Scaling, Catalyzing, Advocating, Learning, Evidence-Driven

MID-TERM REVIEW

March-April 2017

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External Reviewer (Consultant):
La Rue K. Seims

For Additional Information Contact:
Judith Robb-McCord, MAAS, MPH
Sr. Director, Every Preemie—SCALE
Project Concern International
1140 Connecticut Ave NW #900
Washington, DC 20036

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Appendix 1: Persons Interviewed or Surveyed

ACRONYMS

ACNM	American College of Nurse-Midwives
ACS	Antenatal corticosteroids
AOR	Agreement Officer Representative
bCPAP	Bubble Continuous Positive Airway Pressure
DHMT	District Health Management Team
ENAP	Every Newborn Action Plan
ENC	Essential newborn care
EPS	Ethiopian Pediatric Society
EWEC	Every Woman Every Child
GAPPS	Global Alliance to Prevent Prematurity and Stillbirth
GFF	Global Financing Facility
HSA	Health Surveillance Assistant
IR	Implementation Research
IRB	Institutional Review Board
KMC	Kangaroo Mother Care
LBW	Low birthweight
LOP	Life of project
MCH	Maternal and child health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organization
NICU	Neonatal Intensive Care Unit
ONSE	Organized Network of Services for Everyone's Health project (in Malawi)
PACHA	Pediatric Association of Malawi
PCI	Project Concern International
PGI	Postgraduate Institute of Medical Education & Research
PMNCH	Partnership for Maternal, Newborn, and Child Health
PMP	Performance Monitoring Plan
PTB	Preterm birth
PTB TWG-ICS	Preterm Birth/LBW Global Technical Working Group on Implementation Challenges and Solutions
RMNCH	Reproductive, Maternal, Newborn, Child Health
SCALE	Scaling, Catalyzing, Advocating, Learning, Evidence-Driven
SNL	Saving Newborn Lives
TA	Technical assistance
UNCoLSC	UN Commission on Life-Saving Commodities
USAID	United States Agency for International Development
USAID/W	USAID/Washington
WEF	World Economic Forum

EXECUTIVE SUMMARY

Project Background and Purpose of Review

Every Preemie--SCALE is a five-year, $8,999,296 project awarded in September 2014 by the USAID/Washington (USAID/W) Bureau for Global Health to Project Concern International (PCI) as the prime, the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) and the American College of Nurse-Midwives (ACNM). The project's five-year strategic objective is the *Increased global utilization of prioritized evidence-based and underutilized PTB/LBW interventions.*

In March-April 2017, the Every Preemie project conducted an internal mid-term review with guidance and support from the USAID/W Newborn Health Team and an external consultant. The purpose of the review was to inform any necessary mid-course corrections to implementation and life of project (LOP) outcomes, and to guide the prioritization of activities and resources in years four and five of the project.

Methodology

The largely qualitative review collected data through four electronic surveys of health officers from 24 of USAID's 25 priority countries, USAID/W Maternal Health staff, global partners, and Every Preemie staff. Open-ended interviews were conducted with members of the USAID/W Newborn Health Team, USAID Mission staff in Ethiopia, India, and Malawi, Implementation Research (IR) study directors in the project's demonstration countries[1], and MOH staff and other stakeholders in Malawi. These interviews were conducted by telephone or Skype. Most interview data were recorded and transcribed and analyzed using Dedoose Version 7.5.16.

Progress towards Project Outcomes

Outcome 1 - Improved translation of evidence into action through consolidation of evidence and focused implementation research

Four IR studies were designed and in various stages of development, implementation, and completion in the project's four demonstration countries at the time of the Mid-Term Review. Study directors and other stakeholders commented on how their projects were positioned to translate research into action, *Outcome 1* of the project. Some study directors had their eye on innovations with frontline health care workers in order to immediately apply their results with concrete tools and job aids (Bangladesh and India) while others looked at developing and/or testing more robust models for improved preterm birth/low birth weight (PTB/LBW) outcomes, such as Family-Led Care in Malawi and community-based newborn care in Ethiopia.

Outcome 2: Increased capacity of local, national and global entities (health care providers, community groups) to scale up and sustain the utilization of high impact interventions

The project is actively engaged with a number of global stakeholders around newborn health and is a lead voice for PTB and LBW. Engagement globally is designed to catalyze action towards

[11] Bangladesh, Ethiopia, India and Malawi

a sustained response for PTB/LBW; and, as noted under Outcome 1, findings from the IR in the four demonstration countries (if positive) will inform the scale up of key interventions or packages of interventions to improve care for early/small newborns. The IR findings will be key in providing stakeholders the necessary evidence to scale up interventions and to change related policies where needed. IR study directors in the demonstration countries were often responding to felt needs within their countries and had involved local ministries from the inception of the studies in order to promote ownership.

The project's work in Balaka district, Malawi focuses on building capacity for improved newborn care among health care providers in nine facilities and among family members with early/small babies via the Family-Led Care model. The project team works closely with the Balaka District Health Management Team (DHMT) and has seen some key shifts including the appointment of a Kangaroo Mother Care (KMC) focal person at the DHMT.

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

Every Preemie is actively engaged with a range of partners and is seen as a lead voice for PTB/LBW among partners. The project leads the PTB/LBW Global Technical Working Group on Implementation Challenges and Solutions (PTB TWG-ICS) and Every Preemie – SCALE staff regularly provide technical expertise to key global working groups. The IR studies are also helping to increase prioritization of PTB and LBW. Finally, the Every Preemie – SCALE Country Profiles for Preterm and Low Birth Weight Prevention and Care provide the most current national-level information on the status of prevention and care for PTB/LBW in each country and aid in prioritizing PTB and LBW within newborn and child health.

Partner Perceptions

Many partners who participated in the interviews, and those who were surveyed, felt that the project will provide valuable insights into key aspects of programming for PTB and LBW, such as improvements in home-based KMC, more feasible ways of accurately measuring gestational age, and safe and effective ACS use. This included USAID representatives in Washington and Malawi, the four IR study directors, and global partners including Saving Newborn Lives, members of the Every Newborn Action Plan metrics working group and members of the PTB TWG-ICS.

Challenges

The challenge most frequently mentioned involved the length of time required to design and implement IR, including the long approval process. Several partners suggested that this concern be mitigated by sharing interim results. The second most frequently mentioned challenge, especially by IR study directors, was the concern of wanting to test their models in more settings and alternate contexts, or with larger sample sizes. Also mentioned as challenges were funding constraints, lack of human resources within public health facilities, and gaps in knowledge among clinical providers about PTB/LBW interventions, such as how context affects interventions and how to best measure gestational age. Among the minimal challenges mentioned related to project implementation were the length of time required for conducting

implementation research; funding constraints for testing research in multiple settings using larger sample sizes; funding constraints to do more with midwives; and MOH constraints to pay for staff, data collection forms, and infrastructure.

Emerging Opportunities

Emerging opportunities were identified, especially by USAID/W and USAID Missions. These included investing more in the management of sick babies, some of whom may be full-term. This was seen to be a departure from the project's mandate, but still not "too far away from what [the project was] designed to do" as the large majority of sick babies are preterm and low birth weight. Other emerging opportunities included the promotion of the Do No Harm concept and promoting the use of high-quality data. In addition, the global partners surveyed suggested topics that they would like to see have greater emphasis in the future of the project, and topics they would like to see discussed at meetings including gestational age, care of small/sick newborns, and follow up of small babies after discharge/linking to community health.

Every Preemie – SCALE Project Background

Every Preemie is a five-year, $8,999,296 project awarded in September 2014 by the USAID/Washington (USAID/W) Bureau for Global Health to Project Concern International (PCI), the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) and the American College of Nurse-Midwives (ACNM).

Every Preemie was designed in response to the exceptionally high rates of under-five mortality due to complications of PTB, the number one cause of under-five mortality globally. Its five-year strategic objective is the *Increased global utilization of prioritized, evidence-based and underutilized PTB/LBW interventions*. A key strategy, central to the catalytic role which the project was designed to play, is implementation research (IR) which is being conducted, through partners, in Bangladesh, Ethiopia, India, and Malawi.

