Malawi Newborn Health Program
Report of the Midterm Evaluation

National Level - Expanded Impact

(with learning activities in the districts of Chitipa, Mzimba, Mchinji, Dowa, and Thyolo)

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Required and Additional Annexes

Acronyms

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services (USAID)
ACSD	Accelerated Child Survival and Development
ANC	Antenatal Care
BASICS	Basic Support for Child Survival (USAID)
BCC	Behavior Change Communication
CBMNC	Community-Based Maternal and Newborn Care (package)
CCAP	Church of Central Africa (Presbyterian)
CHAM	Christian Health Association of Malawi
CM	Community Mobilization
CS-22	USAID/CSHGP - 22nd cycle
CSHGP	Child Survival and Health Grants Program
DHMT	District Health Management Team
DHO	District Health Officer/District Health Officer
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DIP	District Implementation Plan
DSMB	Data Safety Monitoring Board
EHO	Environmental Health Officer
EHP	Essential Health package
ENC	Essential Newborn Care
EONC	Essential Obstetric and Newborn Care
FTE	Full Time Equivalent
GOM	Government of Malawi
HMIS	Health Information Management System
HSA	Health Surveillance Assistant
ICH	Institute of Child Health
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program (USAID)
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNC	Maternal and Newborn Care
M&E	Monitoring and Evaluation
MNBHP	Malawi Newborn Health Program (Save the Children)
MOH	Ministry of Health
MTE	Midterm Review
NBHP	Newborn Health Program
NMR	Neonatal Mortality Rate
PNMCH	Partnership for Newborn, Maternal, and Child Health

PNC	Postnatal Care
RCT	Randomized Control Trial
RHU	Reproductive Health Unit
SWAp	Sector Wide Approach
SNL	Saving Newborn Lives (funded by the Bill & Melinda Gates Foundation)
SNL1	Saving Newborn Lives (phase 1)
SNL2	Saving Newborn Lives (phase 2)
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nation's Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRASM	White Ribbon Alliance for Safe Motherhood

NOTE

The Malawi Newborn Health Program midterm evaluation (MTE) was conducted 20-30 April, 2009, prior to posting by USAID/CSHGP of revised *Guidelines for the Mid-Term Evaluation Report* in July 2009. Every effort was made to configure the report using the prescribed new format. Please advise if CSHGP requires additional information or clarification for any section.

A. Preliminary Information

Description of program Save the Children (SC) is implementing the Malawi Newborn Health Program (MNBHP or NBH Program), a five-year Expanded Impact (CS-22 cycle) project at the **national-level** (100% maternal and newborn health with focus on the neonate). The MNBHP - carried out in partnership with the MOH, UNICEF, and other key stakeholders - reaches approximately 500,000 neonates (0-28 days) born in Malawi every year and their mothers. The national-level MNBHP supports the government's Essential Health package (EHP) and Accelerated Child Survival and Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI), including community IMCI (c-IMCI); and is integrated into a multi-year (2005-15) national initiative led by the MOH and guided by *The Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity in Malawi* (Road Map), the national framework adopted by the Government of Malawi (GOM) in 2005 and launched officially in March 2007. The Malawi NBH Program is co-funded from two complementary sources: the United States Agency for International Development (USAID)/Child Survival and Health Grant Program (CSHGP) and SC Saving Newborn Lives II (SNL Phase II – match and cost-share), supported by the Bill & Melinda Gates Foundation. The MNBHP is integrated as a single program through a merged work plan and unified team functioning. The NBHP is closely coordinated with SC's community-based ACCESS activities in partnership with JPIEGO. CSHGP funds also support learning activities at the district level, including (1) a sub-grant to Ekwendeni Church of Central Africa Presbyterian (CCAP) Mission Hospital (Ekwendeni) – a Christian Health Association of Malawi (CHAM) facility - for development, documentation, and dissemination of the *Agogo* Approach; and (2) technical assistance to Mzimba District for essential newborn care (ENC) and Kangaroo Mother Care (KMC). As match, SNL funds a three-district demonstration of the national community-based maternal and newborn care (CBMNC) package in the districts of Chitipa, Dowa, and Thyolo.

Goal, strategic objective, intermediate results The overarching strategic objective of the MNBHP is *increased sustainable use of key maternal and neonatal health services and practices*. There are four intermediate results that support attainment of the strategic objective and ultimately, the program goal of *reduced neonatal mortality and morbidity to meet Malawi's Millennium Development Goals (MDGs) by 2015*: **IR-1:** Increased availability of and access to key maternal and newborn care services; **IR-2:** Improved quality of key maternal and newborn care services; **IR-3:** Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors; and **IR-4:** Improved policy and enabling social environment for maternal and newborn health.

Main accomplishments Key accomplishments to date include (but are not limited to): (1) design and use, with MOH and partners, of the *Integrated Maternal and Newborn Care (IMNC) Training Manual* to train health workers; (2) expansion of kangaroo mother care (KMC) in 14 program-supported facilities; (3) development and use of the Health Surveillance Assistants (HSA) community-based maternal and newborn care (CBMNC) training package; (4) training of forty district-level trainers in CBMNC; (5) supervisor training in the three demonstration ("learning") districts; (6) training HSAs and health workers in the three demonstration districts in community- and facility-based maternal and newborn care, respectively; and, (7) deployment of HSAs to the field with extensive contacts at the household level in MNC resulting in reported increases in antenatal care (ANC) and facility-based deliveries in program sites.

The MNBHP is well designed and strategic in its approach. Noteworthy is its commitment to working within the MOH structure and avoiding the creation of parallel systems. Since inception, SC has continually adapted to the program environment and has seized opportunities to improve programming and address gaps as identified. The program team has worked hand-in-hand with the MOH/RHU, UNICEF and other partners throughout programming to maintain momentum and a commitment to excellence. As a result, SC's role in implementing the MNBHP has expanded beyond the original design. The team has risen to the challenges inherent in program expansion and has maintained complete dedication to the program's vision, goals and objectives. At this point in programming, it is evident that SC is a well respected partner in Malawi's health sector arena via: a) global and local technical leadership in newborn health; b) long-

term relationships with partners and stakeholders in Malawi; c) strategic technical input for policy and guidelines dialogue and development, training curricula design and development; and, d) technical and material input for building health provider capacity to provide quality essential newborn care (ENC). SC's primary role as a national-level partner to the MOH is as a reference, catalyst and technical resource for newborn health in Malawi. The match-funded community-based MNC package, including its facility component, is a sound model for the delivery of these critical services in rural areas of Malawi. This effort is led by the MOH/RHU and is in direct alignment with the *Road Map* and the GOM's *ACSD Framework for IMCI* and supports and enhances the EHP. Demonstration of the package was designed as a partnership between and among the MOH/RHU, SC and UNICEF, with periodic participation from WHO and UNFPA. The program is designed as an implementation and learning activity to demonstrate the scalability of a model for delivering a package of facility and community-based maternal and newborn care services.

Table 1: Summary Table of Major Project Accomplishments (all in partnership with MOH/RHU, UNICEF, others)

Strategic Objective: Increased sustainable use of key maternal and neonatal services and practices			
Inputs	**Activities**	**Outputs**	**Outcome**
IR-1: Increased availability of and access to key maternal and newborn care services			
Roll out of MOH CBMNC package in 3 districts (+ 3 ACCESS districts). Adaptation of TOT and HSA training materials; training funds from SC and UNICEF; development and production of BCC materials; development of Integrated Manual for health workers	Training of trainers and HSAs in CBMNC package and CM	292 HSAs trained in CBMNC package; 376 HSAs trained in community mobilization in 3 demonstration districts	Improved community-based access to quality ENC
Development of Integrated Manual with KMC module; training funds from SC and districts; supplies for health facilities	Training of health workers in KMC	292 HSAs deployed to field and making antenatal and post-natal visits 14 KMC units operational	Improved access to KMC
IR-2: Improved quality of key maternal and newborn care services			
Transport, supervision tools, joint planning	Joint supervision (DHMT, SC, UNICEF, RHU)	Joint supervision held in all 3 demonstration districts	Improved HSA quality and accountability
IR-3: Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors			
Sub-grant agreement to Ekwendeni Mission Hospital	Training/refreshing of grandparents in Mzimba District	4100grandparents trained in ENC and BCC messages	Increased demand for key services and practices
IR-4: Improved policy and enabling social environment for maternal and newborn health			
Collaboration with RHU, UNICEF, WHO, USAID, ACCESS, others	Writing, organizing, reviewing, joint decision-making	Integrated Maternal and Child Health Manual	National standards for training and practice in health facilities

Primary constraints, problems, areas in need of further attention The greatest threat to the success of the MNBHP is resource availability - human and financial - to take the CBMNC package to scale at a national level. In spite of MOH "ownership" and likely final endorsement of the package, it is unclear how a large-scale implementation of the package in all 28 districts will be funded. In general, challenges to scaling up newborn care are serious: resource limitations, structural impediments and competing political priorities across the MOH. Funding constraints are common across the health sector, and without stronger political priority for newborn health, it is uncertain whether models like the CBMNC package can be fully implemented or sustained. Malawi's decentralized government health system complicates the funding and coordination of newborn care across the country. District health budgets, created by District Health Management Teams

(DHMT), reflect the priorities of the district and non-government donors, not necessarily directives from the national MOH. Both the central Ministry and the DHMTs rely on the Sector Wide Approach (SWAp) as the source of funds for their health sector investments. Over the past two years, SWAp funds have declined considerably (though no one was able to give a precise figure), pushing central and district health authorities to cut their budgets. In addition, program partners at the national level have delayed their funding commitments for implementation of the package. UNICEF originally committed to support the training of HSAs in the CBMNC package in the three pilot districts and to provide supplies and equipment to the HSAs and participating health facilities. While it did support training of trainers and some of the subsequent training, it has not yet met its full commitment, resulting in a delay in training and fully equipping HSAs.

Summary of conclusions In a key relationship with the Malawi Ministry of Health Reproductive Health Unit (MOH/RHU), SC has stepped into the maternal and newborn health arena with a full commitment to introducing and scaling up evidence-based best practices for improved health outcomes, with a particular focus on the neonate. In one of the poorest countries in the world, this is no small task. The design and intent of the MNBHP are exactly right. The program is led by the MOH and framed within both the *Road Map* and the *ACSD/IMCI Framework*. The development environment in Malawi is extraordinarily challenging. The health indicators are indicative of a fragile system and of a population with limited access to quality care—if even available. The MNBHP responds to the absolute need for community-based access to improved services for mothers and newborns. Through its catalytic role, SC is facilitating Malawi's first real opportunity to address this dramatic gap in services at the community and household levels. At the same time, the program recognizes the need to strengthen facility capacity for MNC. At this point, the package is added to existing services as opposed to being fully integrated – this is fine now but will need to mature over time, to move beyond the pilot stage to a point where all elements of the package are truly institutionalized into the health service delivery system.

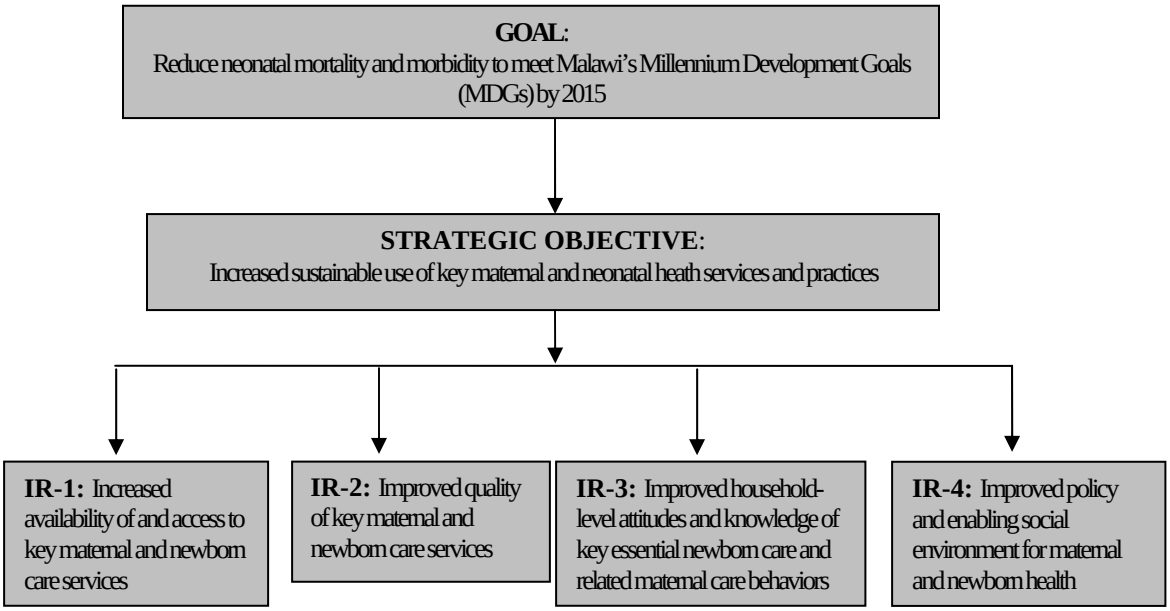
Selected key recommendations

- Establish performance criteria to objectively measure the quality of KMC services being provided. Criteria to measure provider performance for KMC would be developed from standards of care for KMC such as consistent warming, use of calibrated cups to measure breast milk intake, proper weighing of newborns.
- Move forward with the development of messages and dissemination plans with districts to educate district transport officers to include sick newborns as a priority for emergency transport.
- Collaborate with DHMTs and UNICEF to develop a training plan for remaining HSAs and supervisors. Outline funding requirements and partner funding commitments as well as partner roles and responsibilities and complete remaining training by the end of 2009.
- Identify other program platforms, e.g.., CHAM, Catalytic Initiative in 10 districts, new USAID program and most importantly, new districts via government investment.
- Work closely with the national Health Management Unit (HMU) in its review and revision of the HMIS indicators and ensure that all newborn health indicators are consistent with global standards (e.g. the indicator of postnatal care of the newborn is listed as "one week visit" as opposed to the current standard of 24-48 hours). During this process, review and amend the Road Map indicators that have been met or surpassed.
- To work with key partners in safe motherhood programs, review and identify performance and quality improvement tools available to measure the quality of facility-based MNH services. Tools can be introduced to DHMTs to reinforce clinical supervision.
- There is a need to define the product(s) and the "packaging" of materials the MNBHP wants to have at the conclusion of their activities to document the processes that led to stated successes.

