

EVERY PREEMIE—SCALE

Scaling, Catalyzing, Advocating, Learning, Evidence-Driven

END-OF-PROJECT EVALUATION REPORT

JULY 2019

COOPERATIVE AGREEMENT NO. AID-OAA-A-14-00049 Every
Premie—SCALE

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Acronyms

ACNM	American College of Nurse-Midwives
ACS	Antenatal corticosteroids
AG	Abdominal girth
ASSIST	Applying Science to Strengthen and Improve Systems
CHW	Community health worker
COINN	Council of International Neonatal Nurses
DRC	Democratic Republic of Congo
ECEB	Essential Care for Every Baby
ECSB	Essential Care for Small Babies (ECSB)
ENAP	Every Newborn Action Plan
FMOH	Federal Ministry of Health
GAPPS	Global Alliance to Prevent Prematurity and Stillbirth
GOI	Government of India
HSA	Health surveillance assistant (Malawi)
ICN	International Council of Nurses
IRB	Institutional Review Board
KMC	Kangaroo mother care
LBW	Low birth weight
MCH	Maternal and child health
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organization
ONSE	Organized Network of Services for Everyone's Health Activity
PAG	Project Advisory Group
PCI	Project Concern International
PGIMER	Postgraduate Institute of Medical Education and Research
PTB	Preterm birth
PTB TWG-ICS	PTB/LBW Global Technical Working Group on Implementation Challenges and Solutions
QI	Quality improvement
SCALE	Scaling, Catalyzing, Advocating, Learning, and Evidence-driven
SFH	Symphysis fundal height
SNL	Saving Newborn Lives
TWG	Technical Working Group (PTB TWG-ICS)
UN	United Nations
UNCoLSC	United Nations Commission on Life-Saving Commodities
UNICEF	United Nations Children's Fund
US	United States of America
USAID	United States Agency for International Development
USAID/W	USAID/Washington
WHO	World Health Organization

Acknowledgements

A sincere thank you to all the informants who were willing to give their time for an interview and share their views. Irene Kamanga's meticulous organization of the logistics for the evaluator's visit to Malawi is much appreciated. Enormous appreciation goes to Mindy Hochgesang who worked closely with me to organize the evaluation scope of work, tools and processes and for her leadership in providing comments and input to draft documents. Thank you also to the Project Director, Judith Robb-McCord, and team leads, Jim Litch and Patrice White, for the intellectual sharing and to Rebecca Freeman and Chelsea Dunning for assisting with all the administrative matters around this evaluation. The assistants and administrators at the Centre for Fetal, Maternal, Newborn and Child Health Care Strategies of the University of Pretoria are also thanked for their contributions and support, especially Riaan Pretorius, Lumbani Tshotsetsi and Cathy Bezuidenhout.

Declaration. The evaluator assisted the Malawi research teams with their Implementation Research protocol development, data analysis and report writing.

Executive Summary

Every Preemie—SCALE (henceforth called “Every Preemie”) is nearing the end of a five-year award from the USAID/Washington (USAID/W) Bureau for Global Health. The project was awarded September 1, 2014 and ends August 31, 2019. A team of three organizations received the award: Project Concern International (PCI) (the prime partner); the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS); and the American College of Nurse-Midwives (ACNM).

The partners worked together collaboratively across the project while each led in specific areas:

- PCI led overall project management, global partner engagement, implementation of Family-Led Care in Malawi and supported research, learning and global communications;
- GAPPS led evidence, research and learning activities; and
- ACNM led health provider capacity building and performance improvement activities in Malawi and supported the development of global tools and products.¹

As designed, Every Preemie’s primary objective was to serve as a catalyst for change: accelerating and supporting innovative approaches for evidence-based preterm birth (PTB) and low birth weight (LBW) interventions in 24 USAID priority maternal and child health countries.² Through its work, Every Preemie sought to expand the global conversation, stimulate country-specific adoption of these interventions, overcome obstacles to their delivery, and increase the coverage and utilization of services.”³

Did Every Preemie succeed as a catalyst for change?

There were multiple stakeholders with whom Every Preemie engaged and many who benefitted from the roll out of project initiatives. To gauge its success and determine the degree to which the project affected or catalyzed change, Every Preemie contracted the University of Pretoria to conduct a thorough evaluation. Several tools were developed and used to collect data, including online surveys, questionnaires, e-mails, and interviews. Evaluation questions centered on the project’s three main outcomes:

- **Outcome 1:** Improved translation of evidence into action
- **Outcome 2:** Increased capacity of local, national and global entities to scale-up and sustain the utilization of high impact interventions
- **Outcome 3:** Increased prioritization of PTB and LBW with in-country decision-makers and other relevant stakeholders at global and national level

¹ <https://www.everypreemie.org/>

² Afghanistan, Bangladesh, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Myanmar, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia

³ Work plan Year 1

This Executive Summary highlights major findings for each outcome. The full End-of-Project Evaluation Report illustrates the deeper details and uses extensive quotes to form an authentic narrative reflective of themes and findings.

Outcome 1: An applied learning approach

The Every Premie team, in collaboration with USAID/W and USAID field missions, selected four demonstration countries to receive support for implementation research: Bangladesh, Ethiopia, India, and Malawi. The goal was to learn more about specific preterm birth and low birth weight (PTB/LBW)-focused interventions, obtain evidence of what worked during implementation, and determine how this knowledge could be shared with and applied by stakeholders to replicate and scale successful models. The Every Premie team designed its implementation research agreements and partnerships with this in mind; and committed to strengthen the capacity of local research organizations and other partners through mentoring and technical support.

In alignment with the vision of Every Premie, each country-specific study “was developed in collaboration with the government and local partners to address questions central to moving evidence to action in an effective and feasible way within their unique settings.”⁴ This directly linked their work to the applied learning approach promoted in Outcome 1.

Country-specific implementation research models

Each country had a contextually appropriate model of implementation research and a focus that was negotiated with local partners:

1. Bangladesh provided an opportunity to advance work on maternal gestational age assessment by an already existing project led by the Projahnmo Research Group.
2. The goal of the Ethiopian study was to “inform the development of recommendations to the Federal Ministry of Health (FMOH) on national programming to support the implementation, coverage and

BUILDING SCALE

SCALING—expanding the Family-Led Care model in Malawi to 16 new districts; with other countries showing interest in adapting the model.

CATALYZING—sparking global and national dialogue to bring attention to PTB and LBW and care of the small/sick newborn; using implementation research results to build the national response to PTB and LBW; developing products and tools to accelerate information-sharing and action.

ADVOCACY—serving as the active global champion for essential newborn care and care of the vulnerable newborn; supporting national engagement in IR countries and in others to bring attention to PTB and LBW.

LEARNING—broadly disseminating findings from landscape analyses; supporting the development and dissemination of global products and publications; sharing implementation research findings to influence country level action.

EVIDENCE-DRIVEN—ensuring that global and national stakeholders had access to the most recent evidence on the safe and effective care of small and sick newborns; generating evidence for country programming.

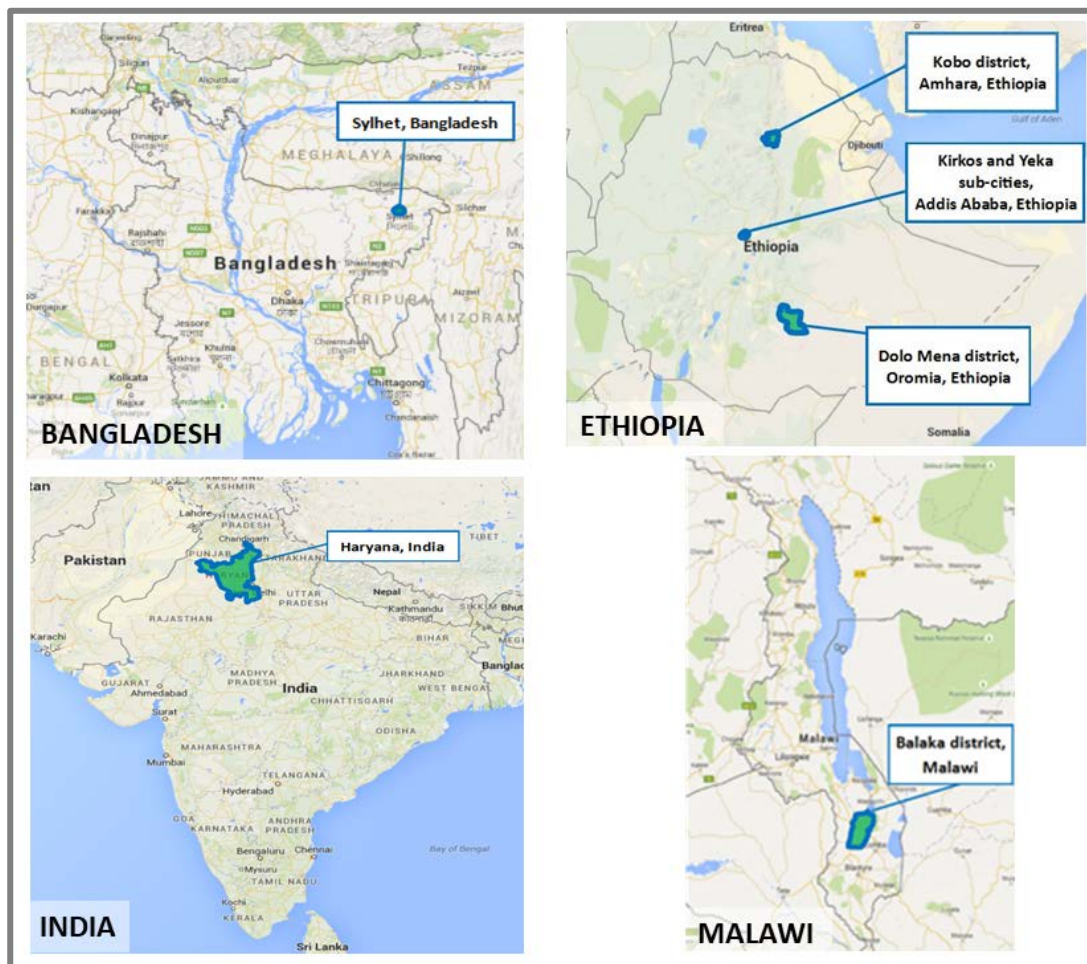
⁴ Biannual Report, Year 5

quality of select interventions and services within the public health care system to improve outcomes for small and sick newborns in Ethiopia.”⁵

3. In India, the aim was to inform policy and operational guidelines to improve clinical practice, to revise the current Government of India (GOI) antenatal corticosteroids (ACS) operational guidelines and to assess the implementation of the revised ACS operational guidelines in two districts in Haryana State.⁶
4. In Malawi, Every Preemie assessed the implementation of its new model of care for early/small newborns – Family-Led Care – in Balaka District.

All four implementation studies occurred in specific geographic areas, as depicted in the study site maps below.

Study site maps



⁵ Ethiopia study protocol

⁶ India study protocol

The value of participating in implementation research

Those interviewed for this End-of-Project Evaluation Report (informants) provided feedback on the value of participating in the research for individuals, institutions and ministries.

Individuals valued the entire research process and experience, particularly learning about the context of health facility-based research. Some saw benefits in making research efficient and more productive and collaborating with other partners and non-governmental organizations (NGOs). Those in group interviews mentioned being able to improve their own skills and perspectives through their involvement with Every Preemie.

Institutions benefited from increased visibility and recognition that opened doors to future collaborations. One research team mentioned that the experience helped with other grant applications.

Ministries of health emphasized the importance of involving the government at national and sub-national levels from the outset to facilitate a sense of ownership and greater adoption of recommendations. Involving Ministry of Health (MOH) officials was not without challenges, however, due to issues related to their availability.

Driving ambitious innovation

Every Preemie's commitment to implementation research was considered both ambitious and innovative. In each country, the research model evolved to leverage existing situations, priorities and resources. Each had its own history, including varying levels of engagement by principal investigators and study coordinators.

Yet all experienced great success against their individual agendas. With extensive involvement from U.S.-based colleagues and in-country stakeholders in Ethiopia, India and Malawi, all countries completed their research. As of this evaluation, all were positioned to share findings both globally and at the national level through various meetings and via peer-reviewed journal publications.

Findings across the board are significant and relevant.

- Bangladesh findings demonstrate that ultrasound technology remains the gold standard for gestational age estimates, even in low- and middle-resource settings. These findings will push the global community to continue to explore new ultrasound technologies for these settings.
- The depth of analysis in the Ethiopia public health system for care of the early/small/sick newborn is noteworthy. Exploring different geographies and providing insights into obstacles, challenges and opportunities will strengthen the government's commitment to building the public health system as they continue to work towards improvements in under-five and newborn outcomes.
- Government representatives in India are engaged in a robust debate regarding the safe and effective use of ACS for women in imminent preterm labor as a result of Every Preemie–Postgraduate Institute of Medical Education and Research (PGIMER) research. It is critically important that ACS is used appropriately as the results of unsafe use can lead to poor maternal and newborn outcomes including death. Identifying weaknesses in the previously launched ACS operational guidelines has enormous value as they advance their work in maternal and newborn health.

- In Malawi, the Family-Led Care model has been well received and is currently being scaled throughout the country. While there are areas for improvement, the model is the first of its kind in Malawi. In a resource-limited environment, it is crucial to identify innovative ways to engage families in the care of their early/small baby, build health care provider competence, and link community health workers (health surveillance assistants (HSAs), in this case) to households post-discharge.

Outcome 2: The implementation of Family-Led Care in Malawi

With USAID/Malawi field support, Every Premie worked with the Balaka District Health Management Team (DHMT) to design and implement an innovative and new model of care for early and small babies – Family-Led Care. The model is designed to improve the quality of care in facilities; empower families to participate in the care of their small babies in the facility and at home; and strengthen post-discharge follow-up care. Family-Led Care was implemented in nine health facilities in the district, including Balaka District Hospital.

The *services pathway* of the model focused on improving provider skills and quality of care in KMC units through clinical training and capacity strengthening, quality improvement (QI) processes and the procurement of essential supplies and equipment:

1. *Capacity strengthening through training.* From 2016 through 2018, 128 health care providers (nurse-midwives, medical assistants and clinical officers) from the designated health facilities were trained in Essential Care for Every Baby (ECEB) and Essential Care for Small Babies (ECSB). These providers and 20 support staff (mainly hospital attendants) were trained in Family-Led Care. To strengthen the link from facility to home, 93 HSAs were also trained on Family-Led Care.
2. *Quality improvement.* Every Premie worked with MaiKhanda Trust, an NGO specializing in QI, to focus on PTB/LBW interventions in the target facilities and create stronger links between communities and facilities. Mentors from the district hospital were nominated to conduct monthly coaching visits to improve regular monitoring of and documentation (data quality) for preterm/LBW babies.
3. *Infrastructure, equipment and supplies.* Prior to the design and implementation of the model, two health facility assessments were conducted to identify clinical care needs for early/small babies in Balaka district. This was followed by infrastructure upgrades, the procurement of equipment (e.g. weighing scales) and supplies (e.g. feeding cups).

The *practices pathway* focused on families continuing care of their baby after returning home:

1. Mothers and families were taught to care for their early/small newborn during their stay in the health facility, and upon discharge, received a reminder leaflet and monitoring form to help them continue caring for their baby and recognize danger signs that require immediate care from the facility;
2. HSAs and Care Group Lead Mothers were introduced to Family-Led Care as part of their training in maternal health and essential newborn care; and
3. Community sensitization continued through existing structures, such as meetings and special events.

The link between facility and community is the referral system that ensures the mother and family continue caring for their small baby at home, are able to identify danger signs and seek immediate treatment, and regularly return to the facility for post-discharge follow-up of the baby.

To implement the model, a Family-Led Care package of materials and tools was developed. These included a flipbook with messages on the care of preterm/LBW newborns for providers to use at admission to KMC; a take-home leaflet with a summary of key messages; an easy-to-use newborn monitoring form for families to use in the facility and at home; and a feeding chart for clinical providers to use during inpatient care. These materials also formed the basis for a Global Family-Led Care Package which can be adapted for use in other countries.⁷

Measuring success

In addition to the implementation research study assessing the Family-Led care model in Malawi, data were collected from MOH facility records to measure the model's effect. The model's greatest influence and impact, supported by review of MOH data, is improved health outcomes for preterm/LBW newborns and higher survival rates. Specifically, there was a reduction of in-facility preterm/LBW newborn deaths during the project period, from 11% in 2016 to 4% in 2018 ($p=0.018$). This is a significant finding.

There was little observed improvement in the percentage of KMC newborns with adequate weight gain at the first facility-based follow-up visit. However, data quality/completeness for this indicator (complete recording of follow-up date and weight) improved from 16% in 2016 to 69% at the end of 2018.

While Every Premie's work centered on facilities in Balaka district, the project built a strong network of stakeholders, including the national MOH Reproductive Health Directorate, implementing partners such as the National Safe Motherhood Working Group, and health care providers at the community level. This network coupled with the key inputs left in place by the project, will help to facilitate future implementations by the MOH and other USAID partners.

For all of these reasons, the End-of-Project Evaluation found many informants optimistic about the Family-Led Care model and the idea that it is "here to stay".

Outcome 3: Preparing countries to focus on preterm and low birth weight care

To prepare countries to focus on preterm and low birth weight care, Every Premie contributed to eight pivotal global activities. These include:

1. Tracking and monitoring country level indicators in 24 USAID priority countries;
2. Developing a PTB/LBW Continuum of Care matrix;
3. Conducting a multi-country ACS landscape analysis;
4. Leading efforts for a Joint Statement on Preterm Birth;

⁷ <https://www.everypremie.org/family-led-care-global/>

5. Collaborating as part of the team behind the WHO document *Survive and Thrive: Transforming care for every small and sick newborn*;
6. Conducting a multi-country situation analysis of inpatient care for small and sick newborns;
7. Developing the Global Family-Led Care package; and
8. Synthesizing global evidence on nurturing care for small and sick newborns.

Tracking and monitoring country-level indicators

As part of the commitment to inspire action in the 24 USAID priority countries, Every Premie compiled data on PTB and LBW and created individual country profiles. These provide a national-level report on the status of the prevention and care for preterm/LBW babies for each country and highlight related risk factors and coverage of important interventions. Profiles were launched in November 2015 at an Every Premie-sponsored World Prematurity Day event on Capitol Hill in Washington, DC, as part of a global multi-partner call-to-action. Country profiles were updated in 2017, with a new profile added for Myanmar. Further updates are expected in 2019. According to the Every Premie annual and biannual reports, the profiles were disseminated via USAID missions in these priority countries as well as at various events.

In addition to profiles, a country-level tracking and monitoring system was developed, featuring a dashboard indicator to track clinical standards and operating procedures based on the WHO *Recommendations on interventions to improve preterm outcomes*.

A Continuum of Care matrix

Another early product designed and disseminated by Every Premie was the PTB Continuum of Care matrix. It highlights “priority evidence-based interventions for the prevention of PTB, the management of preterm labor, and care of the preterm and small newborn”.⁸ The matrix serves as a roadmap for partners to design and plan activities related to preterm birth and LBW and is the first time this type of information and guidance has been organized and framed in this manner. The matrix was disseminated to USAID missions and country-level stakeholders, as well as during meetings in Washington, DC and around the world. However, the End-of-Project Evaluation found that awareness levels for the matrix could be higher.

Multi-country antenatal corticosteroids landscape analysis

One of the project’s more hands-on activities involved the *Antenatal Corticosteroids for Women at Risk of Imminent Preterm Birth in the Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Sierra Leone, Tanzania and Uganda: A Policy and Implementation Landscape Analysis*. It was conducted in seven of the eight Pathfinder countries of the UN Commission on Life-Saving Commodities (UNCoLSC) in sub-Saharan Africa on behalf of the UNCoLSC Newborn Health Technical Resource Team. Results were

⁸ Annual Report Year 1

published in 2016 as an internal report and shared at a UNCoLSC ACS Technical Working Group meeting. In 2018 it was published in *Global Health: Science and Practice*.⁹

Joint statement on preterm birth

Every Premie was also involved in developing and reviewing three international joint statements disseminated in 2016/7 to demonstrate professional associations' commitment to action and the implementation of key World Health Assembly resolutions such as the Every Newborn Action Plan (ENAP), the Global Strategy for Women's, Children's and Adolescents' Health, and the 2015 WHO recommendations on interventions to improve preterm birth outcomes. Every Premie led the development of the Joint Statement *International WHO Recommendations on Interventions to Improve Preterm Birth Outcomes: A Commitment to Action from Professional Health Organizations*. In addition, the Every Premie team contributed significantly to the development of the statements on Kangaroo Mother Care (led by Saving Newborn Lives [SNL]) and Quality of Care (led by the USAID-funded ASSIST project).

The Joint Statement on Preterm Birth recognizes the important and collaborative role of national professional associations to assist countries to update policies and programs and support the safe and effective implementation of the WHO recommendations. Five relevant international professional associations reviewed and endorsed this joint statement, namely the Council of International Neonatal Nurses (COINN), the International Confederation of Midwives, the International Council of Nurses (ICN), the International Federation of Gynecology and Obstetrics, and the International Pediatric Association.

The joint statements were distributed through Every Premie's networks, with the intention to also have them disseminated through the respective international professional association memberships. Collectively, according to Every Premie, the three joint statements "represent a significant global move to catalyze action for improved maternal and newborn health in low resource settings".¹⁰

Multi-country situation analysis

Midway through the project cycle, at the request of USAID/W, Every Premie broadened its scope beyond PTB and LBW to include a focus on sick newborns and inpatient newborn care.

There is a need to define, standardize, and mainstream inpatient care of small and sick newborns on the essential newborn care platform. Every Premie's expanded focus include the design of a multi-country situation analysis of inpatient care of newborns and young infants in order to gain greater understanding of the service readiness landscape. Every Premie led the development of the protocol and tools for this analysis in collaboration with other partners. The tools were tested in Malawi and Nepal; posted on the Every Premie website;¹¹ and made available to low- or middle-income countries wishing to assess service readiness and quality of care provided to inpatient small and sick newborns. As of the End-of-Project Evaluation, Ghana, Nepal, Rwanda, Tanzania and Uganda had completed or were

⁹ Greensides D, Robb-McCord J, Noriega A, Litch J. Antenatal Corticosteroids for Women at Risk of Imminent Preterm Birth in 7 sub-Saharan African Countries: A Policy and Implementation Landscape Analysis. *Global Health: Science and Practice*. 2018;6(4):644-656.

¹⁰ Annual Report Year 2

¹¹ <https://www.everypremie.org/technical-materials/>

in the process of completing the situation analysis. The project plans to create a multi-country profile of key findings across Ghana, Nepal, Rwanda and Uganda.¹²

Survive and Thrive: Transforming care for every small and sick newborn

Every Preemie collaborated with WHO, UNICEF, USAID, the Bill & Melinda Gates Foundation, the London School for Hygiene and Tropical Medicine and others to design and develop a global document on inpatient care of the small and sick newborn, titled *Survive and Thrive: Transforming care for every small and sick newborn*. It targets country-level managers in ministries of health “with a goal to provide a programmatic framework for integrating this critical work into newborn inpatient care.”¹³ Every Preemie provided the project coordinator and the Senior Director, who was one of four managing editors and a lead author for the publication. The GAPPS Evidence and Learning Lead provided publication review. The Key Findings Report¹⁴ was launched on December 13, 2018 at the global Partnership for Maternal, Newborn and Child Health Partners Forum in New Delhi, India. The full document was launched at the World Health Assembly in May 2019; and a related panel discussion was held at the Vancouver Women Deliver conference in June 2019.

Evidence synthesis on nurturing care

In Year 5, Every Preemie worked with WHO, UNICEF, USAID and the USAID-funded MCSP project to design and conduct an evidence review around nurturing care for small and sick newborns. The evidence synthesis was designed based on the Nurturing Care for Early Childhood Development—A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential. The report will include a summary of findings from peer-reviewed literature, country case studies (including country-specific grey literature) and a gap analysis. It is expected to be finalized in July 2019. Findings will be used by WHO and UNICEF to develop guidelines for nurturing care to complement the clinical standards of care for small and sick newborns currently in development (with other partners including Every Preemie).

Propelling the global agenda

From 2015 through 2018, Every Preemie convened six meetings of the PTB/LBW Global Technical Working Group on Implementation Challenges and Solutions (PTB TWG-ICS), a group of more than 200 thought-leaders representing a wide range of clinical and public health disciplines.¹⁵ The meetings provided a multidisciplinary forum for sharing “emerging evidence, relevant research and learning across the range of PTB and LBW interventions and implementation in low-income countries”.¹⁶ The TWG explored opportunities to address gaps in critical knowledge and identify priorities for future implementation research. This evaluation informants considered the TWG’s contribution necessary for maintaining momentum and moving the global preterm birth agenda forward.

¹² Tanzania data were not ready for inclusion in the multi-country document.

¹³ Annual Report Year 3

¹⁴ <https://apps.who.int/iris/bitstream/handle/10665/276655/WHO-FWC-MCA-18.11-eng.pdf?ua=1>

¹⁵ Annual Report Years 3 & 4

¹⁶ Annual Report Year 4

Do No Harm Technical Brief Series

A key spinoff of the TWG was the development of technical briefs on the safe and effective use of inpatient newborn care interventions in low-resource settings. The “Do No Harm” series provided evidence-based guidance on how to avoid harm and improve newborn health outcomes and were grounded in WHO guidelines and recommendations. “The target audience for the briefs is a wide range of policymakers, program managers and clinicians with the intended outcome of guiding decision-makers to integrate the WHO recommendations in their country in a safe and effective way.”¹⁷ These briefs were shared at numerous meetings and conferences; and, more than 4,300 copies have been downloaded to date from the Every Preemie website.

Advocacy, media and meeting participation

Most of Every Preemie’s activities included an advocacy component through sharing evidence for best practices and by promoting the implementation research conducted in the four demonstration countries. Major advocacy efforts involved creating and maintaining a website; supporting social media; participating in international awareness days and campaigns; and using meetings and conferences to raise awareness for Every Preemie, its expertise, and its cause. The Every Preemie website launched in May 2015¹⁸ and has since garnered more than 200,000 page views and 30,000 downloads.

Achievements in cross-cutting priorities

Every Preemie’s Results Framework features six cross-cutting priorities: (1) local capacity strengthening, (2) gender equity, (3) knowledge management, (4) action-oriented advocacy and awareness raising, (5) access to commodities and (6) sustainability.

- **Local capacity strengthening**¹⁹ was evident in all four demonstration countries vis-a-vis work with the local research partners. In Malawi, this extended to the improvement of knowledge and skills in the care of preterm/LBW newborns by health workers and professionals, support staff, HSAs and community volunteers. A key element of the Family-Led Care model was also building the capacity of families to actively engage in the care of their babies during inpatient KMC and at home.
- **Gender equity** appears to have received less attention and should benefit from more careful thought in future projects. In Balaka district in Malawi, however, there were anecdotal reports of male involvement in community awareness activities (e.g. fathers’ groups) and observations of fathers carrying their babies skin-to-skin.
- **Knowledge management** and shared learning are central to Every Preemie and are linked to **action-oriented advocacy and awareness raising**. The project’s mandate to share evidence through a variety of means – including the implementation research, Joint statements, TWG, conference attendance, web and social media campaigns, and Do No Harm briefs – heightened awareness and influenced meaningful action.

¹⁷ Annual Report Year 3

¹⁸ www.everypreemie.org

¹⁹ We used a broad definition here of local capacity strengthening.

- **Access to commodities** was implicated in the implementation research in Ethiopia, India and Malawi. In Ethiopia, the research looked at the availability of basic commodities for newborn care; and, in India, research focused on the safe and effective use of ACS across levels of care. In Malawi, the Family-Led Care model implementation included procurement of essential items for the care of early/small newborns (e.g. weighing scales, feeding tubes and cups). The project also looked carefully at the use of ACS in seven countries via the landscape analysis and included commodities in the situation analysis for inpatient newborn care.
- **Sustainability** was addressed indirectly, as the Every Premie project focused on inspiring action and preparing the landscape for future implementation of PTB/LBW interventions.