Overview and Purpose of Every Preemie – SCALE Mid-Term Review

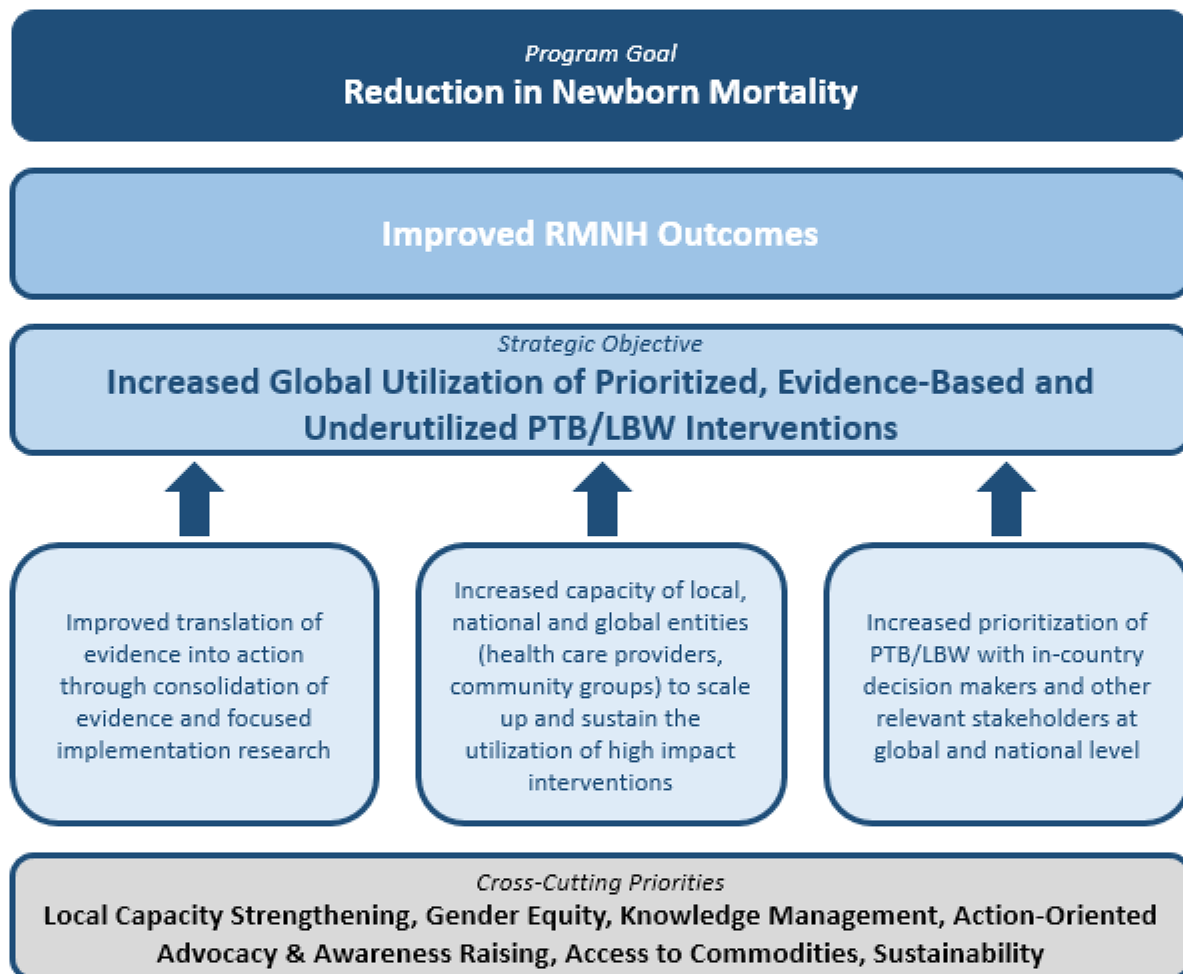
In March-April 2017, the Every Preemie project conducted an internal Mid-Term Review (MTR) with guidance and support from the USAID/W Newborn Health team and an external consultant employed by Every Preemie. The qualitative review assessed project performance since inception, including partnership engagement, perceived value of the project and opportunities going forward. Furthermore, the review was designed to answer the question "are we doing the right things," not just "are we doing things right?" Questions were asked of USAID representatives as well as local and global partners to identify any gaps in programming or changes needed in the original design. The review will be framed around the project's strategic objective framework (see Figure 1 in this section).

The purpose of the review was to inform any necessary mid-course corrections to implementation and life of project (LOP) outcomes, and to guide the prioritization of activities and resources in years four and five.

Audiences for the review findings are primarily the USAID/Washington Newborn and Maternal Health teams, the Every Preemie—SCALE project team, and USAID bilateral missions in Bangladesh, Ethiopia, India and Malawi[2].

[2] Communication regarding the findings for the MTR with USAID field missions will be managed by the USAID/W Newborn Health Team.

Figure 1. Project Results Framework



Mid-Term Review Methodology

Every Preemie worked in collaboration with the USAID/W Newborn Health Team to design both the protocol and the tools for the MTR. A participatory team approach was employed in the implementation of the MTR which emphasized learning and use of data for decision-making. In addition to document and data review, primary data for the MTR were collected through four electronic surveys using Survey Monkey and open-ended interviews conducted by telephone or Skype. (See Appendix 1 for a list of those surveyed or interviewed.)

Tools included:

Tool 1: USAID health officers in 21/25 priority MCH countries (Survey Monkey)
Tool 2: USAID/Washington Maternal Health Team (Survey Monkey)
Tool 3: USAID/Washington Newborn Health Team (Interviews)
Tool 4: USAID health officers in demonstration countries (Ethiopia, India) (Interviews)

Tool 5: USAID/Malawi health officer[3] (Interview)
Tool 6: Implementation research partners: Bangladesh, Ethiopia, India, Malawi (Interviews)
Tool 7: Malawi stakeholders (Interviews)
Tool 8: Global partners (Survey Monkey)
Tool 9: Every Preemie Staff (Survey Monkey, November 2016)

Document and Data Review

The external consultant reviewed key project documents in conducting this review, including the Every Preemie proposal and project agreement, bi-annual and annual reports for Years 1 and 2 of the project, project work plans for years 1, 2 and 3, the project Performance Monitoring Plan (PMP), and Family-Led Care materials in use in Malawi.

Electronic Surveys

Data were collected via Survey Monkey in four separate surveys:

1. Health officers from 24 of USAID's 25 priority maternal and child health countries[4] were surveyed to determine their interest in PTB/LBW issues, possible interest in providing field support funding for technical assistance from Every Preemie, and the use of Every Preemie PTB//LBW profiles at the country level. Health officers were encouraged to consult with colleagues while completing the survey and/or to refer the survey to the person most in-charge of newborn health.

   A total of ten of the 25 countries responded to the survey: Afghanistan, Burma (Myanmar), the Democratic Republic of the Congo (DRC), Nepal, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia. Those countries which expressed an interest in technical assistance were referred to the Every Preemie Agreement Officer's Representative (AOR) for follow up.

2. USAID/W Maternal Health staff were surveyed and two of four responded. The remaining two were traveling outside Washington, DC. Both respondents were familiar with the project. Topics included their familiarity with the project, their perceptions of the project's contributions and added value, ways of learning about the project, and any technical gaps.

3. Global partners were surveyed, including Saving Newborn Lives (SNL), the Maternal and Child Survival Project (MCSP), the Every Newborn Action Plan (ENAP) metrics group and active participants of the PTB TWG-ICS. Topics included all questions asked of the USAID/W Maternal Health Team staff, with additional questions about collaboration with the project, topics addressed at global meetings, and priorities for the remainder of the project. Of the 16 global partners surveyed, 13 responded – seven of whom chose

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[3] This is a separate tool from Tool 4 due to the targeted technical assistance (TA) that is underway in Malawi.
[4] Afghanistan, Bangladesh, Burma, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Sierra Leone, Tanzania, Uganda, and Zambia.

to do so anonymously. All agreed, or strongly agreed that they were familiar with the project's work, largely through collaboration with the project or participation on the PTB TWG-ICS. All but two were in regular contact with Every Preemie team members, and the majority (62%) of those responding were kept informed through collaboration or engagement in the PTB TWG-ICS.