B. Overview of the Project

Goal, strategic objective, intermediate results The overarching **strategic objective** of the MNBHP is *increased sustainable use of key maternal and neonatal health services and practices*. There are four intermediate results that support attainment of the strategic objective and ultimately, the **program goal** of *reduced neonatal mortality and morbidity to meet Malawi's Millennium Development Goals (MDGs) by 2015*: IR-1: Increased availability of and access to key maternal and newborn care services; IR-2: Improved quality of key maternal and newborn care services; IR-3 Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors; and IR-4 Improved policy and enabling social environment for maternal and newborn health.

Figure 1: Results Framework



Project location This is a **national level Expanded Impact** project - with learning activities in the districts of Chitipa, Mzimba, Mchinji, Dowa, and Thyolo.

Estimated project area population The MNBHP - carried out in partnership with the MOH, UNICEF, and other key stakeholders - reaches approximately 500,000 neonates (0-28 days) born in Malawi every year and their mothers. (This population figure was agreed upon with CSHGP at DIP review.)

Technical and cross-cutting interventions The MNBHP is a five-year Expanded Impact (CS-22 cycle) project at the national-level. The CSHGP technical intervention is **maternal and newborn** health (100%) with focus on the neonate.

Cross-cutting interventions include: advocacy for policy change, community mobilization, and process documentation. Behavior change communication is a cross-cutting intervention used by Ekwendeni Mission Hospital, SC's sub-grant partner for the *agogo* approach.

Project design The MNBHP supports the government's Essential Health package (EHP) and Accelerated Child Survival and Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI), including community IMCI (c-IMCI); and is integrated into a multi-year (2005-15) national initiative led by the MOH and guided by *The Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity in Malawi* (Road

Map), the national framework adopted by the Government of Malawi (GOM) in 2005 and launched officially in March 2007. Road Map partners at the national level include the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and others. SC is also a core member of USAID global flagship project Maternal and Child Health Integrated Program (MCHIP), and has been a partner with JHPIEGO in Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) in Malawi. **SC's primary role as a national-level partner to the MOH is as a reference, catalyst and technical resource for newborn health in Malawi.** At the community level, SC has supported sub-grant partner Ekwendeni Mission Hospital in Mzimba District to develop and package its *agogo* approach to community mobilization and behavior change. With match funding from SC SNL, SC is collaborating closely with MOH/RHU in the design, monitoring, and evaluation of a demonstration of the national CBMNC package in the districts of Chitipa, Dowa, and Thyolo. Through its partnership in ACCESS, SC has led community mobilization in three additional districts where the CBMNC package is being demonstrated. This effort will continue under MCHIP.

SNL matching funds are primarily focused on design, development, and evaluation of a community-based maternal and newborn care (CBMNC) package and operations research/evaluation to generate feasibility evidence for delivery of the package by Health Surveillance Assistance (HSAs) in the three learning districts of Chitipa, Dowa, and Thyolo. Roll-out of the community-based package is led by the Ministry of Health (MOH) Reproductive Health Unit (RHU) and partially funded by UNICEF with significant technical, material, and funding inputs from SC. KMC scale up is cost-shared. In addition, SNL supported the Mai Mwana Project - carried out by the Institute for Child Health (ICH), University of London – in Mchinji District, a randomized control trial (RCT) of a set of community-based interventions for newborn care, now coming to an end. Through SC, Mai Mwana has contributed its experience and lessons learned to development of the CBMNC package.

Partnerships, including USAID Mission collaboration To address the many challenges to achieving impact at scale for maternal and newborn health, SC works at the national level and: (1) supports Government of Malawi strategies and integration of maternal and newborn care into existing strategies, programs, and packages, including: (a) Sector Wide Approach (SWAp), (b) Essential Health Program (EHP), (c) Road Map for Accelerated Reduction of Maternal and Newborn Mortality and Morbidity, (d) Accelerated Child Survival and Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI); (2) generates evidence through implementation research and evaluation on design and delivery of a community-based maternal and newborn care package integrated with the SWAp, EHP, Road Map, and ACSD/IMCI to be taken to scale in all 28 districts of Malawi; (3) partners with the Ministry of Health (MOH), UNICEF, WHO, UNFPA, and other national and international stakeholders in supporting joint planning, review, implementation, and evaluation to reach common goals and objectives; (4) plays a technical leadership role on national-level task forces and working groups in order to ensure quality newborn care along the household-to-facility continuum of care; (5) engages strategic partnerships at the national level, including: (a) Partnership for Maternal, Newborn, and Child Health (PNMCH), (b) White Ribbon Alliance for Safe Motherhood in Malawi (WRASM); (6) in partnership with JHPIEGO, cooperates with the USAID Mission in implementation of ACCESS and upcoming MCHIP; and (7) influences national policy through strengthening the enabling environment, including local advocacy capacity (WRASM), and ensuring incorporation of evidence-based best practices into Malawi's policies, norms, and protocols.

C. Data Quality: Strengths and Limitations

The MNBHP overlaps in time with the Malawi *Road Map's* first two phases (2005-08 and 2009-11) and contributes to achieving *Road Map* goals, objectives and targets. To ensure that progress towards the MNBHP goal and objectives of the program is tracked and assessed, an M&E plan was designed by the MNBHP team. The development and refinement of this M&E plan has been a long and complex process. As part of the DIP development process, a review of

indicators from the *Road Map*, MICS, MDHS and the HMIS was done. This resulted in the selection of national-level program indicators relating to the neonate.

Apart from the national-level data from DHS and MICS being used to track progress, the indicators in the CBMNC package M&E plan include high level (impact and outcome), district-level Management of Information Systems (MIS) and lower-level process indicators (output, activity and input). The higher level indicators include population-based data; and lower-level indicators refer to program data. Indicators with their detailed definitions, sources and the person responsible for collecting the data for each indicator are available in the MNBHP Performance and Monitoring Plan. Each indicator has a baseline value and a target for 2010. The baseline values and the targets are district specific. Higher-level indicators are measured at baseline and endline and by using national level data from the MICS and DHS. The implementation schedule for lower level indicators will be tracked using a quarterly reporting format.

After discussion with USAID/CSHGP – and to satisfy the CSHGP requirement for Rapid CATCH data - a standard 30-cluster Knowledge, Practice, and Coverage (KPC) survey was conducted in Mzimba District at baseline. The Mzimba survey will be repeated at endline (mid-2011) to capture changes in the Rapid CATCH and maternal/newborn indicators measured. Lot Quality Assurance Sampling (LQAS) methodology will be used at endline in order to determine differences (if any) between *agogo* approach areas and those not covered by that approach. In addition to the population-based survey in Mzimba, a qualitative assessment was conducted at baseline by sub-grantee partner Ekwendeni Mission Hospital to inform the *agogo* approach activities.

For the match-funded CBMNC package being tested in Chitipa, Dowa, and Thyolo Districts - in collaboration with DHOs and MOH/RHU - M&E tools and approaches include formative research, population-based surveys (baseline and endline), a baseline health facility assessment, process monitoring, process documentation, and a costing study. Beneficiaries are also tracked annually. These tools and approaches are described in detail below.

Formative Research In Chitipa, Dowa, and Thyolo, a formative inquiry focusing on household roles, knowledge and practices for maternal and newborn care was conducted in October 2008. This formative research included a study of HSA workload and perceptions (acceptability) of HSAs in the delivery of maternal and newborn home care.

Population-Based Survey In addition to the Mzimba baseline for CC-22, SC also conducted a population-based 30-cluster survey in the three learning districts prior to introduction of the CBMNC package; and an endline survey will be conducted at the end of the program so that changes in the knowledge, behavior, and coverage of essential maternal, and newborn care services and practices can be assessed. The baseline survey was carried out between November 2007 and January 2008, surveyed 300 women ages 15-49 with a live birth in the previous year. These additional surveys were funded through SNL match.

Health Facility Assessment A health facility assessment focusing on availability and quality of maternal and newborn care services, supplies, infrastructure, and manpower was carried out in the three learning districts in January 2008. This assessment was conducted to assess the situation in health care facilities. There are currently no plans to conduct a follow-up study at endline to assess any changes. Routine assessment of health facility supplies and equipment is done through district reports or routinely collected HMIS data.

Process Monitoring The three CBMNC learning districts are expected to submit data on: (1) background information of HSAs trained in CBMNC and community mobilization; (2) ANC and PNC home visits[a]; (3) community mobilization activities; (4) HSA supervisor information. All data was to have been sent to SC at the end of every month up

a ANC, PNC and skilled attendance at birth facility-based data is collected via the routine HMIS

to July 2009 and quarterly thereafter. At the time of the MTE, the only data that have been sent are data from the ANC and PNC home visits (a total of about 100 forms as of mid April 2009). The three districts are also expected to report process indicators quarterly. Reporting of these indicators to the CBMNC partners through the MOH is to begin in mid-2009.

Supervisory Visits Supervision is expected to take place at the district and partner levels. At the district level, the HSA supervisors are expected to supervise the HSAs monthly. The DHMT, on the other hand, is expected to supervise the health centers quarterly. Supervision of health facilities and HSAs has been limited (for reasons discussed above). HSA supervisors are expected to use an HSA supervision checklist. At the partner level, joint supervision visits are planned every quarter. These joint visits are expected to involve representatives from the MOH/RHU, UNICEF, SC and representatives from the two other learning districts that are not being supervised at that time. The purpose of the joint supervision visits is to assess progress and to provide a forum for the districts to learn from each other. No joint supervision has been conducted yet though there are plans to have the first joint supervision in late May 2009[b]. The difference between the HSA supervision checklist and the monitoring checklist is that the former only focuses on the procedures an HSA undertakes during home visits, while the latter focuses on issues like data management, supervision, and demand for MNH services.

Summarizing and Sharing of Data with MOH and Other Partners Most of the data that is collected has been summarized and shared with partners. This includes data that was gathered from the formative research, health facilities assessment and the baseline survey. Reports of all these studies were sent to all the partners. Dissemination meetings were also organized at the district level for the DHMT, the extended DHMT and the district executive committee, which includes chiefs, politicians and traditional leaders. Reports on all the trainings that have been conducted in the districts (funded by SC and UNICEF) have been shared with all the partners including the MOH/RHU. Reports for all the supervision visits that have been conducted by SC only or SC and MOH/RHU have also been shared with partners. During the last taskforce meeting (held in January 2009), the districts shared with all the partners details of how they had started implementing the program.

Use of Information to Inform Programming In terms of programming, results from the formative research guided the review, adaptation and development of the BCC materials. The results also informed critical socio-cultural issues in the three districts that had to be taken into consideration during program introduction and in the design of the community mobilization component. Results from the baseline survey and health facility assessment were used to set targets for the three districts. Routine data collected from the districts will be used to track program progress and guide adjustments to programming, if needed. However, at this time, the data flow from the district level to the MOH/RHU remains weak. The program M&E team will work with data managers at the district level and the central MOH to better understand the weaknesses and gaps and work to identify solutions. Ideally, the use of routine data to assess progress and inform decisions will take place right from the first level of data collection – the HSAs and to the facility level.

Mini LQAS Survey In April, just prior to the MTE, a mini LQAS survey sought to assess coverage of ANC and PNC services offered by HSAs in the 3 learning districts. The findings gave an insight in how the program was progressing; however, the need was noted for all three districts to ensure data was entered on time and shared with RHU to give a better picture on how the program was progressing. Thyolo, which was performing poorly compared to the other two districts, acknowledged it needed to revisit implementation standards. (See Annex 14 for a full report on the mini LQAS survey.)