USAID/Washington’s investment in the Every Premie—SCALE project ensured that a consistent spotlight was put on preterm birth, low birth weight and inpatient newborn care over the last five years. Every Premie—SCALE was appreciated by global and national partners and was commended for its engagement in the global newborn health arena and for bringing attention to these critical topics. The global conversation is evolving and there is significant attention being paid to moving global evidence to action at the country level. Every Premie has been engaged in and led key conversations and activities at the global level that will influence country-level commitment to PTB/LBW and inpatient newborn care. At the same time, there is great interest in learning from countries, and Every Premie’s research findings in Bangladesh, Ethiopia, India and Malawi will contribute significantly to the global body of knowledge while also influencing national action.

“Every Premie—SCALE was quite successful in bringing a new perspective to topics that were not otherwise being discussed and will definitely last into the future.” (GP04)

1 Background

Every Premie is nearing the end of a five-year award from the USAID/W Bureau for Global Health. The project was awarded September 1, 2014 and ends August 31, 2019. A Consortium of three organizations received the award: PCI (the prime partner); (GAPPS); and the ACNM. Each Consortium partner played unique and specific roles in global and country engagements and in implementation research activities: “PCI leads overall project management, global and partner engagement, and supports research and learning; GAPPS leads evidence, research and learning activities; and ACNM leads health provider capacity building and performance improvement activities”.²⁰

The project was designed to accelerate and support innovative approaches to expand the uptake of evidence-informed PTB/LBW interventions in 24 USAID priority countries.²¹ SCALE is the acronym for Scaling, Catalyzing, Advocating, Learning, and Evidence-driven, which summarizes the project’s five-year strategic objective as “to catalyze global uptake of PTB and LBW interventions, overcome obstacles to the delivery of interventions and services, and increase coverage and utilization of services.”²²

According to two informants in the end-of-project evaluation, the conceptualization of Every Premie had similarities with that of the Prevention of Postpartum Hemorrhage Initiative in that both focused specifically on high-priority global public health issues. Given their singular focus, the projects were designed to highlight these issues – PTB and LBW, and postpartum hemorrhage, respectively – and build global and country-level attention and momentum for a concerted response.

Since its inception, Every Premie has organized the project’s focus, resources and activities around the Results Framework depicted in Figure 1. A snapshot of project highlights and accomplishments over the project’s life cycle is provided in Figure 2 below.

²⁰ <https://www.everypremie.org/>

²¹ Afghanistan, Bangladesh, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Myanmar, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia

²² Work plan Year 1

Figure 1. Every Premie Results Framework

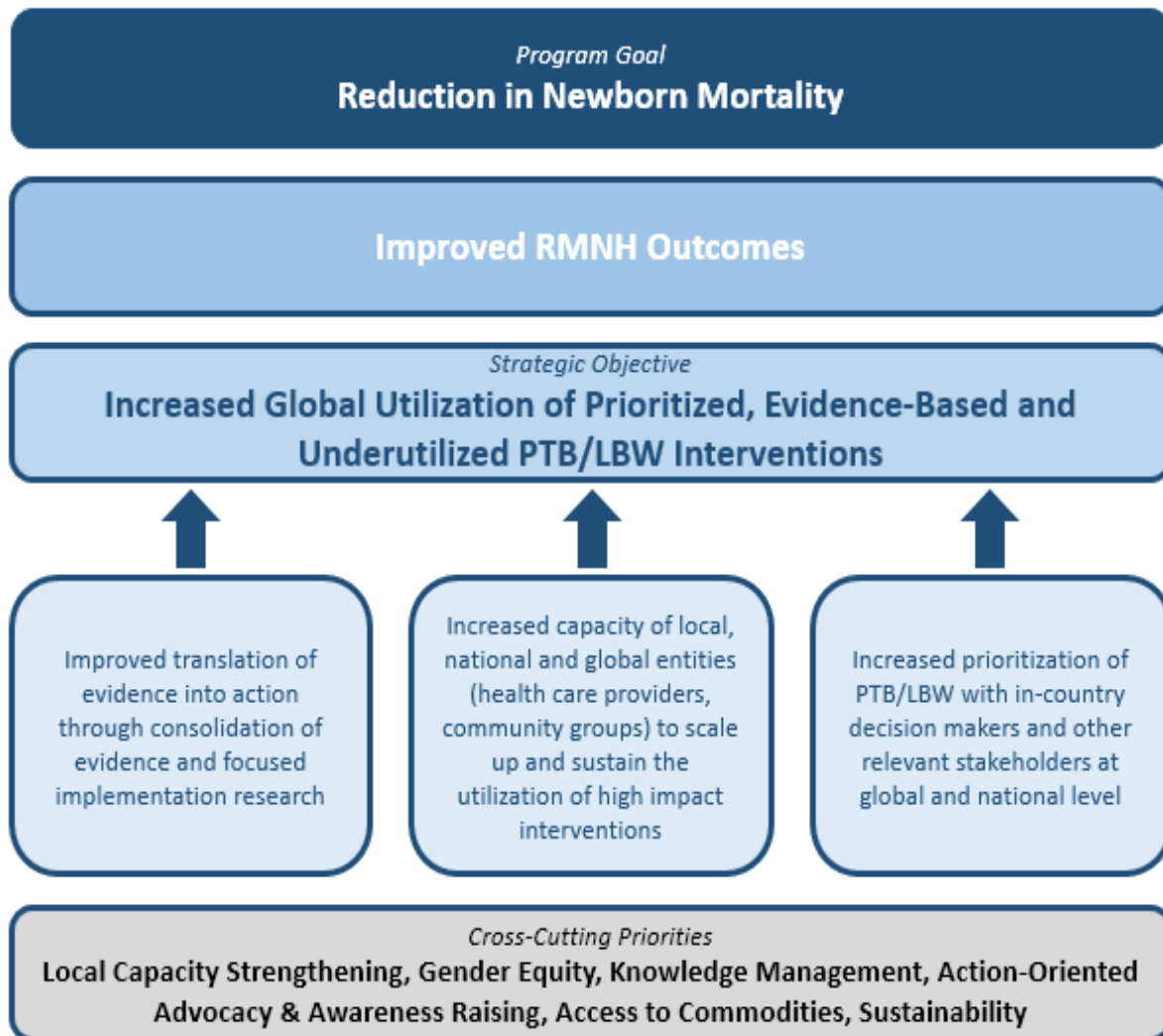
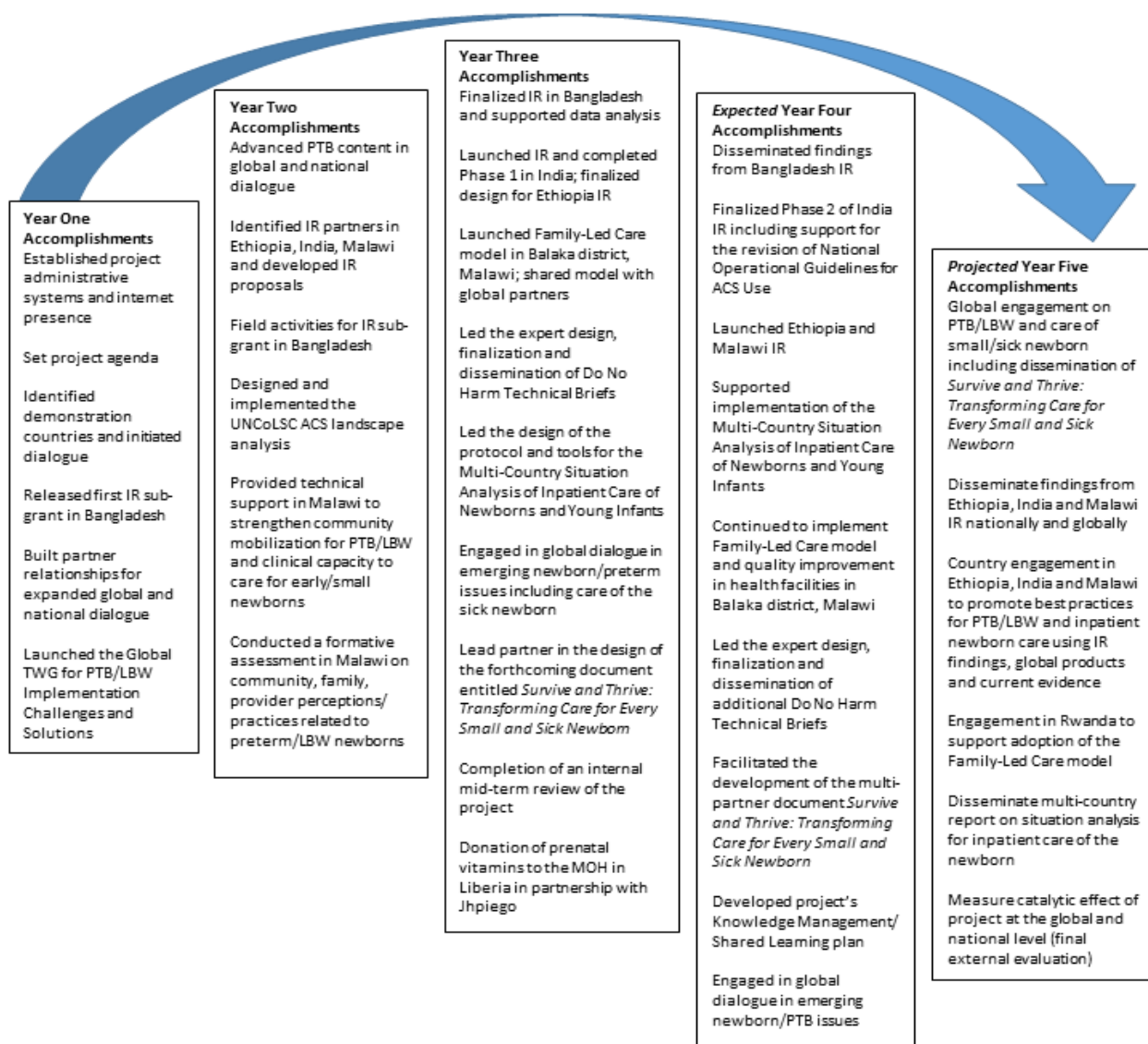


Figure 2. Project life cycle and accomplishments



1.1 Beneficiaries of Every Premie—SCALE

There were five main groups of stakeholders that were engaged and/or benefited in some way from being engaged with Every Premie:

1. Partners who participated in Every Premie activities such as attending the PTB TWG-ICS, participating in the writing and reviewing of materials developed under the umbrella of or in collaboration with Every Premie; and participating in the implementation of the situation analysis in different countries (See Sections 3.3 and 3.4.);
2. In-country researchers whose skills and experience in implementation research were developed (See Section 3.1.);

3. Health care providers who could use the materials developed for global use, those who have been involved in the implementation of Family-Led Care in Malawi and those benefitting from the pilot implementation of the revised ACS guidelines in India (See Sections 3.1 and 3.2.);
4. The health system stakeholders in the different countries who may use the findings from the implementation research to improve the quality of care for preterm and LBW babies; and
5. The most important ‘stakeholders’ in the rollout of Every Preemie initiatives are the preterm and LBW newborns who directly and indirectly benefit from improved quality of care immediately or in the future.

2 Evaluation Approach and Methods

The Year 4 Annual Report refers to the intention of Every Preemie to “undertake an end of project evaluation to document its key achievements and results at both national and global levels.”²³ The terms of reference of the evaluation consultancy describe the purpose of the evaluation as follows:

“Given the specific focus of the project to catalyze action at the country and global level around PTB/LBW, the evaluation will focus on the ‘catalytic effect’ that the project has had over the life of the project. Specifically, the evaluation aims to document where the project has facilitated change or catalyzed acceleration or scale in the areas of PTB/LBW and inpatient care of the small and/or sick newborn. The evaluation will explore the types of changes the project has influenced and how.”

The University of Pretoria was contracted to conduct the end-of-project evaluation from February to May 2019. The evaluation was designed and the tools developed at an evaluation-planning workshop between February 6 and 8, 2019 in Pretoria, South Africa. The planning meeting was attended by the external consultant, the Every Preemie Senior Director, PCI’s Director of Monitoring, Evaluation, Research, and Learning supporting the project, and the Every Preemie Technical Advisor based in Malawi. Over the period of data collection, the consultant gave regular feedback to the Director of Monitoring, Evaluation, Research, and Learning and a Senior Every Preemie Program Officer.

The evaluation questions are organized around the project’s three main outcomes:

Outcome 1: Improved translation of evidence into action

- b. How has the project’s IR agenda contributed to or influenced improved knowledge among key stakeholders/decision makers around PTB/LBW interventions and/or programming in demonstration countries?
- c. How has the project’s IR agenda contributed to or catalyzed change/s in policy or action targeting PTB/LBW interventions and/or programming in Every Preemie demonstration and focus countries?

²³ Annual Report Year 4

- d. How is the project perceived and valued among demonstration country partners, including stakeholder perceptions at the country level regarding Every Premie's contributions?

Outcome 2: Increased capacity of local, national and global entities to scale-up and sustain the utilization of high impact interventions

- b. What progress has been achieved in enhancing PTB/LBW interventions in Malawi (and other countries where relevant) and what has been the role of the project in these changes?
- c. How is the project perceived and valued among partners in Malawi, including stakeholder perceptions at the country level regarding Every Premie's contributions?

Outcome 3: Increased prioritization of PTB and LBW with in-country decision-makers and other relevant stakeholders at global and national level

- a. What progress has been achieved in raising awareness about and action for PTB/LBW and inpatient care for the small and/or sick newborn at the global level during the project period and what role has the project played in this progress?
- b. What are the pathways of change to raise awareness and catalyze action for PTB/LBW and what role has the project played among global partners and stakeholders?
- c. How is the project perceived and valued among global partners, including stakeholder perceptions of Every Premie's role and contributions?

2.1 Definition of “catalyze” and “catalyst”

One of the overarching objectives of this evaluation was to document stakeholder perspectives on the catalytic effect or influence that the project had over time. For a common understanding, the following dictionary definition of “catalytic” was used as point of departure: “If you describe a person or thing as having a *catalytic effect*, you mean that they cause things to happen or they increase the speed at which things happen” (our emphasis).²⁴

Applied to the Every Premie project's strategic objective, this evaluation focused on partners at various levels (from country to global level) and their views regarding how Every Premie, with its limited budget, was able to engage strategically and contribute to:

- the acceleration of global advocacy around PTB and LBW and action for change at the country level;
- the assessment of models of care for early/small babies and the identification of opportunities and challenges for improved service delivery via implementation research;
- the development of government-owned recommendations to improve services and increase coverage and service utilization for the small and/or sick newborn; and
- the adoption of a new model of care (Family-Led Care in Malawi) for improved outcomes among early/small babies.²⁵

²⁴ <https://www.collinsdictionary.com/dictionary/english/catalytic>

²⁵ The expansion of the Family-Led Care model was underway in Malawi in Years 4 and 5; other models of care including changes to the India Operational Guidelines for ACS use were in review.

2.2 Tool development

A number of evaluation tools were developed to cover the project's three outcomes. The target audience for each tool was determined according to the role of individuals, institutions (including Ministries of Health) and organizations with regard to the realization of each outcome. There were two online surveys administered with Qualtrics software, one for USAID health officers in USAID-supported countries prioritizing maternal and child health (MCH) and an anonymous questionnaire for global partners involved in Every Premie's PTB TWG-ICS. An e-mail survey on ACS policy and use was conducted using individualized e-mails sent to seven individuals who were involved in the development of the multi-country policy and landscape analysis on ACS use for women at risk of imminent preterm birth. The rest of the tools included six interview guides shaped around the interest, focus, tasks or responsibilities of the particular informants. Table 1 gives an overview of the target audiences and data collection methods. The tools are included in Annexure A.

Table 1. Overview of target audiences and data collection methods

Tool #	Target audience	Method
OUTCOME 1 (Implementation research)		
1A	Implementation research partners in the 4 demonstration countries	Individual and group interviews
1B	Implementation research partner stakeholders in Ethiopia and India*	
OUTCOME 2 (Targeted technical assistance – Malawi)		
2A	Participants in Family-Led Care Other stakeholders in Malawi	Individual and group interviews
2B	MaiKhanda Trust	
OUTCOME 3 (Global and national partners)		
3A	USAID health officers in USAID priority MCH countries	Online questionnaire
3B	Global partners involved in the PTB TWG-ICS	Online questionnaire
3C	USAID/W Newborn Health Team	Individual and group interviews
3D	Selected global partners	Individual Interviews
3E	People involved in the ACS landscape analysis	Open-ended e-mail

* USAID missions and government officials

2.3 Data collection

Major documents obtained from the Every Premie team and the official Every Premie website were reviewed for relevant information on different aspects of the project. The documents included annual

and biannual reports and annexures, work plans, inventories, assessments, protocols and tools, presentations, blogs, regular and ad hoc reports from the four demonstration countries, and the Midterm Review.

Invitations for participation in the end-of-project evaluation were issued by Lily Kak, USAID/W Newborn Health team, Judith Robb-McCord, Senior Director, Every Premie, and the external consultant, depending on target audience. Data collection took place between February 25 and April 30, 2019 and included the following activities:

1. Visit to Malawi – 16 face-to-face interviews with 21 informants plus one Skype and one phone interview – priority informants: implementers of Family-Led Care in Balaka District; partners; MOH officials; and implementation research partners (Tools 2A, 2B).
2. Telephone, mobile, Skype and other online interviews – informants: implementation research stakeholders (Tools 1A, 1B); global partners (Tools 3C, 3D); and one Malawi informant (Tool 2A).
3. Online survey sent to USAID mission officials in 20 countries (excluding the four demonstration countries) (Tool 3A) – five countries responded.
4. Online survey sent to 22 global-level partners (Tool 3B) – 17 potential informants started the survey, only 10 completed the full survey.
5. E-mail invitation to respond to questions regarding ACS policy and use (Tool 3E) – information was obtained from four of the seven sub-Saharan countries targeted.
6. Conversations with five members of the Every Premie core team to corroborate some of the information provided by the other informants.
7. Potential informants invited to participate in an interview or an online survey received one or two reminders if there had been no response to the first invitation.

One global partner and one government official declined an interview because they felt others had already provided or would be in a better position to provide the necessary information. Interviews were only audio-recorded where informants gave oral permission. Three informants declined audio-recording but were willing to be interviewed. During one interview, the audio-recorder malfunctioned. Detailed notes were taken during all interviews. Table 2 gives a breakdown of the interviews conducted with different groups. Although a maximum of 35 interviews was envisaged, we eventually conducted 44 interviews with 55 informants. Six interviews were conducted with groups of 2-4 informants, while the rest were individual interviews.

2.4 Data management and analysis

Responses to the online questionnaires were received directly through the Qualtrics program and were exported to Excel. A few basic frequencies were calculated and responses to open-ended questions were used to add relevant information and perceptions to Sections 3.3 and 3.4 of this report.

Table 2. Breakdown of types of interview participants

CATEGORY	Individual interviews (n)	Group interviews* (n)	Interviews completed (n)	Total informants (n)
Global partners	6	0	6	6
Implementation research partners and stakeholders**	10	2	12	16
Malawi	14	3	17	23
USAID newborn team	2	1	3	5
Every Premie Consortium members	6	0	6	5
TOTAL	38	6	44	55

* 2-4 informants per interview ** Including Malawi research partners

Each interview recording was allocated a unique ID number. Audio-recordings were transcribed by a professional transcription company. Seven audio-recordings were of poor quality because of poor online connectivity or unavoidable background noises and were not submitted for full transcription. Because of the tight time frame and the late availability of some of the informants, a further six interviews could not be transcribed in full. However, the consultant listened to all these recordings again and transcribed important sections.

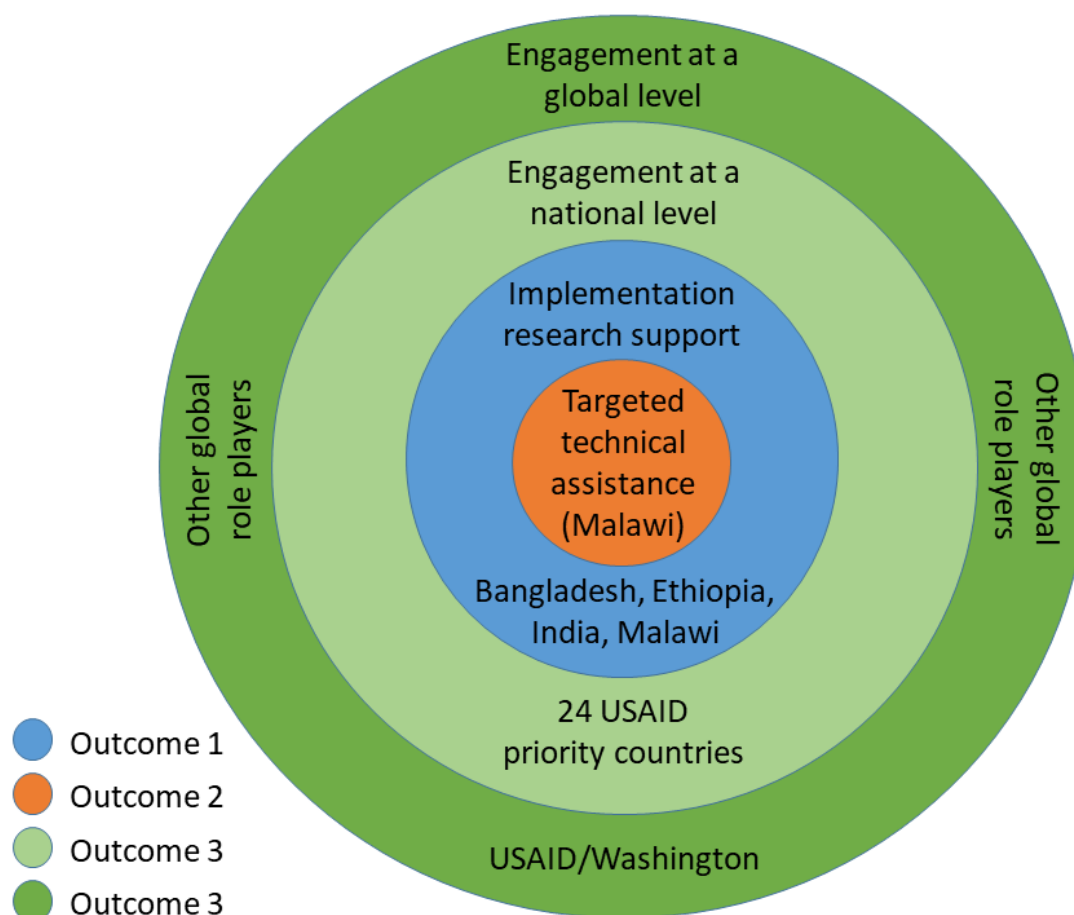
The interview transcripts, the notes of interviews not transcribed, and a selection of Every Premie documents were uploaded to NVivo 9 for qualitative analysis. Documents were read several times to identify potential themes. Excerpts of the transcripts, notes and documents were then allocated to different nodes corresponding with the identified themes. Nodes also received a tag to distinguish between different data sources (documents and informant groups) to facilitate the review of text excerpts and the triangulation between sources when writing up the findings. The text of some of the nodes was exported to Microsoft Word® for further analysis and nodes with the same name but different tags were combined in one document where there was a need to analyze a particular theme from different perspectives.

2.5 Structure of the report and presentation of findings

Figure 3 is an illustration of how different countries and stakeholders have been involved with the Every Premie activities and how they were approached to participate in the evaluation. The two inner circles focus on the four demonstration countries (Bangladesh, Ethiopia, India and Malawi) targeted for implementation research (Outcome 1). The inner circle focuses on Malawi, the country that received targeted technical assistance with the implementation of the Family-Led Care model (Outcome 2). The two green circles reflect the project's engagement at the global level, development of country profiles, global technical documents, technical working group, and includes both the 24 priority USAID-supported countries (light green) and global partners (dark green circle) (Outcome 3). An element of the catalytic nature of the project is the interaction between and among activities and stakeholders within these different

levels. Evaluation findings are presented by outcome, according to the Project Results Framework (Figure 1) and the evaluation questions formulated for each outcome.

Figure 3. Different levels of engagement in the Every Premie—SCALE project, by outcome



The Every Premie project is not conducive to a quantitative approach to measure the achievement of objectives and intended outcomes. This report is therefore a reconstruction of events and ensuing products and derivatives and the experiences of various stakeholder groups. Although it contains many verbatim quotes to provide an authentic narrative, they reflect primary themes and are not exhaustive.

To ensure confidentiality of participant responses, this report does not contain a name list of informants. To protect the identity of participants that could be easily recognized in direct quotations, only four broad reference categories were created for these quotations, namely “IR” for all informants in the category of implementation research (including Malawi), “MW” for all other Malawi informants, “GP” for global partners and USAID/W informants, and “CO” for Consortium members.

Other editorial styles include the following:

- Direct quotations from informants are presented in italics, whereas quotations from documents are not;
- It is presumed that when an informant uses the term “LBW” in a direct quotation, preterm babies are included in this designation.

2.6 Limitations of the evaluation

As this evaluation was conducted before the closeout of the Every Premie project, there are inherent challenges to evaluating this type of project within the program period. It is only post-project that one can fully see and document the level of change resulting from a project. Some of the findings in this report may reflect current perceptions of the status or achievements of the project but not reflect changes that may occur in the coming years.

This evaluation is mainly based on the self-reporting of information and experiences by evaluation participants. Most of the stakeholders were also identified as those who had been actively involved in one or more of the Every Premie activities and who in general may have had a positive experience of their involvement. To enhance validity, the findings were triangulated from various data sources wherever possible.

Although reminders were sent to follow up with potential participants in the two online surveys and in the ACS e-mail survey to improve response rates, responses remained low (USAID missions 5/20 = 25%; global-level partners 10/22 = 46%; ACS survey 4/7 = 57%). The reasons for this are not clear. One reason may be end-of-project ‘fatigue’ in some potential respondents or the fact that USAID missions had bigger projects that demanded attention and Every Premie was funded centrally from Washington. A few e-mails from potential global informants indicated that they felt they had only participated in a limited number of activities during the initial stages of the project. Regarding the ACS survey, at least one potential informant had moved on to another position and a possible substitute did not respond to e-mails. Another one had retired, but it was possible to get more information from current government officials.

Although this report is considered an “evaluation”, it is more a review of the achievements (“catalytic effect”) and accomplished or potential impact of the Every Premie—SCALE project as described in documents and perceived by beneficiaries, stakeholders and partners from the global to the local level. The scope of the evaluation did not include other aspects often associated with a formal evaluation such as management and logistics of the project or the management of projects in the four demonstration countries. This report also does not include an assessment of the quality of the implementation research processes or the findings from the studies in the four demonstration countries. Management issues were only considered when they could have had a negative impact on the outcomes of the project or when there was a potential for future learning.

3 Accomplishments of Every Premie—SCALE: “large mandate”, “limited funding” and “high expectations”

The three Every Premie—SCALE outcomes illustrate the project’s large mandate. The project was implemented under a central funding mechanism managed by USAID/W and received \$7.2 million US dollar over the life-of-project.²⁶

“If I were being asked this question with regard to the donor I would say that they (Every Premie) were limited by their funding envelope and had a lot expected of them with a limited funding envelope and that was a little bit of a handicap I think.” (GP04)

This section is divided into five subsections; the first addresses cross-cutting accomplishments, with the subsequent four corresponding to the explanation in Section 2.5 and Figure 3, and shown below:

Subsection heading	Outcome
3.2 Applied learning through implementation research in four demonstration countries	1
3.3 Family-Led Care in Malawi	2
3.4 Preparing countries to focus on preterm and low birth weight care	3
3.5 Moving the global agenda forward	3

3.1 The Every Premie project – “as a team they are very respected”

Overall informants had tremendous appreciation for the passion, leadership, management skills and responsiveness of all Every Premie team members including the three team leads. Team members were described with phrases like *“a tremendous advocate for the newborn, a huge wealth of knowledge and very respected in the field.”* (GP08-1), *“great as a technical leader”* (GP07), *“an excellent systems thinker”* (GP08-2), *“a great manager and good partner”* (GP07) and *“superior quality technical assistance”* (Midterm Review).