4. Every Preemie staff were surveyed in November 2016, just prior to this review, and these data were included in the review.

Interviews

Interviews of USAID Mission staff in Ethiopia, India, and Malawi were conducted by Lily Kak, the project's USAID/W Agreement Officer's Representative (AOR). In Malawi, the external consultant, La Rue K. Seims, a newborn health monitoring and evaluation specialist, solicited input from the MOH for the Balaka DHMT and other partners such as MaiKhanda regarding Every Preemie's targeted technical assistance in Malawi and the design/implementation of the Family-Led Care model. She also interviewed the USAID/W Newborn Health staff and Project Directors from all four IR studies in Bangladesh, Ethiopia, India and Malawi.

Ten of the 13 interviews conducted as a component of this review were recorded and were transcribed verbatim by the external consultant. All recordings were with permission. The remaining three interviews were recorded in detailed notes.

Data Analysis and Reporting

All interview data were analyzed using Dedoose, Version 7.5.16. Data were coded using a total of 34 codes, including 181 excerpts from the interviews and 271 code applications. Results of each of the four electronic surveys were compiled using the Survey Monkey CX analysis program.

The external consultant prepared a draft report, using the results of document and data review, and the results of analysis using Dedoose and Survey Monkey. The draft was shared with Every Preemie team members, including in the field, and with the USAID/Washington Newborn Health Team for comments to be incorporated into the final document. A debriefing and presentation of the results with USAID/Washington is scheduled for early July 2017.

Mid-Term Review Findings

Progress-to-Date

Progress regarding activities completed during the first half of the Every Preemie project has been well-documented in the Year 1 and Year 2 bi-annual and annual reports, and soon-to-be submitted Year 3 bi-annual report. The information in those reports will not be repeated here. Rather, this report will very briefly describe the major accomplishments of the project up to the present, and then discuss the reactions to and significance of those accomplishments by members of the various groups surveyed and interviewed for this review. Both will be

described according to the three outcomes in the project framework shown previously in Figure 1.

Outcome 1: Improved Translation of Evidence into Action

Improved translation of evidence into action is largely supported through IR designed to inform MOH leadership on the design and scale up of newborn care packages (Ethiopia) and to provide frontline health care workers with improved approaches and tools to strengthen PTB/LBW related care (Bangladesh, India, Malawi). See Table 1 below for a summary of the IR projects in each country.

Table 1. Every Preemie IR by country, topic and local partner

Demonstration Country	Research Topic	Local Research Organization
Bangladesh	Development and Validation of Methods for Maternal Abdominal Girth and Symphysis Fundal Height Measurement to Improve Prediction of Gestational Age before Birth	Projahnmo Research Group Brigham and Women's Hospital
Ethiopia	Evaluate the strength of implementation of a multi-partner MNH service delivery model from the community to the district hospital level in three districts	St. Paul's Hospital Millennium Medical College
India	Assess the safe and effective use of ACS among women in imminent preterm labor	Post Graduate Institute of Medical Education and Research
Malawi	Investigate a comprehensive community mobilization approach designed to better link communities to preterm/LBW-related health services via a bi-directional referral system between the household and the facility	University of Malawi, College of Medicine

The studies are in various stages of development, implementation, and completion. The protocol for the study in Malawi is still under design, whereas the study in Bangladesh is nearing completion. Results in Bangladesh have not yet been released. Still, study directors and other stakeholders were able to speculate about how the projects were positioned to translate research results into action using a variety of platforms. Each study director articulated different priorities for the IR in their particular country.

Each of the four IR study directors have their eye on innovations with frontline health care workers in order to immediately apply their results. For example, the study director for Bangladesh, is looking at concrete tools to translate the study results into practice:

> **IR Study Director, Bangladesh**
> *If [we] get an accurate prediction model, then there's two ways that we could help the health workers, even at the peripheral levels, pretty easily. . . if it included fundal height, the abdominal circumference, and the maternal BMI there may be a simple way of using paper forms or a paper wheel, like a pregnancy wheel. Then you could dial in the values for those three things, or measurements, and come up with an estimate of gestational*

age. Another option would be to have either a mobile apt or web-accessible program, that would be computerized, and certainly easier to use, but the goal would be to have this available at peripheral level facilities so that gestational age is important so that they need to know if they need to give the mom antenatal cortical steroids. So, I think the two methods would be either some kind of paper form or chart or wheel and then the second would be through either a mobile apt or web-based form.

The hope is to change national or global policy to get the tools into the hands of the greatest number of health care workers as soon as possible:

USAID/W Newborn Health Staff
. . . in India. . . where they're doing a study on antenatal cortical steroids, and the government has a policy on antenatal cortical steroids, and they're just waiting for this study to make some changes in the policy. So, the study was designed to be very, very catalytic.

IR Study Director, Malawi
O.k., so what we've proposed is to disseminate at a national level, but also to disseminate the findings at the district level. . .the lingering question as to whether this works or it doesn't work then would have been addressed.

IR Study Director, Ethiopia
[The Government of Ethiopia] wants the outcome of this implementation study to guide them in their subsequent policies regarding preterm newborns and deliveries in the whole project. So, it's not a single point intervention.

We need to agree within our own local evidence. These things are working; these things are not working for the ministry to focus on very important policies. . .

USAID/W is especially interested in moving the lessons learned in operationalizing the Family-Led Care Model and in the Do No Harm technical briefs to action. Every Preemie designed the Family-Led Care model in Y2 in Malawi in partnership with the DHMT. This model is designed to enhance provider skills and the quality of care for early/small newborns and to empower families to become active participants in the care of their newborns at the facility. This active participation is designed to build family confidence to then care for these fragile newborns at home. At the same time, the model includes strengthening the referral system to ensure that families receive the life-saving care these newborns need, when they need it. The referral system will link facilities to community networks, with the Care Groups and participating Health Surveillance Assistants (HSAs) as critical lynchpins (community practices pathway). The Family-Led Care model is being tested in Balaka district, Malawi.

USAID/W Newborn Health Staff
I think Every Preemie is really on to something important by designing the Family-Led Care, I hope that we will be able to provide our partners and the whole global

community with a model that would integrate the family into the care of preterm babies, which is an extremely important thing given the scarce human resources in the health facilities and the need to be more respectful of newborns, to include families in their care. The Family Led Care that they are doing in Malawi – it's not in the NICU or in the Newborn Care Unit, this is Family-Led Care once the baby's discharged in the community, which is important.
. . . would be a great opportunity to share and then having them to roll out this model. So, I don't think we need to wait another year. These countries will begin to roll it out if we provide them with sufficient information on how it works and . . . at least some process indicators. Malawi is one example of where I feel they are working on a topic that I think would have global relevance. . ."

Every Preemie is working with global partners to develop a series of technical briefs on specific components of inpatient care of small/sick newborns with a focus on the approaches, measures and system inputs that facilitate the safe and effective use of key interventions in low-resource settings. These briefs will be developed with subgroups of content experts drawn from the global MNH community and the PTB TWG-ICS[5]. The PTB TWG-ICS initiated a day-long meeting on the safe and effective use of specific interventions for inpatient newborn care on November 16, 2016 and gained buy-in from participants on the technical briefs and their participation for technical reviews throughout their development. [See also Section on Emerging Opportunities.]

Central to this series of briefs is the guiding principle of "Do No Harm". The topics are:

1. Thermal stability and monitoring in facilities;
2. Lactation support and breast milk feeding practices;
3. Management of infection prevention;
4. Safe use of oxygen in care of newborns; and
5. The prevention of Retinopathy of Prematurity.