M&E Challenges

- Limited district capacity to collect, input and analyze data.

[b] The joint supervision did take place as planned in May 2009.

- Targets of some indicators in the *Road Map* had already been reached and surpassed when the *Road Map* was launched. As part of the current national HMIS review, these targets will be reset.
- Listing of women of child bearing age took more time than expected and affected the start of home visits. This is due in part to HSAs who were busy with other activities or who did not have clear guidance from supervisors on this exercise.
- Delays in the supply of data collection tools to HSAs. District roles were not very clear.
- There have been numerous changes at the national level regarding the demarcation of villages. This has created confusion in completing the village health registers, which are used by the HSAs as codes for villages (used to identify mothers visited by the HSAs). This had led to HSA home visits forms that are not coded and can't be entered into the database.
- The district HMIS team does not prioritize data entry for the HMIS or the CBMNC project delaying the availability of important information.
- The current M&E plan is not designed to capture program impact in specific catchment areas. The impact of the program and the effectiveness of the CBMNC model will be evaluated based on a district-wide population-based survey giving the possible impression that the service delivery model was not effective.

Process Documentation Documenting the process of implementation is important for replication and scaling up. The NBHP team has an elaborate process documentation plan for the three-district CBMNC demonstration project. The plan is designed as a guide for capturing all "critical steps, decisions, activities, milestones, problems and their solutions"[1] in the preparation and implementation phases of the project. It is anticipated that by the end of this program, the MNBHP will have documented the processes and sub-processes undertaken to deliver a package of life-saving maternal and newborn interventions within the Malawian health system. The outputs of this on-going exercise are aimed at informing the scale-up of the CBMNC package internally and externally to Malawi.

The MNBHP process documentation plan provides an outline for the key activities that influenced the design of the CBMNC interventions and the overall program design. It also provides a set of tools to be used during the project's implementation to capture relevant program information. The project's M&E plan incorporates a broad list of process indicators. Also part of the process documentation is a costing exercise intended to document the added costs of delivering the CBMNC package through the Malawi health system.

Process documentation is the responsibility of the MNBHP team. Other than outlining the flow of data from the HSA to the district and the district to MOH/RHU and SC, there is no mention of documentation occurring by the districts or other project partners.

Accomplishments of process documentation include:

- Detailed process documentation plan developed—as a precursor to developing the process documentation plan for the CBMNC package, MNBHP received guidance from SC home office on process documentation. MNBHP Research Manager and M&E Officer developed the CBMNC process documentation plan and circulated it to the MNBHP team for input. The plan was then circulated to the taskforce team members prior to a meeting but no members came back with feedback. Plan was also shared with SC/home office M&E Advisor who had minimal feedback and shared the plan with other country offices as an example of a comprehensive process documentation plan.
- Preparatory phase documents compiled. The MNBHP team has written and accumulated a vast number of documents relevant to the planning and designing of the CBMNC three-district demonstration project. These include reports from the learning exchange visit to India which was the impetus for designing this project; CBMNC design workshop report; taskforce meeting minutes summarizing discussions and highlighting key

decisions; SNL planning reports; formative research and baseline survey reports; target setting exercise report; and tool and manual adaptation reports. The ACCESS project also piloted data collection forms and a report of the pilot has been drafted.

- Plan and tools for quarterly program reviews developed. Included in the process documentation plan are a set of tools to be used during quarterly visits to the project sites by a team representative of MNBHP, MOH/RHU, UNICEF, and the districts of Thyolo, Dowa, and Chitipa. During these visits, the review team will document the project's progress, changes from the original course, challenges, lessons learned and next steps. It is also a great opportunity to share successes and lessons learned between sites given that representatives from each district will visit the other two districts.
- Compilation of program implementation documents under way. The MNBHP team is compiling training reports, supervision and trip reports, training materials, job aids, program monitoring tools, and data collection tools. In preparation for the mid-term review a list of reference document was developed and this list is something the MNBHP team can add to as the program continues to evolve. The current list of documents goes beyond the CBMNC package and includes all documents related to the MNBHP.

The MNBHP M&E plan states that a case study will be developed through interviews and analysis of data measured against process indicators. It appears that this will be a one-time piece to be written at the end of the project. However, it relies on those involved in the project to be accessible and recall events that may have occurred one or more years past.

It is important to note that there are many documents beyond the CBMNC package that capture the "process" and "lessons learned" of very important work of SNL1 and the expanded MNBHP. These include the KMC retrospective study report, the documentation of the *agogo* (grandparents) approach, and the draft report on generating political priorities for newborn health.

SC is working with Ekwendeni Mission Hospital to develop and package a "How To" guide on involving and working with grandparents to improve health outcomes. The report, *The Ekwendeni Agogo Approach: grandparents as agents of newborn survival*, is still in draft stage and in the process of being packaged in a way that can be shared with partners and will ensure a complete understanding of the process.

So far, the MNBHP team has focused mainly on compiling relevant documents of an "output" or process nature (e.g. meeting or program reports). All the information is relevant to the project in one way or another. However, there are already a lot of documents and these will continue to accumulate as the project continues.

The documentation process is central to the program's ability to effectively advocate for the scale up of the facility and community-based MNC package. This aspect of the program's work is critical and will draw on the knowledge and experience of the program/technical team and the M&E team. It is imperative that the staff responsible for articulating a documentation process move beyond the collection and compilation of reports. The team and its partners, especially the MOH/RHU, must be fully engaged in strategic discussions and planning and critically assess what information is needed to boost the evidence base for the facility and community-based MNC package as a successful service delivery model and work to ensure that the MNBHP team has the necessary documents and information for implementation of their advocacy plan.

D. Assessment of Progress toward the Achievement of Project Results

Table 5: M&E Plan for National Newborn Health Program, ***NOTE: National Road Map targets were set low (sometimes lower than baseline) and were to have been reviewed and revised, along with indicators, at a national MOH/RHU HIS meeting planned for late April 2007. As of mid-October 2008, this national meeting had not yet happened and Save the Children has been unable to move the agenda forward.***

Objective/ Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Progress (2007 – 2008)	EOP Target
Goal: To reduce neonatal mortality and morbidity at scale to meet Malawi's MDGs by 2015	Neonatal mortality rate	Probability of dying within the first month of life		Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	33/1,000 live births	NOTE: BASELINE VALUE AMENDED PER MICS FINAL REPORT	25/1,000
		Deaths at ages 0-28 days in preceding 5 years	# of surviving children at beginning of age range 0-28 days during preceding 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	27/1,000		25/1,000
	Perinatal mortality rate	Sum of the # of stillbirths and early neonatal deaths 0-6 days	# of pregnancies of seven or more months' duration	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	34/1,000		30/1,000
	Size at birth	Mother's assessment that her baby was very small or smaller than average (Note: birthweight was missing for 51.3% of the sample.)	# of births in the last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	16%		15%
IR1: Increased availability of and access to key MNC services	Antenatal care	# of women who receive any antenatal care for their last birth by a doctor/clinical officer or nurse/midwife	# of women with a birth in the last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	92%		95%

Objective/ Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Progress (2007 – 2008)	EOP Target
		# of women who received 4+ antenatal care visits by anyone	# of women with a birth in the last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	57%		80%
		# of women aged 15-49 that were attended at least once during pregnancy in the 2 years preceding the survey by skilled health personnel	Total # of women surveyed aged 15-49 with a birth in the 2 years preceding the survey	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	92%		95%
		# of pregnant women starting antenatal care	# of estimated pregnant women	Malawi: Health Management Information Bulletin	Service Statistics	Annual	82% Annual Report, July 2005-June 2006	87% Annual Report, July 2007-June 2008	95%
		# of pregnant women starting antenatal care during the first trimester	# of estimated pregnant women	Malawi: Health Management Information Bulletin:	Service Statistics	Annual	6% Annual Report, July 2005-June 2006	8% Annual Report, July 2007 – June 2008	15%
		Total # of antenatal visits	Total # of registrants	Malawi: Health Management Information Bulletin:	Service Statistics	Annual	3 Annual Report, July 2005-June 2006	3 Annual Report, July 2007 – June 2008	4
	TT	# of mothers with live births in previous 2 years given at least 1 dose of tetanus toxoid (TT) vaccine within appropriate	Total # of women surveyed aged 15-49 with a birth in the two years preceding the survey	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	85%		85%

Objective/ Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Progress (2007 – 2008)	EOP Target
		interval prior to giving birth							
		# of women receiving 2+ TT injections during the pregnancy of the most recent birth	# of women with a birth in the last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	66%		80%
	Delivery in health facility	# of live births taking place in a health facility	#of live births in last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	57%		60%
		# of women aged 15-49 years with a birth in the 2 years preceding the survey that delivered in a health facility	Total # of women surveyed aged 15-49 years with a birth in 2 years preceding the survey	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	54%		60%
	Skilled attendant at delivery	% of live births assisted by a doctor/clinical officers or nurse/midwife	# of live births in last 5 years	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	56%		60%
		# of women aged 15-49 years with a birth in the 2 years preceding the survey that were attended during childbirth by skilled health personnel	Total # of women surveyed aged 15-49 years with a birth in the 2 years preceding the survey	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	54%		60%
		# of deliveries conducted by skilled health personnel. (Note: those delivering in institutions are assumed to have skilled attendant.)	Total # of expected deliveries	Malawi: Health Management Information Bulletin:	Service Statistics	Annual	40% Annual Report, July 2005-June 2006	46% Annual Report, July 2007-June 2008	60%

Objective/ Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Progress (2007 – 2008)	EOP Target
	Postnatal Care	# of women with a delivery outside of a health facility who received a postnatal checkup within 2 days of delivery	# of women with a live birth in the last five years who delivered outside a health facility	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	21%		30%
		# of women receiving post partum care within 2 weeks of delivery	Total # of expected deliveries	Malawi: Health Management Information Bulletin:	Service Statistics (Note: Data Incomplete)	Annual	19% Annual Report, July 2005-June 2006	24% Annual Report, July 2007-June 2008	30%*
IR 2: Improved quality of key maternal and neonatal care services	Components of antenatal care	# of women who were given iron tablets or syrup	# of women with a birth in the last five years who received antenatal care for their last birth	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	79%		86%
		# of women given iron tablets	Total # of women surveyed aged 15-49 years with a birth in the 2 years preceding the survey	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	81%		85%
		# of women who were given anti-malaria drugs	# of women with a birth in the last five years who received antenatal care for their last birth	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	81%		85%
IR 3: Improved household level knowledge and attitudes for key essential newborn care and related maternal care behaviors	Exclusive breastfeeding	# of infants aged 0-3 months that are exclusively breastfed	Total # of infants aged 0-3 months surveyed	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	72%		80%
		# of infants aged 0-5 months that are exclusively breastfed	Total # of infants aged 0-5 months surveyed	Multiple Indicator Cluster Survey (MICS) 2006	MICS Survey	Combined MICS/DHS scheduled in 2010	57%		65%

Objective/ Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Progress (2007 – 2008)	EOP Target
		Children given nothing but breast milk in the 24 hours prior to interview	Women interviewed with child <6 months	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	53%		60%
	Immediate breastfeeding	# of children who started breastfeeding within one hour of birth	# of children born in the five years preceding the survey who ever breastfed	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	69%		80%
	Use of mosquito nets by pregnant women	# women who slept under an ITN the preceding night	# pregnant women	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	15%		40%*
	IPT	# of pregnant women who took at least 2 doses of Sp for IPT of malaria during pregnancy	# of pregnant women who had a live birth in 5 years preceding the survey	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	47%		60%
	Birth Interval	# of births whose interval between the most recent birth and the preceding birth is 36 months or more	total # of births	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	50%		50%
IR4 Improved policy and enabling social environment for maternal and neonatal health	Government budget allocation to health sector	Government of Malawi budget allocated to health sector	Total Malawi government budget to all sectors including health						
	Total allocation to health sector: cost per capita	Government and donor total allocation to health sector (in US $)	Total estimated mid-year population						

*2010 Target from "Road Map for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Malawi: October 2005," Republic of Malawi, Ministry of Health.

E. Discussion of Progress toward Achieving Results

In a key relationship with the Malawi Ministry of Health Reproductive Health Unit (MOH/RHU), SC has stepped into the maternal and newborn health arena with a full commitment to introducing and scaling up evidence-based best practices for improved health outcomes, with a particular focus on the neonate. In one of the poorest countries in the world, this is no small task.

SC's current phase of newborn health programming in Malawi has been operational since 2006. The program is at the halfway mark. This mid-term review (MTE) provides an opportunity for SC staff members in Malawi and Washington, DC and key in-country partners to take stock of progress to date and to better position the MNBHP to reflect on program priorities as they relate to the pathway for scale-up and to revisit critical interventions along this pathway. At the same time, the MTE allows time to ensure that MNBHP activities and stated goals and objectives are aligned with the MOH/RHU's expectations and needs for improved maternal and newborn health in the country.