There was particular mention of how the different competencies and experiences of the three consortium partners and the project leads complemented each other to bring *“a clinical perspective”* (GP08-1), *“a health-systems and on-the-job perspective”* (GP08-1) and a training perspective for *“understanding the Family-Led Care model”* (IR01-1).

“They got some of the right people involved in the project and they picked the right application. Because they could [capture] all that momentum [of the technical knowhow] of GAPPS, while they could use the strength on community engagement, mother care groups and on-the-ground presence of PCI and the capacity building of ACNM. ... So everybody contributed differently in very important ways.” (CO5)

²⁶ The established ceiling for the Every Premie award was \$8,999,296.

3.1.1 Relationship with the donor – “wish list exceeded their bandwidth or budget ...”

The Every Premie team had good relationships with the donor – “*there was a mutual respect*” (GP08-1) and “*quick responses and quick support when that was requested*” (GP08-3). This is how a USAID/W staff member commented in the Midterm Review:

“I value their responsiveness. I value their flexibility. Every time I come up with a hairbrained idea, they are willing to listen and debate. If they don’t like the idea, they’ll say so. And that’s fine with me. I feel like we have a very professional, collegial, trusting relationship and I feel we have good partners that I can rely on, and I feel that they are implementing one of USAID’s highest priority technical areas so I view them to be very important – an important part of the newborn portfolio so I treat them very seriously ... I think they do very high-quality work. They are top notch. So, I value all of that.” (p. 23)

“Overall I think the project has been very responsive to all USAID requests and not just responsive because USAID as a donor is asking them to do something, but also because I think they believe that we are working on this together as partners and that they believe that all the requests that USAID is making is truly of global relevance and importance. So I believe we have really worked as partners, I have enjoyed working with [the Every Premie advisors], they are colleagues and partners, we have good discussions on: is this an important issue – and if we agree mutually that yes it is important, then we figure it out how do we implement it. So I feel like we are really good partners, I have been really grateful for that.” (GP07)

Mention was also made about the trade-offs that had to be made in terms of being “*very clear about what can and cannot be done*” (GP08-2).

“I also really appreciated that at times when our wish list exceeded their bandwidth or budget that [the project director] would very directly and forthrightly state that so that we weren’t – she wasn’t making promises for the project that were just infeasible. That was appropriate and it’s important for us to sort of then step back and say, ‘Okay, well what are we going to give up in order to get this done?’ Or whether we want to continue and scale back.” (GP08-1)

3.2 Outcome 1: Applied learning through implementation research in four demonstration countries – “brave” and “ambitious”

The Every Premie team, in collaboration with USAID/W and USAID field missions, selected four countries as demonstration countries to receive support for undertaking implementation research.

Although the initial plan was to identify two countries in the first year of the project, high interest from field missions, and a unique research opportunity in Bangladesh, led to the selection of four countries: Bangladesh, Ethiopia, India, and Malawi. The work in these four countries links very closely to the applied learning approach promoted in Outcome 1. The aim was to learn more about the implementation of specific PTB/LBW-focused interventions and obtain evidence of what worked and how this knowledge could inform local stakeholders on how to translate it into action through replicating and moving successful models to scale. The Every Premie team designed “*the implementation research agreements and partnerships as a chance to develop in-country capacity to do [implementation research]*” (CO1). Every Premie therefore committed to advance the leadership and

strengthen the capacity of local research organizations and other partners, where requested, by means of ongoing mentoring and technical support.

The Every Preemie team “had to balance the project’s unique mandate with available resources and country expectations and priorities.”²⁷ Activities included identifying in-country research partners, developing a learning agenda and research questions, designing the studies, and getting the necessary approvals from ministries and Institutional Review Boards (IRBs). Each country also had its unique challenges in dealing with delays at various points of the study. According to Every Preemie, establishing implementation research projects required “significant effort and extensive coordination with local partners to write concept notes, engage local stakeholders, and finalize corresponding budgets and contracts.”²⁸

The implementation studies in Ethiopia, India and Malawi each had to align their work with the vision of Every Preemie. To do so, they generated research questions that “are central to moving evidence to action for preterm birth and LBW by supporting governments and their partners to identify interventions and models of care that are effective and feasible within their setting, while informing global learning.”²⁹

“The idea was that we would set priorities with countries for critical questions that would be acted on locally, but would have global importance and that that priority would be set in partnership with the governments, in the individual governments and then we would identify local partners and work together.” (CO1)

A consortium of partners led by Brigham and Women’s Hospital designed the implementation research in Bangladesh and Every Preemie primarily provided resources to work already underway.

3.2.1 Different models: questions, designs, geographies, timelines, partners

Each country’s research process and highlights are described in separate boxes in Subsection 3.2.2 below. Annexure B contains two tables that give an overview of the study titles, aims and objectives, and a description of the annual accomplishments. Each country had a unique, contextually appropriate model of implementation research and a focus that was negotiated with the in-country partners.

“The thing that was kind of interesting about it is that [Every Preemie] really had very disparate foci in these different countries. ... So in the way that the program evolved it just so happened that Malawi was the one that really required a lot of kind of onsite, face-based technical support. Whereas in India it was more policy, it had to do with auxiliary nurse-midwives in India being enabled to provide first dose of antenatal corticosteroids. And in Ethiopia it was really just working with a whole-systems approach in terms of how prematures were dealt with. ... The way that the program was structured in-country, was based to a large to extent on how the country shaped, what they felt they needed in terms of programming and understanding of premature birth.” (CO7)

²⁷ Annual Report, Year 1

²⁸ Annual Report, Year 3

²⁹ Annual Report, Year 2

“If each country played out differently in terms of the priorities, we will talk about the priorities, but they also somewhat varied on the kind of relationship we had with the investigator team in-country.” (CO1)

Implementation research in the four countries included:

5. Bangladesh provided an opportunity to advance work on maternal gestational age assessment by an already existing project led by the Projahnmo Research Group.
6. The goal of the Ethiopian study was to “inform the development of recommendations to the FMOH on national programming to support the implementation, coverage and quality of select interventions and services within the public health care system to improve outcomes for small and sick newborns in Ethiopia.”³⁰
7. In India, the aim was to inform policy and operational guidelines to improve clinical practice, to revise the current GOI ACS operational guidelines and to assess the implementation of the revised ACS operational guidelines in two districts in Haryana State.³¹
8. In Malawi, Every Preemie provided targeted technical assistance in Balaka District for the implementation of a new model of care for early/small newborns – Family-Led Care. The aim of the implementation research in Malawi was to assess caregivers’ and health care providers’ experience with Family-Led Care.

All four demonstration countries had multiple partners and collaborators whose representatives attended in-country stakeholder meetings or provided specific support for the rollout of the research. Deliberations at these meetings informed the subsequent course of the in-country projects and models. Table 3 provides a list of country stakeholders.³²

Table 3. Country partnerships

Bangladesh	Ethiopia	India	Malawi
- Ministry of Health and Family Welfare (MOHFW) - USAID/Bangladesh - Centre for Diarrhoeal Disease Research, Bangladesh - Shimantik (NGO) - Child Health Research Foundation - Brigham & Women’s Hospital/Harvard Medical School - Johns Hopkins Bloomberg School of Public Health	- FMOH - USAID/Ethiopia - Ethiopian Pediatric Society - Ethiopian Society for Obstetrics and Gynecology - St. Paul’s Hospital Millennium Medical College - Ethiopian Public Health Institute	- MOHFW, Government of India - USAID/India - Department of Health and Family Welfare, Government of Haryana - All India Institute for Medical Sciences (AIIMS) - National Neonatology Forum of India (NNFI)	- Ministry of Health RH Directorate - Balaka District Health Management Team (DHMT) - USAID/Malawi - National Safe Motherhood Technical Working Group - PCI Njira Project - Save the Children - University of Malawi, College of Medicine, School of Public Health and Family Medicine

³⁰ Ethiopia study protocol

³¹ India study protocol

³² Annual Report, Year 1

Bangladesh	Ethiopia	India	Malawi
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• MaiKhanda Trust

In the implementation research, it was important to find “*the right partners who are credible*” (IR07). One of the challenges in forging in-country partnerships was to get everyone on the same page regarding their understanding of what implementation research was:

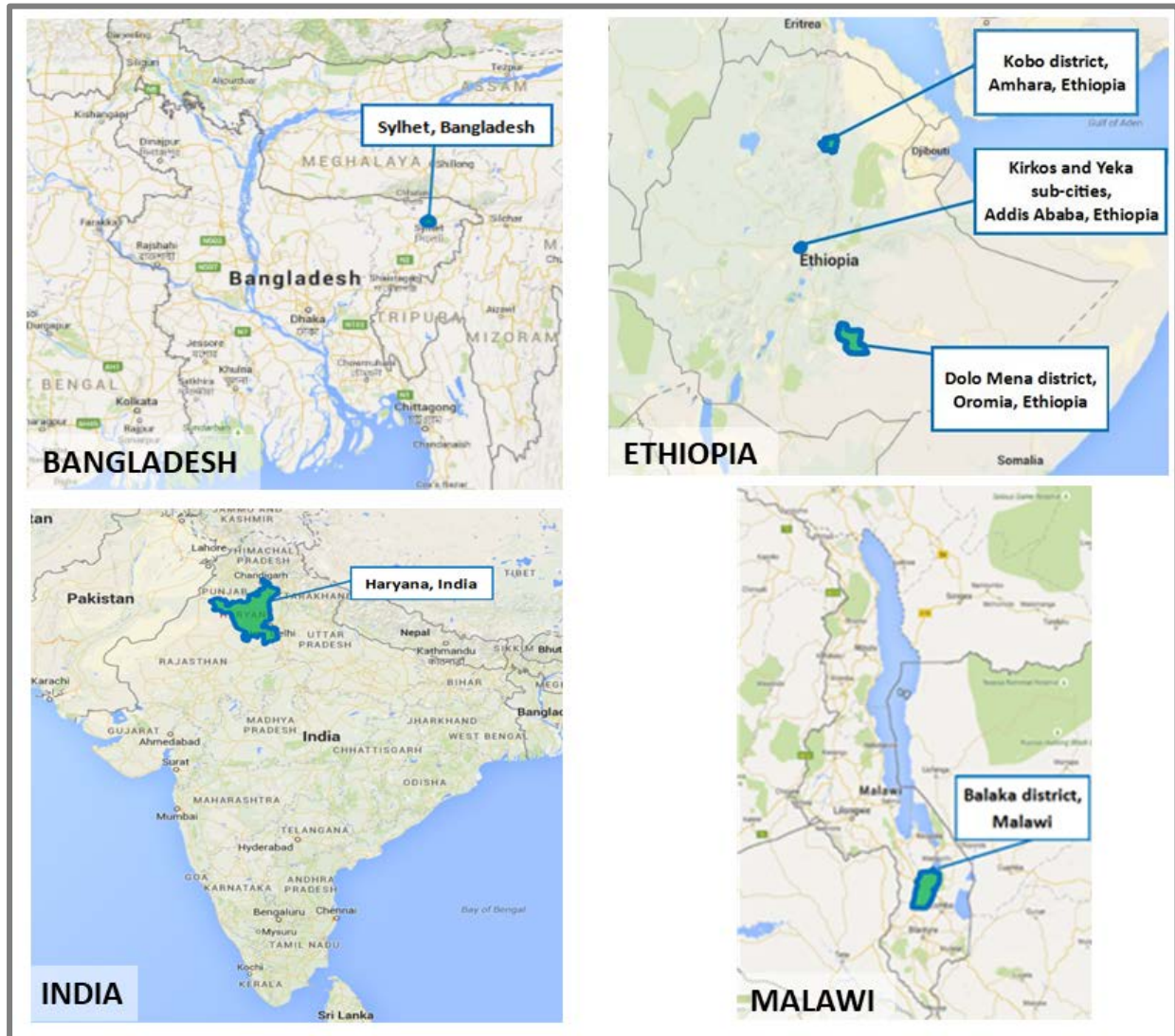
“... on who should actually do IR [implementation research] and how it contributes to and complements clinical trials; that it’s quite a different type of science and has not been appreciated and utilized much in the maternal and newborn health space to date. ... The trialists just could not appreciate it ... but in every case, the local researchers and I think the government really appreciated it and took it deeply and was very committed to do this kind of work. ... People were appreciating it as the way to find critical information and evidence efficiently.” (CO1)

In India and Ethiopia, current government policies and interventions were taken as a point of departure to phrase the research questions. India had an in-country Project Advisory Group (PAG) that included government officials, donor and in-country partners. The research team worked closely with the PAG and government, donor, and in-country partners were all included as investigators. An informant from Ethiopia reflected that it would have been good for the study to have had some form of advisory group.

“A ... point I would have changed is I would establish some kind of ad hoc group that would look at the progress by inviting the Federal Ministry of Health, USAID, PCI. ... Although the follow-up was not loose, it would have been good to kind of get guidance from a team that comprises of the funding agencies, the implementers and the technical support providers. ... When you have undertakings which engage a lot of people, I feel like it’s really important to make sure you have representatives [advisory board] and those that are involved in making decisions, because there will not be any surprises in the process.” (IR03)

All four implementation studies occurred in specific geographic spaces. In the case of Bangladesh, the space was determined by a pre-existing study in Sylhet. The Ethiopian study was conducted in three different regions representing different geographies and demographics. In India, two districts in Haryana state were identified as study sites and in Malawi, the study took place in Balaka district. Figure 4 contains maps of the four countries’ study sites.

Figure 4. Study site maps



3.2.2 Implementation research: country highlights

Highlights of the implementation research in each country are presented in Boxes 1-4.

BANGLADESH

“We were able to start pretty quickly”

Study title:

Maternal anthropometrics and statistical modeling to improve prediction of gestational age before birth in low-income settings

The Bangladesh implementation research project had a shorter and easier inception than the other three countries. Every Premie’s Evidence and Learning Lead’s ongoing relationship and interactions with researchers at Brigham & Women’s Hospital facilitated the identification of an excellent opportunity to advance work in the critical area of gestational age assessment.

The Sylhet study site in Bangladesh is managed by the Projahnmo Research Group (now a Foundation) and the local NGO Shimantik. They have an international partnership with Johns Hopkins University and a relationship with the Brigham & Women’s Hospital. These connections enabled the development of a research proposal that could complement existing National Institutes of Health-supported trials aimed at improving *“pregnancy-related screening and the treatment of infections in pregnancies to try to prevent preterm birth”* (IR08). The Midterm Review quotes the Bangladesh study director as saying that “the major challenge affecting preterm birth is either lack of gestational age dating or the inaccuracy of gestational age dating in these [low-income] settings” (p. 29). Work on better ways for community health workers (CHWs) to identify premature infants at birth was already ongoing through a USAID Saving Lives at Birth award in the same study area, which *“created a nice platform to build on that platform to add a few more additional questions”* (GP07) and to include *“a new measurement as part of this study”* (IR08).

“We were lucky because we already had the infrastructure in place in the trial phase; we had all of our staff, our health workers, the cohort that was doing an ultrasound screen for gestational age; that was already happening. So we just kind of added on this intensive module for training of health workers for the physical anthropometrics at the start. ... It was an opportune moment ...we just needed that infusion of funding to be able to devote staffing, to devote the training material, the physicians that could oversee everything, do the quality control.” (IR08)

As envisioned, the Bangladesh study could complement other studies in low- and middle-income countries to address the need for an affordable, simplified and appropriate method for pre-birth gestational age assessment. The Every Premie project focused on the development and validation of methods for measuring maternal abdominal girth (AG) and symphysis fundal height (SFH) to improve prediction of gestational age before birth. The aim of the study was to determine the accuracy, reliability and feasibility of maternal anthropometric measurements (e.g. SFH and AG) in the third trimester of pregnancy to estimate gestational age compared

with the gold standard of ultrasound dating in early pregnancy (<20 weeks). Standardized methods for CHWs to measure SFH and AG in pregnancy were tested. Procedures were also developed and tested to improve the reliability of SFH and AG measurement by different levels of health workers (CHWs, nurses, and physicians) to assess the programmatic feasibility of implementing these procedures in low-resource settings. If this method could be shown to be effective for determining pre-birth gestational age, it had the potential for rapidly improving life-saving clinical care such as the use of ACS and antibiotics, kangaroo mother care (KMC), the management of obstetric complications, and addressing referral needs in resource-limited settings.

“They were important findings, but they were disappointing”

The results were disappointing – *“not the findings that we had hoped for”* (GP07). Findings showed that the tested method was not successful at estimating gestational age to an acceptable level of precision to guide clinical management. Nevertheless, these findings provided significant learning for the global community and confirmed the continued importance of ultrasound for accurate gestational age estimation. The learning points to the need for global advocacy and research prioritization in making ultrasound technology more readily available and user-friendly in low-resource settings.

“The clear message is that ultrasonography needs to be scaled up. ... I think it’s more evident that there needs to be more resources towards [expanded use of] ultrasound, both for dating but also for general pregnancy care. There needs to be that within the health system. It helps to provide that information that without the resources it may not shift the needle that much ... it’s to get the message out there and hopefully it will really help to kind of move the needle and make people think more.” (IR08)

Data analysis was completed in Year 3 of the Every Preemie project and further advanced statistical modelling were undertaken in Year 4. Results were shared at multiple conferences and technical meetings. At the time of the evaluation, manuscripts based on this research were still being submitted and reviewed for publication.

“I think that hopefully once the reviewers review it and we respond to everything that it will be in a kind of polished version where all the results will be final. And then we would disseminate it both to our local partners, the ministry, as well as EP SCALE or whatever ...” (IR08)

ETHIOPIA

“A whole-systems approach”

Study title:

Assessment of the scope and implementation of services for small and sick newborns within the Ethiopian public health care system: a health systems implementation study

Activities in Ethiopia in the first year of the Every Preemie project revolved around the development of a learning agenda through extensive dialogue with various partners and the approval of a concept note. The design of the implementation research started in Year 2 in collaboration with the FMOH and USAID/Ethiopia. They identified St. Paul's Hospital Millennium Medical College (St. Paul's) as the research partner. In Year 2, two protocol writing and instrument development workshops were conducted.

The study's goal was to describe the implementation of newborn interventions and services for small and sick newborns in the Ethiopian public health care system in three regions representing three different geographic settings:

- K'obo Woreda (district), North Wello Zone, Amhara Region (settled agrarian)
- Dolo-Mena Woreda, Bale Zone, Oromia Region (semi-pastoral agrarian)
- Kirkos and Yeka Sub-cities, Addis Ababa Region (urban)

A further aim was the identification of key challenges to and opportunities for improving preterm, LBW and sick newborn services nationwide, specifically health-system structural factors and essential service-delivery processes. It was envisaged that the learning and evidence emanating from this study would inform recommendations to the FMOH on an effective essential package of PTB/LBW interventions for national scale-up, based on current capabilities, practices, experiences, and strengths and weaknesses of the newborn care system. The findings could potentially contribute to the strengthening the FMOH's promotion of equitable access to health care services for the Ethiopian population.

The study included multiple data collection activities and designs (mixed methods, prospective, cross-sectional). It focused on the evaluation of the structures, processes and outcomes of a set of priority interventions essential to small and sick newborns and the assessment of current delivery and readiness to deliver such services within levels of care and by setting. The following were main focus areas of the research:

- Facility readiness
- Health systems readiness
- Referral and transfer system
- Experience of care /quality of care

- Post-discharge care utilization and mortality

In each region study populations included clinical leaders in the health facilities, administrators in obstetric and newborn health, medical professionals and staff providing obstetric and/or newborn care, health extension workers and various groups of mothers whose newborns had been admitted and not admitted to newborns units in tertiary and secondary hospitals.

The choice of study sites and the development of the protocol posed some challenges. Originally, an urban setting was not included. A contribution of USD100,000 by USAID/Ethiopia as part of their field support made this addition possible. Some of the initially selected sites had to change because of persistent drought and security concerns. A similar study working with the same patient population at St. Paul's Hospital also necessitated a change of sites for the post-discharge care study in the urban area.

“The original belief we had ... was that there are a lot of babies who are being discharged from the NICUs [neonatal intensive care units] ... meanwhile the study enrolment rate was low. That resulted in a significant delay in completing our cohort, which called for making changes to the protocol, asking for additional funding.” (IR03)

At the time of the end-of-project evaluation, the analysis of qualitative and cross-sectional data and data collection for the post-discharge care study had been completed. There was planning underway for in-county dissemination and two draft manuscripts on quality of care and health-system readiness were in process.

“We didn't actually have a new model that we designed through our project, but what we did was really document how different partners have come together and implemented a program for preterm babies and small low birthweight babies. ... It was just looking at what's happening in the country, what are different partners doing and how does it all come together, and how is it being implemented. So it has become an interesting study, I still have to wait and see how useful it will be for the country to roll out as a model of care and can we use that model globally.” (GP07)

INDIA

“There was a global burning need to find out whether antenatal corticosteroids was feasible administering at a lower level of the health system”

Study title:

Assessment of use of antenatal corticosteroids and national operational guidelines in Haryana state, India

In 2014 the GOI published policy and operational guidelines for the use of antenatal corticosteroids (ACS) in preterm labor that included support for auxiliary nurse-midwives to administer a pre-referral dose to pregnant women in preterm labor at public health facilities. This policy, together with the publication of the Indian Newborn Action Plan, provided an opportunity for Every Preemie to work with the MOHFW of the GOI to evaluate the implementation of the ACS policy in two districts in Haryana State (Hisar and Ambala). The local research partner was the PGIMER in Chandigarh. Year 2 was devoted to protocol writing and instrument development and the final IRB approvals were obtained in Year 3.

The aim of this mixed-methods study was to assess the utilization and practice of ACS administration for women in imminent preterm labor in selected childbirth care facilities in Haryana State. There was a particular focus on the safe provision of pre-referral dose by auxiliary nurse midwives. It was anticipated that the findings from this study would provide important lessons for the safe and effective rollout of ACS in low-income settings.

The three main study objectives corresponded with the three phases of engagement in Years 4 and 5:

- Phase 1 assessed the current ACS availability and utilization practices and compliance with the MOFWH operational guidelines and identified critical pre-conditions for the safe administration of the pre-referral first dose ACS within the primary health care unit setting.
- Phase 2 was informed by the findings from Phase 1. The focus was to review current practices and to revise and update the GOI operational guidelines/policy for the use of ACS. Job aids and training materials to accompany the three-month pilot of the implementation of the revised guidelines were also developed. The table below shows how the findings were translated to revisions in the guidelines:³³

IR Findings	Revisions to Guidelines
Standard protocols/job aids, training and supervision not available for health workers	Job aids and guidelines developed to support training, performance standards and supervision
Mismatch between health worker confidence	Guidelines and job aids designed to address

³³ Annual Report, Year 4

in providing ACS, attitude on safety of ACS, and knowledge on proper use of ACS	knowledge and competencies
Use of ACS by health workers not standardized (timing, dose, medication choice, indications)	Job aids, ACS indication checklist, and requirements for documentation in the case record provided
Clarification on roles of providers lacking	Roles and responsibilities for each level of cadre specifically outlined
Authorization of level of facility for providing ACS lacking	Roles and responsibilities for each level of facility providing services specifically outlined
Typical referral time to reach a facility with adequate care for threatened preterm labor/PTB: 2-3 hours	Full-course ACS use limited to facilities with adequate care for threatened preterm labor/PTB
Key indicators for monitoring ACS use not reported	Appropriate, measurable indicators with clear definitions

- In Phase 3, the implementation of standard practice of the revised operational guidelines and algorithm for ACS administration was evaluated in facilities that met the health-system preconditions in the same sites within Haryana State. These findings would further inform the revision of the national ACS operational guidelines and the scale-up of such guidelines. A staff member of the USAID/W's newborn health team commented in the Midterm Review that "the study was designed to be very, very catalytic" (p. 13).

A PAG established in collaboration with the GOI oversaw the research and the dissemination of findings with a view to make recommendations for revision of the final ACS guidelines. When this end-of-project evaluation was conducted, the first two study phases had been completed and findings disseminated. For the third phase, implementation and data collection had been completed and planning with the GOI for the final dissemination of findings in India and beyond was underway. The research team had also completed two manuscripts reporting on findings.

MALAWI

“An ideal and very unique situation”

Study titles:

Knowledge, perceptions and practices of families who have experienced Family-Led Care
in Balaka district, Malawi

AND

Health care providers’ experience of implementing Family-Led Care for preterm and low
birthweight newborns in Balaka district, Malawi

The aim of the implementation research in Balaka district, Malawi was to assess caregivers’ and health care providers’ experience with Family-Led Care, a new model of care for the early/small newborn. Implementation research was complemented by data collection on key health facility indicators over time using MOH facility registers. The latter is further discussed in Section 3.2.3.

Two research partners in Malawi were contracted to conduct two studies, a provider study and a caregiver study, to assess the implementation of the Family-Led Care model. Both studies have been concluded and the findings are reported in three separate reports. Meetings for the dissemination of findings to stakeholders are forthcoming.

MaiKhanda Trust conducted the caregiver study on families’ knowledge, perceptions, practices and experiences of Family-Led Care in Balaka district. The specific study objectives were to assess:

1. Family perceptions of their inpatient care experience in relation to the implementation of the Family-Led Care model;
2. Family perceptions of whether Family-Led Care prepared them to confidently assume care for their newborn at home;
3. Family readiness/knowledge to continue care provision of their early/small newborn at home post discharge;
4. Family knowledge on the management of kangaroo mother care prior to discharge; and
5. Actual home-based care practices post discharge.

The caregiver study consisted of two consecutive data collection phases. A cross-sectional, quantitative, descriptive survey was conducted between February and November 2018. A number of qualitative individual and group interviews were conducted in two study sites in November and December 2018 to gain a deeper understanding of caregiver experiences of Family-Led Care. The first phase had 222 participants; the second phase had 25.

The Centre for Reproductive Health of the University of Malawi’s College of Medicine was responsible for the study on health care providers’ experience of implementing Family-Led Care in Balaka district. The study had the following specific objectives:

1. Assess provider ability (including HSAs) to accurately identify preterm/LBW newborns for admission, referral and discharge (knowledge);
2. Assess provider adherence to the clinical care standards set out in the Family-Led Care model (adherence);
3. Assess provider competency in providing care (inpatient and follow-up care) for early/small newborns (competence);
4. Explore staff and HSA attitudes towards the Family-Led Care model, the Quality Improvement intervention and the donations of material/equipment to implement the model (attitudes); and
5. Explore staff and HSA perceptions of how mothers/families reacted to the Family-Led Care model (perceptions).

The provider study used a mixed-methods approach targeting health care providers and support staff practicing or having been exposed to the Family-Led Care model in five health facilities. An in-depth understanding of providers' perceptions of and attitudes towards Family-Led Care was sought through qualitative methods like focus group and in-depth interviews. Quantitative methods (e.g. record review, questionnaires and clinical observations) were used to gathered data about providers' knowledge of, adherence to, and competency in providing Family-Led Care. Data were collected at two points during the implementation of Family-Led Care with the same set of data collection tools – midway through the implementation (February-March 2018) and towards the end of the project (November-December 2018). Two different groups of health care providers were targeted for the two data collection events, respectively – those who had initially been trained in Family-Led Care in 2017 and those who had been trained in the course of 2018. Sixty-two staff took part in the first round and 61 in the second round.

Data from the Malawi implementation research have been presented within Malawi and in various international meetings including the 2018 12th International Conference on KMC; 2018 Priorities in Perinatal Care Conference (poster session); the 2018 COINN Africa Conference; and the 2019 International Pediatrics Association meeting.

3.2.3 Flexibility and responsiveness as hallmarks of managing implementation research

Global and country informants all commented positively on the responsiveness and flexibility of the Every Preemie team in searching for mutually acceptable solutions to problems. The research partners were appreciative of the support – *“very supportive and very easy to work with and obviously understanding of the kind of real field challenges, the timelines and things like that”* (IR08). Another point of appreciation was budget flexibility – *“that was a huge lesson for us, because many funding agencies are not very flexible”* (IR04-2).

“I have to appreciate PCI in this process because they have been very practical and very responsive to the reality on the ground and we have had actually a good amount of flexibility from their side. One of which is the timelines and the second one is the associated budget.” (IR03)

Some of the research partners also referred to the quality research guidance they received.