In the first half of Y3, the templates were created in collaboration with the USAID/W Newborn Health Team and terms of reference were developed for each of the five briefs. The briefs will be authored by experts engaged by Every Preemie in each of the topic areas and reviewed by global experts. The target audience for the policy briefs is a wide range of policy-makers, program managers and clinicians with the intended outcome of guiding decision-makers in integrating WHO recommendations in their country in a safe and effective way, taking into consideration the potential for harm in low-resource settings. The briefs are expected to be disseminated at the International Confederation of Midwives (ICM) June 2017 Triennial Conference and again at the KMC Acceleration Partnership meeting in Malawi scheduled for October 2017. Future dissemination will be done globally via other international associations, donor organizations, and non-governmental organizations (NGOs). At the country level, the technical briefs will be disseminated to ministries of health and other country-level

[5] Drafting of the technical briefs had not started while the Mid-Term Review was underway.

stakeholders. The briefs will be housed on the Every Preemie website with links to the Healthy Newborn Network.

> **USAID/W Newborn Health Staff**
> *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. . .*

Outcome 2: Increased Capacity of Local, National and Global Entities to Scale-Up and Sustain the Utilization of High-Impact Interventions

Capacity Building

Capacity building on the project to scale-up and sustain interventions takes many forms. There have been presentations which support the dual role of advocacy and information. Country profiles have been launched and used extensively; the project designed the Continuum of Care model for the prevention of preterm birth, management of preterm labor and delivery, and care of preterm/LBW newborns; staff have presented at global and national fora; local stakeholders are briefed on a regular basis, especially in Malawi; USAID representatives are briefed regularly; and formal training has taken place at the district level in Malawi.

Within Outcome 2, Every Preemie has focused on its targeted technical assistance in Malawi, specifically in the Balaka district with the design and launch of the Family-Led Care model. The project has trained health care providers in newborn care as well as the care of early/small babies and has launched a quality improvement initiative (QI) with Maikhanda, a local NGO. The project is also supporting the capacity of the Care Groups as implemented under PCI's USAID-funded Njira project in Malawi. The project has reviewed and provided extensive input into the Care Group modules for Maternal Health and Newborn Health as well as the Fathers Groups. Ultimately, the project's work is focused on improving health care services as directly related to care of early/small babies. This includes their care in the facility, their care at home and all related follow up care.

> **Malawi Key Informant**
> *We think that we're going to make some considerable modification as to how the system operates looking at how leadership. . . how health care leadership is engaged at the front line, you know like how the support team, the health care provider actually take care, good care, quality care of the baby and then to see that. . . there's that kind of continuum – linkage between the health centers and the district hospital in terms of leadership.*

And those trained are cascading the training to new providers:

> **MOH Staff, Malawi**

I can have my two or three students. Each and every provider can impact the knowledge to newly-coming graduates and nurses coming into the KMC. . .

Learning, and building capacity, has been built into the Malawi community-based project both in the overall design of interventions and in the development of specific trainings:

PCI Staff, Malawi
Njira and Every Preemie involve each other in the development of training materials and plans (activities) for management of preterm and low birth weight babies. For example, Every Preemie took part in the development of the Newborn and Maternal Care modules which Njira is using to teach the community how to look after pregnant, lactating women and newborn especially preterm/ low birth weight babies. Njira also took part when Every Preemie was developing tools and aides that service providers will use when managing preterm and low birth weight babies at health facilities. Every Preemie also took a major role in training trainers in newborn care. Every Preemie taught about management of preterm babies at home, how to monitor the condition of the babies, how to breastfeed them and also helped participant gain skills on positioning babies in Kangaroo position. Every Preemie provided teaching aides, dolls which participants used to practice Kangaroo Mother Care.

PCI Staff, Malawi
Looking at the resources and the capacity building, Every Preemie is focusing on training the health care providers, including in Family-Led Care. . . There has been a lot of expertise that has gone into that.

The MOH is interested in receiving additional training, which is consistent with what Every Preemie has planned for the remaining years of the project:

MOH Staff, Malawi
And then maybe the other thing is the orientation of health workers. We need to orient more health workers. . . It's not always those ones who are managing Every Preemie now. In a year or two, the ones who are in that ward, they do their rotations. My wish is to train or orient the people in KMC or Every Preemie – we just orient every provider who is at the District Hospital. . . Let's say quarterly, we could also train another group and then another quarter, we train another team. . .

Scale-Up

The IR studies and technical assistance in Malawi are being implemented with a vision of scaling up interventions within the countries in which they are being implemented and, potentially, globally. The following shows how the IR study will be key in providing the evidence to scale up interventions within India:

IR Study Director, India

And from these two districts we assume that we will be able to find the bottlenecks, what are the barriers, and how we can facilitate. So, by the end of the project we will have basically pretested in two districts and then we will be more confident of how it can be effectively implemented countrywide or even in similar other countries. It's likely to be more effective, safe, and we would obviously have learned the – what works and what doesn't work, and so all of that experience will be useful.

The USAID Mission in Ethiopia gave advice on the scale-up of their IR study results (when available). They suggested promoting the results at the Reproductive, Maternal, Newborn, and Child Health (RMNCH) annual review meeting, the Ethiopian Paediatrics Society (EPS) Annual Meeting, and to globally share the results with other USAID Missions.

IR Study Director, Ethiopia
Regarding other developing countries, Ethiopia is a very good example of one of the poorest countries in the world with high fertility rate and lots of - huge number of neonatal mortality and low resources. So, if we can suggest very important suggestions from this study, and I'm sure we'll do. We'll have an impact not only in Ethiopia, but other developing nations like ours which have high fertility, very low resources. And the other important thing about this Every Preemie project is, it has also other study areas which are being done in India, Malawi, Bangladesh so we will have very important collaborative kind of outputs toward developing nations regarding preterm/newborn care in general.

The Ethiopia IR is testing a service delivery model in various geographic settings to increase the evidence for scale up of the model throughout the country.

IR Study Director, Ethiopia
I would say that they [results] will be directly transferrable, because when you look at our study group, the study sites, there are three completely different sites. . . Even though we cannot say for sure 100% will be translated, we can say most of it can be translated into most parts of Africa.

NGOs and other USAID-funded projects are seen as another way of increasing scale up. Within Ethiopia, for example, the IR results could be integrated into a new $120 million five-year bilateral project which prioritizes newborn health.

The IR Study Director in Bangladesh suggested that her prediction model for gestational age could be scaled up by Save the Children and other NGOs in Bangladesh.

Every Preemie is currently expanding its project within Balaka district. It has trained about 60% of the nurses in the district using the Helping Babies Survive learning materials and will provide refresher training in years four and five. The project will also consider training any new health care providers in the district, as staff turnover is quite high. Also in Malawi, the USAID Mission suggested that findings could be implemented via their new health bilateral.

USAID Malawi

. . . we have funds through the ONSE project [Organized Network of Services for Everyone's Health]. So, whatever we learn through the EPS project will be scaled up through ONSE in 11 districts where they are implementing MCH activities. Globally, we hope that lessons will be shared through conferences. . .

The PCI Njira project in Balaka district presents another opportunity for scale up. Every Preemie provided extensive input into the design of the Njira Care Group modules for maternal health and newborn health and will support the orientation of Health Surveillance Assistants (HSAs) and Care Group Lead Mothers in the Family-Led Care materials. The Care Group modules are also being used in the Machinga district under the Njira project. If resources are available, Every Preemie could also work with Njira to orient HSAs and Care Group Lead Mothers there on Family-Led Care. In addition, other NGOs are open to exploring the introduction of Care Groups in their geographic areas.

Malawi Stakeholder

I think what I'd like to share is mostly on the training that has been a few days ago on the Family-Led Care. I think that is a very, very good initiative, and then I looked at the tools that will be on the Every Preemie project, I would say that I want to believe that if implemented effectively, this project is going to give a very good result, so the tools that the providers have been trained on in Balaka in this Every Preemie project, I think these are some things that need to be scaled up in the country.