Through the MNBHP, SC is contributing to supporting, improving, expanding and taking to scale a set of approaches and interventions and activities in the health sector as outlined in collaboration with the MOH/RHU and other stakeholders. Other key partners include UNICEF, USAID, UNFPA, WHO, and CHAM. Partners are combining expertise and material and technical resources towards *Road Map* implementation.

Key accomplishments to date include (but are not limited to): (1) design and use, with MOH and partners, of the *Integrated Maternal and Newborn Care (IMNC) Training Manual* to train health workers; (2) expansion of kangaroo mother care (KMC) in fourteen program-supported facilities; (3) development and use of the Health Surveillance Assistants (HSA) community-based maternal and newborn care (CBMNC) training package; (4) training of forty district-level trainers in CBMNC; (5) supervisor training in the three demonstration ("learning") districts; (6) training HSAs and health workers in the three demonstration districts in community- and facility-based maternal and newborn care, respectively; and, (7) deployment of HSAs to the field with extensive contacts at the household level in MNC resulting in reported increases in antenatal care (ANC) and facility-based deliveries in program sites.

The MNBHP is well designed and strategic in its approach. Noteworthy is the program's commitment to working within the MOH structure and avoiding the creation of parallel systems. Since inception, SC has continually adapted to the program environment and has seized opportunities to improve programming and address gaps as identified. The program team has worked hand-in-hand with the MOH/RHU, UNICEF and other partners throughout programming to maintain momentum and a commitment to excellence. As a result, SC's role in implementing the MNBHP has expanded beyond the original design. The team has risen to the challenges inherent in program expansion and has maintained complete dedication to the program's vision, goals and objectives.

At this point in programming, it is evident that SC is a well respected partner in Malawi's health sector arena via: a) global and local technical leadership in newborn health; b) long-term relationships with partners and stakeholders in Malawi; c) strategic technical input for policy and guidelines dialogue and development, training curricula design and development; and, d) technical and material input for building health provider capacity to provide quality essential newborn care (ENC).

The community-based MNC package and its facility component is a sound model for the delivery of these critical services in rural areas of Malawi. This effort is led by the MOH/RHU and is in direct alignment with the *Road Map* and the GOM's *ACSD Framework for IMCI* and supports and enhances the EHP. Demonstration of the package was designed as a partnership between and among the MOH/RHU, SC and UNICEF, with periodic participation from WHO and UNFPA. The program is designed as an implementation and learning activity to demonstrate the scalability of a model for delivering a package of facility and community-based maternal and newborn care services.

Although an Expanded Impact project operating at the national level, the MNBHP actively incorporates **community-based elements** with activities in select district settings. Program activities are designed to promote, implement, monitor, evaluate and inform scale up of evidence-based best practices for newborn care within the formal health system. Key community components include:

- The SNL/UNICEF-funded demonstration of the CBMNC package in Chitipa, Dowa, and Thyolo Districts, building health facility capacity to deliver quality MNC services and expanding access to quality community and home-based services via the HSAs;
- Sub-grant support to partner Ekwendeni Mission Hospital, a CHAM facility, to refine, document and package its *agogo* (or grandparent approach) for community mobilization and behavior change;
- Support at the national level to construct a foundation or platform to take evidence-based best practices to scale in all 28 districts of the country; and
- Disseminating best practices and lessons learned from the SNL-funded Mai Mwana project, a randomized controlled trial in Mchinji District, carried out by the Institute for Child Health in London.

The CBMNC package

As previously stated, the program to demonstrate the CBMNC package in the three learning districts is led by the MOH/RHU and was designed as a partnership between and among the MOH/RHU, SC and UNICEF. The effort is designed to demonstrate the effectiveness of an integrated facility and community-based model for scaling up newborn care in Malawi with the "overall goal of contributing to the country-wide effort of reducing child and maternal mortality in line with the Millennium Development Goals"[2].

The impetus for this program focus came from a UNICEF-sponsored visit to India in 2006 by key MOH officials who were interested in the SEARCH project in Gadchiroli, a community-based initiative delivering maternal and newborn health care services, led by Dr. Abhay Bang. The SEARCH project received research funds and support through SNL 1. What they saw and experienced in India inspired the team to introduce community-based maternal and newborn care in Malawi.

Shortly after, with engagement from SC, UNICEF, WHO, national health training institutions and others, the MOH/RHU held a national design workshop and established a National Task Force on Community-Based Newborn Care in Malawi. The Task Force benefited from high-level participation and commitment from various players in the MOH. The Task Force formulated the overall framework for the integrated package and laid out key elements of the implementation plan. Both the demonstration project's design workshop and the National Task Force were facilitated and supported by SC. UNICEF has also provided periodic financial support for the task force meetings.

The design workshop participants selected the three demonstration districts, Dowa, Thyolo and Chitipa; and agreed that this program would be devoted to implementing an integrated package of maternal and newborn care at the facility and household levels using HSAs as the link to the community level. Using a manual developed by UNICEF's East and Southern Africa Regional Office and later adapted by SEARCH in India, the Task Force, with broader participation from the MNH stakeholder community, developed an integrated training manual for the HSAs and a separate manual for trainers. All agreed that the processes and ultimately, results, of the demonstration project would establish an evidence-base for the delivery of integrated maternal and newborn care that would be used to inform other districts about this important work and its scale up throughout Malawi.

The Task Force only recently ended its bi-monthly meetings as the MOH/RHU asked that it integrate with the National Safe Motherhood Task Force. Stakeholders for program implementation, including District Health Officers, will continue to meet bi-annually (or more frequently if necessary) for working group meetings to review program implementation,

challenges and successes. In an interview during the MTE, Dr. Mathias Joshua, Chair of the National Task Force on Community Newborn Care recognized the financial support from SC for running the Task Force and supporting field visits, and emphasized the critical technical role that SC played in the design of the integrated package and the implementation approach.

At this point in program implementation, it is important to recognize that the MNBHP has co-evolved with the Government of Malawi's commitment to improving newborn health and with MOH policies, plans and priorities. The MNBHP includes health system strengthening interventions at the national level to lay a foundation for success in the three target districts. At the national level, the SC team has worked in close collaboration with the MOH/RHU, UNICEF, WHO, ACCESS - a USAID-supported global MNC program - and other partners to adapt and harmonize a range of training materials into the national *Integrated Maternal and Newborn Health (IMNC) Training Manual* for facility-based health workers. The integrated manual has been endorsed by MOH/RHU to be used for all essential MNH training including essential newborn care, basic emergency obstetric and newborn care, kangaroo mother care (KMC) and post-natal care conducted in Malawi.

Using this manual the program has developed fifteen master trainers and trained an additional 20 national trainers that can be used by the MOH/RHU or any other program to improve the knowledge and skills of facility-based MNH service providers including clinical officers, midwives and nurses. Six of the additional trainers were from the three program districts. ACCESS also recently trained an additional fifteen trainers.

Also in collaboration with the MOH/RHU and other partners, SC facilitated the adaptation and production of the CBMNC counseling cards for HSAs. Counseling cards were adapted from those used under the first five-year phase of SNL (with inputs from partners, including ACCESS, Ekwendeni and Mai Mwana) and 1,600 sets of cards were printed for distribution to all HSAs in the three program districts. These same materials are also being used by ACCESS in its CBMNC program districts of Rumphi, Nkhotakota and Machinga. Forty district level trainers have been trained in the CBMNC package. Eighteen of these trainers are operational in each of the MNBHP districts and the three ACCESS districts.

The MNBHP, together with ACCESS, took the lead in developing the community-mobilization training manual for HSAs. Although a manual on Community Initiatives had been developed by UNFPA, it was not operationalized with implementation tools. The community mobilization manual, based on the SC Community Action Cycle and developed with extensive consultation with national and district level MOH stakeholders and development partners, has been used to train a total of 53 community mobilization trainers, including nine from the three program districts.

The primary population for this program objective is pregnant women of reproductive age (15-49), postnatal mothers and neonates. The program also recognizes that other stakeholders at the household and community levels who are influential in care-seeking behaviors and practices around maternal and newborn care. These stakeholders are targeted primarily through HSA-led community mobilization activities.

Each of the three districts has chosen sites where program activities are directed (see Table 1). Selection criteria included health facilities with larger catchment areas and health centers with at least two health workers. The total population across the three districts is 1,323,205. The catchment population in the program area is approximately 630,000 representing 48 percent of the total district population.

Prior to the completion of the *IMNC Training Manual*, WHO used its Essential Newborn Care training manual to train a select number of service providers in the three program districts as part of a national technical update. The new facility-

based training targets service providers in both MOH and CHAM hospitals and health centers in the three districts and several other districts in the country, including the three ACCESS districts for community level programming. In addition to the training, UNICEF, through the MOH, provided MNH equipment and supplies to program hospitals and health centers in the three demonstration districts.

During field interviews, service providers and DHMTs reported increases in ANC attendance and facility-based deliveries. Interviews conducted during the MTE indicated that hospital and health center MNH service providers are using evidence-based practices for labor and delivery including active management of the third stage of labor, drying, warming the newborn, skin-to-skin contact at birth, immediate breastfeeding and delayed bathing.

Given the nature of the MTR, it is difficult to ascertain the consistency or quality of facility-based care. Much of this information will be gathered as part of the endline survey for the CBMNC package scheduled in 2010. A second, Health Facilities Assessment, if conducted would also provide very useful site-specific information about these key services. The program should assess developing a sub-sample for the HFA at endline to maximize cost-effectiveness. The HSAs and the linkages they provide for maternal and newborn care from the health facility to the community and household levels are the centerpiece of the three-district demonstration program.

As previously mentioned, SC facilitated the adaptation and production of the CBMNC training manual and counseling cards for HSAs. Using the adapted manual, a total of forty national CBMNC trainers have been trained. Each demonstration district has six trainers available. The training of trainers was supported by UNICEF, ACCESS and SC.

Training of HSAs on the CBMNC package was initiated in July 2008 with funding from UNICEF. Overall, 232 of the targeted 453 HSAs in the selected health facility catchment areas (7 in Thyolo and Dowa, and 6 in Chitipa) have been trained. Additionally, a total of 38 supervisors (Environmental Health Officers, Medical Assistants and Midwives) have been trained in the three program districts. Program partners recognize that HSA training needs to be completed within 2009. Some HSAs, however, cannot be trained in the CBMNC package until they have received their 10-week basic training.

Financial support for the remaining trainings must also be secured.[c] There are expectations that UNICEF will support the remaining HSA training with direct funding to the districts. In discussions with UNICEF, it was apparent that the districts are not funding the HSA training from their SWAp budgets (within their annual District Implementation Plans) but are instead relying on direct budget support from UNICEF. While the UNICEF team stated that they do not currently have "dedicated funding" for future training, funds could be made available. However, they expressed the need for a training plan that outlined exactly what the future training needs are for the program so that they can respond more strategically and ensure adequate financial support.

Both HSAs and the district trainers stated that the duration of the training was adequate but felt that additional time on skills practice and completion of home visit forms would have helped them avoid some of the problems they experienced when they first began their home visits. UNICEF provided the three program districts with the essential equipment such as thermometers and weighing scales for the HSAs to use in their assessment of newborns during the postnatal home visits. Most HSAs reported having the necessary equipment but some reported not having received bicycles as originally promised (by the DHOs) or weighing scales; and, requested bags to carry their equipment and forms. Others also talked

[c] To complete the initial HSA training targets in the three districts with both the CM and CBMNC packages would cost about $170,000 excluding operational costs for staff monitoring/oversight. This is about $770 per HSA or $850 with equipment (and HSA thermometers, scales, bags, and registers at $80 per HSA). To complete the training for the additional 789 untrained HSAs in the three districts would add an additional estimated $700,000, or about $765,000 with equipment. Overall, this would result in 1,242 trained HSAs in the three districts.

about the need for protective clothing, such as boots and raincoats, during the rainy season so they could continue with their home visits.

HSAs have a range of responsibilities not associated with the CBMNC package. Other non-CBMNC activities include community case management of diarrhea and pneumonia, family planning counseling and provision of condoms and pills, voluntary counseling and testing for HIV, as well as hygiene and sanitation activities. As part of their CBMNC responsibilities, HSAs are working closely with personnel at their assigned health centers. HSAs in Thyolo, for example, work at the health centers supporting under-five clinics, ANC, immunization and other maternal and child health programs including community outreach clinics. HSAs also refer and often accompany women and families to the health centers for care.

Although proud of their work, many HSAs reported feeling overwhelmed by the range of their responsibilities. Many HSAs also reported having catchment populations of more than 1,000 people - the recommended ratio is one HSA to 1,000 people. This further expands their responsibilities as well as their geographic scope. These multiple tasks and large target populations call for meticulous planning by the HSAs and strong oversight from supervisors.