“We obtained first-hand experience in implementation research with [the Every Preemie technical advisor]. We at the same time learnt a lot ... a practical exercise which we were privileged to have ... [the Every Preemie technical advisor], every time he was approachable and available whenever we had some issues and he was always there to guide, like how it should be approached and what should be the better way to [do something].” (IR04-3) The Every Preemie team faced some challenges in advancing the implementation research: *“it was very difficult to manage research from a distance with local research organizations”* (CO4). One informant considered the country-level implementation as the major challenge of the project.

“It was hard for them in some ways because they didn’t have an on-the-ground presence for the most part and had to work through partners. And I think that there was a long process of trying to get some of that started and decide on what were going to be the priorities...those challenges were not inconsequential and ... maybe the results of those endeavors were not as impactful as were the other outputs ... It’s hard to go into the country and really get people on board unless you bring a lot of money to the program support. ... Basically I think those are sort of inherent in what they were handed, more so than they were sort of mistakes that were made in terms of the EP SCALE team.” (GP04)

It was difficult for in-country partners to understand that all their wishes could not be included in the available time or funding envelope; this challenge was also mentioned in the Midterm Review (p. 27). A few informants referred to perceived missed opportunities in terms of the research projects being too limited in terms of geographic or population coverage, methodological approaches and the use of tools. This is in contrast with project thinking that *“maybe just limiting the scope so that they could be more productive with the implementation research, maybe more focused with that as well would have been useful”* (CO7). It all comes down to what *“can be done realistically”* (CO3) – *“it’s hard to go into the country and really get people on board unless you bring a lot of money to the program support”* (CO7).

“I think the process of trying to do country-level implementation research is a big undertaking if you don’t have an on-the-ground presence ... it’s probably more difficult than they realized it would be to really move that along. I think it moved slowly at times and again I am not clear on the impact of that.” (CO7)

3.2.4 Value of research participation for individuals, teams, institutions, and ministries of health – “the whole research was a great benefit”

Informants participating in the country implementation research commented on what participation in the research meant for them individually, as a research team and for their institutions.

Individuals valued the experience of the whole research process – *“For me like seeing through the whole process from protocol involvement, data collection, analysis, it’s been a wonderful opportunity to do it”* (IR01-2). A number of informants *“gained extensive research skills”* (IR08). Specific skills mentioned included *“preparing protocols”, “analysis of the training data sets”, “qualitative research”* and *“manuscript writing”*. Learning about the context of health facility-based research was also appreciated – *“first-hand information about ... [the] adoption to new interventions”* (IR01-3).

Project management, learning about making research efficient and more productive and collaborating with other partners like NGOs were perceived benefits for some informants, especially those for whom it was a first experience as manager.

“From my side as the program manager this project was a huge learning for me, like starting from the development of the protocol and drafting ... and with stakeholders, it was a great learning, but the main lesson for me was that ... I came to know ... the ground realities. We came to know the actual realities and then it gives us the idea like – before implementing you should pilot, we should make like guidelines or any job which should be customized to look at the context. ... So those were the areas which we think we often neglect when we just introduce new guidelines. ... It really built up capacity in the implementation research, so in future whenever we have a project it could be a great lesson and experience for us to carry out the implementation research processes.” (IR04-3)

Collaboration and teamwork were valuable experience gained through the implementation research – *“it kind of strengthened our research collaborations at every level”* (IR04-2).

“We have this good amount of skill to collaborate with multiple institutions. ... We have gotten the chance to know each other within the organization. You know if you don’t get the chance to work together it’s usually difficult to know who can do what when and this collaboration has given us the chance to learn more about each other.” (IR03)

Informants participating in one of the group interviews mentioned the benefit of talking about the value added to their own skills and perspectives through their involvement in Every Preemie.

“It’s nice to sit down and think about how you have benefited from a particular project, because that’s something that you don’t normally do. You are just working, you are looking to catch deadlines, but you don’t sit down to reflect on how the project as a whole has benefited you.” (IR01-3)

Institutions benefited from the implementation research, especially with regard to institutional visibility and recognition that also opened doors for future collaborations – *“When people are looking for research collaborators, then there will be those who say, ‘Okay, they have done research on this before and we can work with them’”* (IR01-1). One research team mentioned that the research experience assisted them with other grant applications – *“We have cited our involvement in Every Preemie ... in the other grants we applied for it”* (IR01-1). Some institutions also benefited on the administrative side –

“our administration learnt a great lesson because we now know about the fact that somebody should be assigned to handle the admin aspects” (IR03).

Ministries of Health were included in designing, conducting and/or overseeing the implementation research in India and Ethiopia. One informant emphasized the importance of involving the government at national and sub-national levels from the outset so that there is *“complete ownership of the government”* (IR07). Another referred to the challenge of accommodating implementation research projects in the public health system, *“how to work with the public health system”* (IR06). One informant referred to individual research capacity building, implementation research as *“a new bridging mechanism to close the [very huge] gap between the academia and the health managers”* (IR05), and the facilitation of the adoption of recommendations emanating from the research.

“Because someone is part of this process and when the recommendations are believable it will be easier to advocate, or it would be easier to disseminate this information, as opposed to an idle person who is not engaged in this process and we give him or her the article and they may not take it seriously. So it will really strengthen our staff in these kind of studies so that we can easily be able to disseminate, or we can be able to advocate for this particular case for premature babies. So it will really make someone be realistic with this recommendation that will come out ...

So then, I have learnt ... a lot about the challenge of working in the system. It was a good lens to show me where the gaps really exist when it comes to the care of preterm and premature babies. So I think it was highly informative ... it clearly shows how the country has a lot to go to address premature-related diseases.” (IR05)

Another informant described his experience of being on the receiving end of research capacity building:

“Personally ... [I was] engaged in this sort of deep dive and in fact evidence research activities, so it is an eye opener or it is a form of capacitating the health system staff like myself. ... I had to sit and do the write-up, a portion of this one article and I had to read lots of references with my colleagues and other obstetricians from another university. ... So it really capacitates the ministry’s staff on research writing and write-up ... the analysis part ... how to do simple research methodologies, how to critically read journals and how to critically write your research. So personally it is one of capacity building.” (IR05)

Involving ministry officials in the research process also brought challenges, especially in terms of time – *“we have lots of activities to attend to, we run here and there and it is really difficult to get focused on one or two or three research [projects]”* (IR05).

“The results of the implementation research study I think would all be of global relevance and going forward ... I would like to find ways of taking those lessons forward through other projects and through global policies, through bilateral projects and so on.” (GP07)

3.2.5 The legacy of Every Premie's implementation research

Including implementation research in the Every Premie project was considered innovative – “*we chose to be ambitious*” (CO1) and “*it's very ambitious research, which is not a reason it shouldn't be done*” (GP08-2). In each country, the implementation research evolved into a unique model to leverage the existing situation, priorities and resources available. Each project also had its own ‘history’ that included different levels of engagement of the principal investigators and study coordinators across the whole period of each study.

The successful implementation of the project's country level research agenda cannot be overstated. With extensive involvement from U.S.-based colleagues with in-country stakeholders in Ethiopia, India and Malawi all countries completed their research and as of this evaluation, were positioning to share findings both globally and at the national level through various meetings and via peer-reviewed journal publications. Stakeholder engagement in all four countries is exemplary and there is evidence that country-level research partners found the engagement to be hugely beneficial to their institutions, themselves as individuals and to the country. Findings across the board are significant and relevant.

- Bangladesh findings demonstrate that ultrasound technology remains the gold standard for gestational age estimates, even in middle- and low-resource settings. These findings will push the global community to continue to explore new ultrasound technologies for these resource settings.
- The depth of analysis in the Ethiopia public health system for care of the early/small/sick newborn is noteworthy. Exploring different geographies and providing insights into obstacles, challenges and opportunities there will strengthen the government's commitment to further building the public health system as they continue to work towards improvements in under-five and newborn outcomes.
- Government representatives in India are engaged in a robust debate regarding the safe and effective use of ACS for women in imminent preterm labor as a result of Every Premie-PGIMER research. It is critically important that ACS is used appropriately as the results of unsafe use can lead to poor maternal and newborn outcomes including death. Identifying weaknesses in the previously launched ACS operational guidelines as per their implementation is enormous value add to the country as they advance their work in maternal and newborn health. The updated Operational Guidelines are currently under debate elevating this important intervention to the senior most levels of the MOHFW.
- In Malawi, the Family-Led Care model has been well received and is currently being scaled throughout the country. While there are areas for improvement, the model is the first of its kind in Malawi. In a very resource-limited environment, such as Malawi, identifying innovative ways to engage families in the care of their early/small baby, build health care provider competence and link community health workers (health surveillance assistants, in this case) to households post-discharge is deeply important.

See Annexure C for a table of evaluation questions and findings for Outcome 1.

3.3 Outcome 2: Targeted technical assistance to implement Family-Led Care in Malawi – “cutting edge stuff”

Malawi was the demonstration country selected for targeted technical assistance in conjunction with implementation research. The activities in Malawi reflect the pursuance of Outcome 2 of the Every Premie project in that Balaka district became the demonstration site for the implementation of the Family-Led Care model. Balaka district was selected because of the linkage of Every Premie with PCI’s Njira Project, a five-year USAID/Malawi Development Food Assistance Program deployed in a number of traditional authority areas in Balaka district. The community-based health promotion activities within Njira had the potential to be harnessed as a platform to promote and extend quality home-based care for preterm and LBW babies.

This subsection describes the basics of the Family-Led Care model and its implementation in Balaka district, as well as the perceptions of implementers and other stakeholders on the achievements and challenges of implementing the model in Balaka district and the way forward. A more detailed report, “Telling the Story” of Family-Led Care will be produced as a separate document.

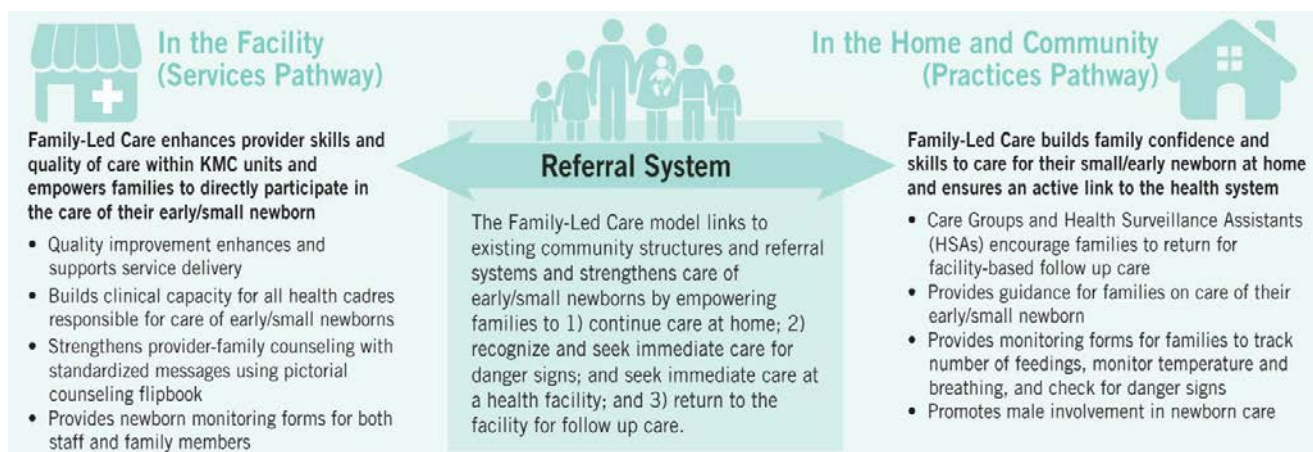
3.3.1 *The Family-Led Care model*

The model depicted in Figure 5 is a theoretical model of the components of Family-Led Care and how it should be implemented. “The Family-Led Care model is designed to improve the quality of KMC provided to inpatient preterm and LBW newborns; strengthen post-discharge follow-up care; and extend care of the preterm/LBW newborn to the community and household levels.”³⁴ The care of the small newborn starts with a services pathway (clinical care) in the health facility with maternity and newborn services (including a KMC space or room) that aims to improve the quality of KMC provided to inpatient preterm and LBW newborns. This component is described in the left-hand column of the figure and focuses on improving provider skills and quality of care in KMC units and on empowering families to participate in the care of their preterm/LBW babies. It also includes clinical training and capacity strengthening, QI processes and the procurement of essential supplies and equipment.

The right-hand column of the figure describes the practices pathway (community engagement), which represents an extension of the care of preterm/LBW newborns to the household level and active links to the health system. This component includes care groups and HSAs who provide home-based follow up visits and encourage families to go for facility-based follow-up care, to give guidance on basic care for preterm and LBW babies, to provide them with the basic family monitoring form on which to track the well-being of the baby and to promote male involvement. The linkage between facility and community is the referral system that should ensure that the mother and family continue caring for the small baby at home, are able to identify danger signs and seek immediate treatment, and regularly return to the facility for post-discharge follow-up of the baby.

³⁴ Annual Report Year 4

Figure 5. Basic components of the Family-Led Care model



To implement the model, a Family-Led Care package of materials and tools was developed. These included an orientation flipbook with messages on the care of preterm/LBW newborns for providers to use at admission to KMC, a take-home leaflet with a summary of key messages from the flipchart, an easy-to-use newborn monitoring form for families to use in the facility and at home, and a feeding chart for clinical providers to use during inpatient care. The tools are available on the Every Premie website.³⁵ During the time of the Every Premie project in Malawi, the resource materials already had wider use – “the materials that they have produced, we are actually using them in other programs” (MW12). Furthermore, the materials formed the basis of the development of the Global Family-Led Care Package with a variety of resources that can be adapted for introduction and scale up of the model in new countries. These will be available in June 2019.³⁶

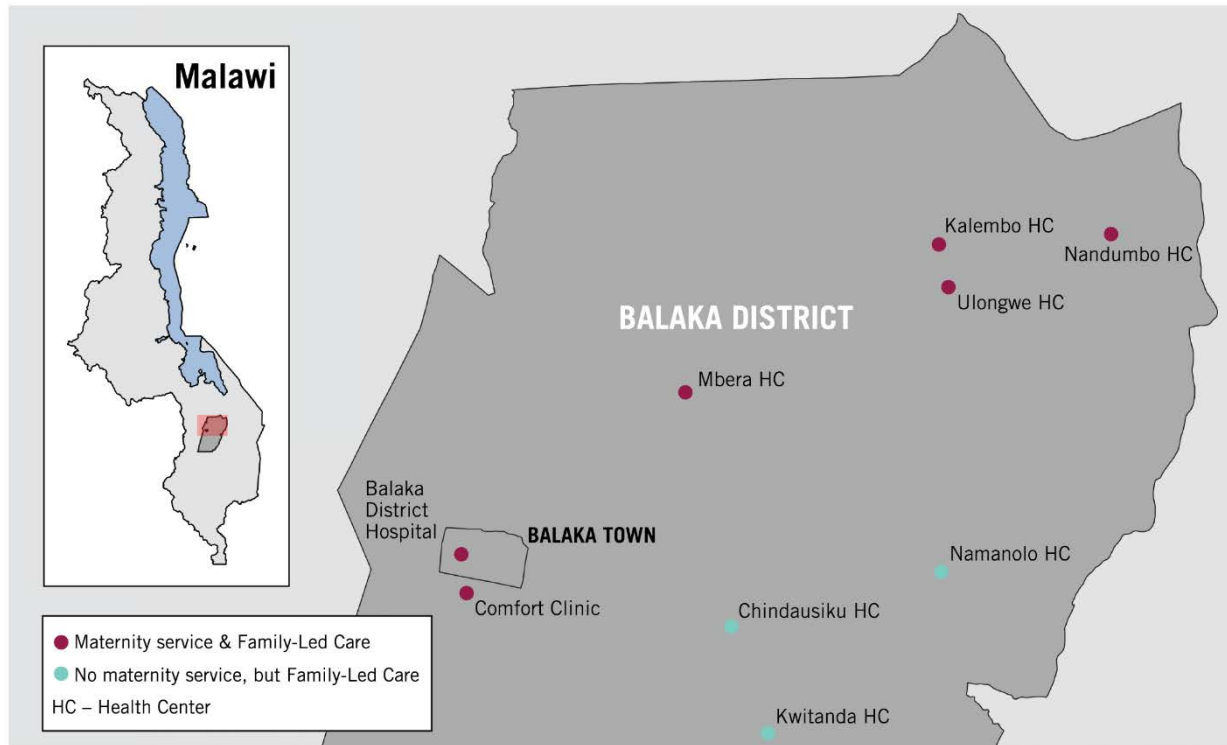
3.3.2 Implementation of the Family-Led Care model

The Balaka District Hospital and eight health centers where most births occurred were identified as the health facilities to receive targeted technical assistance to pilot the implementation of the Family-Led Care model in the district (see map in Figure 6). Five health centers and the hospital had the ability to provide inpatient Family-Led Care and three health centers with no maternity services could provide Family-Led Care-based follow-up.

³⁵ <https://www.everypremie.org/>

³⁶ <https://www.everypremie.org/family-led-care-global/>

Figure 6. Health facilities covered by Family-Led Care in Balaka district, Malawi



(a) The services pathway in the health facility

The services pathway had three components:

1. *Capacity strengthening through training.* From 2016 through 2018, 128 health care providers (nurse-midwives, medical assistants and clinical officers) and 20 support staff (mainly hospital attendants) from the designated health facilities were trained in Essential Care for Every Baby (ECEB), Essential Care for Small Babies (ECSB) and Family-Led Care. To strengthen linkages from the facility to the household post-discharge, 93 HSAs were also trained on Family-Led Care.
2. *Infrastructure, equipment and supplies.* Prior to the design and implementation of the model, two health facility assessments were conducted to identify clinical care needs for early/small babies in Balaka district. This was followed by infrastructure upgrades, the procurement of equipment (e.g. accurate weighing scales) and supplies (e.g. feeding cups).
3. *Quality improvement.* Every Premie worked with MaiKhanda Trust, an NGO specializing in QI, to focus on PTB/LBW interventions in the target facilities and work on creating stronger linkages between communities and facilities. These activities were harmonized with the rollout of the Family-Led Care model. Mentors from the district hospital were nominated to conduct monthly coaching visits to each of the target health facilities. They focused on improving regular monitoring of and documentation for all the preterm/LBW babies and data quality and completeness. Further activities include monthly mentors' meetings to share lessons and challenges and five collaborative learning sessions.

The overall aim of activities and inpatient care at the health facility was for health care providers to use their new skills to improve the quality of care in the KMC unit and to facilitate the empowerment of families to participate directly in the care of their early/small newborns during their stay in the facility and at home post discharge.

“The clinical support, the technical support we provided, it really was couched within the concept of Family-Led Care, given the human resources shortage in the hospitals, then the concept was to involve not only the mothers but the families to a significant extent to actually look at what was needed clinically for the baby.” (CO7)

(b) The practices pathway in the community and at home

The practices pathway also had three components:

1. Mothers and families were taught to take care of their early/small newborn during their stay in the health facility and what to do after discharge. They received a take-home leaflet with key messages and were to continue completing a Basic Family Monitoring Form twice a day;
2. Health surveillance assistants (n=142) and care group leaders (number unknown) were oriented in Family-Led Care as part of their training in essential newborn care and had a support role; and
3. There was ongoing community sensitization through existing structures like community meetings.

3.3.3 Family-Led Care implementation – did it work?

As part of the evaluation, 16 informants who were involved in implementing Family-Led Care in Balaka district and 8 informants working at the national level, in either government or partner organizations or projects, were interviewed.

As part of overall efforts to measure the effect of the implementation of the Family-Led Care model in Malawi, data were collected from MOH facility records to measure key indicators of KMC initiation and

Data collected from MOH facility-based records indicate a high enrollment rate of eligible preterm/LBW newborns (<2500 g) initiated on KMC throughout the project period as well as a significant reduction in in-facility preterm/LBW newborn deaths during the project period, from 11% in 2016 and 4% in 2018 ($p=0.018$).

related service delivery results over time; these indicators were included in the project’s performance-monitoring plan. While there were significant recorded improvements in KMC admissions and reductions in newborn mortality (see text box), there was little observed improvement in percentage of KMC newborns with adequate weight gain at the first facility-based follow-up visit. However, data quality/completeness for this indicator (complete recording of follow-up date and weight) improved from 16% in 2016

to 69% at the end of 2018 in the recording of follow-up date and weight ($p<0.0001$). Collected data helped to track key MOH indicators as well as data quality during the period of project support; however, due to the documented issues with data quality in MOH records, lack of counterfactual (lack of data collected from other sites not receiving project support) and in recognition of the various external factors that might influence results, caution is warranted in (positively or negatively) attributing results to the project.

Table 4 gives a summary of the perceptions of the catalytic achievements of Family-Led Care in terms of facility-based care (the services pathway) and community-based engagement (the practices pathway) for preterm/LBW newborns.

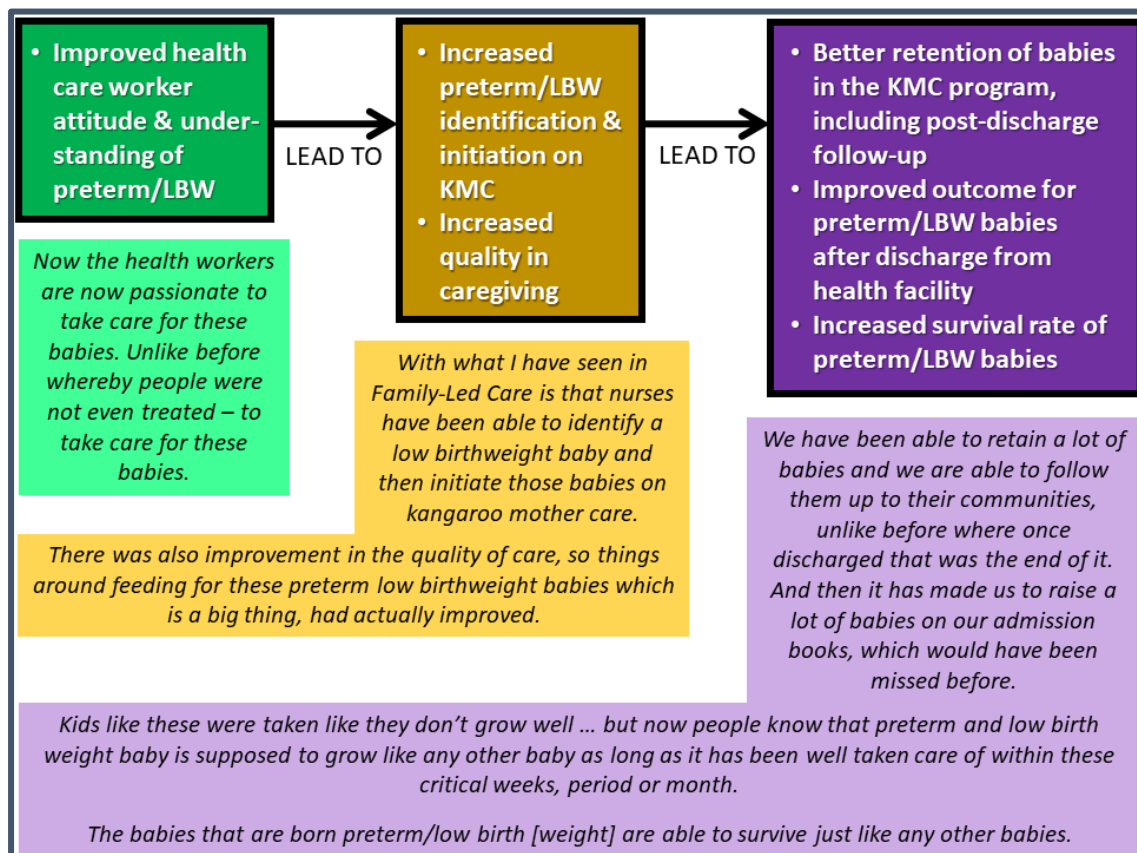
Table 4. Perceived catalytic effect of the implementation of the Family-Led Care model

Services pathway (clinical care)	
As a direct result of Every Preemie engagement in Balaka district around Family-Led Care and KMC, the District Health Officer appointed a KMC coordinator at Balaka District Hospital (a “champion”)	<i>“Before [appointing a KMC coordinator] the program wasn’t that kicking.” (MW04)</i>
Staff dedicated to the care of preterm/LBW newborns	<i>“Before Family-Led Care started ... the staff is the same staff which was in postnatal taking care for these babies. ... During the night it’s only two nurses, so you can imagine nurses should care for the cesarean section patients, care for antenatal patients and the same nurse should care for the sick babies and the same nurse can care for KMC – it was not easy. And these [LBW] babies [in KMC were] left out. ... It was really a fight for KMC ... to be a standalone model [with its own staff]. As for me, I still stand to say, ‘Wow, ... we are able to care... for these babies like special’! They are now special, rather than to be combined with the postnatal mothers. ... But the good thing is they left some people [who were not rotated to other wards].” (MW05)</i>
Staff capacity building improved knowledge, skills, quality of care	<i>“Even the knowledge and the skills of the staff looking after preterm or low birthweight infants had actually improved.” (MW12)</i>
Focused quality improvement and transferability of the approach	<i>“If people are able to see the challenges, this is where we went wrong, and then develop action points, how can we improve this. It helps a lot in terms of improving the outcomes.” (M06)</i> <i>“The approach that this project also took, it was like a linear approach. MNH is too broad, so this project was just focusing on premature babies. ... And then we were also advising ... the QI mentors ... they should use the same QI concept maybe to the MNH, to the other side within the MNH category. So that kind of a thing was also good to us.” (MW13)</i>
Improved monitoring of preterm/LBW newborns	<i>“This time around we are able to identify babies who need KMC. ... All those babies are being monitored effectively.” (MW05)</i>
Resource mobilization and enhancement of the KMC unit	<i>“In the KMC ward we received the mattresses and the beds, the feeding cups, tubes and then the drips and the knowledge how the babies would be draped in front of their mothers.” (MW01)</i> <i>“At first of course the room that we were in we had that one only, so they tried to advocate for another room. ... The space was a challenge, so we negotiated for a space ... another room to keep the mothers.” (MW13)</i>

Counting every baby – improved documentation, data management, tracking, and reporting	<i>“We have seen a tremendous increase in admission of our babies.” (MW01)</i> <i>“At facility level ... I have noted ... the issue of data ... improved ... documentation of KMC registers. ... When you go to a facility, you can ... see data for the low birthweight baby ... and you go into the KMC [space], you actually see that this baby was initiated on KMC. ... When you go even to the other reporting elements, you actually see that this data [can] be traced ... you can actually have a picture to say, ‘Yes, low birthweight babies are being taken care of’.” (MW06)</i> <i>“Before Family-Led Care babies were not admitted, they were not having forms, so we were not able to see if the mother absconded. ... Because of this Family-Led Care, we are now able to identify that the mother has absconded.” (MW05)</i>
Practices pathway (community engagement)	
Empowerment of mothers and guardians to take care of preterm/LBW babies	<i>“Parents are much more involved than they were at the beginning [of the Every Premie project]. ... The parents are going home with some understanding of what to do other than going home totally confused about what is going on. And the parents are coming back more often.” (CO2)</i>
Continuity of care: increased follow-up of babies	<i>“The big achievements with the Family-Led Care project is this that we are able to retain – we have been able to retain a lot of babies and we are able to follow them up to their communities.” (MW01)</i>
Community awareness and acceptance of the LBW/preterm baby	<i>“The other achievement that I have seen is on the involvement of the caregivers. It has helped a lot in terms of even the attitude of the community towards the low birthweight babies. I think by now where the Family-Led Care was, communities have been sensitized and they know that a low birthweight baby or a preterm baby is a baby and if given a chance this baby can also live and grow just like any other baby.” (MW06)</i>
Community participation in management of LBW babies – local support for mothers	<i>“It’s easier for them [cluster/care group leaders] to do home visits and follow-up.” (MW08)</i> <i>“[The] community group is readily available for the family and is able to support the family.” (MW02)</i>
Good collaboration between community, mothers and health care workers	<i>“There’s linkages between nurses and midwives and health workers in the community like the health surveillance assistants in the community, as well as those women, the care-takers in the community, they are being linked in.” (MW02)</i>
Peer motivator – champion mothers who encourage others in the community	<i>“We have champion mothers, we have admitted say 900 grams; the baby has been coming for follow-up. It’s now a big baby. These mothers are able to talk to their friends in the villages, like, ‘You see, this is my baby. You can also practice, you can also do it; your baby will survive.’ So it’s champion mothers who are encouraging their friends in the community.” (MW05)</i>

The major impacts of Family-Led Care mentioned by informants were improved health outcomes for the preterm and LBW newborn and a higher survival rate. This is a significant finding and is supported by review of MOH data. Figure 7 is a causal graph depiction of the influences mentioned.

