (M) Limited	Private Sector

Annex B. Key Research Questions for Condom Distribution and Reporting Assessment

National Level Condom Supply Chain

Key Stakeholders: USAID, UNFPA, Ministry of Health: Division of HIV/AIDS (DHA), Health Technical Support Services (HTSS), Central Monitoring and Evaluation Division (CMED), Central Medical Stores Trust (CMST), Chemonics/Global Health Supply Chain (GHSC), Global Fund: Action Aid and Bollore African Logistics, Population Services International (PSI), Banja la Mtsogolo (BLM), FHI 360/Linkages, Johns Hopkins University/One Community

Procurement

1. Who are the primary organizations involved in male and female condom procurement for reproductive health/family planning and HIV/AIDS prevention?
2. What are the funding levels/volume committed to male and female condom procurement during the last three years by organization?
3. What is the estimated need for 2018 and what organizations have committed to procuring? What is the estimated gap?
4. Have any international donors indicated their intent to phase-out or stop male or female condom procurement in the near future?

Market Size

5. What is the estimated total market size for male and female condoms distributed in the public sector during the last three years?
6. What is the estimated total market size for social marketing of male and female condoms during the last three years?
7. What is the estimated total market size for commercial condom brands during the last three years?
8. What social marketing and commercial brands exist in the private market?

Warehousing

9. What warehousing options exist for male and female condoms at the central level?
10. What warehousing options exist at the regional level for male and female condoms?

Distribution/Supply Chain

11. What is the supply chain system used by Central Medical Stores Trust (CMST), Global Health Supply Chain, and Global Fund for the distribution of condoms? *For example, CMST uses direct distribution from central warehouse to regional warehouses, and then contracts out for distribution from regional warehouse for direct distribution to all approx. 650 health facilities.*

Alternative Supply Chains for Special Project Needs

12. What is the system that is currently in place for PSI to distribute free condoms to public health facilities? How do free condoms get to PSI warehouse (Who requests? Who moves the commodity?)? What information does PSI have, and how do they decide on when and how many condoms to distribute to which facility? How has PSI modified (if at all) their social marketing distribution system to accommodate for public sector distribution?

Reporting

13. LMIS: What are the central reporting mechanisms? What type of analysis is conducted (if any) of condom consumption patterns? How is data used at the central level?
14. HMIS: What are the central reporting mechanisms? What type of analysis is conducted (if any) of condom consumption patterns? How is condom consumption data used at the central level?

District Level Condom Supply Chain

Key Stakeholders: District Assembly, District Health Officer, Condom Coordinator, District Pharmacist/Pharmacist-In-Charge, department heads (antiretroviral therapy, HIV testing and counseling, sexually transmitted infections, family planning, public health, etc.), CBO Coordinator, Youth Coordinator, HSA Supervisor

District Assembly

15. What types of issues does the district assembly address for HIV programming and condom distribution?
16. Who are the major NGOs/CBOs involved in HIV programming?
17. What type of coordination exists at the district level for HIV programming and condom distribution? With donor-funded programs, other NGOs/CBOs, district assembly?

District Health Officer

18. What types of issues does the district face in condom supply, distribution, and reporting?
19. What type of coordination exists at the district level for HIV programming and condom distribution? With donor-funded programs, other NGOs/CBOs, district assembly?
20. How is data used at the central level? What type of analysis is conducted (if any) of condom consumption patterns?
21. What type of data analysis is done at the district level around HIV programming and condom distribution? What departments are the major distributors of condoms?
22. What type of community-level distribution is being conducted? What are the challenges facing these programs?
23. Who are the major NGOs/CBOs involved in condom distribution?

Pharmacy/Pharmacist-In-Charge

24. What issues exist around supply for male and female condoms?
25. When was the last shipment received for male and female condoms?
26. When was the last stockout at district level? Any other stockouts in the last six months?
27. What departments request condoms?
28. What requisition form is used? Who authorizes requisitions?
29. What type of monthly reporting is done?
30. Are condoms kept only in the pharmacy or also at department levels? If so, what control mechanisms exist for condoms at the department level?

31. How are emergency orders handled at the district level? When was the last emergency order for condoms requested? How was it handled?

**If possible, take photograph of cover sheet and latest page of stock card for male and female condoms, requisition form, latest consolidated LMIS reporting form, and male and female condom stock areas.

Department Supervisors

32. What issues exist around supply for male and female condoms?
33. Does your department maintain its own supply of male and female condoms?
34. How often do you request male and female condom commodities?
35. What is the distribution protocol for facility clients receiving condoms, e.g., how many condoms do they normally receive?
36. What are the reporting requirements for the department? How is condom distribution data recorded and reported?
37. What are the challenges to reporting?
38. How is data used at the department level? What type of analysis is conducted (if any) of condom consumption patterns?
39. What type of community-level distribution is conducted? How is condom distribution data tracked/recorded?

**If possible, take photograph of requisition form and HMIS reporting forms used by department.

HMIS Officer

40. What departmental reports include condom distribution data?
41. What type of issues exist with condom distribution reporting?
42. What type of analysis is done at the district level around condom distribution?

**If possible, get sample of 1 or 2 departmental HMIS report forms and ask HMIS officer to demonstrate how the HMIS system reports for condom users and condom volume distributed.

Facility Level Condom Supply Chain

Key Stakeholders: Facility-in-Charge, Pharmacist, department heads (antiretroviral therapy, HIV testing and counseling, sexually transmitted infections, family planning, public health, etc.), CBO Coordinator, Youth Coordinator, HSA Supervisor

Facility-in-Charge

43. What types of issues does the facility face in condom supply, distribution, and reporting?
44. What type of community-level distribution is being conducted? What are the challenges facing these programs?
45. Who are the major NGOs/CBOs involved in condom distribution?

Pharmacy/Pharmacist-in-Charge

46. What issues exist around supply for male and female condoms?

47. When was the last shipment received for male and female condoms?
48. When was the last stockout at the facility level? Any other stockouts in the last six months?
49. What departments request condoms?
50. What requisition form is used? Who authorizes requisitions?
51. What type of monthly reporting is done?
52. Are condoms kept only in the pharmacy or also at department levels? If so, what control mechanisms exist for condoms at the department level?
53. How are emergency orders handled? When was the last emergency order for condoms requested? How was it handled?

**If possible, take photograph of cover sheet and latest page of stock card for male and female condoms, requisition form, latest consolidated LMIS reporting form, and male and female condom stock areas.

Department Heads

54. What issues exist around supply for male and female condoms?
55. Does your department maintain its own supply of male and female condoms?
56. How often do you request male and female condom commodities?
57. What is the distribution protocol for facility clients receiving condoms, e.g., how many condoms do they normally receive?
58. What are the reporting requirements for the department? How is condom distribution data recorded and reported?
59. What are the challenges to reporting?
60. How is data used at the departmental level? What type of analysis is conducted (if any) of condom consumption patterns?
61. What type of community-level distribution is conducted? How is condom distribution data tracked/recorded?

**If possible, take photograph of requisition form and HMIS reporting forms used by department.

Community Level Condom Supply Chain

62. What type of community-level distribution networks do NGOs/CBOs use?
63. Where do they receive commodities from?
64. How many community distribution agents do they work with?
65. Where/whom do they distribute to?
66. What type of reporting is used by NGOs to track/report consumption?

**If possible, take photograph of NGO/CBO reporting forms for requisition, tracking distribution, and reporting.

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