HSAs, as health care personnel, are managed under the central MOH preventive health care unit and are officially supervised by Environmental Health Officers (EHO) from that unit. The EHOs have no clinical background or training on MNH issues. To provide them with the required knowledge and skills they were trained together with the HSAs and received additional training on the use of the CBMNC supervisory checklist. To complement the supervision by the EHOs, the program provided orientation (and full training in CBMNC in one district) for the Medical Assistants and Midwives at the health centers. Supervision of the HSAs is somewhat sporadic and few reported having field-based supervisory visits; although, all HSAs interviewed recognized the value of on-site supervision. Dowa reported a high level of supervisory visits, both formal and informal. Technical supervisors from the DHMT conduct joint supervisory visits with the EHOs and field questions from the HSAs and community members. Supervisors use motorcycles from other programs to conduct field visits.

Interviews with DHMT staff, EHOs, HSAs, health center staff, community leaders, pregnant and recently delivered women, and review of the HSA monitoring forms, confirmed that trained HSAs have initiated household counseling in their respective villages. Both antenatal and postnatal visits are being conducted. The HSAs work closely with community leaders, traditional birth attendants and community groups to identify pregnant women and be informed of deliveries in their assigned villages.

Women who have normal/uncomplicated deliveries at health facilities are discharged to return home within 24 to 48 hours. From interviews, it is apparent that women and their newborns are receiving home visits by the HSAs within three days post-delivery. A review of the monitoring form of a HSA in Chitipa showed that he was able to reach four out of the five deliveries reported to him within 48 hours of hospital discharge.

Unfortunately, lack of readily available data at the district or national levels made it difficult to adequately assess whether HSAs are reaching the homes within the critical period of 48 hours post-childbirth, especially for women who deliver at home. There was some reported confusion about how to count the first day post partum visit for facility-based deliveries. Some HSAs were recording their home visits to mothers and newborns after facility discharge as a "home based visit within 24-48 hours." This will need immediate attention so as to avoid inaccurate data and skewed program information. A few HSAs reported identifying and referring sick newborns to health facilities.

Using the limited training received on KMC during the initial CBMNC training, HSAs are also counseling women on KMC and referring those with LBW babies to the health centers. During home visits, some HSAs also reported following-up on KMC clients who have been discharged. Although, health care personnel in the district hospital KMC units would like stronger linkages with the HSAs to ensure consistent home-based care once women and their newborns have been sent home. With recent consensus building to incorporate ambulatory and community KMC into national guidelines, an elaborated KMC module is now being developed for community KMC that will be incorporated into the training package.

All DHMTs expressed their commitment to CBMNC and were enthusiastic about the program. They attributed the observed increase in MNH facility-based services utilization to the effectiveness of the household counseling by HSAs. One district, Chitipa, reported that 67% of catchment population deliveries took place in facilities in February 2009 compared to 57% in the same month in 2008. Additionally, in February 2009, 123 women attended ANC in their first trimester as compared to only 13 in February 2008.

Challenges

- Supervision of the HSAs by the EHOs and health center staff has been limited. Most supervisors have never been to the community to supervise the HSAs. The reason cited for the limited supervision is the lack of transport and time, particularly among the clinical personnel. Supervision by the district CBMNC team has also been sporadic. In one district the team has been able to supervise trained HSAs only once in the last six months.
- Many HSAs referred to the lack of transport as a key barrier to their work. HSAs require bicycles to travel around their assigned villages and conduct their assigned duties. Some HSAs do not have bicycles or lack the spare parts to repair those that have broken down. It is the districts' responsibility to provide both bicycles and associated spare parts to the HSAs. However, due to budget limitations, the DHMTs have not been able to completely fulfill this responsibility.
- HSA training for the demonstration program has not been completed. Initially, SC supported a limited number of trainings in each of the three districts. UNICEF committed to fund the training of the remaining HSAs but to date has not transferred the required funding to the demonstration districts.
- CBMNC data collected by the HSAs is not being used for program monitoring or decision making at the village, catchment area, district or zonal levels. HSAs are keeping records of their visits using the program monitoring forms and submitting them to the district HMIS Officer through their supervisors. However, when interviewed, most HSAs reported not summarizing their data or using the information to track their work. They are also not sharing the information with the village health committees or community core groups. Currently, the primary purpose of the data collection is to complete the forms and pass them to the next level.
- Less than expected number of pregnancies. A comparison of the total number of pregnant women identified by some HSAs against the expected number of pregnant women, based on a crude birth rate of 50 births per 1,000 population, showed that the HSAs are reaching less than half of the expected number of pregnant women. It may be that the value of crude birth rate currently used by the MOH is too high. But even if a lower figure of 40 births per 1,000 population is used, the number of pregnant women identified by the HSAs is still very low.

Kangaroo Mother Care

A key programmatic component of the MNBHP is the introduction and expansion of KMC services in Malawi including in the three program districts. A retrospective assessment of KMC services established under SNL 1 was conducted in late 2007 to elicit lessons learned and to make any necessary adjustments to the current program. Recommendations from the assessment included the integration of KMC in-service training into the harmonized integrated MNH manual, initiation of KMC services without waiting for the identification and renovation of a separate

KMC ward, and the promotion of both intermittent and continuous skin-to-skin contact for pre-term and low birth weight babies. These recommendations have been incorporated into the current MNBHP.

To ensure that use of KMC is consistent along the household-to-hospital continuum of care, in collaboration with the MOH/RHU and the USAID-funded ACCESS program, the MNBHP revised the draft national KMC service guidelines to incorporate guidance for providing KMC services at the health center and community levels. Each of the three district hospitals in Thyolo, Dowa and Chitipa provide KMC services. In addition, eight service providers from eight health centers in Chitipa have been trained on KMC. Mzimba District established its own KMC unit at the district hospital in 2008 after receiving technical assistance from both SC and Ekwendeni Hospital.

It is important to note that the KMC units in each of the three learning district hospitals are fairly new and in need of equipment such as heaters and calibrated cups and continued training for service providers. MTR team members were able to observe KMC units at the three district hospitals in Dowa, Thyolo and Chitipa as well as in Mzimba. Care issues were observed, such as newborns being placed on beds in the ward and not in skin-to-skin contact with a mother or helper.

Interviews with health facility staff and observation of selected KMC facilities showed that service providers, mothers and their families have accepted this method of care for low birthweight (LBW) babies. Most health centers with trained staff on KMC practice "ambulatory KMC", that is mothers of LBW babies weighing 1800 gm and above, and feeding well are counseled, sent home and come for follow-up on an out-patient basis. Health facilities without trained staff in KMC counsel and refer LBW babies to facilities offering these services in their respective districts.

Challenges

- Supervision is central to ensuring trained service providers use and maintain their updated knowledge and skills. DHMTs are to integrate supervision for program activities into their existing supervisory systems. Trained health facility staff should be supervised monthly by district health coordinators. The three districts should also receive supervisory visits from the national level by a joint team consisting of MOH/RHU, UNICEF and SC staff. This supervision is scheduled to occur on a quarterly basis with the first joint visit scheduled during May and June 2009. Unfortunately, district level supervision has been very sporadic with trained staff reporting having been visited only once post training. The key barrier reported by the DHMT for the limited supervision is transport - both vehicles and motorcycles - and fuel.
- Program health centers highlighted an inadequate number of midwives as a challenge particularly in the face of increases in labor and delivery services. Most health centers have only one midwife who runs a 24 hour labor and delivery service seven days per week. Some do have two midwives who trade weeks, each providing 24 hour care seven days a week while the other is on leave. Given this limited staffing, challenges remain around the absorptive capacity of the health centers to take on increased labor and delivery services and maintain the quality of their services.
- Inadequate number of ambulances, both vehicle and motorcycle ambulances, means delays in transporting pregnant women and/or newborns with complications to the next level of care. At the same time, newborn emergencies are not seen as a priority for emergency transport leaving mothers and/or family members to find their own transport to appropriate care. This is possibly an unintended outcome of Malawi's prioritization of emergency transport for obstetric complications in response to the high maternal mortality ratio.
- Lack of basic equipment at some health facilities. One health center reported lacking basic delivery kits and an autoclave. Others reported not having resuscitation equipment and neonatal suction machines. Some facilities, including two district hospitals (Thyolo and Chitipa), with established KMC services reported not having essential equipment such as weighing scales, calibrated cups and radiant heaters. Facilities are unable to provide

a full range of quality MNC if they do not have the appropriate equipment and supplies. After conducting a brief needs assessment of the KMC facilities in the three learning districts, SC ordered most of the missing items.

- Lack of MNH services in hard to reach areas. Selected communities in the program districts, particularly in Chitipa, do not have access to health facilities during the rainy season when the roads become impassable.
- Tracking of KMC service statistics under the integrated MNC training. Under SNL1, KMC training was conducted as a five-day vertical in-service activity with significant time spent on monitoring and evaluation of the services. A specific register was also developed to collect KMC data. Under the integrated MNC training, KMC was reduced to two days without providing information on M&E. A visit to one of the centers established by staff trained under the integrated training package showed that KMC clients are not being tracked. Apart from a tick in the delivery register and the patient notes, it was difficult to ascertain how many LBW babies have been cared for through KMC and their status at time of discharge.

The DHMTs and facility-based personnel were well versed in the above listed challenges. In conversations, however, the DHMTs highlighted inadequate funding as a critical barrier to closing identified gaps. All three districts reported significant cuts in their annual SWAp budgets forcing them to use most of their available funds for recurrent or operational expenses.

F. Discussion of Potential for Sustained Outcomes, Contribution to Scale, Equity, Community Health Worker Models, and Global Learning

1. Progress toward Sustained Outcomes

The MNBHP was designed to increase use of key newborn health services and practices through improving the enabling environment (policy and community support) and demonstrating a model to increase demand and availability/access to quality care via a community-based model for the delivery of evidence-based newborn health interventions. While the *Road Map* and the ACSD/IMCI strategy provide the vision and framework for improved maternal and newborn health in Malawi; SC, in partnership with other stakeholders, provides technical and programmatic inputs necessary for their implementation. As a key partner in the reduction of Malawi's neonatal mortality, SC is a technical resource and catalyst for dramatic change in the delivery of newborn healthcare services in Malawi.

Funding from both USAID/Washington and SNL (Bill & Melinda Gates Foundation) - as well as complementary funding from USAID/Malawi to ACCESS - places SC at the center of policy dialogue and development, advocacy and communication and the design and management of innovative service delivery models; and, ultimately, taking to scale a comprehensive community-based newborn care package. Program interventions are underway and key accomplishments are evident. The program is a vocal advocate for improved access to maternal and newborn health in Malawi and has influenced and facilitated the development of important foundational documents and guidelines. Through continued dialogue and networking, the program inspires government engagement in the newborn health agenda.

The MNBHP is on target for its national level and Mzimba District activities, including the sub-grant with Ekwendeni for the *agogo* approach. During the MTE, a key point of discussion with the MNBHP team was the recognized delay in implementation of the (SNL-funded) three district demonstration of the CBMNC package. Using the original timeline for the demonstration, it is estimated that the program is about one year behind schedule. The proposal targeted end of September 2008 as the date for completion of "rollout of interventions" but at the time of the MTE, April 2009, rollout of interventions was still underway. The two major reasons for this are:

- MOH/RHU delays in completing the training manuals, all three manuals – *Integrated Maternal and Newborn Care*, *CBMNC* and *Community Mobilization* – due to the many revisions that had to be made during the harmonization/adaptation process and the number of partners involved; and

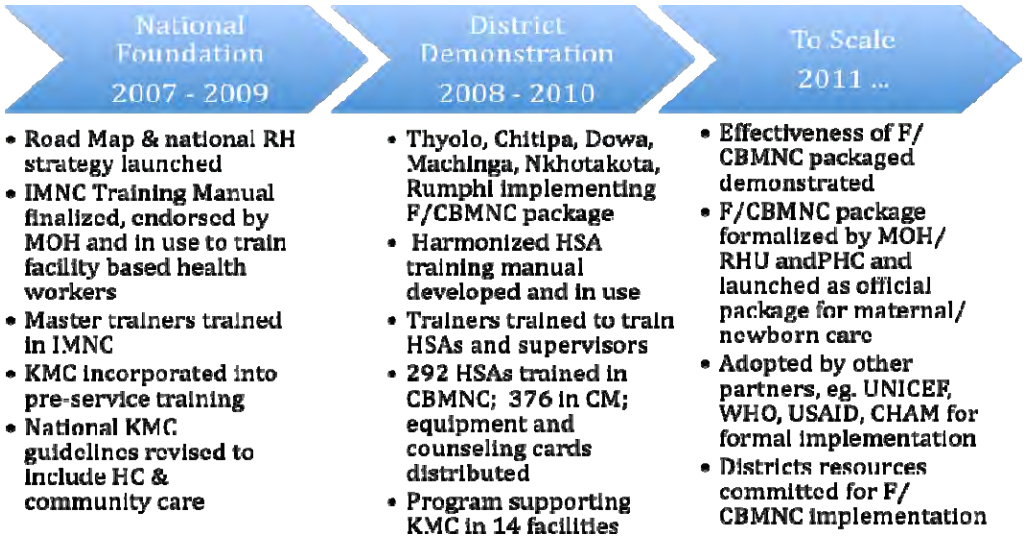
- Delays in meeting funding commitments and/or funding limitations among partners to support the targeted number of trainings needed to complete the rollout of the interventions, both facility and community-based. UNICEF, in particular, has delayed provision of the full complement of its commitment to fund HSA training.