Figure 7. Perceived catalytic influence of the implementation of Family-Led Care in Balaka district



Informants at the national level provided more distal descriptions of perceived benefits of implementing Family-Led Care and focused much more on the facility-community linkage of the model. One informant commented on Every Preemie's achievements as follows:

"I know uptake for kangaroo mother care has gone up, the number of babies being put on kangaroo mother care, that number has gone up. I need to look at the mortality figures at hospital level, but the last time I listened to their presentation there was an impact, KMC uptake, KMC practices and even the knowledge and the skills of the staff looking after preterm or low birthweight infants had actually improved. There was also improvement in the quality of care, so things around feeding for these preterm low birthweight babies which is a big thing, had actually improved." (MW12)

The following is a view from a global informant on how Family-Led Care brought together multiple issues in preterm and LBW care because the model was established in a holistic systems approach:

We weren't completely off base to think that parents have the capacity to really provide some very robust clinical care and to help them understand what is needed in a way that's accessible and feasible for them. I loved the project ... it was something that addressed so many gaps in terms of clinical care, in terms of systems care, in terms of human resources, in terms of psychosocial cultural aspects. And we looked at it from a systems perspective ... I feel like we are getting a better and better understanding what the system perspective needs to be, rather than these isolated, disconnected things that [we did] 20 years ago ..." (CO7)

(a) Challenges with implementation

Three main challenges to the implementation of Family-Led Care were mentioned: (1) as a pilot, Family-Led Care was not implemented in the whole district; (2) there were concerns about the sustainability of the provision and completion of Family-Led Care forms and charts (particularly post-project); and (3) there were expressed concerns about the care of preterm/LBW newborns post-discharge including follow up provided by HSAs (and Care Groups) at the household level.

Some informants referred to the **limitation of piloting the model** in a selected number of health facilities only. This exposed a further weakness in the reinforcement of the community component, especially regarding the facility-based follow-up of the preterm/LBW newborns. Not all babies initiated on KMC (especially in Balaka Hospital) were followed up at the same health facility – *“at the centers who do not practice Family-Led Care ... we are having challenges in case of follow-up of the babies”* (MW05-1). The health care providers from these centers were not familiar with the special community care provisions for preterm/LBW babies, as they did not participate in the training and rollout of Family-Led Care. They also did not have the counselling materials to guide and reinforce the key messages. One informant suggested, *“instead of having implemented in selected sites, it should be all sites”* (MW06).

There were also remarks about the **sustainable provision of the forms and charts** adapted and developed as part of the Family-Led Care package and the motivation for continuing to complete all the forms once the project ended. It is important to highlight that prior to Every Premie’s engagement in Balaka district, health care providers were not consistently or adequately capturing key elements of care and outcomes related to provision of KMC and newborn outcomes. Newborn charts were largely incomplete; feeds and weight gain were not monitored, and babies were discharged with little information about their growth during KMC or their stability upon discharge. In response, Every Premie worked with the DHMT and introduced a feeding/growth chart and a family monitoring form and through the QI work strengthened the completion of existing MOH maternal and newborn registers.

One informant viewed the Family-Led Care forms and charts as *“the complementary way of documenting the project”* (MW14).

As time goes I am sure some of the forms would be lost, people will stop filling the forms – because ... they may not have the forms and because some health workers will not be willing to fill the forms. So I am afraid as time goes they might lose the forms.” (MW14)

Facility-based providers commented on the number of forms, documents and registers that had to be completed (beyond the feeding form and family monitoring form introduced by Every Premie). They suggested merging documents for the MOH.

“In terms of the monitoring forms I think there are many. It’s like we have the feeding charts, we have the vital signs, the one which we record vital signs and we have the admissions. I think if it can be possible to maybe combine to one form.” (MW05-1)

There were high expectations for the **mobilization of the community** towards the implementation of the Family-Led Care: *“I think the work in Malawi was really very much at the grassroots level ... So that might be one aspect that again was unique”* (GP08-2). However, multiple informants indicated that the HSAs were a weak link in the implementation of the model for many reasons. These include overload with many different tasks, lack of knowledge of or training in preterm/LBW newborn care and Family-

Led Care, inadequate supervision, expectation of remuneration to attend meetings, mobility and transport issues, and living far from their catchment area.

The three Family-Led Care health centers without maternity services did undertake QI projects to improve the follow-up of preterm/LBW babies by communicating with the district hospital and using community health advisory committees and HSAs to sensitize communities.³⁷ It appears that the HSAs in the district were not always included in the district health activities related to Family-Led Care and the follow-up of preterm/LBW newborns in the community. This is how a member of the DHMT explained the situation:

“The biggest challenges ... we noted very late that not everybody was involved in the Family-Led Care ... For instance the HSAs, the health surveillance assistants who are right in the communities, they weren’t involved in the review meetings ... But now we wanted them to be implementing the programs, whereas we haven’t trained them, or they were trained but now we wouldn’t take them on board during the review meetings to see what problems we were having and so on. ... So it ... was the key problem ... a shortfall. ... We would like the HSAs to be following up ... Now we were not taking those HSAs on board to give us feedback of what they are finding in those – we just told them that you have to be following them up in the communities as well, but we are not receiving feedback from them ... when we were having the review meetings it was just [the District Health Management Team] and the facilities. ... We were not getting a voice from them, so maybe that’s how you take it as a challenge.” (MW01)

Informants highlighted issues around the scale up of Family-Led Care in Malawi under USAID/Malawi’s bilateral project — Organized Network of Services for Everyone’s Health (ONSE). In FY18, Every Preemie was informed by USAID/Malawi and USAID/Washington that future implementation of the model would be managed by ONSE. Training-of-trainer sessions in Family-Led Care took place for 16 ONSE-supported districts, as well as the rest of the districts in Malawi in FY18 with support from Every Preemie. There was no further training in Balaka district in the last year of the project and ONSE did not manage to conduct the additional training needed to get more health centers on board or to do refresher training for health facilities already providing Family-Led Care.

Some informants indicated that PTB and LBW may not get the same focused attention under ONSE that it had received under Every Preemie, because ONSE structures were different, for example quality improvement was a separate department – *“we have QI as a component, but we haven’t incorporated it yet”* (MW06). ONSE technical support is mandated to include other activities (FP/RH, MNCH, malaria, WASH) and cannot be organized in a vertical fashion for PTB/LBW or inpatient care for small and sick newborns only.

“ONSE said that the system will change, it cannot continue supporting as the PCI was doing just because it has a lot of things to support. So, it’s like we will see many changes like the QI team and in terms of supervision, supervisory review meetings they will be adjusting it.” (MW05-1)

Managing this transition and changes to the in-depth implementation of the model are beyond the scope of Every Preemie.

³⁷ MaiKhanda. Every Preemie - Scale narrative programme report for deliverable number eight (August-November 2018)

3.3.4 The way forward – “the whole concept of Family-Led Care is here to stay”

Every Preemie’s work focused on nine health facilities in Balaka district; however, the project built a strong network of stakeholders from the national MOH Reproductive Health Directorate to the Balaka DHMT; among implementing partners operating in Malawi including the National Safe Motherhood Working Group; and among health care providers both within facilities and at the community level. At the completion of implementation, the project had left key inputs in place³⁸ that, if taken up adequately by the MOH and USAID implementing partners, will ensure a smooth transition to future implementation.

When probed about the legacy of the Family-Led Care project in Balaka district, many implementers felt that Family-Led Care was there to stay – “Family-Led Care will continue, that we should assure you” (MW05-1). Some of the reasons for the optimism was the approach to embed Family-Led Care in the district health system and the visibility of the Family-Led Care model in national newborn structures.

“Some of the activities that we have done, I believe they will still be there [in three years’ time]. I will give an example in terms of following up the babies in the community. Since the structures are still there and then there is nothing new that they have actually brought in, like parallel structures. We have used the same structures that were there in the community and then my hope is that we will continue.” (MW03)

“Every Preemie was part of the Safe Motherhood Technical Working Group, for example, in Malawi and so their level of influence would be that they were working with ministry in the districts and they were doing the implementation research and feeding back to government. I think that that’s a good thing, that’s what we want to see happening. And so that contributes towards moving towards scale, rather than just kind of coming in and doing your project and not necessarily feeding back.” (GP01)

One informant provided advice to other districts wishing to implement Family-Led Care:

“I would advise the guys that this is the programme and this programme is here to stay. We have tried it in Balaka and then we have seen a lot of good results, a lot of fruits.” (MW01)

Despite the confidence of informants in the effectiveness of the Family-Led Care model and in continuing to provide quality support for preterm and LBW newborns, they acknowledged that Family-Led Care was still in its infancy – “a toddler just starting to crawl” [CO2]. The need for more advocacy and strengthening the community component of the model was specifically mentioned.

“I wouldn’t say [the sand] has shifted as in fully shifted. We are still in the process ... to get their [the sceptics’] fuller buy-in to say yes of course, we are able to track each and every person who has been discharged from the facility who is under KMC and now has been discharged in the community ... So we are still in that process of getting to know. I wouldn’t say that we have reached the final stage and say okay now we are doing fine.” (MW01)

³⁸ The project has trained master trainers in Malawi; updated the Family-Led Care orientation package for providers; given templates of forms to the MOH (and ONSE) for their use; and strengthened provider capacity through training and the QI work.

See Annexure D for evaluation questions and achievements by Outcome 2.

“We’re leaving behind some staff who understand how to do QI. We have greatly strengthened documentation. I think overall we’ve built some capacity to deliver KMC.” (CO2)

“If we have our heads together Balaka should actually be a shining example to the other districts. ... Then Balaka would easily be a model district where you get people from other districts, go and learn from Balaka. ... So I know that once Every Premie and the Family-Led Care is shared, it cascades in the other districts. ... Because we have got evidence of the best practice, the other districts will not be starting from scratch. ... That will be a best practice that can actually be shared even with other countries.” (MW16)

3.4 Outcome 3: Preparing countries to focus on preterm and low birth weight care – “a platform for action and for strategic planning”

3.4.1 Development of global documents – “a significant contribution”

This section reports on global activities including (1) tracking and monitoring country level indicators in 24 USAID priority countries, including (a) the publication of country profiles highlighting country-specific information on PTB and LBW for each USAID priority country and (b) a dashboard indicator; (2) a PTB/LBW Continuum of Care matrix; (3) a multi-country antenatal corticosteroids landscape analysis; (4) a Joint Statement on Preterm Birth; (5) a multi-country situation analysis of inpatient care for small and sick newborns; (6) the WHO document *Survive and Thrive: Transforming care for every small and sick newborn*; (7) the development of the Global Family-Led Care package that can be adapted by individual countries, has already been mentioned in the discussion of the Malawi experience in Section 3.2.1; and (8) a global evidence synthesis on nurturing care for small and sick newborns.

3.4.2 Tracking global coverage of PTB/LBW and country profiles – “good for advocacy”

(A) Country Profiles

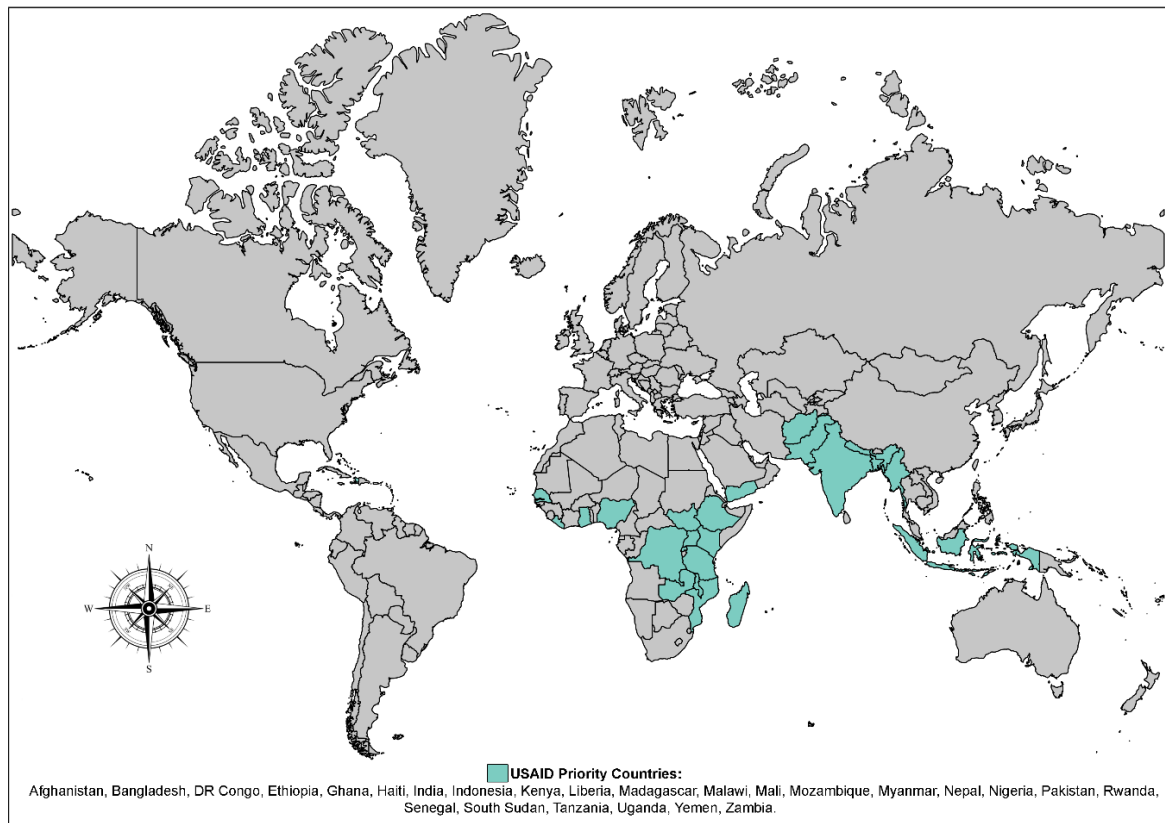
As part of the commitment to catalyze action in the 24 countries prioritized by USAID for MCH (see map in Figure 8), data on PTB and LBW for each country were compiled. From this, individual country profiles and a summary profile were created. The aim was to provide a national-level report on the status of the prevention and care for preterm and LBW babies for each country and to highlight related risk factors and the coverage of important reproductive, maternal and newborn health care interventions. “For most countries these profiles represent the first compilation of data focused on PTB/LBW”³⁹. National-level information related to PTB and LBW was extracted (e.g. from UN estimates for population and mortality rates); other primary data sources were consulted (e.g. available population-based surveys); and secondary data such as basic demographic information related to PTB/LBW were compiled (e.g. neonatal mortality rate, preterm birth rate, babies born <2500 grams and babies born <28 weeks of gestation). PTB/LBW interventions that occur across the continuum of care (pre-pregnancy to the postnatal period) and at various levels of the health system (household to hospital) were also interrogated (e.g. adolescent birth rate, short stature of women and obesity in women of childbearing age). Interviews with key country informants provided insights “into the health system as related to PTB/LBW including health policy, pre-service and in-service provider training from the community to hospital level and data on PTB/LBW generated by the national Health Management Information System (HMIS).”⁴⁰

The country profiles were launched in November 2015 at an Every Preemie-sponsored World Prematurity Day event on Capitol Hill in Washington, DC. This was part of a multi-partner global-level call for action for improved maternal and newborn health through partnerships and innovations.

³⁹ Annual Report Year 1

⁴⁰ <https://www.everypreemie.org/country-profiles/>

Figure 8. Map of USAID priority countries



The country profiles were updated in 2017 and a new profile was created for Myanmar, a new addition to USAID's priority countries. A further update is expected before the end of the Every Premie project in 2019. There are also French translations of the profiles for the Democratic Republic of Congo (DRC), Haiti, Madagascar, Mali, and Senegal and a Portuguese translation for Mozambique. In 2016, a profile for Sierra Leone was added to the set of country profiles given the project's inclusion of Sierra Leone in the multi-country analysis of ACS use (see Section 3.3.2).

According to the Every Premie annual and biannual reports, the profiles were disseminated to all USAID priority countries via USAID missions in these countries. Hard copies were also distributed throughout the project's life cycle at various other events where Every Premie had a presence.

Project annual reports anticipated that the country profiles would "be used to catalyze dialogue and action"⁴¹ and "energy"⁴² around PTB/LBW across the priority countries. By the time this evaluation report was compiled, the country profiles had been downloaded from the website over 26,000 times. Downloads, distribution and dissemination do not equal actual use, which is impossible to measure.

Informants operating at the global level who were interviewed were mostly positive about the development of the country profiles – *"we made use of them and they were very valuable"* (GP04). One

⁴¹ Annual Report Year 1

⁴² Annual Reports Year 3

referred to the profiles as “*fantastic*” (GP02). Two referred to them as “*good for advocacy*” (GP04/06). Another informant described the available information as follows:

“The thing is that you want to see information about countries and those profiles are brought together with what was available in the public sector. Then there isn’t much new to offer and the gaps in the information remained. I don’t say that it was the fault of the profile. Profiles can be like the ones highlighting that there isn’t actually a lot of information.” (GP03)

Of the representatives of the six countries that responded to the online survey, only three were familiar with their country’s profile and two indicated that they had used it and had shared it with their ministries. Three of the 10 global-level respondents to the survey had used the country profiles. They were not asked how they had used it. Anecdotally, Every Preemie team members report hearing other partners including Born On Time, Saving Newborn Lives and the Maternal & Child Survival Project using the profiles.

(B) Dashboard Indicator

A country-level *tracking and monitoring* system was developed that included a *dashboard indicator* to track clinical standards and operating procedures for the care of preterm and LBW newborns at the hospital level in each of the USAID priority countries based on the WHO *Recommendations on interventions to improve preterm outcomes*. The WHO Recommendations include ten critical elements for preterm care:

1. Antenatal corticosteroids
2. Tocolytics
3. Magnesium sulphate
4. Antibiotics for preterm premature rupture of membranes
5. No antibiotics with intact membranes
6. Vaginal birth preference
7. Kangaroo mother care
8. Continuous positive airway pressure (CPAP) for respiratory distress syndrome
9. Safe oxygen use
10. Surfactant

This is how one partner described the development of this dashboard indicator:

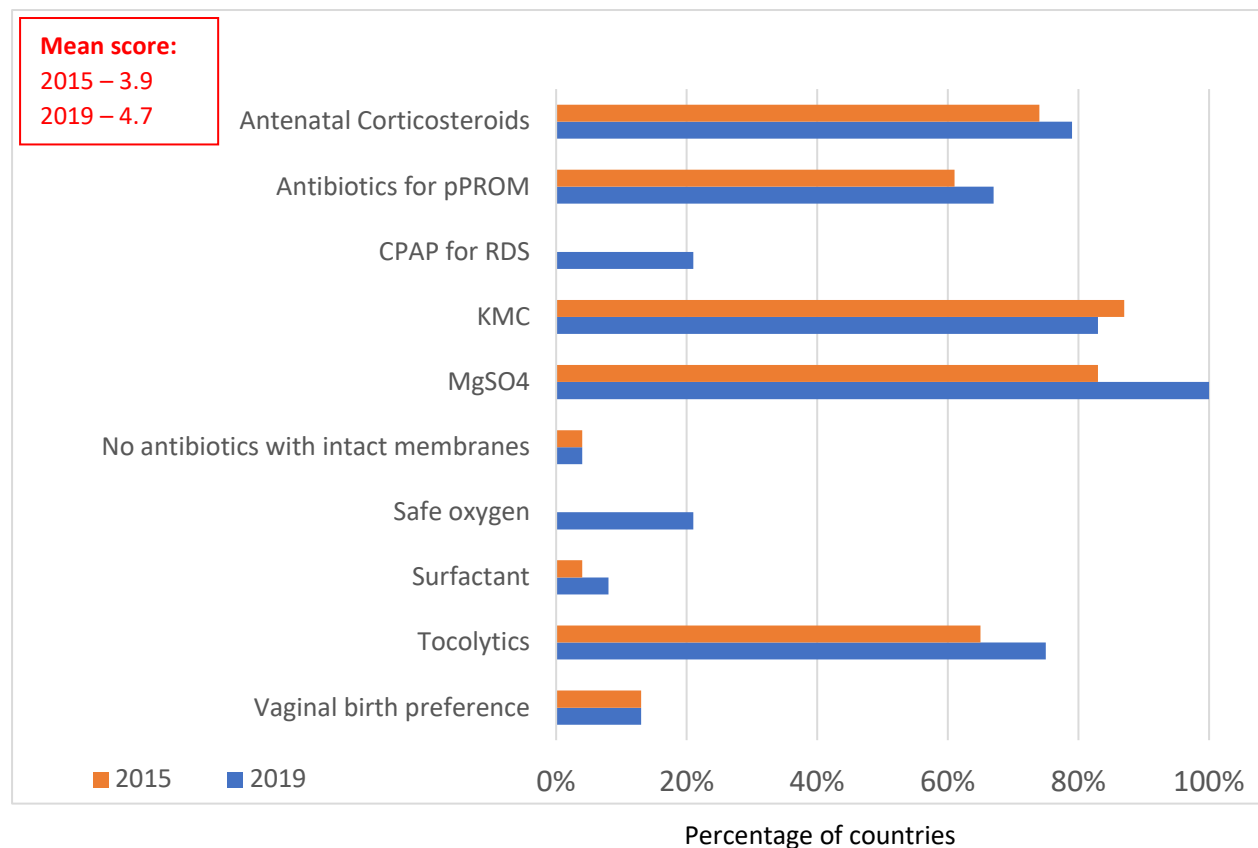
“And so going back to the indicator that I thought was pretty clever, was that around the time we were struggling to find one indicator to track as global coverage. We couldn’t find any indicator, so they said that why don’t we look at the 10 recommendations that WHO had made for addressing preterm birth complications ... the preterm guideline, its 10 recommendations. So we said okay let’s look at countries, do they have policies in place for these 10 recommendations. And do they have drugs in place, like antenatal corticosteroids was one of their recommendations. Do countries have policies on antenatal corticosteroids, or do they have antenatal corticosteroids the commodity itself in the country. So that’s how they combined these 10 different recommendations and came up with like one consolidated indicator.

It’s not easy, but they are tracking that now. If you look at the country profiles, they have one indicator I think under health systems or something like that, tracking the global coverage of these

recommendations. So they did that once at the beginning of the project and we are doing that again at the end of the project and see if any changes occurred over time.” (GP07)

A blog post describing the development of this indicator and the scores for the different countries on this indicator was also posted on the website in 2016.⁴³ Figure 9 gives an overview of the performance progress on the 10 elements of the dashboard indicator by country from 2015 to 2019. The elements that were included in more than 15 national clinical standards in 2015 were magnesium sulphate and KMC. For all the elements, except for no antibiotics with intact membranes, the number of countries having these elements in their standards increased from 2015 to 2019, with five elements in more than 15 countries’ standards, namely ACS, tocolytics, magnesium sulphate, antibiotics for preterm premature rupture of membranes and KMC. The guideline for CPAP increased from no country in 2015 to five countries in 2019. The mean score for this dashboard indicator increased from 3.9 in 2015 to 4.7 in 2019, which means an average increase of slightly less than one element per country.

Figure 9. Performance of the dashboard elements over time



⁴³ <http://www.everypreemie.org/are-preterm-and-low-birth-weight-babies-treated-as-a-priority/>

3.4.3 Continuum of Care for Prevention of Preterm Birth, Management of Preterm Labor and Delivery, and Care of the Preterm and Small Newborn

An early product designed and disseminated by Every Preemie was a matrix on the Continuum of Care for the Prevention of Preterm Birth, Management of Preterm Labor and Delivery, and Care of the Preterm and Small Newborn, known as the PTB Continuum of Care matrix. The matrix highlights “priority evidence-based interventions for the prevention of PTB, the management of preterm labor, and care of the preterm and small newborn”.⁴⁴ It was designed to provide a road map for partners who are involved in designing and planning activities related to preterm birth and LBW and is the first time this information was organized and framed in this manner. The matrix was disseminated to USAID missions, country-level stakeholders and in meetings in Washington, DC and globally. Although it seems as if this matrix did not attract enough attention, individuals reported using it for strategic planning.

One informant described it as “a great tool to look strategically at what are the gaps” (GP09).

A few individuals reported on how they had used the matrix, especially for strategic planning. Pakistan provided a more detailed description in the online survey:

“The continuum of care matrix was an integral part and basis of our Maternal, Newborn and Child Health (MNCH) award that was implemented at a larger scale in 16 districts of Sindh. Interventions were designed and implemented based on the components of the matrix both in the community and at the facility level. The Activity was implemented in close coordination with Sindh Government and all the materials produced in relation with various components of continuum of care were shared with care providers and government officials.”

It seems as if the Continuum of Care matrix “did not attract enough attention” (CO3) and not many of the informants remembered seeing it – “I am not sure if I am familiar with that one” (GP05). Of the six USAID priority countries responding to the online survey three were familiar with the document and used it for planning interventions for implementation. Three of the 10 global partners who completed the full online survey had used the matrix.

One partner acknowledged the value and usefulness of the matrix – “there is more detail for the sick newborn” (GP06) – but was concerned that duplication and overlap with other similar attempts might be confusing to ministries of health.

3.4.4 Multi-country antenatal corticosteroids landscape analysis

One of the more ‘hands-on’, country-level activities of Every Preemie was the *Antenatal Corticosteroids for Women at Risk of Imminent Preterm Birth in the Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Sierra Leone, Tanzania and Uganda: A Policy and Implementation Landscape Analysis*. This analysis was conducted in seven of the eight Pathfinder countries of the UN Commission on Life-Saving Commodities (UNCoLSC) in sub-Saharan Africa on behalf of the UNCoLSC Newborn Health Technical Resource Team. MOH representatives were interviewed in each country and government documents were reviewed for ACS-specific content.

⁴⁴ Annual Report Year 1

The results of this survey were published in 2016 as an internal report and shared at a UNCoLSC ACS Technical Working Group meeting. In 2018 it was published in a journal article format in *Global Health: Science and Practice*.⁴⁵ For each country, information is provided on the following: use of ACS at different levels of care; providers authorized to prescribe and/or administer ACS; critical maternal and newborn health care services available for safe and effective use of ACS; and tracking methods for ACS use. This is the short summary that appeared in the journal article:

“Countries have put in place some elements necessary for safe and effective ACS use, but significant challenges remain including: ensuring accurate gestational age determination, establishing clear treatment guidelines, strengthening provider capacity, incorporating obstetric indications for ACS use in national essential medicines lists, and collecting and using ACS-related data in the HMIS [Health Management Information System]. Most importantly, the quality of maternal and newborn care, including specialized newborn care, needs improvement to ensure a strong foundation for the safe and effective use of ACS.”

As part of the end-of-project evaluation, representatives in the seven countries that featured in the landscape analysis were contacted by email to inquire about any further developments with regard to national ACS policies and practice. Responses were received from four of the seven countries. This exercise yielded little information on specifically if/how the analysis had been used to influence policy or practice at the country level. No country could provide examples of anecdotal data on the use of ACS in the respective countries, though two countries indicated that there had been an increase in the use of ACS in a number of pilot sites. Ethiopia reported that there had been “*no bold policy change regarding ACS*” but that it was expected that “*some of the ACS policy issues*” would get attention in the Basic Emergency Obstetric and Neonatal Care guidelines that were under revision. This is what the respondent from Uganda said:

“ACS were included in our guidelines just before the embargo following a pilot in Uganda supported by the UN Life Saving Commodities commission and USAID/URC [University Research Company]. When the embargo came on we waited for further guidance from WHO. We are implementing the revised policy but it is not extensively disseminated. That is where we need to put more strength.”