Another promising platform for scaling up newborn interventions in Malawi includes using the Paediatric Association of Malawi (PACHA). PACHA is influential and currently is working with UNICEF in ten districts. Recently, the Every Preemie Technical Advisor in Malawi made a presentation of the Family-Led Care model at a national stakeholders meeting attended by several MOH Directors and other partners, including representatives from the districts. Attendees were open to seeing the results of the application of the model in Balaka district with a view toward scale up in other parts of the country. Another possibility for scale up would be among other USAID-funded projects in Malawi with technical support from Every Preemie.

Sustainability

Sustainability of Every Preemie—SCALE project interventions is promoted by:

- designing IR studies that involve ministries of health, local IR partners and institutions and global partners from the beginning to create ownership;
- designing and implementing IR studies and program interventions that can lead to policy change at the national and global levels thereby institutionalizing the lessons learned;
- supporting IR studies that may provide evidence to answer important questions and promote models that will support quality care at the national and local levels;

- providing data via the country profiles that can be used for advocacy to promote policy changes;
- disseminating evidence regarding key newborn health interventions (Do No Harm Technical Briefs) to health care providers, and global and country partners and,
- providing a platform to further the global conversation about what works to improve care for preterm/LBW babies via the PTB TWG-ICS.

The IR studies are responding to a felt need within the countries which was important for creating a sense of ownership of the results. The idea of focusing the IR in India on ACS, for example, arose from an initial discussion with the Ministry of Health and Family Welfare (MOHFW). The Government of India needs the results to inform the safe roll out of maternal ACS use in India.

> **IR Study Director, India**
> *The MOHFW has full buy-in – they have been very engaged from the very beginning. The topic is of great value to India since revisions in the national ACS guidelines will be influenced by the study.*

The following quotes from Ethiopia illustrate how stakeholders were involved in the project from the beginning in that country, which ensured ownership:

> **IR Study Director, Ethiopia**
> *[We] do not wait until the end of the second year when we finalize the reporting and give it back to the Ministry of Health and from the Ministry of Health side, the Maternal and Child Health Directorate is highly involved in this project. They want the outcome of this implementation study to guide them in their subsequent policies regarding preterm newborns and deliveries in the whole project.*

> **USAID Mission, Ethiopia**
> *Two years ago, when the team came to Ethiopia, we saw this as an opportunity to do the IR. Jim built relationships with the in-country PCI and St. Paul's Hospital. They held an excellent stakeholder meeting, clarified what IR was and then established a regular collaboration over two years.*

In Malawi, the USAID Mission felt that the project was well-positioned for sustainability:

> **USAID/Malawi**
> *We have buy in from the district government and the RHU [Reproductive Health Unit] recognizes this too. So, the model will be institutionalized. . . They have involved the government so the intervention is based on needs.*

One Malawi partner expressed that private facilities had a high sense of ownership: "S*o it's quite easy to work with the CHAM*[6] *facility because of that kind of ownership."* The MOH in Balaka district also expressed a great deal of ownership and engagement with the project. One Malawi partner, however, felt that more needed to be done with the MOH at the central level.

Malawi Stakeholder
I think that if the central level is involved at this stage of the project – at this early stage of the project so that they should also be trying to understand what is happening – they should be able to monitor progress, because I know that maybe the zone supervisors are involved, DHO is involved, but it would be important to actually start engaging the central level.

After initiation of the activities, Every Preemie continues to work closely with partners:

Malawi Stakeholder
Actually, we are working hand-in-hand with our partners at PCI. . . we are always in touch. Before each and every activity, she [Elimase] undertakes here, she informs my office that we are doing that together and briefs me of the meetings with staff, orientations with staff.

An important component of sustaining results is to integrate interventions and approaches into MOH strategies:

Malawi Stakeholder
What I would see is that as MaiKhanda, we started Quality Improvement in the country way back, so we have experience to be included in a small technical working group. It's more a task force that's looking at the policy trying to come up with this policy and the quality management strategy.

Among Every Preemie staff, three disagreed, two agreed and one remained neutral on the statement that the project should change course (to do something different) in order to maximize its potential for sustainable impact. The need to focus on how to translate the results of the IRs into action was emphasized:

Every Preemie team member
We need to really focus in on what it will take to translate the results of the IRs into action, how to mainstream the findings into policy, advocacy and behaviors. . . But it needs to be practical, feasible, actionable, and productive (focused on using tools like the country profiles) and it needs to identify and optimize opportunities for influencing and convincing key leaders.

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[6] Christian Health Association of Malawi

Outcome 3: Increased Prioritization of Preterm Birth and LBW with In-Country Decision Makers and Other Relevant Stakeholders at the Global and National Level

Prioritizing PTB/LBW through IR studies

The IR studies are helping to increase prioritization of PTB and LBW in the demonstration countries.

> ***USAID/Malawi***
> *Newborn health has been an issue for a long time in Malawi but it has not progressed very far. We have implemented many newborn interventions but still not doing so well. . . So, it was an opportunity for us to focus on this issue of preterm birth.*

> **IR Study Director, Malawi**
> *Our country has the highest incidence of preterm birth. So, one would, without looking at the content, say that anything that has to do with preterm, that addressing some gap would have some benefit.*

One stakeholder in Malawi was drawn to Every Preemie because of an interest in reducing deaths due to asphyxia and drawing attention to the number of babies dying from this cause:

> **Malawi Stakeholder**
> *So basically, we will be looking at the baby that's been born preterm or low birth weight, and as far as asphyxia, we'll have to look at how they've been managed. . . how they have been managed in Kangaroo Mother Care and then how they have been managed in the post-natal ward.*

And in Ethiopia:

> **USAID/Ethiopia**
> *We did a lot on ENC [essential newborn care] and sepsis, but the preterm piece was a gap in Ethiopia. The technical office at the Mission and at the government understood the gap and saw the opportunity to leverage a global initiative for a topic that was unaddressed by others.*

Prioritizing PTB/LBW through Global Dialogue

Every Preemie – SCALE staff regularly provide their technical expertise to key global working groups, such as:

- United Nations Commission on Life-Saving Commodities (UNCoLSC) ACS Technical Working Group
- UNCoLSC Chlorhexidine Technical Working Group

- UNCoLSC Newborn Resuscitation Technical Working Group[7];
- Pre-eclampsia/Eclampsia Technical Working Group;
- KMC Acceleration Partnership; and
- WHO/ENAP Metrics Group.

Staff also are active participants and presenters at conferences such as the Global MNH Conference in Mexico City.

Among Every Preemie staff members, six out of seven (one was neutral) believe that the project is engaged with the right partners for the right discussions. Staff also suggested a greater focus on dialogue at the country level:

> **Every Preemie Staff**
> *I was surprised by how quickly Every Preemie became a "player" in the global discussions on PTB/LBW. To be catalytic, we might be more effective if a greater portion of these discussions were happening at the country level.*

Prioritizing PTB/LBW through Country Profiles

On November 17, 2015 (World Prematurity Day), Every Preemie–SCALE launched the *Country Profiles for Preterm and Low Birth Weight Prevention and Care* for 23 USAID priority countries. The profiles provide the most current national-level information on the status of prevention and care for PTB/LBW in each country and aid in prioritizing PTB and LBW within newborn and child health. They are currently being updated, in Year 3, and an additional profile will be created for Burma, a new addition to USAID's priority MCH countries.

Among the global partners surveyed, ten of the thirteen respondents were familiar with the Country Profiles and seven had used them. Reasons given for the use of the profiles included to:

- design projects and implementation plans, specifically a Minimum Newborn Care Package at facility level and a KMC project;
- discuss maternal and newborn health in meetings;
- review data for projects in which the respondent was engaged;
- write articles to advocate for increased investment with donors;
- advocate for similar profiles in other technical areas of global health, such as breastfeeding.