Assuming the necessary funding for programming is available by June 2009[d], the program districts should be able to complete district-wide roll out of the interventions by the end of December 2009. According to the original demonstration project proposal, the endline survey and final evaluation are scheduled to take place during the April-May 2010 period. Assuming the program is able to complete its rollout of the interventions by December 2009, this only allows about 4-6 months for implementation. This will not allow adequate time for significant district-wide change in MNH practices and service utilization and will limit the program's ability to establish an evidence-base for this service delivery model. This evidence-base is a central element to effective advocacy for scale up. This is a critical point. As a catalyst for community-based newborn care, SC must allow sufficient time for implementation so that the information used to inform scale up is valid and robust. The program endline survey and final evaluation may have to be shifted to December 2010 to allow at least 12 months of full implementation thus making it possible for the program to achieve its set objectives and more adequately document the implementation process and measure the impact of the demonstration project.

2. Contribution to replication or scale up

Working at the national level in this Expanded Impact project, SC has developed a strategy to achieve "leveraged impact at scale" aimed at demonstrating, expanding and scaling up quality neonatal care at all levels of service delivery, with a particular focus on rural communities. Documenting the process of implementation in the three-district pilot and capturing other processes at the national level are important to informing scale up across Malawi. Program documentation is detailed in Section C. Data Quality above.

Key accomplishments along the pathway to scale up for the match-funded three district demonstration of the CBMNC package are outlined below. These are not exhaustive but offer insight into SC contributions in setting the stage for moving evidence-based maternal and newborn care interventions to scale. The final arrow below entitled "To Scale 2011…" is also not exhaustive but reflects dialogue with the MNBHP team and offers direction for the program as it supports package scale up.



[d] Update: No additional funds for district scale up have been made available by UNICEF but may be in the coming year. In the meantime, SC has re-programmed some funds to augment training and is developing additional training resources (e.g., Save the Children Italy).

In April 2008, the MNHBP team reviewed accomplishments to date and identified five key areas for scaling up newborn health nationally. Within those priority areas, the program identified specific steps required for scale up and strategic roles and investments for SC Malawi. The five priority areas identified and specific actions for scale up are:

- **Quality Essential Obstetric and Newborn Care Services Delivered at all Health Facilities and Outreach**
  - Advocate for incorporating KMC into pre-service training for the last remaining cadre of workers - medical assistants - and for adequate allocation of districts budgets for ENC/KMC trainings;
  - Initiate discussions to identify issues pertaining to newborn emergency transport and if necessary orient transport staff on prioritizing newborn emergencies; and
  - Initiate discussions with MOH-RHU to encourage integration of PNC into mobile clinics to increase access to critical maternal and newborn care services after delivery.
- **Appropriate Household Practices for NBC**
  - Initiate and facilitate discussions with MOH-RHU to encourage the development of an integrated behavior change strategy that includes maternal, newborn, and child health to improve household newborn care practices; and
  - Improve availability of IEC materials at community and facility levels, SC will take a lead in supporting the development and review, field testing, monitoring, and provide funding for printing and dissemination.
- **Quality ENC Services Available at the Community Level by Health Surveillance Assistants (HSAs)**
  - SC and partners (MOH-RHU, UNICEF, DHMTs) to support activities to finalize and implement the HSA training manual and ensure an effective supervisory system including appropriate transport, checklists, and orientation;
  - Facilitate discussions with DHMTs and advocate for posting new and existing CNMs in the community;
  - Provide assistance for developing sepsis management protocols for HSAs, for drafting an implementation plan including developing/adapting a supplementary manual, developing logistical (drugs, supplies) support systems, supervisory systems, TOTs, and trainings for HSAs; and
  - SC and partners (RHU, UNFPA, and UNICEF) to follow through with the next steps for implementing the harmonized community mobilization manual including supporting the finalization of the manual, revising job aids, supporting printing costs, conducting TOT, and supporting HSA training.
- **Improved Newborn Policies and Coordination at National Level**
  - Hold discussions with RHU and facilitate meetings with partners to develop a comprehensive and consistent list of indicators and targets for newborn health; and
  - Work with MOH-RHU to co-facilitate meetings with key partners to develop plans for ensuing effective implementation of harmonized MNH activities, support a consultant to conduct an inventory of MNH programs in Malawi, and facilitate semi-annual meetings to help improve national and district coordination.
- **Documentation of Implementation and Scale up Activities for MNH**
  - Finalize and implement the process documentation system; and
  - With an effective process documentation system in place, SC will take lead in developing a final report, peer-reviewed articles, and support dissemination of findings at national and district levels in Malawi to inform scale up and contribute to the global evidence base.

The program team recognized the importance of partnerships to ensure the successful scale up of newborn health interventions in the country and dedicated themselves to continue to foster and maintain strong collaboration with key partners. The team also highlighted the need for a comprehensive communications/advocacy strategy to guide activities in this area including messaging around newborn care practices, funding for KMC and PNC, and target audiences such as families, TBAs and community elders and parliamentarians.

An "Action Plan for Scale-up Matrix" was developed and reflects desired outcomes, action steps, SC's role and investments, estimated costs, partner roles, milestones and timeframe for the desired outputs through 2011.The Action Plan was integrated into the joint work plan and presented in the Year II Annual Report. As a result, the MNBHP implementation plan is framed within the overall mandate to inform and actually take maternal and newborn care interventions to scale in Malawi.

In a discussion with the MNBHP team during the MTE, the team reiterated six key end-of-project milestones for scale up:

I) Government resources for newborn care committed
II) Improvement in values across baseline indicators
III) Fully functional facility and community-based MNC package in the demonstration districts and incorporated into the district implementation plans
IV) MOH/RHU and MOH preventive health care units promoting and monitoring utilization of facility and community-based MNC package in additional districts (using partner platforms)
V) Documents and shared learning being used by MOH to establish and disseminate the evidence-base for the delivery/implementation of proven newborn interventions.
VI) Enabling environment has been catalyzed through standardized training (in service and HSA basic training) and the development and formalization of policy and guidelines

Role of Key Partners The greatest threat to the success of the MNBHP is resource availability - human and financial. In spite of a likely MOH endorsement of the CBMNC package, it is unclear how a large-scale implementation of the package in all 28 districts will be funded. In general, challenges to scaling up newborn care are serious: resource limitations, structural impediments and competing political priorities across the MOH. Funding constraints are common across the health sector, and without political priority for newborn health, it is uncertain whether newborn health programs like the CBMNC package can be fully implemented or sustained. In a study funded by SNL, Shiffman and Kazembe reported that few politicians in Malawi named newborn health a health sector priority compared to issues like HIV/AIDS and maternal mortality[3]. (See Annex 15 for a copy of the study report.) Malawi's decentralized government health system complicates the funding and coordination of newborn care across the country. District health budgets, created by DHMTs, reflect priorities of the district and non-governmental donors, not necessarily directives from the national MOH.

In meetings with representatives of the central MOH and the DHMTs during the MTE, the decline in budgets was highlighted as a significant problem. Both the central MOH and the DHMTs rely on the SWAp as the source of funds for their health sector investments. Over the past two years, SWAp funds have declined considerably (though no one was able to give a precise figure), pushing central MOH and district DHMTs to cut their budgets. In this scenario, managers cover their operating costs first and ensure that funds to run existing health services are in place. Unfortunately, new initiatives such as the CBMNC package are not prioritized for funding. Many of the recognized gaps in programming at the district level (e.g. training, supplies for the HSAs and equipment at health facilities) are a result of funding shortfalls.

The critical gap in health care professionals in Malawi is no secret. There is a reported 60% gap in doctors and nurses in health facilities. The *Road Map* lists "shortage of staff and weak human resource management" as contributing to the high maternal mortality ratio in the country. During site visits, the need for more service providers, especially midwives to manage increasing demand for labor and delivery care, was emphasized across the board. Gaps in supervision - both clinical and field-based - were also highlighted. Staff shortages and weak supervision can limit or even undermine program success.

In addition, program partners have delayed their funding commitments for implementation. UNICEF originally committed to support the training of HSAs in the CBMNC package in the demonstration districts and to provide supplies

and equipment to HSAs and participating health facilities. While it has supported some of this work, in a meeting with the UNICEF health team, representatives reported not having "dedicated money for training" and further stated that the districts did not add funding to their district implementation plans for the training. UNICEF also stated, however, that it is actively engaged in the district planning process and will allocate funds after DIPs are finalized and resources from the SWAp are allocated. While this input is greatly appreciated, the process has nonetheless delayed training and equipping program HSAs.

3. Attention to Equity

While more than half (57%) of Malawian mothers deliver in health facilities; still, some three-quarters of rural women in Malawi deliver their babies at home or in the community[4]. Now that national policy prohibits traditional birth attendants (TBAs) from delivering mothers in the community, it is more urgent than ever to address the gaps in key maternal and newborn services, and to move these critical services closer to the community. While national in scope, the MNBHP focuses on rural areas, where access and availability of formal health services is most limited. The CBMNC package is designed to provide critical community-based post-natal care to women who deliver outside of health facilities, as well as to provide important follow up to women after they return home with their newborns. Expanding KMC to district hospitals - and promoting ambulatory and community KMC - also address equity issues for rural women with limited access to higher level facilities. Improving the knowledge and performance of facility-based health workers similarly contributes to equitable distribution of quality care at lower levels of the health system, reaching more residents closer to the household. Finally, HSAs and *agogos* - trained in community mobilization, linked with health facilities, and active in village health structures - provide greater opportunities for isolated community members to participate in activities designed to build knowledge and demand.

4. Role of Community Health Workers

The CBMNC package is delivered by HSAs, a paid cadre of government worker supervised by the DHO and linked to health facilities and community structures. At this point in time, the set of CBMNC interventions is additive to the EHP delivered routinely by HSAs at the community level. The MOH "owns" the CBMNC package and will likely certify it. The demonstration in the three learning districts (plus the three ACCESS districts) is intended to provide and document an experience in integrating this package with the EHP. At present, supervision of the HSAs is conducted jointly by DHO and partners (SC and UNICEF), sometimes with MOH/RHU participation.

In Mzimba District, our Ekwendeni sub-grant partner trained 4,000 *agogo*, or grandparents to serve voluntarily as mobilizers for positive change in their communities - to promote demand and support use of key services and practices. These *agogo* are a naturally occurring cadre of community actor. As elders, they are trusted and listened to in their communities. Grandmothers are close advisors to their daughters and daughters-in-law; and grandfathers carry a great deal of influence in the household and in the larger community, especially in allocating resources and decision making. *Agogo* are gatekeepers and custodians of traditional practices, some of which are harmful to newborns; and, for that reason, should be engaged as change agents and not overlooked. (See Annex 7 for a review of the Elwendeni *agogo* approach experience.)

5. Contribution to Global Learning

Because the MNBHP is linked to SC's SNL initiative, its learning and results contribute to global reach for best practices and delivery research. Moreover, SC is one of three core members of USAID MCHIP, as well as a partner in a number of other global and bi-lateral efforts positioned to transfer learning and results. One significant vehicle for dissemination and advocacy in 2007 was the publication *Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa*[5]. With a global team that included the USAID ACCESS and ACQUIRE projects, the International Paediatric Association, the International Federation of Gynecology and Obstetrics, the Population

Council, UNICEF, WHO, the World Bank, and many other contributing partners; SC played the role of manager and technical editor for the publication, which has become a key reference for newborn health on the continent. French and Portuguese editions are now available.

In July 2009, the WHO/UNICEF (with USAID and SC) will launch the *Joint Statement: Home visits for the newborn – a strategy to improve survival* at the United Nations Economic and Social Council (UN-ECOSOC) in Geneva. The evidence-based Joint Statement - available in English, French, and Spanish - stresses that home visits for newborn care by a trained health worker can save lives.

6. Cost Effectiveness

Cost effectiveness, and determining the incremental cost of adding the CBMNC package to the standard EHP package delivered by HSAs is an important consideration for the MOH in taking the package to scale. Match funds were made available through SNL to conduct a costing study to calculate incremental cost-effectiveness ratios and to assess the costs of scaling up the intervention. Start up cost and recurrent costs are tracked in this study. Data is captured monthly. All the partners in the CBMNC package are supposed to document any costs for the package and submit the information to SC. As of February 2009, all the start up costs for activities (taskforce meetings, adaptation of manuals, trainings etc) undertaken/implemented by SC had been captured and entered into the costing database.
Costs for activities funded by UNICEF and the districts are still being followed up with their respective administration departments. With respect to recurrent costs, forms for time spent by HSAs during home visits, community mobilization activities and meetings are coming from the districts for data entry, though there have been many delays in the process. Costs for general operations such as transport costs and electricity still need to be collected from the districts. The districts need an additional orientation on what they need to submit. Additional match funds have been made available to compensate a consultant, based in Malawi, who will assist the NBHP team with refining and finalizing the costing study in the coming project year, and a scope of work is being prepared.