One informant referred to ongoing challenges to updating national ACS guidance, including the need to harmonize different guideline documents that were in existence. Another informant referred to a problem with stock-outs of ACS. ACS had previously been procured from a trust fund but ongoing procurement was taken over by the Central Medical Stores.

In the Year 2 Annual Report mention was made of the “valuable relationships” established that could “provide valuable inroads with ministries of health in these countries and can be tapped in the future as the project continues to advocate for action at the country level”.⁴⁶ At the UNCoLSC ACS Working Group feedback meeting, country representatives “emphasized that ACS use is fairly new and that countries

⁴⁵ Greensides D, Robb-McCord J, Noriega A, Litch J. Antenatal Corticosteroids for Women at Risk of Imminent Preterm Birth in 7 sub-Saharan African Countries: A Policy and Implementation Landscape Analysis. *Global Health: Science and Practice*. 2018;6(4):644-656.

⁴⁶ Annual Report Year 2

need support to institutionalize WHO recommendations for improved maternal and newborn health”.⁴⁷ It appears as if Every Preemie could not maintain these relationships, inter alia because of the limited budget and the small team.

3.4.5 Joint statement on preterm birth

Every Preemie was involved in the development and review of three international joint statements disseminated in 2016/7 to demonstrate professional associations’ commitment to action and the implementation of key World Health Assembly resolutions such as the ENAP, the Global Strategy for Women’s, Children’s and Adolescents’ Health, and the 2015 WHO recommendations on interventions to improve preterm birth outcomes. Every Preemie led the development of the Joint Statement *International WHO Recommendations on Interventions to Improve Preterm Birth Outcomes: A Commitment to Action from Professional Health Organizations*. The Every Preemie team also contributed significantly to the development of the statements on Kangaroo Mother Care (led by SNL) and Quality of Care (led by the USAID-funded ASSIST project).

The Joint Statement on Preterm Birth recognizes the important and collaborative role of national professional associations to assist countries in updating policies and programs and supporting the safe and effective implementation of the WHO recommendations. Five relevant international professional associations reviewed and endorsed this joint statement, namely COINN, ICN, the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, and the International Pediatric Association.

The joint statements were distributed through the Every Preemie networks, but the intention was to have them disseminated through the membership of the respective international professional associations as well. None of the respondents from the USAID countries who completed the online survey was familiar with the Joint Statement on Preterm Birth, whereas five of the ten global-level respondents had used it. The global informants interviewed were not very familiar with the Joint Statement either. One gave a more general view on the purpose of joint statements, which resonates with the Every Preemie view that the three joint statements “represent a significant global move to catalyze action for improved maternal and newborn health in low resource settings”.⁴⁸

3.4.6 Multi-country situation analysis of inpatient care of newborns and young infants – clinical care and “a snapshot of systems”

Midway through the project cycle the “goal posts changed” (CO2) and, at the request of USAID/W, Every Preemie broadened its scope beyond LBW and PTB to include a focus on sick newborns and inpatient newborn care. A USAID staff member described the rationale for this emerging priority in the Midterm Review report as follows:

“I’m really happy with the focus on the slightly broadening of the target population to look at sick newborns. So, it was an idea that became – it’s a huge priority for USAID now – focusing on sick

⁴⁷ <https://www.healthynewbornnetwork.org/blog/every-preemie-scale-launches-multi-country-report-antenatal-corticosteroid-policy-implementation/>

⁴⁸ Annual Report Year 2

newborns. And so, I'm happy with the way the Every Premie team has been responsible to that. It doesn't take them away – too far away from what they were originally designed to do ... because the large majority of sick babies anyway are preterm and low birth weight.” (p. 30)

There is a need to define, standardize, and mainstream inpatient care of small and sick newborns on the essential newborn care platform. This expanded focus enabled the conceptualization of a multi-country situation analysis of inpatient care of newborns and young infants in order to get a better understanding of the country service readiness landscape. Every Premie led the development of the protocol and tools for this analysis in collaboration with other global partners. The tools were tested in Malawi and Nepal. The protocol and tools are posted on the Every Premie website⁴⁹ and are available for global use by any low- or middle-income country wishing to assess service readiness and quality of care of inpatient small and sick newborns in public and/or private health facilities. The analysis *“gives a snapshot of systems and procedures at multiple service delivery points”* (GP09). It investigates health system structures, facility processes, national policies and clinical standards and parent/ caregiver experience of this care with a view to identify structural and procedural enablers, as well as challenges and gaps that hinder the quality of inpatient care of newborns and young infants.

The protocol and situation analysis tools were highly commended by informants from global partner groupings. One informant felt that *“although it may not be perfect”*, there would be refinements as more countries conduct the analysis and the WHO standards of care for small and sick newborns become available – *“I think we are now much, much better shaped to have a more consolidated situation assessment tool”* (GP03).

“I think that was a very big critical piece of work that Every Premie led. They led the whole discussion; they brought UNICEF, WHO and Saving Newborn Lives, USAID of course, to develop these tools that have been now used in several countries for conducting the assessment of small and sick newborns. ... That was a really good piece of work and I appreciated working with Every Premie on that. ... We appreciated it when they brought in their consultants to help us understand the tools further and they shared all of the analysis framework, the protocols, helped us in any way that we needed whenever we went to the countries. ... I feel it was a very good leadership on the part of Every Premie; they have been very happy to be able to take all of that that they would have loved to implement it at the country level.” (GP02)

The assessment was conducted in Bangladesh, Ghana, Nepal, Pakistan, Rwanda, Tanzania and Uganda. These countries self-selected based on the interest of the USAID mission, UNICEF or WHO country office, and the presence of an implementing partner interested in conducting the assessment. Every Premie provided additional support to the African countries according to needs (e.g. for data analysis in Ghana and Tanzania), and supported a consultant to provide guidance with the implementation process throughout Years 4 and 5 – *“so it has been used by different partners, but a prominent protocol was developed by Every Premie”* (GP07).

Despite an ambitious goal, different forms of delays were experienced, especially around IRB approvals and changes in government. By the time of this evaluation, Ghana and Uganda had produced a final

⁴⁹ <https://www.everypreemie.org/technical-materials/>

report and data collection was completed in four more countries. Two informants referred to this as follows:

“I felt [it] was extremely ambitious ... but I did feel that through the review process that we were able to focus it down more which was really needed, but ... it’s not entirely clear to me how that has panned out.” (GP04)

“So even the situational analysis I think we had hoped to have results from that to be available on World Prematurity Day last November and in fact I think we had one situational analysis report completed by that time.” (GP08-2)

Informants discussed the future use of the situation analysis tools and the results from the current situation analyses, all commenting on the importance of initiating an exercise that will *“give fruit for a long time on what needs to be done just strengthen newborn and young infant care ... [and] will have lasting implications” (GP-08-1).*

“But now, if one can do the country situation assessment for every country ... now that we have the situation assessment tool, if one has to redo the [country] profiles it would be really very good.” (GP03)

“The situational analysis ... we undertook ... not just to get a read on a situation, but to provide a platform for action and for strategic planning and quality improvement of individual country services, but also to look at them as an aggregate to say, ‘Here are different stages of this process and we have learnt from this overview what might be a larger goal progression and some common barriers and perhaps common solutions that can be found’. So I again hope that there’s some mechanism to use this data when it all comes together and to keep it alive and really realize its value.” (GP08-2)

Because of the limited time available for completing implementation, data analysis and report development, it will not be possible to produce a combined report of all the country analyses. Every Premie committed to develop a multi-country infographic and organize a webinar to share highlights (with available country data):

“Every Premie will develop a brief to share an overview of the assessment, and if country reports are available by early June 2019 will include a synthesis of key findings from each implementing country, as well as a 2-page brief for in-country use. The project will organize a webinar to disseminate the full implementation package and country highlights. Representatives in each country will be invited to present their key findings.”⁵⁰

Use of the data at the country level is beyond the mandate of the Every Premie—SCALE project. Anecdotally, in-country stakeholders are reviewing the findings and are using them to establish action plans and prioritize resources for future investment.

⁵⁰ Biannual report Year 5

3.4.7 *Survive and Thrive: Transforming care for every small and sick newborn*

Every Preemie collaborated with WHO, UNICEF, USAID, the Bill & Melinda Gates Foundation, the London School for Hygiene and Tropical Medicine and others to design and develop a global document on inpatient care of the small and sick newborn, titled *Survive and Thrive: Transforming care for every small and sick newborn*. It targets country-level managers in ministries of health “with a goal to provide a programmatic framework for integrating this critical work into newborn inpatient care.”⁵¹ Every Preemie

This document is a major contribution to global advocacy for care of the small and sick newborn and is setting the stage for other significant WHO publications including standards of care for inpatient newborns and guidelines for nurturing care of small and sick newborns.

provided the project coordinator and the Senior Director, who was one of four managing editors and a lead author for the publication. The GAPPS Evidence and Learning Lead provided publication review. The Key Findings Report⁵² was launched on December 13, 2018 at the global Partnership for Maternal, Newborn and Child Health Partners Forum in New Delhi, India. The full document was launched at the World Health Assembly in May 2019. Every Preemie also co-hosted a panel with WHO at the Vancouver Women Deliver conference in June 2019.

3.4.8 *Evidence synthesis on nurturing care of the small and sick newborn*

In Year 5, the project carried forward activities initiated in prior years in response to the global priority around inpatient care of small and sick newborns. Every Preemie worked with USAID, UNICEF, WHO and the USAID-funded MCSP to design and conduct an evidence review around nurturing care for small and sick newborns – “a very exciting piece of work working on evidence synthesis and case studies on nurturing care for small and sick newborns” (GP02). The aim of this report is to build on the Nurturing Care for Early Childhood Development—A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential launched at the 71st World Health Assembly by providing guidance with a summary of evidence and best practice on approaches to nurturing care for small and sick newborns. The report will include a summary of findings from peer-reviewed literature, country case studies (including country-specific grey literature) and a gap analysis. It is expected to be finalized in July 2019. Findings will be used by WHO and UNICEF to develop guidelines for nurturing care to complement the clinical standards of care for small and sick newborns currently in development (with other partners including Every Preemie).

“I think the work that we are going to be doing on the nurturing care aspect will have longer term repercussions and will influence many changes in the coming times when ... the [current] projects are gone.” (GP02)

⁵¹ Annual Report Year 3

⁵² <https://apps.who.int/iris/bitstream/handle/10665/276655/WHO-FWC-MCA-18.11-eng.pdf?ua=1>

3.5 Moving forward with the global agenda on preterm birth – “foresight” and “leadership”

The achievements of Every Preemie at the global level are tightly linked to Outcome 3 of the project and will be discussed in terms of two of the top accomplishments emerging from the evaluation, namely Every Preemie’s leadership in the PTB TWG-ICS and the corresponding Do No Harm technical brief series. Over the life of the project, members of the Every Preemie team participated in numerous events focusing on PTB/LBW and small and sick newborns.

3.5.1 The PTB/LBW Technical Working Group – “very successful to bring top leaders together on technical subject matters”

From 2015 through 2018, Every Preemie convened six meetings of the PTB TWG-ICS, a group of more than 200 thought-leaders representing a wide range of clinical and public health disciplines.⁵³ The meetings were framed to provide a multidisciplinary learning forum sharing “emerging evidence, relevant research and learning across the range of PTB and LBW interventions and implementation in low-income countries”.⁵⁴ The TWG explored “potential opportunities to address gaps in critical knowledge that will help to overcome bottlenecks to implementation, and significantly increase coverage and quality of PTB and LBW evidence-based interventions.”⁵⁵ These meetings were meant to inform “priorities for future IR [implementation research] investments, and to provide focus and technical insight into the development of PTB and LBW interventions and implementation approaches.”⁵⁶ Table 5 lists the topics and the meetings that included a virtual component to maximize partner participation across the globe. Presentations, materials, and more information on these meetings are available on Every Preemie’s official website.⁵⁷

⁵³ Annual Report Years 3 & 4

⁵⁴ Annual Report Year 4

⁵⁵ <https://www.everypreemie.org/global-technical-working-group/>

⁵⁶ Annual Report Year 1

⁵⁷ <https://www.everypreemie.org/global-technical-working-group/>

Table 5. Topics discussed at the Technical Working Group meetings

Date	Topic	Venue
1 May 2015	Gestational age estimation in low-income countries	Washington, DC
16 May 2016	Preventing PTB/LBW through Lifestyle, Infection, Nutrition, Contraception (LINC) factors plus maternal complications*	Copenhagen
16 November 2016	Safe and effective use of preterm birth interventions**	Washington, DC
26 September 2017	Respectful newborn care	Washington, DC
13 June 2018	Family member engagement during inpatient newborn care	Washington, DC
7 November 2018	Management of newborn infections and use of antibiotics during inpatient newborn care	Washington, DC

Plus web conference

* Co-hosted with Ending Eclampsia

** Oxygen use, thermal stability, and lactation support

Informants considered the contribution of the PTB TWG-ICS meetings to the discourse needed for moving the global preterm birth agenda forward as very informative and useful because of the expertise that could be gathered. One referred to an important vacuum that the TWG filled with its coordinating role to keep momentum and accelerate the preterm and LBW agenda when other partners were moving on to other foci and scaling down on global meetings.

“[The TWG] would pick a topic and they would focus on that topic on that day, they would bring in experts and there were these speeches or kind of presentations. And then they would have a broader discussion about the topic. So it was a learning opportunity for international global partners working in preterm birth. And I think that was a really great – that indicated to me that there was value in Every Premie SCALE and keeping the momentum going through those technical working group meetings. ... I found it extremely enriching, it was a fantastic opportunity to network with partners, specifically on ... preterm birth and newborn health.... I was especially impressed that they brought in a number of country colleagues to the meeting as well, to present and to learn. ... It was a kind of a link in the chain that they were helping to keep the momentum going. ... We were no longer kind of like catalyzing something to start momentum, we had this journey and we are going on this journey and it’s a matter of keeping that momentum and continuing to build that network, and I think they contributed through those meetings very, very clearly.” (GP01)

The expertise that was brought together through the TWG elevated the discussion – “having those experts engaged has been very helpful in terms of helping prioritization of preterm birth” (GP01). The video-conferencing facilities for the meetings probably enabled “broad geographic representation”⁵⁸.

“I would really single out what I think the Every Premie team did to pull together experts for the technical working group. Every Premie really did a great job in getting people from very different perspectives, cutting-edge perspectives and bringing them together at those meetings. So I think they were revelatory and as a clinician I really appreciated the currency and some of the controversy

⁵⁸ Biannual Report Year 5

that Every Premie was willing to pull, because that's where we need to [be] operating now, not just focusing on the problems and the difficulties, but how are we going to solve these things.” (GP08-2)

3.5.2 Do No Harm Technical Brief Series – “a big piece” with “longstanding benefit”

One of the spinoffs of the Technical Working Group activities was the development of a series of technical briefs on the safe and effective use of inpatient newborn care interventions in low-resource settings.

“We found a lot of harmful practices in [five] countries and we came back saying we really must have some way of addressing these harmful practices. ... We all felt this was important and there was some ... sort of a felt need that we had to address harmful practices. So that's how we came up with the idea of having a series of technical briefs to address a series of harmful practices.” (GP07)

The guiding principle of this series was “Do No Harm”, i.e. providing evidence-based guidance on how to avoid harm and improve newborn health outcomes, and were grounded in WHO recommendations and guidelines – “*quality of care and especially for the preemies that's also important that we are not doing damage*” (GP03). “The target audience for the briefs is a wide range of policymakers, program managers and clinicians with the intended outcome of guiding decision-makers to integrate the WHO recommendations in their country in a safe and effective way.”⁵⁹

“When you want to strengthen your program for small and sick newborn care, we would like you to integrate the standards recommended by WHO, but even before that, make sure that that there are no harmful practices. That is like job number one – ensure that you are addressing harmful practices before you do anything, that's like the most basic thing for strengthening care of small and sick newborns, addressing harmful practices first, it's job number one.” (GP07)

The topics of the series, as well as the languages in which they were published, are listed in Table 6. The brief on human milk feeding is currently being updated. The subgroup of content experts who wrote and reviewed the briefs were drawn from numerous United States (US) and international organizations, institutions and programs (see Annexure E).

The “*enormously popular*” (CO3) briefs that “*stand on their own*” (GP08-2) were shared at numerous meetings and conferences in presentations and through distributed copies. Other international associations, donor organizations, and NGOs were also targeted for global dissemination, whereas ministries of health and other stakeholders were recipients at the country level. Some global partners acknowledged that they were not in a position to gauge how the briefs were being used – “*I informed the country offices or regional offices about the existence of those materials, but I cannot state whether they have listened to my advice and are using it or not*” (GP05). At the time of this evaluation, more than 4,300 copies of the briefs had been downloaded from the Every Premie website.

⁵⁹ Annual Report Year 3

Table 6. Topics of the Do No Harm technical brief series⁶⁰

Topic	English	French	Spanish
Safe and Effective Oxygen Use for Inpatient Care of Newborns	✓	✓	
Safe and Effective Infection Prevention for Inpatient Newborn Care	✓	✓	
Safe and Effective Thermal Protection for Inpatient Care of Newborns	✓	✓	✓
Safe and Effective Human Milk Feeding for Inpatient Care of Newborns	✓	✓	
Prevention and Screening of Retinopathy of Prematurity (ROP)	✓	✓	
Family Participation in the Care of the Inpatient Newborn	✓	✓	✓
Management of Newborn Infections and Safe Use of Antibiotics	✓		

Information on the geographical distribution of material is not available. Five of the 10 global partners who responded to the online survey indicated that they had used the Do No Harm technical briefs. Three of the six USAID priority countries responding to their survey were familiar with this series and used them “in providing inputs in national newborn health strategy documents” and “as a guide to provide technical direction to our implementing partners”. Rwanda reported:

“The materials reinforce our interventions in newborn care. They were shared with the national technical working group for MCH and the newborn subgroup. Our implementing Partner was able to use the content to improve patient care. The materials drew special attention to oxygen use and thermal care.”

With regard to the contribution and usefulness of the Do No Harm series – “very well thought through intellectual property” (GP02) – informants thought that “amongst global partners and the global sphere [the briefs] definitely had an important role to help ensure the continued kind of elevation of preterm birth amongst a very long priority list” (GP01). Two informants described the contribution of the briefs as follows:

“The advantage of much of what we did both from a technical level and from a policy and advocacy statement point is that it was groundbreaking, it just hadn’t been done before. So that’s where I appreciated [the] foresight ... and leadership around it in the sense that they [Every Preemie] felt like it was a priority. ... I do appreciate them highlighting the issue.” (CO7)

“I think that what they produced was really sound evidence-based and frankly with the Do No Harm series it’s a unique approach to kind of evaluating interventions and risk and benefit. ... So seldom do we consider risks and risk of harm and trying to minimize or mitigate against harmful practice. So I felt that they offered a very unique perspective and one that we in the development community were not – many of us were worried about overuse of oxygen and things like that, but it had not been formally put forward, even by WHO or anything like that.” (GP04)

One informant felt the briefs were packaged in a way that health professionals and policy makers needed to pay attention. They were “catchy and short” (GP01), “well reviewed by leading thought

⁶⁰ <https://www.everypreemie.org/donoharmbriefs/>

leaders” (CO2) and “the whole effort was worthwhile” (GP03). UNICEF included the technical briefs in their KMC training package, because “the technical content was good” (GP03). In the Midterm Review, an informant also referred to the importance of the basics:

“I think it’s a very important part of sick newborn care – that you’re not only doing high tech stuff, but you’re beginning first by making sure that you’re not doing harm – inflicting harm on those babies in those sick newborn care units – making sure that they’re getting the basics of warmth and feeding – that they’re getting breastmilk, even if they’re not able to suckle, and that they are getting safe oxygen. These are so basic.” (p. 15)

Informants were of the view that the Do No Harm briefs would outlast the Every Preemie project. While the Do No Harm briefs will need to be updated as new evidence emerges, they “...will continue to be useful for a while and used in countries as a guideline” (CO6).

“And if our [USAID] bilateral project doesn’t take it up or the governments don’t think it’s very important then it remains at a global level. ... going forward we really must have a way of disseminating it at a national level and really make sure that they are integrated into national programs. ... I feel like we can integrate the use of these Do No Harm series as WHO rolls out the new standards of care for small and sick newborn care. So even though we may not see countries using the Do No Harm series right now, I am hopeful that going forward once the standards are recommended ... that we will be able to integrate all these different pieces together.” (GP07)

“I think Every Preemie—SCALE was quite successful in bringing a new perspective to topics that were not otherwise being discussed and I think that will definitely last into the future and it really is sort of a new perspective that had previously not been there.” (GP04)

3.5.3 Advocacy, media and meeting participation

Most of the Every Preemie activities, especially at the global and country level, included an advocacy component through sharing and producing evidence for best practices and by means of advocating for implementation research in the four demonstration countries. One informant also referred to how USAID advanced Every Preemie’s agenda: “I think they were beyond kind of just the normal dissemination channels, there was also this kind of big advocacy push for the contents from USAID which helped as well.” (GP01)

Two major advocacy activities were the creation and maintenance of a website and associated contributions through social media, and participation in international awareness days and campaigns linked to PTB/LBW. At a more technical level advocacy was promoted by attending meetings and conferences that increased the visibility of the expertise associated with Every Preemie, but that also advocated for the cause of PTB and LBW.

(a) Website and social media

The Every Premie website was launched in May 2015.⁶¹ It served to build the project's visibility as a viable partner and technical resource. The website is organized under the following tabs: About Every Premie—SCALE; Demonstration Countries; Global Technical Working Group; Country Profiles; News and Blogs; Resources; Contact. It acts as a repository for existing Every Premie resources and provides links to partner websites and external partners. Every Premie also tracked the number of users and the number of downloads of country profiles and the Do No Harm technical briefs. At the time of this evaluation, the website had more than 200,000 page views and 30,000 downloads of materials.

Every Premie was particularly active in advocacy activities during several international awareness days and campaigns linked to PTB/LBW. The blogs and press releases on the Every Premie website are listed in Annexure F. Social media engagement was ongoing throughout the year, but focused especially on important international days and weeks like World Prematurity Day, International KMC Awareness Day, International Breastfeeding Week, Father's Day, the International Day of the Midwife, and World Pre-eclampsia Day.

Every Premie also played an active role in coordinating some of the World Prematurity Day activities and materials. In 2017 and 2018 Every Premie led message design and the development of the advocacy toolkits with the themes 'Let them thrive!' and 'Working together: Partnering with families in the care of small and sick newborns', respectively. One global partner described the role of Every Premie in coordinating advocacy activities:

"They stepped in to engage from 2016, '17 and '18 as they were extremely pivotal. They took over ... the messaging department which is obviously very critical towards the whole planning process for World Prematurity Day ... the kind of ground work of putting together all of the different messages. ... It essentially ... needs people to do the work and its resources, but a lot of organizations don't have that capacity to donate time of their staff to do these types of things, so it was really useful."
(GP01)

(b) Global engagement: technical meetings, working groups and other events

In addition to the organization of the PTB/LBW TWG meetings, members of the Every Premie team attended global conferences, meetings, workshops, webinars and other types of events as part of providing visibility to preterm and LBW issues in maternal, newborn and child health. The meetings were either led or co-led by Every Premie, or its team members played a leadership (e.g. planning, facilitation) or technical role (e.g. oral and/or poster presentation). Meetings in the four demonstration countries are referred to elsewhere. Respondents in the online survey for global partners were asked about their engagement or participation in Every Premie activities. Seven of these respondents indicated that they had attended "meetings" or "webinars" organized by Every Premie, although respondents provided no specificity.

According to the annual reports on meetings attended by Every Premie team members, the group had a fair-to-strong presence in the following activities at certain times:

- UNCoLSC working groups (chlorhexidine, ACS and neonatal resuscitation);
- ENAP (management team, partners, country implementation, metrics);

⁶¹ www.everypremie.org

- KMC Acceleration Partnership and the associated Community of Practice group;
- Respectful Maternity Care Newborn Technical Working Group (working on an updated charter for respectful maternal and newborn care);
- Public Private Partnership for the Prevention of Preterm Birth, Global Steering Committee; and
- CORE Group (Global Health Practitioners).

Individual team members and Every Preemie consultants were also involved as experts or promoters of Family-Led Care in meetings and working groups on themes around KMC and the care of small and sick newborns including the following:

- Prevention of preterm birth (general, eclampsia/pre-eclampsia);
- KMC;
- World Breastfeeding Week;
- Standards of care for the small and sick newborn;
- Integration of maternal and newborn health;
- Midwifery and neonatal nursing, including Women Deliver conferences;
- Pediatrics;
- Discussion of global documents and action plans;
- Research; and
- Metrics.

3.5.4 The Legacy of Every Preemie’s global engagement

Over its five years, Every Preemie worked closely with partners to raise awareness and visibility around preterm birth and low birth weight, and inpatient care of the small and sick newborn through a variety of mechanisms. Work in this arena is central to the project’s mandate and strategic objective. Project team members were vocal advocates for preterm birth and LBW across the maternal and newborn health continuum of care. Global engagement and the design and development of products was highly interactive, and the project consistently promoted evidence-based interventions. Informants cited Every Preemie’s leadership on the development of key global products (listed above), and the availability of materials and products for future work in this realm (e.g. the protocol and tools for the inpatient newborn care situation analysis) as valuable. Informants placed emphasis on the Do No Harm Technical Brief series. These briefs are recognized as significant “value add” to the global and country level landscape and can be promoted and used in the future as countries move to upgrade their inpatient newborn care systems and services.

From its variety of products and the activities Every Preemie was engaged in, including support for advocacy efforts such as World Prematurity Day, it can be concluded that the project has done “*a good job responding to the global agenda*” (CO3). It honored its acronym SCALE⁶² and its strategic objective of “the increased global utilization of prioritized evidence-based and underutilized PTB/LBW

⁶² Scaling, Catalyzing, Advocating, Learning, and Evidence-driven

interventions”⁶³ through advocacy and learning with a view to the future scale-up of interventions – “as a catalytic project ... it wasn’t about reaching scale” (CO5).

“The work of Every Premie is focused on the preterm baby – [it] clearly kind of catalyzed this global effort, this global focus on small and sick newborn care which is sort of now the next phase of newborn programming. ... I think that this focus on the preterm baby was a key way that sort of sparked a number of conversations and streams of work on small and sick newborn care. So I think that is an important legacy for them and their leadership.” (GP08-1)

“It just simply became a topic of conversations in a way that – it had never been a topic of conversation. I mean people were so focused and it makes perfect sense on just providing kind of basic fundamental care to both a mother and a newborn infant that the preterm infant or the infant with special needs has just not been a discussion topic in the global arena. So this suddenly became a topic of conversation and what kind of moral responsibility do we have and what can we do given the situation that exists in many of these countries, what can we do to help this dilemma.” (CO7)

See Annexure G for questions and achievements related to Outcome 3.

4 Achievements of Every Premie in cross-cutting priorities

At the basis of Every Premie’s Results Framework (Figure 1), there are six cross-cutting priorities. They are: (1) local capacity strengthening, (2) gender equity, (3) knowledge management, (4) action-oriented advocacy and awareness raising, (5) access to commodities and (6) sustainability. Although informants did not comment on these priorities directly, we can deduce how these were achieved through Every Premie.

- **Local capacity strengthening**⁶⁴ was evident in all four demonstration countries vis-a-vis work with the local research partners (see Section 3.2.4). In Malawi, capacity strengthening also extended to health workers’ improvement of knowledge and skills in the care of preterm and LBW newborns, ranging from professionals, support staff, HSAs and community volunteers such

⁶³ Midterm Review, p. 5

⁶⁴ We used a broad definition here of local capacity strengthening.

as Care Group Lead Mothers. A key element of the Family-Led Care model was building the capacity of families to actively engage in the care of their babies during inpatient KMC and at home post-discharge. Families were taught how to monitor their babies and to identify danger signs and were given easy-to-use monitoring forms both at the facility and when they were discharged.