Among the ten health officers from USAID priority countries, five were aware of the Country Profiles. Uses were:

[7] A number of the UNCoLSC TWGs have closed out. Every Preemie is currently engaged in a discussion with global partners about the usefulness and value of establishing a new TWG that would focus on newborn health commodities including those required for sick newborn care.

- Checking validity of data;
- Review and share with partners;
- Engaging government at national and sub-national levels on the magnitude of newborn mortality;
- Used the DRC profile while attending the Regional Inter-Agency Forum on Neonatal Health October 2016 in Dakar to develop the DRC Every Newborn Action Plan.

Among the persons interviewed, one of the IR study directors and Malawi stakeholders in the MOH were unaware of the profiles. They were, however, used by the USAID India Mission in project design. The Ethiopia USAID Mission reported that the Ethiopian Paediatric Society had used them. Malawi PCI staff reported that they use the profiles in project design to address important issues and to identify gaps in programming. The IR study directors in Bangladesh and Malawi reported that they used the profiles in teaching medical students. The IR study directors in Ethiopia and Malawi have also used the profile data in various presentations.

Partner Perceptions

Many partners interviewed felt that the project will provide valuable insights into key aspects of programming for PTB and LBW babies. This was voiced by USAID/W, the USAID missions, IR study directors and Malawi partners, especially the MOH.

In the words of USAID:

> **USAID/W Newborn Health Staff**
> *I value their responsiveness. I value their flexibility. Every time I come up with a hair-brained 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.*
>
> *[Global partners] are beginning to appreciate their role now I feel like because their discussion on the Situational Analysis. They are engaging them much more – in phone calls. They're getting more familiar with the Every Preemie Project. . .*

The project is well-known in Balaka district, according to both the MOH and other stakeholders, especially after the project engaged a full-time advisor for the district.

> **MOH Staff, Malawi**
> *But after Elimase engaged the office of the District Health Officer and we took advantage of the morning handover meetings, I can now tell you that staff here at Balaka Hospital have welcomed the project and are keen to take part in each and every activity.*

I'm expecting to see a lot of low birth weight babies living – I mean a lot of low birth weight babies to make it. To reduce the deaths which we are having. . . We are happy with how they are working with us. They are very free and flexible. . . Whenever they want to check our staff or health workers, they follow very normal, proper channels.

PCI Staff, Malawi
They view it in a very positive way and think that it's a very good project with a lot of resources, because it is very visible in Malawi and knowing that it's also tackling issues. It's receiving a lot of support. That is evidenced by the number of emails, invitations from other service providers and other partners.

Interestingly, it's also known among the frontline health care workers and even by mothers and families in the communities:

Malawi Stakeholder
So, I would say that Every Preemie is perceived as that kind of organization that is giving an opportunity for the mothers to stay with their families at home and also take care of the baby who is in KMC. So as opposed to where you just have to stay at the facility for KMC so it looks like Every Preemie is actually being praised for actually letting the mothers at some point do KMC in the communities so that the mothers are at home with their families.

Other perceptions and expectations were:

IR Study Director, India
The work is of high quality. PGI and the support partners are all very good. The tools were reviewed at the PAG meeting yesterday and were very good. Jim Litch's technical assistance has also been excellent. He is very engaged – he spent a week in Haryana providing superior quality technical assistance.

IR Study Director, Bangladesh
Just that granting organizations and partnership with Jim in Seattle were wonderful. They are very engaged partners, in terms of study design. They were very flexible and understanding with the many challenges that we have in global health research.

IR Study Director, Ethiopia
It's highly accepted at the level of the ministry and other NGOs.

Two of four members of the USAID/W Maternal Health Team surveyed responded with their perceptions. Both were familiar with the project and <u>felt that Every Preemie is successfully contributing to the field of PTB/LBW, valued as a thought leader, engaging with the right partners, and filling an important gap</u>. One felt that the project was engaging on the right issues, and the other was neutral.

Of the 13 global partners who responded to the survey, all but two were in regular contact with Every Preemie team members, and the majority (62%) of those responding were kept informed through collaboration or engagement in working groups. All 13 global partners responding agreed or strongly agreed that Every Preemie is successfully contributing to the field of PTB/LBW and that Every Preemie is valued as a thought leader. Ten felt that Every Preemie was engaging with the right partners, and the remaining three were neutral.

Six of seven Every Preemie staff who responded to a survey felt that Every Preemie is making a valuable contribution to the field of PTB/LBW, and one was neutral. Five felt the project is advancing creative and innovative ways to move evidence to action.

Lessons Learned and Challenges

Lessons Learned

Lessons learned at the global leveled include:

- Evidence-based interventions and effective models, such as Family Led Care, are essential to inform health care policy;
- Quality data are useful at the country level in order to prioritize PTB/LBW issues;
- Health care for PTB/LBW babies is much more effective with strong links between facilities and communities;
- Participation in national-level fora from the beginning of IR fosters ownership, support, and scale-up of results.

Lessons learned regarding project activities in Malawi include:

- Good collaboration with the MOH is key for project support and sustainability;
- Readily available transport is a facilitator for success;
- Learning trips for government officials are a good motivation;
- Country-level PMP indicators ought to be reviewed annually, especially targets.

A number of suggestions were made by the global partners surveyed regarding platforms for sharing lessons learned from the IR and other project work, including:

- Website (4)
- Webinars (2)
- Conference presentation, nationally and globally (4)
- TWG meetings, including that of Every Preemie and the Child Survival TWG (2)
- Published papers, reports, and briefs
- Annual RMNCH review meeting
- Quarterly platforms
- Health Newborn Network (2), CORE group, MCSP web platform link
- Work directly with countries in need (2)
- Existing newsletters, such as Saving Newborn Lives (SNL)

- EWEC [Every Women Every Child], GFF [Global Financing Facility], WEF [World Economic Forum], PMNCH [the Partnership for Maternal, Newborn, and Child Health], Maternal Mortality platforms, e.g. Maternal Health Taskforce.

Challenges

The challenge most frequently mentioned involved the length of time required to design and implement research, including the long approval process. Often USAID Missions and country-level Ministries of Health are in urgent need of data to make policy decisions that will improve health care and reduce deaths. This challenge was mentioned by USAID/W, USAID Missions, IR directors, MOH partners, and Every Preemie staff. The IR study directors and donors concluded that the slow pace was often necessary in order to secure all the approvals necessary for development of an accepted protocol and for ownership of the results. The USAID Mission in India noted a delay in implementation necessitated by the Institutional Review Board (IRB); but IRB approval was necessary for the Project Advisory Group to sanction moving forward with study implementation, for example.

Comments included:

USAID/W Newborn Health Staff
The only thing is, the results of those four studies, you know, it'll take four years before results of studies are available. So really the pressing needs, the pressing issues for which we need answers quickly or urgently, now because they are designed into these projects, we must wait patiently for the findings to be available. . . I feel it slowed the project down.

. . . the study [in India] was designed to be very, very catalytic. Unfortunately, the study is taking so long. That's why I'm really impatient with these implementation research studies. Why does it have to take three years?

We take our time – the whole process of approvals for any research. There's so many steps in the approval process, so even USAID sometimes delays the process, but in the end, we lose out because we're not able to give the government what it wants in a timely fashion.

It's my thing about implementation research. They take time, and we have to be patient. But sometimes countries are not patient. They want to move on. So, it's a philosophical question.

IR Study Director, India
So, on the other hand, I think that this intervention is rather urgent. I don't think that we can wait for many years to do this and then come out with recommendations.

USAID/India Key Informant

It has progressed but there have been some delays. We wanted the field activities to be implemented earlier but the approval process was beyond the control of the project.

USAID/Ethiopia Key Informant
I was expecting a protocol to be finalized by now. It seems to have taken a long time. But drought, emergency have delayed the progress.

Both USAID/W and USAID Mission staff suggested releasing preliminary findings at conferences and other fora before studies have been completed to mitigate this challenge.