G. Conclusions and Recommendations

The design and intent of the MNBHP are exactly right. The program is led by the Ministry of Health and framed within both the *Road Map* and the *ACSD/IMCI Framework*. Programming responds to the absolute need for community-based access to improved services for mothers and newborns. Through their catalytic role, SC is facilitating Malawi's first real opportunity to address this dramatic gap in services at the community and household levels. At the same time, the program recognizes the need to strengthen facility capacity for MNC. At this point, the package is added to existing services as opposed to fully integrated – this is fine now but will need to mature over time to move beyond the pilot stage where all elements of the package are truly institutionalized into the health service delivery system.

Successes from SNL 1 have carried over to this program period assuring SC a continued seat at the table and influencing the direction of the MNBHP. Government commitment continues as is evidenced by the engagement of DHMTs in the MNBHP districts and the ACCESS program districts. Securing this commitment and engagement through continued program presence at the district level is essential. Bringing the district teams together to share their experiences and innovative solutions to the challenges at hand can also help to further solidify their interest and commitment to program interventions.

A number of health sector partners in Malawi are engaged with the program and optimistic about projected outcomes. UNICEF and WHO plan to incorporate the CBMNC package into their Catalytic Initiative in ten districts[e] and are urging

e The Catalytic Initiative is a program implemented via the Partnership for Maternal, Newborn and Child Health In Malawi. The partnership includes the MOH, UNICEF, WHO and UNFPA. Program activities are funded via a grant from the Bill & Melinda Gates Foundation to WHO and a grant from

the program team to communicate successes regularly. The MOH/RHU is enthusiastic about the program and ready to endorse it for national scale up once results are presented.

USAID/Malawi is supporting the expansion of the CBMNC package in three additional districts—Machinga, Nkhotakota and Rumphi—via the ACCESS program (in which SC is a global partner). To date, 120 HSAs (40 in each district) have been trained in the CBMNC and community mobilization packages. Ten Master Trainers and 30 district level trainers have been trained in community mobilization and thirty district level trainers have been trained in the CBMNC package.

Newborn interventions such as KMC are in demand beyond the three MNCP districts. Already, six facilities including hospitals and health centers in non-program districts have established KMC units. The ACCESS program is also supporting the scale up of KMC in their program districts and is using materials developed with the MNBHP. Tutors of nursing institutions have been trained on KMC. The Malawi College of Health Sciences - a training institution for medical assistants - has incorporated KMC into their curriculum. Continued engagement with the KMC stakeholders can further solidify the expansion of KMC in Malawi.

In short, the enabling environment for successful programming is in place. The CBMNC package is well regarded and the GOM recognizes the centrality of improved maternal and newborn health to their broader development objectives. Though fragile, the structure for the delivery of primary health care in Malawi is in place. Whether the program can overcome considerable challenges on the pathway to scale is a different discussion.

In closing, the development environment in Malawi is extraordinarily challenging. Current values for key health status indicators are indicative of a fragile system and of a population with limited access to quality care - if even available. SC is responding to this environment and has worked with partners to design and initiate a program that is completely relevant to the health sector development context in Malawi. Program gains will be hard won and will inform a community of partners about what is required to improve the delivery of critical facility and community-based care for mothers and newborns and ultimately, to save the lives of newborns in Malawi.

The facility- and community-based MNC package is a sound model for the delivery of these critical services in rural areas of Malawi. Again, limitations are the product of the environment as opposed to flaws within the program design or program team. It is critical, however, that the MNBHP team remains strategic in its engagement with the MOH/RHU and partners. At every turn, the team needs to remind partners that SC's role is one of catalyst, technical advisor and advocate for improved newborn health in Malawi. The team needs to constantly look at its engagement from this vantage point and consistently refer back to the end point for the program and articulate the key investments along the pathway to scale up of the program interventions.

In the coming year it is imperative that the program holds partners to their commitments for program support. This may require engagement from the SC Country Director and headquarters staff. However, it is critical that the remaining HSAs, supervisors and any facility-based providers are trained in the facility and community-based MNC package and community mobilization (where relevant) by the end of 2009; and that supervision is consistent and effective. This will ensure that full implementation of the program is underway.

The importance of this in terms of establishing the evidence base for this service delivery model cannot be overstated. Minimally, the program needs one year of full implementation before an endline survey is conducted - this is essential to a

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CIDA to UNICEF. The program is committed to the accelerated implementation of MNCH activities in ten districts: Balaka, Chiradzulu, Dedza, Karonga, Kasungu, Lilongwe, Mzimba, Nsanje, Ntcheu and Phalombe.

credible statement about moving the model to scale. In the absence of a credible statement, advocacy efforts will be completely undermined. At the core of any statement of success (or failure or both) is the whole documentation process. This aspect of the program needs serious attention. To date, the team has done an excellent job of amassing a range of program documents. However, now is the time to apply real strategic thinking to this process. It would be well worth the team's effort to develop the long-awaited advocacy strategy or plan and then review and revise the process documentation plan, ensuring that the documents essential to effective advocacy are envisioned and developed when appropriate.

As for the program's advocacy and communications work, it is apparent that the program is not in a position to invest further in BCC for field-based implementation. This is reasonable; however, the team needs to stay engaged with partners working on BCC to ensure that messaging is consistent and that appropriate and available materials are used. The real investment at this time, as stated above, is advocacy to shift some of the major program threats and challenges and to continue to build the platform for newborn health in Malawi. At the same time, via the linkages with documentation, valid data and credible anecdotes need to be used to tell the program story.

In the words of Dr. Mathias Joshua, former Chair of the National Task Force on Community Newborn Care, SC's MNBHP is "beautiful." It is well designed and strategic in its approach. A particular highlight is that the program works within the Ministry of Health structure and has not created parallel systems. There is real dedication to this among team members. Given the capacity limitations of the MOH, centrally and at the district level, this can create real delays and a certain sense of frustration that the program is not moving as quickly as it could. Yet, at the same time, this allows a real point of learning and will allow the program team to critically reflect on program successes, failures and limitations as well as to create innovative system-based solutions. An honest statement about scale up of this dynamic program will recognize the implementation environment and present realistic findings.

Recommendations

Access, Availability, Quality

- Meet with the DHMTs and UNICEF to develop a training plan for remaining HSAs and supervisors.Outline funding requirements and partner funding commitments as well as partner roles and responsibilities and complete remaining training by the end of 2009.
- Explore the feasibility of structured group supervision to complement and strengthen the current individualized supervision. Group supervision could include monthly meetings of HSAs with supervisors at assigned health centers.
- Based on reported successes in supervision in Dowa, further explore the supervisory structure in Dowa to see if there are successful approaches that can be shared in Chitipa and Thyolo.
- Meet with zonal and district health teams to discuss the supervisory structure of the HSAs and identify action steps to ensure consistent and quality supervision at the field level.
- To ensure an adequate implementation period prior to the final evaluation of the program, the remaining HSAs must be trained as soon as possible.
- Advocate with the DHMTs and partners to ensure immediate training of HSAs in the basic HSA package, so that they can be trained in CBMNC as soon as possible. If there will be delays in basic training, work with districts to explore the feasibility of training the HSAs in the community-mobilization package and/or CBMNC package first.
- Identify resources at the district level to ensure all HSAs have their required equipment, including bicycles. Cost the procurement of rain gear and bags for HSAs and identify resources for these supplies.
- Work with the DHMTs and district hospital KMC units to outline a referral chain for HSA follow up of discharged KMC clients.

- Assuming the success of the CBMNC package as delivered by HSAs, advocate at the central MOH to update/revise the HSA basic training package to incorporate the CBMNC package as well as other components of their work, e.g. FP, VCT, malaria, etc.
- Review training plans for facility-based personnel with the DHMTs and UNICEF to ensure that all program health centers and hospitals are on track to receive program training.
- To improve facility capacity to manage increases in labor and delivery services in program facilities, efforts via the CBMNC Task Force have been made to encourage the MOH to place additional midwives in these health centers. While the MOH does not typically earmark districts for additional support, it may be worthwhile to further advocate with the MOH on this point.
- Work with each DHMT and UNICEF to review and delineate exactly what equipment and supplies have been delivered and to which health facilities. Identify gaps in equipment delivery and work with partners to ensure that commitments are met.
- Meet with partners supporting facility-based training in the program districts and ensure that trainings incorporate the development of action plans for trainees including an outline of equipment and supplies required to deliver updated services.
- Establish performance criteria to objectively measure the quality of KMC services being provided. Criteria to measure provider performance for KMC would be developed from standards of care for KMC such as consistent warming, use of calibrated cups to measure breast milk intake, proper weighing of newborns. Criteria could also be pulled from admittance, discharge and follow up records.
- Work with the MOH/RHU to review and update the integrated RH supervisory checklist to incorporate KMC and other evidence-based knowledge and skills to align supervision with the Integrated Maternal and Newborn Care training package.
- Via ACCESS and other safe motherhood programs, review and identify performance and quality improvement tools available to measure the quality of facility-based MNH services. Tools can be introduced to DHMTs to reinforce clinical supervision.
- Work with each DHMT and other program partners to review supervision schedules and identify where there will be delays and to outline a plan of action to reduce these delays.
- Move forward with the development of messages and dissemination plans with districts to educate district transport officers to include sick newborns as a priority for emergency transport.

Demand

- Advocate with the DHMTs to consider training HSAs who are waiting for their 10*-week basic training in the community mobilization package first.
- Work with the DHMTs and partners to identify funding sources to support the remainder of HSAs to receive their community mobilization training.
- Ensure that funds are available to procure the supplies needed for effective community mobilization and work with the district to ensure that the supplies are procured and distributed.
- Ensure the MNBHP has the capacity to fully inform and track this program component or identify this capacity in another partner that is working in community mobilization for improved maternal and newborn care. The MNBHP is in a unique position to share learning from community mobilization for CBMNC in Malawi and beyond.

Enabling Environment

Develop a scale up advocacy plan that includes:

- Engage at the national level to maintain and generate new political will for newborn health and the facility and community-based MNC package;

- Facilitate the MOH to take the lead to identify funding to support scale up of facility and community-based MNC package;
- Introduce the package and materials to the five Zonal Health Offices and identifying opportunities to reach new districts via the zonal platform;
- Work closely with MNBHP and ACCESS districts during the DIP process to keep facility and community-based MNC in place;
- Stay closely engaged with UNICEF and WHO by communicating program results, challenges and ensuring their continued financial and technical engagement in newborn health in Malawi;
- Work with program partners to respond to identified challenges to realize program potential in select districts and to more fully inform package scale up;
- Set milestones/benchmarks on the implementation of the CBMNC package to ensure that the program is ready for the addition of new activities such as community case management or sepsis management (once these have been piloted and are ready for broader programming);
- Outline key action steps that will ensure the institutionalization of the facility and community-based MNC package into the health services delivery system and identify where and how the program can become engaged to ensure this process is underway;
- Identify other program platforms, e.g. CHAM, Catalytic Initiative in 10 districts, new USAID program and most importantly, new districts via government investment;
- Partner with other groups working in the health sector such as family planning and adolescent health to continue to raise awareness about MNC and newborn health issues and to raise the program's visibility;
- Develop a scale up plan or framework for taking facility and community based MNC package to other districts including the design of a Technical Resource package for facility and community-based MNC service delivery; and
- Hold regular implementation review meetings with key stakeholders from the MOH, UNICEF, WHO, USAID, the MNBHP and ACCESS districts, zonal health offices, a select number of DHOs from the Catalytic Initiative districts, CHAM and, if feasible, a small number of HSAs from program districts.