- **Gender equity** appears to have received less focused attention and should receive more careful thought in future projects. It could be argued that the Family-Led Care model has a built-in equity principle in that the care of early/small newborns is meant to extend beyond traditional reliance on mothers and female relatives to include fathers. In Balaka district in Malawi, there were anecdotal reports of male involvement in community awareness activities (e.g. fathers' groups) and observations of fathers carrying their baby skin-to-skin.
- **Knowledge management** and shared learning is a central feature of Every Preemie and links directly to **action-oriented advocacy and awareness raising**. The project's knowledge management mandate was centered around sharing evidence, heightening awareness and influencing action for preterm birth and LBW. The project initiated and led the PTB TWG, bringing experts together to share evidence and information on priority issues. The subsequent development and broad dissemination of the Do No Harm technical briefs provides a strong example of sharing global evidence to improve care of small and sick newborns at the country level. The project participated in global conferences, workshops and other meetings to build global and country action around PTB and LBW; and, in addition to the technical briefs, the project created products that were used to inform stakeholders and build advocacy and action. This includes the PTB Joint Statement and the country profiles. Other project initiatives like the ACS Landscape Analysis and the situation analysis of inpatient care prompted unique learning opportunities for participating countries. Ideally, information gleaned from this work will be used to transform care of small and sick newborns. It is also important to highlight the implementation research and the project's efforts to share early findings with in-country stakeholders (and globally as in the case of Malawi). As of this evaluation, in-country research partners were preparing to share final implementation research findings with country stakeholders before the close of the project. It is expected that the findings will be used to inform country action.
- **Access to commodities** was implicated in the research in Ethiopia, India and Malawi. In Ethiopia, the implementation research looked at the availability of basic commodities for newborn care; and, in India, the study focused on the safe and effective use of ACS across levels of care. The multi-country ACS landscape analysis looked critically at ACS use in seven UNCoLSC priority countries. The project also designed a new Terms of Reference for a newborn commodities group that would replace the UNCoLSC and related working groups; however, that effort was not pursued by funding partners. At the country level, implementation of the Family-Led Care model in Malawi included the procurement of essential commodities for the care of early/small newborns (e.g. weighing scales, feeding tubes and cups). The project also included commodities in the situation analysis for inpatient newborn care.
- **Sustainability** was addressed more indirectly, as the Every Preemie project focused on catalyzing action and preparing the landscape for others to take forward the implementation and scale-up of PTB/LBW interventions. Issues of sustainability in Malawi and the succession

plan for ONSE to take forward the scaling up of Family-Led Care have been described under Outcome 2 (Section 3.3).

5 Every Premie—SCALE “catalyzed this global effort” – “a great learning opportunity”

This evaluation was a review of Every Premie activities and products over the project life cycle. It provided insights and reflections from various project stakeholders on the catalytics processes that pushed both the global and national preterm and LBW agenda. Despite the core Every Premie team being thinly spread and operating on a small funding envelope, the project provided an excellent platform for evidence generation and sharing; advocacy and awareness raising; and partnership engagement. Every Premie fulfilled its mandate to affect change and acted as an important link in global-country advocacy and action around essential newborn care and the care of vulnerable newborns.

Several informants commented on the “*high visibility*” and “*influence*” of Every Premie – “*we were at the table of every major initiative*” (CO3) and partners were receptive to the information.

“Well, I think it had high visibility. That was actually the way that the project was designed ... to call attention to this particular aspect of newborn care and I appreciate that...” (CO7)

One informant felt that Every Premie filled a specific vacuum: “*Once the Born Too Soon report [was] released, globally there wasn’t any other visible commitment from global partners*” (GP05). Another had the view that Every Premie came along at a particular point on a continuum, although not all new activities by other role players in the small and sick newborn movement could be attributed to Every Premie, they all had “*a touch point with Every Premie*” (CO5). There

BUILDING SCALE

SCALING—expanding the Family-Led Care model in Malawi to 16 new districts; with other countries showing interest in adapting the model.

CATALYZING—sparking global and national dialogue to bring attention to PTB and LBW and care of the small/sick newborn; using implementation research results to build the national response to PTB and LBW; developing products and tools to accelerate information-sharing and action.

ADVOCACY—serving as the active global champion for essential newborn care and care of the vulnerable newborn; supporting national engagement in IR countries and in others to bring attention to PTB and LBW.

LEARNING—broadly disseminating findings from landscape analyses; supporting the development and dissemination of global products and publications; sharing implementation research findings to influence country level action.

EVIDENCE-DRIVEN—ensuring that global and national stakeholders had access to the most recent evidence on the safe and effective care of small and sick newborns; generating evidence for country programming.

was also appreciation for partners supporting each other in advocacy and that *“there was more convergence than five to ten years ago”* (GP06).

A project like Every Preemie that accelerates change is *“designed mostly on focusing on global leadership rather than providing support to country implementation”* (GP07). However, informants also recognized the importance of linking global and national evidence generation for continued learning and action.

“The goals will never be achieved by just the global partners sitting out there and planning and targeting things. The changes have to happen at the country levels for any of us to achieve the targets and goals set for newborn health.” (GP02)

“Whatever we do at the global level eventually it has to hit the ground on the local level. So if we do any research it has to be done at a country level, but it has to be a topic ... it ... should be like a burning need to understand at the global level ... [or] a question that we are asking for global replication. So for example, the antenatal corticosteroids study in India was of interest to India as well as of great interest at the global level. ... Similarly, we had the same question, the Malawi study ... Can you empower a family even after the baby goes home from the facility to empower these families to continue taking care of that very vulnerable baby? ...

Learning that informs the global agenda must come from evidence emanating from the grassroots.

“My expectation from a program [was] that [it] would work as a catalyst in bringing attention, so it’s like a mixture of advocacy and also additional – some experience on the ground to inform what are the solutions for managing preterm births” (GP02).

... So that’s how we keep learning, we move from the global level down to the national, country level and then pick it up again, the lessons we learnt, pick it up again to the global level for global replication and advocacy.” (GP07)

Findings from the implementation research need further dissemination and uptake in order to develop into implementable and scalable models. Findings will be shared nationally and will ideally be used to shape future action for improved newborn outcomes. At the same time, findings will be shared globally via peer-reviewed journal articles and global networking and can be used to both shape the global-country conversation around care of vulnerable newborns and drive change across countries.

A few informants wished that the project could be extended for another 6 to 12 months in order to wrap up their country projects for greater learning.

“The thing that we always have it’s a three year project, two year project, so there isn’t really time to do that, so it’s always difficult – only a year post the closure of the project you can be able to see whether things have been embedded in the routine system.” (MW12)

The question is: should other organizations pick up where Every Preemie ended and if so, how? Some informants referred to the importance of a succession plan that *“will also help inform future programs that we are going to be embarking on”* (GP08-3). Every Preemie’s succession plan for the scale-up of the Family-Led Care model in Malawi (and beyond) was the transition to ONSE and the development of a Global Family-Led Care Package. How Malawi and other countries will continue the management of the implementation and scale-up of Family-Led Care or similar models will depend on advocacy and funding support. It is anticipated that the succession plan for the activities in Ethiopia and India will be the

uptake of findings and recommendations in future strategic planning and in the development and revision of policies and guidelines.

One informant was of the view that at the global level *“some of the things are going to carry forward, like World Prematurity Day is not going to stop”* (GP01). It can be expected that partners such as WHO, UNICEF and USAID will continue to work on issues highlighted by Every Premie. The care of small and sick newborns will continue to be highlighted through the *Survive and Thrive* document, the nurturing care activities aligned with the Nurturing Care for Early Childhood Development framework, the ENAP activities and in the work on the standards of care for small and sick newborns coordinated by the WHO.

“I think that it’s going to be incumbent on the global newborn community overall to sort of support some of this continuity. ... So I think it’s sort of a multi-pronged effort and so no one entity holds responsibility, but there are opportunities at various levels.” (GP08-1)

“USAID will continue to shepherd the legacy, will continue to advocate and talk about it with WHO and UNICEF and national governments in our bilateral projects. Things don’t just happen on their own, you have to have somebody to continue advocating for them and shepherding it along. And then when there is a new project ... you make sure that these are integrated into that follow-on project, that’s how we make sure that it continues to be alive.” (GP07)

5.1 Recommendations

Three main recommendations for future projects at the global and national level emerged from informant interviews:

1. **Do not lose the focus on essential care for every newborn including early/small newborns** whose main needs are thermal care and appropriate feeding. As more emphasis is placed on technology for the care of sick newborns, there is a concern that *“fairly simple clinical interventions”* (GP11) may not be prioritized.

“I feel it’s not just technology that partners should be paying attention to, the work that we are doing just recently on nurturing care is going to be important. In low-income countries ... I am getting more convinced that it’s not about just saving them ... it’s about the longer-term implications and that’s where I think the people-centered care, the nurturing care, respect for newborn care is going to be important.” (GP02)

2. **Increase the focus on community engagement in the care of early and small newborns** – *“preemies can’t be saved without community”* (CO5). Ensure that the Family-Led Care model is *“used to inform ongoing work which, maybe in a different country or maybe in multiple countries, but we shouldn’t lose that”* (GP08-2).

“I think the involvement of the families themselves, the involvement of the community, that’s something that needs to [be expanded to] ... other districts, or other countries ... the

communities are the pillars for the Family-Led Care. If the mother doesn't get the support from the community she might as well abandon the care of the baby." (MW14)

3. **Have an "advocacy push"** (GP01) with innovative ways to advocate for preterm and LBW newborns and rely more on parent groups.

"I feel this time if they have a second phase they should really build an advocacy program, a [stand] alone advocacy program ... or with the parent organizations, because we see a lot of work for parent organizations in Europe and also in some of the African countries, but it has [to be] more organized and [with] more support globally and at country level." (GP03)

Other priority recommendations include the need to determine how the global leadership established under the PTB/LBW TWG will continue and with whom; invest in implementation research as the issues related to preterm birth are "countless" (CO5); develop and share evidence around models of care that improve newborn outcomes; and translate research findings into policy and practice. Additionally, as countries move to strengthen inpatient care for small and sick newborns, it is expected that they will need significant support to effectively establish and provide that care, including support for innovative technologies and bundles of care for low- and middle-income settings.

Annexures

A. Evaluation tools

TOOLS FOR OUTCOME 1

(Improved translation of evidence into action)

TOOL 1A:

Target audience: Implementation research partners (demonstration countries)

Data collection method: key informant individual or group interviews

Interviewer: Anne-Marie Bergh

Introductory e-mail: Judith Robb-McCord

Organization of the date/s and time/s: Anne-Marie in follow-up e-mail

1. Could you tell me a little bit about yourself,
 - [Bangladesh] your work and the kinds of research projects that you are involved with
 - [Ethiopia] the St. Paul's Hospital Millennium Medical College and the kinds of research projects that you are involved with
 - [India] the Post Graduate Institute of Medical Education & Research and the kinds of research projects that you are involved with
 - [Malawi] where you work in the College of Medicine and the kinds of research projects that you are involved with

[For Maikhanda Trust this will be the second part of the interview and one does not need this icebreaker]
2. How did you become involved in this study on
 - [Bangladesh] the prediction of gestational age before birth in low-income settings?
 - [Ethiopia] the assessment of services for small and sick newborns?
 - [India] the assessment of antenatal corticosteroids use and the implementation of the national operational guidelines?
 - [Malawi] providers' knowledge and perceptions of the Family-Led Care project? [COM] families' experience of Family-Led Care? [Maikhanda]
3. Can you tell us more about the process you are following in this implementation research?
Possible probes to use:
 - [Bangladesh] At what point did Every Preemie come on board? What was their role?

[All countries:]

- Can you tell me something about the process of developing the research design and the protocol?

Further probes:

- i. How were the implementation research questions identified and prioritized?
 - ii. Who were the key players in the design process and what were their roles? What was the role of Every Premie?
 - iii. How did the research plan evolve over time? Did it change from its original intent? (What changes were / had to be made in relation to the original thinking and intent?)
- What would you consider as the highlights during the **process** of doing the research?
 - What were the challenges encountered or issues that needed to be resolved?

4. Now we'd like to talk a bit more about data analysis.

[Bangladesh] Your study has been completed.

- How was Every Premie involved in the data analysis?

[India, Ethiopia and Malawi]:

- How has Every Premie been involved in the analysis of data?

[India and Ethiopia]

- How far are you with the analysis of data and the writing up of results?

[Malawi] You have most of the results of your study already and you shared the results of the first round of data collection in August last year with the Balaka District Management Team.

- i. In your view, which of the results are the most striking / powerful / significant?
- ii. What surprised you about the results?

5. [Dissemination of results]

[Bangladesh] Although the results of your study were not what you had hoped for/anticipated, how have you disseminated the results? *[Probe for role of Every Premie if needed]*

[India & Ethiopia] Have the results of your study already been disseminated or used? (Y/N)

If Yes: Can you give some examples?

What are the plans for dissemination (who is it important to reach with these findings and what are planned dissemination strategies)?

[Malawi] How have the results of your study been disseminated up to now? What are the plans for the dissemination of results?

Possible probes to use for all countries:

- a. Stakeholder meetings (government, funders, NGOs, health facilities, research participants, etc)
- b. Research days

- c. Conference presentations
- d. Other

6. [Use/Application of results]

[Bangladesh] Although the results of your study were not what you had hoped for/anticipated, how have/will the results influenced future thinking?

Possible probes to use:

- a. In Bangladesh?
- b. For future research on your topic in general?

India, Ethiopia and Malawi:

Have the results of your study been used? (Y/N/Unsure)

If No or Unsure:

How do you think the results could be used?

If Yes:

How have the results been used?

Possible probes to use:

-
-

7. How do you think the results of your study could be used to influence change?

Possible probes to use:

- a. Influence on clinical practice and quality of care
- b. Influence on the government and other development partners for programmatic or funding priorities
- c. Influence on changes in policy or guidelines for clinical practice
- d. What else could be done to influence change?
- e. Other

8. [Ethiopia] One intervention related to preterm birth in which there is currently a lot of interest is the use of antenatal corticosteroids. Your country was part of the landscape analysis that was done in seven sub-Saharan African countries in 2016.

- Are you aware of any activities with regard to ACS that took place in the past few years? (Y/N)
- Have there been any changes in the utilization of ACS for maternal health or in the government policies and guidelines for clinical practice?

[If informants do not know, ask if they can refer the interviewer to a knowledgeable person to write to, and add this to Tool 3E]

9. Undertaking this research, what do you think was the value of being involved / conducting this research? [Bangladesh: for institutions or organizations in Bangladesh]

Possible probes to use:

- a. Capacity building? [Ask to elaborate]
- b. Partnerships? [Ask to elaborate]
- c. Visibility? [Ask to elaborate]
- d. For you personally and for your institution?

e. Other

10. Looking back: If you had to do this research again, what would you do differently?

Possible probes to use:

- a. Design of project
- b. Protocol development
- c. Scope of the project
- d. Management of the research
- e. Liaison with partners
- f. Other

11. In conclusion, what would you say are the three main lessons you learned from doing this research?

Possible probes to use:

- a. Research topic and question(s)
- b. Management of the research
- c. Dissemination and use of results
- d. Other

TOOL 1B:

Target audience: In-country stakeholders

Data collection method: individual or group interviews

Interviewer: Anne-Marie Bergh

Introductory e-mail: Anne-Marie Bergh

Organization of the date/s and time/s: Anne-Marie in follow-up e-mail

1. Icebreaker: Tell me a bit about the work that you are involved with.
2. When / how did you first become involved in the implementation research?
3. Were you engaged / Did you assist in identifying research partners, location and defining the implementation research question / priorities on
[Bangladesh] the prediction of gestational age before birth in low-income settings?
[Ethiopia] the assessment of services for small and sick newborns?
[India] the assessment of antenatal corticosteroids use and the implementation of the national operational guidelines?
[Malawi] client and health care provider perspectives on Family-Led Care?

(Y/N) → **If No: Go to Question 5**

If Yes: What was your role?

4. What were your initial expectations of the research?

Possible probes to use:

- a. What did you want to see as outcomes of the research?
- b. Did your expectations change over time? (Y/N) [*Probe:* Can you elaborate?]

5. Have you seen any findings of the implementation research study?

• *If Yes:*

- i. In what format were the findings presented? (*Probes:* informal communication, presentation at a specific meeting)
- ii. Did the presentation of findings meet your expectations? (Y/N)
If Yes: Could you please explain/elaborate? (*Probes:* powerful or surprising findings)
- iii. Looking at the [government/agency] structure you work in, how else do you think should the findings be disseminated?

• *If No:*

- i. Do you have any information on how the findings will be disseminated? (Y/N)
If Yes: Could you give some more information?

6. What value would you say research such as

- [Ethiopia] the assessment of services for small and sick newborns
- [India] the assessment of antenatal corticosteroids use and the implementation of the national operational guidelines

will add / added to the improvement of the outcomes for preterm birth and low birth weight?

Possible probes to use:

- Influence on clinical practice and quality of care
- Influence on the government and other development partner priorities and health sector investments
- Influence on changes in policy or guidelines for clinical practice
- How do you think the research will influence changes in policy and guidelines in the state / districts?
[*Probe:* How do you anticipate these changes will impact on the care of preterm and low birth weight babies?]
- Wider influence – other countries take up the findings in changing their guidelines/policies – improvement at a global level
- Value of capacity building of in-country researchers
- Other

7. [Ethiopia] One intervention related to preterm birth in which there is currently a lot of interest is the use of antenatal corticosteroids. Your country was part of the landscape analysis that was done in seven sub-Saharan African countries in 2016.

- Are you aware of any activities with regard to ACS that took place in the past few years? (Y/N)
- Have there been any changes in the utilization of ACS for maternal health or in the government policies and guidelines for clinical practice?
[If informants do not know, ask if they can refer the interviewer to a knowledgeable person to write to, and add this to Tool 3E]

8. What key developments or milestones do you anticipate in the next 1-3 years in preterm birth and low birth weight programming in Ethiopia / India?

- a. Probe for those that may be directly related to work of Every Preemie versus other development/milestones that may be occurring in broader landscape

9. Looking back: If you (or the country) had to do this research again, what would you do differently?
Possible probes to use:
- a. Design of project
 - b. Protocol development
 - c. Scope of the project
 - d. Management of the research
 - e. Liaison with partners
 - f. Other
10. In conclusion, what would you say are the three main lessons you learned from this implementation research?
Possible probes to use:
- a. Research topic and question(s)
 - b. Management of the research
 - c. Dissemination and use of results
 - d. Other
-

TOOLS FOR OUTCOME 2

(Increased capacity of local, national and global entities to scale-up and sustain the utilization of high-impact interventions)

Tools 2A

Target audience: Malawi: Implementation/targeted technical assistance stakeholders

- a) MoH & Newborn Steering Committee:
- b) District management:
- c) Implementers (Balaka district):
- d) Partners:
- e) USAID:

Data collection method: key informant individual or group interviews

Interviewer: Anne-Marie Bergh

Organization of the date/s and time/s: Irene Kamanga

[Questions will vary slightly, depending on the person / stakeholder group that is interviewed]

- 1. Icebreaker: Tell me a bit about the work you do.
- 2. How were you involved in the Every Preemie/Family-Led Care project in Malawi?

3. Can you tell me more about the process of developing and implementing Family-Led Care? *Possible probes to use:*

- a. What was the original intent of the Family-Led Care model? What were the needs it was trying to address?
- b. How did the model evolve over time?
- c. What do you see as the key or most significant components that took place as part of the implementation of Family-Led Care? (Probe: Training, Quality improvement)
- d. What additional resources were made available as part of the implementation of Family-Led Care?
- e. What would you say went well in the implementation of Family-Led Care?
- f. What were the challenges encountered or issues that needed to be resolved?
- g. What would you say were the highlights of the project?

[Specific questions for MaiKhanda:]

- a. What was the original intent of the QI model developed/adapted to support Family Led Care? What were the needs it was trying to address? How did the model evolve over time?
- b. How did the QI initiative work together with the Family-Led Care project?
 - Overlaps
 - Tensions
- c. What additional resources were made available as part of the implementation of the QI activities?
- d. What would you say went well in the implementation of QI to support Family-Led Care?
- e. What were the challenges encountered or issues that needed to be resolved?
- f. What would you say were the highlights of the activities?

4. In your view, what has changed as a result of the implementation of Family-Led Care in Balaka district?

Possible probes to use:

General:

- a. Awareness of the special needs of preterm and LBW babies and their families?
- b. Knowledge on care of preterm and LBW babies
- c. Impact on families / community

Balaka district:

- d. Provision of care (Balaka) – better quality care
- e. System: staffing support

National:

- f. In Balaka district vs National MOH
- g. Operationalization of KMC Guidelines
- h. Adaptation of policy
- i. Expansion of the model

5. What would you say were the main lessons learned through the implementation of Family-Led Care in Balaka?

Possible probes to use:

- a. What do you consider to be the successes and achievements of the Every Preemie project?
 - Outcome 1: Improved translation of evidence into action
 - Outcome 2: Increased capacity to scale-up and sustain the utilization of high impact interventions – local, national and global entities
 - Outcome 3: Increased prioritization of PTB and LBW with decision makers (in-country) and other relevant stakeholders (national and global level)
 - b. What are the conditions for sustaining Family-Led Care beyond the Every Preemie project?
 - c. What is needed for scaling up the Family-Led Care model in other districts in Malawi?
 - d. If you implement Family-Led Care in other districts in Malawi, what will you do differently?
6. What do you think the influence of the Family-Led Care model is?
- a. In Balaka district?
 - b. Beyond Balaka district?
7. What would you say will be the legacy of Family-Led Care in the next 1-3 years?
What key developments or milestones do you anticipate in the next 1-3 years in preterm birth and low birth weight programming in Malawi?
- a. Probe for those that may be directly related to work of Every Preemie versus other development/milestones that may be occurring in broader landscape

(TOOL 2B)

Additional questions on the implementation research for country stakeholders with information/insight about the research:

8. Have you been involved with or have you heard about the implementation research among health care providers and clients about their experiences with the implementation of Family-Led Care? (Y/N/Not really)
- *If No or Not really:* Conclude interview
 - *If Yes:* Could you please tell me more?
9. What were your initial expectations of the research?
- Possible probes to use:*
- a. What did you want to see as outcomes of the research?
 - b. Did your expectations change over time? (Y/N) [*Probe:* Can you elaborate?]
10. Have you seen any findings of the implementation research study?
- *If Yes:*
 - i. In what format were the findings presented? (*Probes:* informal communication, presentation at a specific meeting)
 - ii. Did the presentation of findings meet your expectations? (Y/N)
If Yes: Could you please explain/elaborate? (*Probes:* powerful or surprising findings)
 - iii. Looking at the [government/agency] structure you work in, how else do you think should the findings be disseminated?

- *If No:*
 - i. Do you have any information on how the findings will be disseminated? (Y/N)
If Yes: Could you give some more information?

11. What value would you say the research on the implementation of Family-Led Care will add / added to the improvement of the outcomes for preterm birth and low birth weight?

Possible probes to use:

- Influence on clinical practice and quality of care
- Influence on the government and other development partner priorities and health sector investments
- Influence on changes in policy or guidelines for clinical practice
- How do you think the research will influence changes in policy and guidelines in the country?
[Probe: How do you anticipate these changes will impact of the care of preterm and low birth weight babies?]
- Wider influence – other countries take up the findings in changing their guidelines/policies – improvement at a global level
- Value of capacity building of in-country researchers
- Other

MaiKhanda: Use Tool 1A for probing on their research experience

TOOLS FOR OUTCOME 3

(Increased prioritization of PTB and LBW with in-country decision makers and other relevant stakeholders at global and national level)

TOOL 3A

Target audience: USAID health officers, or his/her designee, in the 20 of 24 USAID priority MCH countries (less Ethiopia, India, Malawi who are interviewed separately as demonstration countries and Yemen, a non-presence country)

Data collection method: online questionnaire

Introductory email: to be sent by Lily Kak

1. In what country do you currently work? _____
2. Which of the following are currently important components of the Ministry of Health's national maternal and newborn health response? (Tick all that apply.)
☐ Maternal health

- ☐ Newborn health
- ☐ Preterm birth and low birth weight
- ☐ Inpatient newborn care
- ☐ Other

2.1. Please give more detail for ALL your answers above.

3. Managing newborn health, including preterm birth and low birth weight, is an important component of our USAID Country Development Cooperation Strategy.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

3.1 Please give a reason or reasons for your answers above.

4. Which of the following are currently important components of your health project portfolio? (Tick all that apply.)

- ☐ Maternal health
- ☐ Newborn health
- ☐ Preterm birth and low birth weight
- ☐ Inpatient newborn care
- ☐ Other

4.1. Please describe ALL your answers above.

5. Is USAID supporting the management of preterm birth and low birth weight within the current health project portfolio?

- ☐ Yes
- ☐ No

(Branch: Yes = 5.1 and No = 5.2)

5.1. If Yes, which of the following mechanisms are being used? (Tick all that apply.)

- ☐ Bilateral health project
- ☐ Field support project (specify): _____

☐ Other (specify): _____

5.2. If USAID is not currently supporting this work, are there plans in the future to become engaged in preterm birth/low birth weight programming?

☐ No, we have no plans in place

☐ Yes, we have plans in place (specify): _____

6. Which Every Premie – SCALE tools/materials are you familiar with? (Tick all that apply.)

☐ None (→ enable skipping Question 7)

☐ Country profile

☐ Do No Harm technical briefs

☐ Continuum of care matrix

☐ Joint statement on preterm birth

☐ Family-Led Care materials

☐ Inpatient newborn care assessment protocol and tools

☐ Other (specify): _____

7. Which of the Every Premie tools/materials have you used and how? (Tick all that apply.)

☐ None (→ enable skipping Question 7.1)

☐ Country profiles

☐ Do No Harm technical briefs

☐ Continuum of care matrix

☐ Joint statement on preterm birth

☐ Family-Led Care materials

☐ Inpatient newborn care assessment protocol and tools

☐ Other (specify): _____

7.1. Please describe how you have used these materials, including with whom you have shared them.

8. Do you have any other comments or recommendations about the project or about the topic of preterm birth/low birth weight programming that you would like to share?

☐ No

☐ Yes

8.1. If Yes, please describe below:

Thank you for completing this survey

TOOL 3B

Target audience: Global partners

Data collection method: online questionnaire

Introductory email: to be sent by Anne-Marie Bergh

1. What is the main focus of your work?

2. To what extent have you been engaged in initiatives of the Every Premie – SCALE project?

- ☐ A lot
- ☐ Somewhat
- ☐ A little
- ☐ Not at all (→ enable skipping Question 2.1)

2.1. Please describe your engagement or participation:

3. Which of the following Every Premie tools/materials have you used? (Tick all that apply.)

- ☐ None
- ☐ Country profiles
- ☐ Do No Harm technical briefs
- ☐ Continuum of care matrix
- ☐ Joint statement on preterm birth
- ☐ Family-Led Care materials
- ☐ Other (specify): _____

3.1 Please describe any specific examples of use of these tools/materials:

4. Please list 1-5 key accomplishments or areas in which the Every Premie—SCALE project had a significant influence.

5. What do you think are the most significant contributions or influence the Every Premie—SCALE project has made at the **global** level?

6. In what areas (if any) do you think the Every Premie—SCALE project could have made a more significant contribution?

7. What key developments or milestones do you anticipate in the next 1-3 years in preterm birth and low birth weight programming, globally and/or in specific countries where you may work that may occur as a result of the work or influence of the project?

Thank you for completing this survey

TOOL 3C

Target audience: USAID/Washington Newborn Health Team

Data collection method: Key informant interview (preferably as a focus group)

Organization of the date/s and time/s: Lily Kak (in collaboration with Anne-Marie Bergh)

Interviewer: Anne-Marie Bergh

1. Can you give me a short overview of how your team has been involved with the Every Premie—SCALE project?
2. What were your initial expectations of the Every Premie project and what the project was designed to achieve?
Probes if needed:
 - (a) How did your expectations change over time and why?
 - (b) After nearly five years, which expectations have been met? Why? Which have not been met (and why)?
 - (c) How did the design, approach and coverage of the Every Premie project change over time?
 - (d) Other:
3. What has been most effective in informing you about progress with the Every Premie project throughout the life-cycle of the project?