Several others interviewed have also voiced the need for sharing interim results before the studies have been completed:

USAID/W Newborn Health Staff
If we can figure out how to disseminate this model [the Family Led Care model] in the KMC meeting in October . . . I think would be a great opportunity to share and then having them to roll out this model. So, I don't think we need to wait another year. These countries will begin to roll it out if we provide them with sufficient information on . . . at least some process indicators.

Malawi is one example of where I feel they are working on a topic that I think would have global relevance, and we don't have to wait for the final publication to share the findings. . .

IR Study Director, Ethiopia
We go to the Ministry of Health and other international stakeholders like the NGOs who are basically implementing these programs, and we will tell them if you find a significantly important finding we'll try to address it at that time and do not wait until the end of the second year when we finalize the reporting.

The second most frequently mentioned challenge mentioned by IR study directors was a concern of wanting to test their models in more places and alternate contexts or with larger sample sizes but feeling constrained by funding or time:

IR Study Director, India
Except maybe that in ideal circumstances one would have liked to do this project in four different corners of the country because you know India is a huge country and the health system, the cultural practices, changes as we go across. . . but at the same time, I do realize that it is an expensive proposition and very difficult to do.

IR Study Director, Malawi
. . . the size of the study and duration and number of persons involved, may not give us, as yet, definitive data on certain outcomes so we learn something that may be different with larger and longer studies, but some information will be obtained.

And I guess like most implementation research, there will be different kinds of contexts that will influence outcome and so we may have to be learning. I mean things just like the geographical terrain may make it easier to implement the interventions in some districts. Some districts are much, much larger making issues to deal with. Some districts have health centers that are close to one another; some at large distances.

IR Study Director, Bangladesh
And it may be, before it's disseminated, it needs to be validated in different populations, probably about 200 sample size - pretty good sample size - before scaling it up nationally. It would probably be good to test it in different populations.

Malawi Stakeholder
. . . but what it means is that, yes, we are comparing within the same district but for learning, if there were another district where we would also learn the same thing so that the findings would be much more nuanced and much more informative because there would still continue to be a questions as to whether if there is any difference between the intervention and the non-intervention areas, the issue of what extent the district is contributing to what we are observing. So that is the part. . . it's still there, but the funds are finite.

Funding constraints were also often mentioned:

PCI Staff, Malawi
. . . but the resources that have been made available are very limited. Even if Every Preemie didn't have the Njira platform, I would see a lot of challenges because they don't have even the vehicles so whenever they need to go, they have to depend on Njira resources. Given the enormous scope of the project, they could have done more if they had separate resources.

Malawi Stakeholder
There's of course a gap in the learning, and of course the budget is also capped to a finite amount but I mean that the issue is that we will learn from Balaka and we will learn whether the intervention functions, but although within the same district there are some communities where the project is not operational . . .

USAID/W Newborn Health Staff
I know there was some discussion of linking up with ICM. ACNM was going to do something with ICM in Toronto, and we were all quite excited about that opportunity. Now, with the funding cuts, we don't even want to start out new activities at this point. You know, we were talking about giving maybe small grants to some midwife's associations, especially from the three countries that are actually doing the implementation research. I don't know how they would do it with the budget cuts.

There are things that need to be done, but don't know if the Every Preemie project would have the capacity to do it in terms of funding levels. You know, if we don't give them more funds, or if we – yeah, it's mostly funding because they would have to increase their own staff to address other needs. So, for example, the whole sick newborn care focus now has increased the importance of health systems – strengthening health systems.

The lack of human resources, especially health care staff in government facilities, was mentioned as a constraint, especially in Malawi, although stakeholders saw it beyond Every Preemie's ability to address:

Malawi Stakeholder
[Human resources is] also another problem, and we've seen some other facilities where a nurse or a midwife hasn't been assigned or allocated to the KMC room. So, they look at processes. They go to the nursery. They go to the labour ward, but they don't go to the KMC.

Another Malawi Stakeholder
. . . there are resource constraints within the ministry facilities and, I would say that there are inadequate human resources. So, for the CHAM facilities, I would say that the challenges are not as big as those in the ministry of health facilities. So most of their facilities would have the resources that you want, and mostly there's that kind of ownership of the processes.

Some study directors focused on gaps in knowledge as a major constraint for addressing PTB and LBW concerns:

IR Study Director, Bangladesh
I would say the major challenge affecting preterm birth is the either lack of gestational age dating or the inaccuracy of gestational age dating in these settings. . .

Emerging Opportunities

Several themes emerged as opportunities for the focus of Every Preemie's work for the remainder of the project.

Focus on sick newborns
Frequently mentioned was the need to address sick newborns who may be full term. The comments:

USAID/W Newborn Health Staff
So now, our priority is small and sick babies, and we agreed that one of the important activities that we should do in this area is the Situational Analysis. So they've been busy developing a protocol, and I've been saying from the very beginning that it should be inclusive. We should have a team of people beyond us, beyond our little group. Include

UNICEF, include London School, MSCP, and they have included them all, you know. So, I have been very happy with the way they've handled the design of the protocols for sick newborn care. Very soon, we will have the protocol that can be used by all of us, not just Every Preemie, but the other partners can also use them, which will really shape the global Situational Analysis. We can have a Call to Action on small and sick newborn care. So, I'm happy with that.

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

Do No Harm

Another emerging theme was the concept of Do No Harm:

USAID/W Newborn Health Staff

I'm also very excited about the Do No Harm series. That's also a huge priority for USAID, and I know Jim and Judith are also quite excited about the Do No Harm series. It's begun to resonate a lot with USAID Missions in some countries. 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. . .

Field Support

Field support came up as both a challenge and as an opportunity. Every Preemie was designed as a very focused project. Those projects with a high level of field support tend to be broad-based. As originally conceived, Every Preemie was expected to have no more than 20 percent field support.

Of ten total responses from Health Officers in Missions who were surveyed, eight were interested in discussing support from Every Preemie – SCALE. Of the six countries who responded that they would like to support, five responded with specific topics of interest. Two each responded that they would like to discuss (1) the use of data, (2) the facilitated development of strategies, plans, or programs, or (3) a situational analysis. These discussions are currently underway.

Several IR study directors and country-level stakeholders mentioned the usefulness of interns. One pointed out:

Malawi Stakeholder

We had an intern who came to our organization, and then for us that was a chance to get this person out and actually observe what actually happens in the facilities, so this intern, she is doing public health at the University of North Carolina. She's doing something on KMC, so we sent this intern to District Hospital to actually observe because we are not in the facilities, and we really wanted to observe KMC. So, she was there full-time, day and night.

At the country level, limitations of funds, supplies, human resources, and even physical infrastructure in public facilities are well-known, and often beyond the capacity of a small project, like Every Preemie, to address. In Balaka district, Every Preemie has been able to help with training frontline health care workers in care for PTB/LBW babies, especially with KMC. Additional training has been scheduled over the next two years of the project. They have also been able to provide some supplies and equipment, such as weighing scales for babies and KMC registers. MOH representatives expressed their appreciation for the training and supplies. They have other needs, however, beyond the ability of Every Preemie to address. For instance, there are limitations of space for KMC wards. The MOH has also expressed a desire to train managers in leadership skills and to support learning visits to well-functioning facilities.

Other Malawi stakeholders have asked for training to improve the quality of data and using it for quality improvement, which is a need Every Preemie has been addressing through training in data collection and through providing registers:

Malawi Stakeholder
. . . *data quality is a big problem. We actually have tried to do some data management collaborative within the facilities that we are working with so that actually is to improve when we bring in the data clerks to that training. So we've seen some improvement, but the problem is that data is left as the duty of the data clerks, and then that becomes a very big problem so what we are trying to do with our collaborative is seeing how we can bring nurses and midwives and data clerks together to understand that they are responsible for generating the data and then combining this data and making sense out of it for management teams.*

There are quite a number of issues that we've seen in other facilities where sometimes the simple reason is stationary. They simply don't have the charts, and once they don't have the charts that's missed opportunity.