Probes if needed:

- (a) Formal documents (e.g. project reports)
- (b) Informal communications (e.g. emails, monthly or ad hoc calls)
- (c) Review of project products
- (d) Participation in project meetings (e.g. technical working group)
- (e) Other

4. FOUR of the priority USAID countries were involved in conducting implementation research under the umbrella of the Every Premie—SCALE project. *[Recap of the projects, if needed.]* How important do you think the prioritization of these themes was?

Probes if needed:

- (a) How useful will the results of these studies be within the research country and in other countries?
- (b) To what extent do you think countries will be able to apply and utilize results?
- (c) Other:

5. What do you consider to be the successes and achievements of the Every Premie—SCALE project?

Probes if needed:

- (a) Outcome 1: Improved translation of evidence into action
- (b) Outcome 2: Increased capacity to scale-up and sustain the utilization of high impact interventions – local, national and global entities
- (c) Outcome 3: Increased prioritization of PTB and LBW with decision makers (in-country) and other relevant stakeholders (national and global level)

6. What do you consider to have been the challenges of the Every Premie—SCALE project?

Probes if needed:

- (a) Outcome 1: Improved translation of evidence into action
- (b) Outcome 2: Increased capacity to scale-up and sustain the utilization of high impact interventions – local, national and global entities
- (c) Outcome 3: Increased prioritization of PTB and LBW with decision makers (in-country) and other relevant stakeholders (national and global level)

7. Do you think the development investment made in the Every Premie—SCALE project had a catalytic influence? *[Re-explain the understanding of “catalytic” if needed]*

Probes if needed:

- (a) Could you elaborate on your answer? (If Yes or No)
- (b) How did the project influence change?
- (c) How did the project add value to preterm birth and low birth weight globally?
- (d) What would be the lasting impact of the project globally and in specific countries?
- (e) Changes in government policies with regard to resource allocation for the care of preterm and low birth weight babies?
- (f) Would you say the project led to improved preterm and low birth weight care in some of the demonstration countries? (Yes/No) If yes, in what respect?

8. Are there any other comments about the project that you would like to share with us?

Thank informant/s

TOOL 3D

Target audience: Selected global partners (4-8):

Data collection method: Key informant interviews

Interviewer: Anne-Marie Bergh

Introductory email: to be sent by Anne-Marie Bergh (personalized e-mails)

1. Can you give me a short overview of how you or your team have been involved with the Every Premie—SCALE project?
2. What were your initial expectations of the Every Premie--SCALE project and what the project was designed to achieve?
Probes if needed:
 - (a) How did your expectations change over time and why?
 - (b) After nearly five years, which expectations have been met? Why? Which have not been met (and why)?
 - (c) How did the design, approach and coverage of the Every Premie project change over time?
 - (d) Other:
3. What has been most effective in informing you about the priorities of the Every Premie—SCALE project throughout the life-cycle of the project?
Probes if needed:
 - (a) Formal documents (e.g. project reports)
 - (b) Informal communications (e.g. emails, monthly or ad hoc calls)
 - (c) Review of project products
 - (d) Participation in project meetings (e.g. technical working group)
 - (e) Other
4. Have you used any of the materials or tools made available by Every Premie—SCALE? (Yes/No)
Probes if needed (if Yes):
 - (a) Country profiles
 - (b) Do No Harm technical briefs
 - (c) Continuum of care matrix
 - (d) Joint statement on preterm birth
 - (e) The Family-Led Care materials
 - (f) Inpatient newborn care situation analysis protocol and tools

If yes, how have you used these materials or tools?
5. What do you consider to be the successes and achievements of the Every Premie project?
Probes if needed:
 - (a) Outcome 1: Improved translation of evidence into action
 - (b) Outcome 2: Increased capacity to scale-up and sustain the utilization of high impact interventions – local, national and global entities
 - (c) Outcome 3: Increased prioritization of PTB and LBW with decision makers (in-country) and other relevant stakeholders (national and global level)

6. Do you think the development investment made in the Every Premie—SCALE project had a catalytic influence? *[Re-explain the understanding of “catalytic” if needed]*
Probes if needed:
- (a) Could you elaborate on your answer? (If Yes or No)
 - (b) How did the project influence change?
 - (c) How did the project add value to preterm birth and low birth weight globally?
 - (d) What would be the lasting impact of the project globally and in specific countries?
 - (e) Changes in government policies with regard to resource allocation for the care of preterm and low birth weight babies?
 - (f) Would you say the project led to improved preterm and low birth weight care in some of the USAID priority or the demonstration countries? (Yes/No) If yes, in what respect?
7. Are there any other comments about the project that you would like to share with us?

Thank informant/s

TOOL 3E

Target audience: Participants providing information for the antenatal corticosteroids landscape analysis:

Data collection method: Personalized e-mails (in French to DRC)

Person responsible: Anne-Marie Bergh

E-mail template:

Subject: Evaluation of the Every Premie—SCALE project

Dear

You participated in providing information for the landscape survey on the use of antenatal corticosteroids (ACS) for women in imminent preterm labour for the Every Premie—SCALE project. I am doing an evaluation of the project and would like to know more about recent changes in ACS policy, guidelines and use for maternal health in your country.

Would you be able to provide us some information on the following questions?

- 1. Since the landscape survey in 2016, are you aware of any changes in policies and guidelines related to ACS for maternal health? (If so, please describe)
- 2. Since the landscape survey in 2016, are you aware of any change in the uptake and use of ACS? (If so, please describe)
- 3. How would you rate the current interest in ACS in [add country name]?
Great interest / Some interest / Little interest

Your inputs are highly appreciated. Attached please find a copy of the paper that has been published on the analysis.

Yours sincerely,

Anne-Marie Bergh

B. Details of the implementation research studies

Study titles, aims and objectives in the four countries

The information for this table was derived from the study protocols and reports and Every Preemie annual reports.

	Bangladesh	Ethiopia	India	Malawi
Study title(s)	Maternal anthropometrics and statistical modeling to improve prediction of gestational age before birth in low-income settings	Assessment of the scope and implementation of services for small and sick newborns within the Ethiopian public health care system: a health systems implementation study	Assessment of use of antenatal corticosteroids and national operational guidelines in Haryana state, India	1. Knowledge, perceptions and practices of families who have experienced family-led care in Balaka District, Malawi 2. Health care providers' experience of implementing family-led care for preterm and low birthweight newborns in Balaka District, Malawi
Aims and objectives	To develop and validate methods for AG and SFH measurement to improve prediction of gestational age before birth • Develop and standardize programmatically feasible procedures for reliably measuring maternal SFH and AG in pregnancy • Test the inter-rater and intra-rater agreement for the measurement of maternal SFH and AG in pregnancy across different levels of health care providers • Evaluate maternal SFG, AG and estimated uterine volume as predictors of gestational age compared to the gold standard of early ultrasound measures	To describe how maternal and newborn interventions and services for small and for sick newborns are implemented across the Ethiopian Government public health care system in Kobo, Dolo Mena and Addis Ababa regions, and to identify key challenges to and opportunities for improving preterm, LBW and sick newborn services nationally. • Identify health system structural factors that hinder and enable implementation of interventions that improve outcomes among small/sick newborns, and to describe factors that can be modified to improve implementation of small/sick newborn interventions within the health system	To assess the utilization and practice of ACS administration at antenatal and intra-partum settings in selected facilities providing childbirth care in Haryana State (including estimates of the proportion of facility clients who receive ACS, methods used for appropriate identification of clients to receive ACS and relevant newborn and maternal services available at facilities providing ACS) • Identify essential health system preconditions required for the implementation of ACS in alignment with the WHO Recommendations on Interventions to Improve Preterm Birth Outcomes, 2015 • Document the difference between report and actual	To assess experiences of participating in the Family-Led Care model in Balaka District, Malawi <i>Study 1:</i> • Explore family perceptions of their inpatient care experience in relation to the implementation of the Family-Led Care model • Assess family perceptions of whether Family-Led Care prepared them to confidently assume care for their newborn at home • Assess family readiness/knowledge to continue care provision of their early/small newborn at home post discharge • Assess family knowledge on the management of kangaroo mother care prior to discharge • Assess actual home-based care practices post discharge <i>Study 2:</i> • Assess provider ability to accurately identify preterm/LBW newborns for admission, referral and discharge (knowledge)

Bangladesh	Ethiopia	India	Malawi
• Develop a predictive statistical model to estimate gestational age before birth using AG, SFH, and/or estimated uterine volume controlling for potential maternal confounders including nutritional status	• Describe the current essential service delivery processes that will facilitate or hinder implementation of priority services for small/sick newborns within the public health care system • Describe select outcomes of the existing programs for small/sick newborns	- practices of health providers on the administration of ACS • Identify enablers and barriers to implementation of GOI ACS operational guidelines • Document and evaluate approaches to implementation of the revised ACS operational guidelines at delivery points that meet the health system preconditions for ACS administration.	• Assess provider adherence to the clinical care standards set out in the Family-Led Care model (adherence) • Assess provider competency in providing care (inpatient and follow-up care) for early/small newborns (competence) • Explore provider attitudes towards the Family-Led Care model, the Quality Improvement intervention and material/equipment donations provided to implement the model (attitudes) • Explore provider perceptions of how mothers/families reacted to the Family-Led Care model (perceptions)

Timeline of implementation research activities in the four demonstration countries

Most of the information in this table has been derived from the Every-Preemie—SCALE annual and semi-annual reports. A few pieces of information were obtained via the interviews with key in-country partners or Every-Preemie—SCALE team members.

COUNTRY	YEAR 1 (2014/5)	YEAR 2 (2015/6)	YEAR 3 (2016/7)	YEAR 4 (2017/18)	YEAR 5 (2018/19) (incomplete)
Bangladesh	• Finalization of research protocol • Standardization of measurement procedures • Sub-agreement finalized • Field data collections started • First disbursement of sub-grant	• Field data collection completed • Poster presentation at Global Health & Innovation Conference	• Study data collection completed • Data cleaning and preparation of data set for analysis • Primary data analysis • Preliminary findings drafted • End of substantive support	• Technical support for final report writing • Dissemination meeting (June 2018) • Technical support to journal manuscript preparation	• Comments on a manuscript provided • Continued reviews and inputs as requested

COUNTRY	YEAR 1 (2014/5)	YEAR 2 (2015/6)	YEAR 3 (2016/7)	YEAR 4 (2017/18)	YEAR 5 (2018/19) (incomplete)
Ethiopia	• Trips to Ethiopia to introduce the project, meet with stakeholders, travel to the field, conduct site visits and review relevant documents • Extensive dialogue with partners • Project's concept note finalized and submitted to USAID and the FMOH and approved • Discussions with possible local research institutions • National stakeholders meeting held	• Protocol writing workshop and planning of study instruments • Protocol and study instrument refinement workshop • Draft research protocol completed • Additional field support from USAID/Ethiopia identified • Draft sub-agreement with St. Paul's Hospital Millennium Medical College completed	• Protocol and study instrument refinement workshop • Draft research protocol completed • Field support from USAID/Ethiopia secured • Sub-agreement with St. Paul's Hospital Millennium Medical College finalized • Locations revised and approvals for new study facilities secured • Study protocol and data tools finalized and submitted to USAID/W and USAID/Ethiopia for review	• Final IRB approval in Ethiopia and the US. • Approval from USAID/W • Data collection completed for two study components • Ongoing data collection for the third component initiated • On-site compliance review of St. Paul's financials • Data analysis for first two study components initiated	• Data collection third study component completed • Data analysis and synthesis for the qualitative and cross-sectional components completed; • Two draft manuscripts prepared • Planning with FMOH for stakeholder dissemination meeting initiated <i>To be completed:</i> • Data analysis and manuscript for post-discharge care utilization and mortality study • National stakeholder meeting to disseminate preliminary results • Presentation of findings (Every Premie legacy event) • Final manuscripts for relevant findings, and submission to journals • Close out of sub-grant with St. Paul's

India	• Dialogue with representatives of the MOHFW and other stakeholders on Every Preemie engagement • Articulation of the focus on implementation of ACS • Health facility visits • Review of government documents • Every Preemie concept note developed, submitted and accepted.	• Postgraduate Institute of Medical Education and Research, Chandigarh identified as local research institution • Full approval of district selection from the state of Haryana • Formal approval of proposal by the GOI • National GOI ACS PAG formed • Protocol writing workshop conducted • Provisional IRB approval obtained • Sub-agreement with PGIMER developed and submitted to USAID/W for approval	• Sub-agreement approval from USAID/W • Sub-agreement with PGIMER finalized • Updated documented approval obtained from National Health Mission directorships of the state of Haryana and MOHFW • First meeting of the GOI Project Advisory Group • Study protocol and data collection tools; finalized approval received from USAID/W and USAID/India • Approval of protocol and study tools from US and India IRBs • Field data collection in one district completed and almost complete in second district	• Completed data collection and developed preliminary findings; • Convened second meeting of the PAG in January 2018 and shared findings from initial assessment; • Developed and obtained approval of revised operational guidelines from MOHFW; • Finalized job aids and appendices to guidelines for use in pilot implementation of revised guidelines in Year 5; and • Supported first of two districts to launch pilot implementation of revised guidelines.	• Pilot implementation of revised guidelines completed with Haryana state government in two districts • Assessment of pilot implementation in both districts completed • Findings prepared for dissemination at next PAG meeting • Two manuscripts of findings prepared <i>To be completed:</i> • Sharing of findings at next PAG meeting • Final recommendations to MOHFW for revised ACS operational guidelines • Dissemination final revised ACS operational guidelines to state governments at national stakeholder meeting with MOHFW • Completion of manuscripts, and submit to appropriate journals • Participation in collaborative gestational age meeting with MCSP and India MOHFW • Presentation of findings at MCSP Technical Consultation on gestational age
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COUNTRY	YEAR 1 (2014/5)	YEAR 2 (2015/6)	YEAR 3 (2016/7)	YEAR 4 (2017/18)	YEAR 5 (2018/19) (incomplete)
					• Presentation of findings in global webinar • Close-out of sub-grant with PGIMER
Malawi	• Exploration of Every Premie engagement • Participation in launch of national Every Newborn Action Plan • Concept note designed, submitted and approved • Discussions with PCI on administrative and logistical support • Technical advisor: scope of work developed and recruitment • Design for national stakeholders meeting	• National stakeholders meeting • Learning priorities identified and local approval of IR concept note obtained • University of Malawi, College of Medicine identified as IR partner • Study design workshop in September 2016	• Refocus of IR to better meet needs of project and stakeholders • Data collected for key indicators from MOH facility records; • Local partners selected and contracting process initiated • Protocol and tools for caregiver/client study finalized and submitted to IRBs in Malawi and US • Draft protocol and tools for health care provider study prepared	• Contracts with COM and MaiKhanda Trust finalized • IRB approval (with amendments) for both studies obtained • Phase one of data collection for health care provider survey conducted • Ongoing data collection for caregiver/client survey launched • Preliminary results of health care provider survey phase one disseminated locally • Report on results of health care provider survey phase one finalized	• Second phase of data collection for health care provider survey conducted • Data collection for caregiver/client survey completed • Final report for caregiver / client survey completed • Draft report of second phase of provider survey completed <i>To be completed:</i> • Health care provider study final report • Local approvals to disseminate IR results • District and national level stakeholder meetings for dissemination of findings • Manuscripts to be developed and submitted to journals for publication • Close out of contracts with COM and MaiKhanda Trust

C. Answering the evaluation questions for Outcome 1

Question	Achievement
a. How has the project's IR agenda contributed to or influenced improved knowledge among key stakeholders / decision makers around PTB/LBW interventions and/or programming in demonstration countries?	• All countries are planning local and/or national stakeholder meetings to disseminate their findings • Possible journal articles with results from some of the projects would further highlight the importance of the interventions included in the studies
b. How has the project's IR agenda contributed to or catalyzed change/s in policy and/or action targeting PTB/LBW interventions and/or programming in Every Premie demonstration and focus countries?	• Because the findings are still in the dissemination process, knowing how countries would move forward after receiving the findings is beyond the scope of this evaluation • Bangladesh: Conclusive recommendation: the importance of expansion of ultrasonography; services to enable screening for gestational age • Ethiopia: Potential of influencing programming and planning • India: Revised ACS implementation guidelines • Malawi: Potential of scale-up of Family-Led Care
ii. Assess the project's IR agenda including key milestones and results related to IR in Bangladesh, Ethiopia, India and Malawi.	• All countries completed the data collection for their studies • Data analysis and reports of findings range from not yet completed to totally completed and findings written up
iii. Explore changes in policy or practice and the pathways of change related to the IR and related technical support in demonstration countries.	• Although the in-country partners were confident that their governments would take up their recommendations, not enough information was available to get a sense of how these will feature in the way forward • Bangladesh: It is not clear how the Bangladesh government will take forward the bottom-line recommendation for improved sonography services for screening pregnant women. The results should inform global-level planning of future projects on the assessment of gestational age • India: There are high expectations that the revised ACS guidelines will be taken forward by the GOI • Ethiopia: Informants expected the findings to inform a number of initiatives, but some of these activities had already started before the findings could be disseminated • Malawi: It is expected that Family-Led Care will be rolled out to other districts as part of ONSE and other partners' projects, but there is uncertainty how it will be done (see Section 3.2.5 below)

Question	Achievement
iv. 3.1.5 Highlight unanticipated achievements, milestones, or outcomes that Every Preemie has supported or contributed to at the country level in demonstration countries or elsewhere.	• Increased capacity of research partners and a better understanding of how implementation research could inform programming • Ethiopia: A third district was added to be able to cover all three types of geographies in the country • Malawi: Resource materials already used beyond the project and more materials printed by ONSE • Multiple delays required innovative planning to still reach the outputs
v. Share expected / anticipated changes that are likely to occur after the close of the project (next 1 – 3 years).	• It is expected that recommendations mentioned in b. above will be implemented and included in government guidelines and strategic plans • Malawi: Recommendations should be taken up in the District Implementation Plans
vi. Assess how the project is perceived and valued among demonstration country partners, including stakeholder perceptions at the country level regarding Every Preemie's contributions.	• Bangladesh: The study was the output • India: Results have been used to revise the guidelines/training package of ACS • Ethiopia and Malawi: In-country stakeholders are still waiting to learn about the findings, although they have positive expectations

D. Answering the evaluation questions for Outcome 2

Question	Achievements
a. What progress has been achieved in enhancing PTB/LBW interventions in Malawi (and other countries where relevant) and what has been the role of the project in these changes?	• Raised awareness of the Family-Led Care model and its potential impact on the care of preterm/LBW newborns • Introduced a system that has the potential to work if implementation and scale-up is well planned with appropriate resources • The contribution of Every Preemie to nationally scale-up and sustain the utilization of high-impact interventions (i.e. KMC in the Family-Led Care model) may have been modest, although there are

Question	Achievements
	expectations of this happening in future through other partners
i. Assess and document the pathways of change, including key milestones and results related to program technical assistance in Malawi	• The Family-Led Care model presents a pathway of change for care of preterm and LBW babies – implemented in Balaka district • Perception that Family-Led Care is there to stay in Balaka district
ii. Explore changes in policy or practice (e.g. SOPs, systems changes) in Malawi to improve PTB/LBW outcomes	• Visibility of Every Preemie in the Every Newborn Steering Committee and all other national meetings and events related to maternal and newborn health • Potential use of Family-Led Care materials beyond Balaka district
iii. Highlight any unanticipated achievements, milestones, or outcomes that Every Preemie has supported or contributed to in Malawi or elsewhere (as relevant)	• High expectations of a stronger implementation of community component (the practices pathway as weak link)
iv. Share any expected /anticipated changes that are likely to occur in Malawi (or elsewhere) after the close of the project (in next 1 - 3 years)	• Transition to ONSE – some uncertainty, but Family-Led Care concept settled in Balaka district • Continued influence on the work of the Newborn Steering Committee
v. Document the role that the project has played in contributing to and/or catalyzing these changes during the project period	Change in quality of care and follow-up because of Family-Led Care: • Training (health providers and support staff) • Materials (flipchart and brochure) and tools (forms and charts) • Follow-up system that seems to work • QI component
b. Assess how the project is perceived and valued among partners in Malawi, including stakeholder perceptions at the country level regarding Every Preemie's contributions	• At district level high enthusiasm for the changes brought about by the introduction of the Family-Led Care model • Praise at the national level, especially for strengthening the community component through facility-based follow-up care of preterm/LBW newborns • See Subsection 3.2.3 for the details

E. Organizations contributing to the development of the Do No Harm briefs

According to the Year 3 Annual Report the following organizations were involved in the development of the Do No Harm briefs:

- All India Institute of Medical Sciences (AIIMS)
- American College of Nurse Midwives (ACNM)
- Council of International Neonatal Nurses (COINN)
- Global Alliance to Prevent Prematurity and Stillbirth (GAPPS)
- International Council of Nurses (ICN)
- Illinois Eye and Ear Infirmary
- London School of Hygiene and Tropical Medicine (LSHTM)
- Makerere University, Uganda
- Maternal and Child Survival Program (MCSP)
- Oregon Health and Science University
- PCI
- Program for Appropriate Technology in Health (PATH)
- Saving Newborn Lives (SNL)/Save the Children
- Soapbox Collaborative
- United Nations Children's Fund (UNICEF)
- United Nations Populations Fund (UNFPA)
- University of Cape Town
- University of Georgetown
- University of Pennsylvania
- University of Washington
- USAID Child Blindness Program
- USAID/Washington
- WaterAid
- Weill Cornell Medical College
- World Health Organization (WHO)

F. Blog posts and press releases

Title	Website / Press release	Date
Every Premie Publishes Article on ACS Landscape Analysis in <i>Global Health: Science and Practice</i>	Article	Dec 2018
Nearly 30 million sick and premature newborns in dire need of treatment every year	Press release	13 Dec 2018
Every Premie—SCALE Releases Technical Brief on <i>Family Participation in the Care of the Inpatient Newborn</i>	Every Premie website	17 Nov 2018
Midwives Leading the Way with Quality Care	Every Premie website	5 May 2018
Every Premie Partners with University of Malawi College of Medicine and MaiKhanda Trust to Assess Innovative Family-Led Care Model	Every Premie website	4 April 2018
Helping Newborns Survive and Thrive in Malawi	PCI's End Poverty Blog	1 Feb 2018
Give the Gift of Saving Newborn Lives this Holiday Season	Every Premie website	19 Dec 2017
Prenatal Vitamin Distribution to Boost Newborn Outcomes in Liberia	PCI's End Poverty Blog	18 Dec 2017
Let Them Thrive: Quality Care for the Smallest	Healthy Newborn Network	15 Nov 2017
Every Premie—SCALE Convenes Partners around Respectful Newborn Care	Every Premie website	3 Oct 2017
Multi-country Situation Analysis of Inpatient Care of Newborns and Young Infants	Every Premie website	10 Aug 2017
Every Premie—SCALE Launches Do No Harm Technical Briefs to Improve the Safe and Effective Use of Key Inpatient Newborn Care Interventions	Every Premie website	19 July 2017
PCI Secures Private Donation to Benefit Fragile Newborns, Mothers in Malawi	Every Premie website	13 July 2017
Happy Father's Day from Every Premie	Every Premie website	18 June 2017
Every Premie Partners with Ethiopian Ministry of Health and St. Paul's Hospital to Improve Programming for Early and Small Babies	Every Premie website	7 April 2017
Every Premie Partners with Local Research Institution in India to Study Guidelines for Antenatal Corticosteroids Use	Every Premie website	26 March 2017
Launch of Network for Improving Quality of Care for Maternal, Newborn and Child Health	The Partnership for Maternal, Newborn & Child Health	15 Feb 2017
Every Premie—SCALE Convenes Technical Experts Around Safe & Effective Care of Preterm Babies	PCI's End Poverty Blog	17 Nov 2016

Title	Website / Press release	Date
Kangaroo Mother Care Endorsed by Major Pediatric, Obstetric, Nursing, and Midwifery Associations	Press release	16 Nov 2016
New WHO Antenatal Care Recommendations: An Important Step Toward Saving Lives, Says Every Premie	PCI's End Poverty Blog	15 Nov 2016
Every Premie—SCALE launches multi-country report on antenatal corticosteroid policy and implementation	Healthy Newborn Network	20 July 2016
Are Preterm and Low Birthweight Babies Treated as a Priority?	Every Premie website	30 May 2016
Midwives Offer Helping Hands to Ensure Early and Small Babies Survive and Thrive	PCI's End Poverty Blog	5 May 2016
World Prematurity Day: PCI Convenes Congressional Briefing	PCI's End Poverty Blog	8 Dec 2015
Giving Premies a Fighting Chance	PCI's End Poverty Blog	17 Nov 2015
Breastfeeding: Babies' Perfect Food	PCI's End Poverty Blog	4 Aug 2015
World Breastfeeding Week: How to Help Your Newborn Grow Up Healthy	PCI's End Poverty Blog	31 July 2015
Huffington Post "Next 10 Challenge"	Huffington Post	26 May 2015
Every Premie Collaboration to Fight Preterm Birth	PCI's End Poverty Blog	8 May 2015
Highlighting the Work of Midwives: IDM 2015 and the Post-MDG Future	ACNM blog	5 May 2015
Powerful Cross-Sector Push for Global Action to Prevent Preterm Birth	Healthy Newborn Network	2 March 2015
Preterm Birth Linked to Intimate Partner Violence during Pregnancy	PCI's End Poverty Blog	10 Dec 2014
Taking Action to Save Premature Babies	Devex	17 Nov 2014
PCI Works for Infant Health on World Prematurity Day	PCI's End Poverty Blog	13 Nov 2014

G. Answering the evaluation questions for Outcome 3

Question	Achievement
a. What progress has been achieved in raising awareness about and action for PTB/LBW and inpatient care for the small and/or sick newborn at the global level during the project period and what has been the role of the project in this progress?	• PTB TWG meetings • Do No Harm technical briefs • Situation analysis for small and sick newborns • Advocacy activities (e.g. for World Prematurity Day, leading or contributing to developing international documents)
b. Assess and document the pathways of change to raise awareness and catalyze action for PTB/LBW and the role that the project has played among global partners and stakeholders	• <i>“Raising visibility of small and sick newborns through advocacy by expanding the scope to include pregnancy-related issues of preterm birth and moving beyond the 2015 ENAP focus on birth plus one week postpartum”</i> (GP09) • <i>“Gathered a subset of high-level technical expertise in small and sick newborn care”</i> (GP09) • See Subsection 3.4.5: Advocacy, media and meetings
i. Assess key accomplishments during the project period as well as expected / anticipated changes after the close of the project (in the 1 - 3 years)	VISIBILITY • Products – - Clinical technical: Do No Harm series – potential linkage with the WHO standards for small and sick newborns - Advocacy: Joint statements and country profiles that could be linked with the country situation analyses • Events – laid a foundation for World Prematurity Day activities on which others could build • Surveys (especially situation analyses) – tools for others to use • Stimulation of implementation research – built in-country capacity • Clinical and technical capacity in Malawi that will continue to bear fruit after the end of the Every Premie project • Dashboard and single indicator for measuring country status on the provision of preterm and LBW services – baseline for USAID for future measurement

Question	Achievement
ii. Review project engagement in key events and the design of significant products and their influence at the global level	• See (i) above. • <i>“The contributions of the [Do No Harm] briefs and the small and sick new-born [situation analysis] ... are really quite substantial and so I think in that regard the project has really been successful. ... Those had a lot of traction and they were really taking the field into some new areas that had not been addressed previously. So I felt like it was really sort of a breakthrough, the break to endeavors in some ways.”</i> (GP04)
iii. Share unanticipated achievements, milestones, or outcomes that Every Premie has supported or contributed to at the global level	• Shift to broader focus – multi-country situational analysis and participation in global documents (<i>Survive and Thrive</i> and <i>Nurturing Care</i>)
iv. Document the role that the project has played in contributing to and/or catalyzing these changes during the project period	VISIBILITY • Responsiveness of the Every Premie team to requests and unexpected situations
c. Assess how the project is perceived and valued among global partners, including stakeholder perceptions of Every Premie’s contributions / role.	• Dispersed quotations of global and country role players throughout Section 3 and subsections