<u>Gaps in technical/program areas addressed by project</u>

<u>All but two of the 13 global partners surveyed felt that Every Preemie is engaging on the right issues.</u> The one who disagreed felt that not enough emphasis was being placed on prevention. Just over half (7) of the respondents felt that the project was addressing the right technical and programmatic areas, but the remaining six felt that there were gaps that could be addressed. These gaps included:

- Lack of engagement with WHO regarding preterm birth estimates currently underway;

- Emphasizing essential newborn care;
- Implementation challenges and solutions, especially using data for decision making;
- Quality of care for PTB/LBW babies at the community level;
- Prevention and antenatal care; and
- Prioritizing feeding of PTB/LBW newborns.

Some of these “gaps,” however, show a lack of familiarity among global partners with some aspects of the project. Quality of care for PTB/LBW babies at the community level and prioritizing feeding of PTB/LBW are areas strongly emphasized in Every Preemie’s project in Malawi. Also, the Country Profiles show a strong commitment to the use of data for decision making at the national level. Prevention was also strongly addressed at one of the three PTB TWG-ICS meetings and the project co-convened the Public-Private Partnership for the Prevention of Preterm Birth with the MDG Health Alliance and March of Dimes.

TWG Meeting Topics for Technical Discussion

Eight of the 13 global partners responding to the survey were members of the Every Preemie PTB TWG-ICS and had attended at least one of the three meetings held to date. All agreed or strongly agreed that the topics selected for technical discussion at these meetings were important and timely. Ten respondents, however, suggested topics they would like to see in future meetings, including:

- Preterm birth estimates, measurement and documentation;
- Care of small and sick newborns;
- Continuing discussion of gestational age;
- Feeding issues, challenges, solutions at the institutional level (2);
- Follow up of small babies after discharge/linking to community health workers;
- Protocols and checklists for early and subsequent community health worker home visits;
- Facility care for PTB/LBW babies;
- Scale up of KMC;
- Learning from on-going implementation and the way forward;
- Retinopathy of prematurity;
- Continuing discussion and country reviews of ACS (2);
- Country needs;
- Use of traditional practices;
- Prevention of PTB/LBW.

Additional potential opportunities suggested included:

- Advocating about the preterm and LBW programming to RMNCH stakeholders and partners;
- Engaging more in KMC, especially on the continuum of care;

- Highlight the need to integrate care of mothers of preemies as a high-risk mother needing more focused postnatal care; and
- Bring this work out of the narrow MNCH technical community into global health and development mainstream. Preterm birth now is the #1 killer of children under 5, so this work needs to be front and center of the child survival movement and global health agenda 2030.
- The project has already developed documents that are contributing broadly to PTB/LBW. Additional documents that will further the field of PTB/LBW and sick newborn care (an emerging area) will be developed in years four and five. As part of the project's legacy, Every Preemie will have the following documents available by the end of the project in 2019:

    - The Continuum of Care Matrix for the Prevention of PTB, the Management of Early Labor and the Care of the Preterm/LBW Newborn;
    - Updated country profiles for PTB/LBW—including an update of the USAID benchmark indicator[8];
    - At least eight Do No Harm Technical Briefs on the Safe and Effective Use of Interventions for Inpatient Newborn Care;
    - Final reports on IR findings in Bangladesh, Ethiopia, India and Malawi;
    - The Family-Led Care package including provider/family orientation materials, supervisory checklists, provider and family newborn care monitoring forms and indicators;
    - The State of the World's Sick Newborn Care document[9]; and
    - The Situation Analysis of Inpatient Care for Sick Newborns—protocol and tools available for open use in low-resource settings.

Further to this, in years four and five, the project will continue to be actively engaged with global partners and country stakeholders to advance this important agenda. In addition to convening the PTB TWG-ICS as an important forum to address priority topics, Every Preemie will continue to engage with stakeholders via international conferences such as ICM and Women Deliver, and via various meetings with ENAP, WHO, Unicef, the Core Group, and other key partners.

The development and broad dissemination of legacy documents, the implementation of the project's diverse research agenda and technical assistance in Malawi as well as the project team's consistent voice "on the right issues with the right partners" are catalyzing attention and action and will provide a solid platform for expanded investment and programming for preterm birth and LBW into the future.

[8] Ten critical elements for preterm care as listed in the WHO *Recommendations for improved preterm birth outcomes 2015* across the 24 USAID priority maternal and child health countries.

[9] This document was being conceptualized as the MTR report was being finalized but it is apparent that Every Preemie will be significantly engaged in its design and development.

Appendix 1: Persons Surveyed or Interviewed

Type of Contact	Name	Title/Organization
Tool 1 Priority Countries	Responsibility (for sending out Survey Monkey): USAID	
Tool 2: USAID Maternal Health Team	Responsibility (for sending out Survey Monkey): Lily Kak	
USAID	Deb Armbruster	USAID/Washington, Maternal Health Team
USAID	Mary Ellen Stanton	USAID/Washington, Maternal Health Team
USAID	Claudia Morrissey	USAID/Washington, Maternal Health Team
USAID	Nahed Matta	USAID/Washington, Maternal Health Team
USAID	Karen Fogg	USAID/Washington, Maternal Health Team
Tool 3: USAID/Washington	Responsibility: La Rue K. Seims	
USAID	Lily Kak	USAID/Washington, Newborn Health Team
USAID	Emily Hillman	USAID/Washington, Newborn Health Team
Tool 4: Health Officers in Demo Countries	Responsibility: USAID	
USAID/Ethiopia	Smita Kumar	
USAID/India	Sachin Gupta	
Tool 5: Malawi Health Officers	Responsibility: USAID	
USAID/Malawi	Evelyn Zimba/Reuben Ligowe	
Tool 6: Research Partners	Responsibility: La Rue K. Seims	
Implementation Research Partners	Adamson Muula (Malawi)	College of Medicine
Implementation Research Partners	CC Lee (Bangladesh)	Brigham and Women's Hospital
Implementation Research Partners	Praveen Kumar (India)	PGIMER
Implementation Research Partners	Wendmagegn Gezahegn (Ethiopia)	St. Paul's Millennium Medical College

Tool 7: Malawi Stakeholders	Responsibility: La Rue K. Seims	
Malawi	Andrew Samson Nkhoma	Safe Motherhood Coordinator, Balaka
Malawi	Eugene Katenga-Kaunda	District Health Officer, Balaka
Malawi	Irene Kamanga	RMNCH Advisor, PCI Malawi
Malawi	Jones Chimpukuso	Njira Deputy Chief of Party, PCI Malawi
Malawi	Edward Moses	MaiKhanda
Tool 8: Global Partners	Responsibility (for sending out Survey Monkey (Judith Robb McCord/Chelsea Dunning)	
Global Partner	Charlotte Warren	Director, Ending Eclampsia (Population Council)
Global Partner	Joy Lawn	Leads ENAP Metrics Group
Global Partner	Chris Howsen	(previously with March of Dimes)
Global Partner	Neena Khadka	MCSP
Global Partner	Steve Hodgins	SNL
Global Partner	Steve Wall	SNL
Global Partner	Liliana Riva	Director, USAID Child Blindness Program
Global Partner	Trish Coffey	PATH
Global Partner	Kathleen Hill	Jhpiego/MCSP
Global Partner	Leith Greenslade	JustAction
Global Partner	Bina Valsangkar	SNL
Global Partner	Eneles Kachule	KMC Desk Officer, Reproductive Health Unit, MOH Malawi
Global Partner	Lisanu Tadesse	Child Health Technical Assistant - Child Health Case Team, MOH Ethiopia
Global Partner	P.K. Prabhakar (Dr. Khera)	Deputy Commissioner (Child Health), Ministry of Health and Family Welfare (MOH) India
Global Partner	Ajay Gambhir	President, National Neonatology Forum, India (Professional associations - India)
Global Partner	Bogale Worku	Executive Director, Ethiopian Pediatrics Society (Professional Associations - Ethiopia)