H. Action Plan for Responding to Evaluator Recommendations

Malawi Midterm Evaluation Recommendations Tracker (30 September 2009)

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
Mai Mwana Project (match funded)					
2.0.1	Once the RCT trial ends, MOH/RHU and partners (with SC as a catalyst) should encourage/invite Mai Mwana to consider applying its experience and lessons learned to support the government's CBMNC package in Mchinji. Mai Khanda and Women and Children First should also be encouraged to adapt their community packages to conform to the MOH/RHU standard. This could lead to scale up of the CBMNC package in an additional 5 districts (Mchinji, Lilongwe, Salima, Kasungu, Ntcheu).	Possible	• SC will influence invitation of Mai Mwana to MNH forums through the RHU • SC to facilitate meetings between RHU & Mai Mwana so that the latter takes up the CBMNC package. • SC to consult Mai Mwana on their experience in community so that mobilization in the CBMNC districts is improved	Evelyn	On going till 2011
2.0.2	MNBHP Communications Officer should visit Mai Mwana and d time observing its various communication activities, especially the programming, for potential replication in the MNBHP.	Learning visit is possible will learn to and see how the radio programming can be done /adapted in SC	• An orientation visit to Mai Mwana by communications officer. • A report on the feasibility of having a of replicating the radio program in the CBMNC program • Take action based on the report from Patrick	Patrick	15 September 2009
2.0.3	SC should continue to promote Mai Mwana's participation in national-level activities to transfer learning as the CBMNC package is taken to scale.	In collaboration with RHU facilitate their participation to present at RHU documents dissemination forums and other meetings	• SC influences invitation of Mai Mwana to MNH forums through the RHU	Evelyn	On going till 2012
Access, availability, quality					
3.1.1	Review training plans for facility-based personnel to ensure that all program health centers and hospitals are on track to receive program training.	Need to come up with a proper plan on who has to be trained and how it is to be done and also consider the resource aspect	• In coordination with the MOH, districts and partners, come up with a training plan of action. • Lobby districts to include training in their DIPs	Reuben	Ongoing till 2012

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
3.1.2	To improve facility capacity to manage increases in labor and delivery services in program facilities, efforts via the CBMNC Task Force have been made to encourage the MOH to place additional midwives in these health centers. While the MOH does not typically earmark districts for additional support, it may be worthwhile to further advocate with the MOH on this point.	be done using advocacy gh the: Reports and HMIS	• Prepare a power point presentation that highlights demand in MNH vis-à-vis skilled birth attendant availability in the district • Make a presentation at all national MNH forums	Edward Evelyn	9 December 2009
3.1.3	Work with each DHMT and UNICEF to review and delineate exactly what equipment and supplies have been delivered and to which health facilities. Identify gaps in equipment delivery and work with partners to ensure that commitments are met.	Need to work with partners in identifying gaps in delivery of equipment ensuring all communication by all partners in what has been procured	• Identify the list of what has been submitted and compare with the HFA and identify the gaps	Edward	30 August 2009
			• Advocate for more supplies for effective program implementation • Follow up with UNICEF where they are in purchasing supplies for the districts	Evelyn	On going till 2012
3.1.4	Meet with partners supporting facility-based training in the program districts and ensure that trainings incorporate the development of action plans for trainees including an outline of equipment and supplies required to deliver updated services.	I think this is happening. We might only need to see if these plans are being followed.	• Highlight the need of incorporating MNC trainings at district level during the Safe motherhood sub committee meetings	Evelyn	30 October 2009 30 November 2009
3.1.5	Establish performance criteria to objectively measure the quality of KMC services being provided. Criteria to measure provider performance for KMC would be developed from standards of care for KMC such as consistent warming, use of calibrated cups to measure breast milk intake, proper weighing of newborns. Criteria could also be pulled for admittance, discharge and follow-up records.	Criteria for measuring performance in KMC will be important for the progress of the program	• Work with ACCESS to finalize the performance assessment tool that will be used in all health facilities providing KMC. This tool will be used by health care providers.	Richard	30 Sept 2009
3.1.6	Work with the MOH/RHU to review and update the integrated RH supervisory checklist to incorporate KMC and other evidence-based knowledge and skills to align supervision with the Integrated Maternal and Newborn Care training package.	This is important to ensure sustainability	• Source the tool and review • Arrange a meeting with RHU Dept Dir & discuss how to integrate RH supervision checklist to incorporate KMC. • Update the RH checklist	Rueben	23 December 2009
3.1.7	To work with key partners in safe motherhood programs, review and identify performance and quality improvement tools available to measure the quality of facility-based MNH services. Tools can be introduced to DHMTs to reinforce clinical supervision.	Implementation of the performance and quality improvement tool is necessary	• In collaboration with ACCESS & other partners, review the tool that is available and address the gaps. To also work with other key partners • Share the revised/reviewed tool with Zonal Officers and the DHMTs	Maggie	23 Dec 2009

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
3.1.8	Work with each DHMT and other program partners to review supervision schedules and identify where there will be delays and to outline a plan of action to reduce these delays.	This is possible but resources are a big challenge – if they can give suggestions with the limited resources	• Advocate for more motorbikes for each district (SC Italy funds) • Chitipa and Thyolo DHMT to learn from Dowa (exchange visits) • There is need to also involve District Environmental Health Officers (DEHO) in some of the districts • Set up a database that can generate reports that are useful for supervision • Use reports generated by the new access database in identifying areas that need urgent supervision	Evelyn Edward Edward George George	January 2010 & On going Sept 2009 30 October 2009 31 August 2009 31 Dec 2009 and on going
3.1.9	Move forward with the development of messages and dissemination plans with districts to educate district transport officers to include sick newborns as a priority for emergency transport	Recommendation should be taken up	• Develop the orientation manual that seeks to orient transport officers in the 3 districts on including sick newborns as a priority for emergency transport.	Maggie	30 December 2009
3.2.1	Meet with the DHMTs and UNICEF to develop a training plan for remaining HSAs and supervisors. Outline funding requirements and partner funding commitments as well as partner roles and responsibilities and complete remaining training by the end of 2009.	Important for progress of program activities	• Organize a meeting with Grace Mlava (UNICEF) & discuss way forward in training the remaining HSAs • In collaboration with UNICEF discuss with district teams on needs for HSAs training during the review meeting • Reallocate SNL sepsis study money and the money remaining from community mobilization to train HSAs not yet trained, to start immediately	Evelyn Edward Evelyn	17 July 2009 12 August 2009 30 September 2009
3.2.2	Explore the feasibility of structured group supervision to complement and strengthen the current individualized supervision. Group supervision could include monthly meetings of HSAs with supervisors at assigned health centers.	To do both	• Contact districts and explore the feasibility of having structured group supervisions of HSAs. • Encourage districts to continue with the individualized supervisions.	George	30 September 2009
3.2.3	Based on reported successes in supervision in Dowa, further explore the supervisory structure in Dowa to see if there are successful approaches that can be shared in Chitipa and Thyolo.	Good for quality supervision	• Dowa to share its experience during the joint supervision	Edward	30 September 2009 and On going
3.2.4	Meet with zonal and district health teams to discuss the supervisory structure of the HSAs and identify action steps to ensure consistent and quality supervision at the field level.	Improved sustainability of the program	• To involve both - Zonal people to be invited to participate in supervision and bi-annual meetings with effect from the first review meeting to be held on August 12, 2009.	Edward	30 October 2009
3.2.5	To ensure an adequate implementation period prior to the final evaluation of the program, the remaining HSAs must be trained as soon as possible.	Important	• Organize a meeting with Grace Mlava (UNICEF) & discuss way forward in training the remaining HSAs (also see 3.2.1)	Evelyn	17 July 2009

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
32.6	Advocate with the DHMTs and partners to ensure immediate training of HSAs in the basic HSA package, so that they can be trained in CBMNC as soon as possible. If there will be delays in basic training, work with districts to train the HSAs in the community-mobilization package first.	Important	• Evelyn to liaise with RHU on the way forward • Mrs Kachale to advocate for training of 3 district HSAs in basic training through Mr. Nkhono	Evelyn	On going
32.7	Identify resources at the district level to ensure all HSAs have their required equipment, including bicycles. Cost the procurement of rain gear and bags for HSAs and identify resources for these supplies.	Difficult	• Advocate with DHMTs for the purchase of HSAs materials • Identify gaps in rain gear, bikes and supplies for CBMNC. • SC to lobby DHMTs to budget for these in their DIPs. • SC to supply bags for HSAs	Evelyn Edward Evelyn Evelyn	On going 30 September 2009March 2010 30 August 2009
32.8	Work with the DHMTs and district hospital KMC units to outline a referral chain for HSA follow up of discharged KMC clients.	Important	• Tool already developed awaiting approval from RHU & partners	Richard	30 September 2009
32.9	Assuming the success of the CBMNC package as delivered by HSAs, advocate at the central MOH to update/revise the HSA basic training package to incorporate the CBMNC package as well as other components of their work (e.g. FP, VCT, malaria etc.).	For the future	• Update MoH on how successful the HSAs have been in CBMNC & CCM and lobby for the inclusion of these packages in the basic HSA training • Involve partners like UNICEF, BASICS, Mai Khanda etc in lobbying for inclusion of CBMNC package in the basic HAS training.	Evelyn	On going
Demand					
33.10	Advocate with DHMTs to consider training HSAs who are waiting for their 10*-week basic training in the community mobilization package first	To be done	• Discuss the issue during the review meeting with partners on August 12th,2009 • Get buy-in from the Safe Motherhood Task Force on the importance of undertaking this exercise given resource scarcity in the MOH to train all HSAs in basic HAS training.	Edward Evelyn	12 August 2009 On going
33.11	Work with the DHMTs and partners to identify funding sources to support the remainder of HSAs to receive their community mobilization training.	Important	• Advocate for resources during the review meetings and hold period meetings on plans for training HSAs with Grace at UNICEF	Evelyn	15 August 2009
33.12	Ensure that funds are available to procure the supplies needed for effective community mobilization and work with the district to ensure that the supplies are procured and distributed.	Important	• Advocate for resources during the review meetings and hold period meetings on plans for training HSAs with Grace at UNICEF	Evelyn	On going
33.13	Ensure the MNBHP has the capacity to invigorate this program component or identify this capacity in another partner that is fully engaged and committed to the success of community mobilization for improved maternal and newborn care. There is	*Not clear need more explanation of the recommendation*	• Organize a meeting with Mai Mwana to use their lessons learned to be applied to CM. • Share lessons learned from SC, Mai Mwana and other partners involved in community mobilization at		

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
	much to be learned and shared from this work—in Malawi and beyond.		national level so that maternal & newborn health are strengthened.		
3.3.14	Continue assisting Ekwendeni with the packing of reports, materials and tools in a "how-to" guide that can be shared with partners.	In progress	• Finalize packaging of reports – STEPS. In fact, we should be able to submit a draft with the MTE Report at the end of October. • Consult with Ekwendeni on materials to be packaged and move process forward to product • With support from NBH/HO team discuss how information should be packaged.	Patrick	October 31, 2009 31/12/09 31/12/09
3.3.15	Support Ekwendeni in proposal writing and scanning and identifying funding opportunities and possible donors to continue to supervise, monitor and re-train *agogos* as well as to serve as a learning site for interested partners.	Ekwendeni to be supported and to be linked to donors	• Scan for opportunities on their behalf and inform them	Evelyn	On going till 2011
Neonatal Sepsis (match funded – part of CBMNC package)					
3.4.1	Reassess the feasibility of implementing this pilot study in terms of resources available, partner commitment, and whether or not the MNBHP is ready to add an additional component of work to the demonstration project. Specific topics for consideration could include:	On hold	• Following the delays in training HSAs, it was recommended that the program put the sepsis component on hold. • Use findings from the ongoing CBMNC program to advocate for the revival of sepsis management at community level.	Edward	August 2010
3.4.2	Ensure that the selected geographical area for the pilot study will yield enough neonatal sepsis cases to permit adequate assessment of HSA performance in assessing and managing sick newborns.	On hold			
3.4.3	Ensure that the pilot OR study work plan and budget include all aspects of program implementation, such as health center training and preparedness.	On hold			
3.4.4	As a lead player in the pilot study, SC needs to work with in-country partners to identify financial resources for implementation *before* the pilot study is launched.	On hold			
3.4.5	Given WHO's prominent role in newborn and child health globally, WHO/Malawi must be encouraged to send a representative to the Working Group. It is essential that WHO/Malawi is a vocal advocate for and participant in this important work.	On hold			
3.4.6	Ideally, SC/Malawi will have a dedicated full time equivalent (FTE) staff position for the pilot study.	On hold			
Enabling environment					
4.0.1	Develop a scale up advocacy plan that includes:	Important			Dependent on progress on the

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
	• Engaging at the national level to maintain and generate new political will for newborn health and the facility and community-based MNC package; • Facilitating the MOH to take the lead to identify funding to support scale up of facility and community-based MNC package; • Introducing the package and materials to the five Zonal Health Offices and identifying opportunities to reach new districts via the zonal platform; • Work closely with MNBHP and ACCESS districts during the DIP process to keep facility and community-based MNC in place; and • Staying closely engaged with UNICEF and WHO by communicating program results, challenges and ensuring their continued financial and technical engagement in newborn health in Malawi.		• Develop a draft plan related to the national scale up policy and takes it to the NBH team for comments/feedback • An orientation meeting for stakeholders on the scale up policy is developed by SC and oriented to RHU and other key partners such as UNICEF, WHO etc. • Through the Zonal offices, inform that we are available to provide TA during DIP meetings • Share work plans with districts copies and coordinate with district implementation plans (DIPs)	Patrick Evelyn Maggie Evelyn	national plan 30 December 2009 30 January 2010
4.0 2	Work with program partners to respond to identified challenges to realize program potential in select districts and to more fully inform package scale up.	• Need to disseminate the challenges and come up with the strategies on the way forward • Involve document challenges and come up with follow up actions	• Address supervision challenges with possible actions – next time follow up on the actions and use the joint partners meeting.	Edward	On going
4.0 3	Set milestones/benchmarks on the implementation of the CBMNC package to ensure that the program is ready for the addition of new activities such as community case management or sepsis management (once these have been piloted and are ready for broader programming).	• Important • Sepsis management has been put on hold	• Set Milestones • Finish first phase trainings by Dec 2009 • Finish training all HSAs in the 3-districts by 2010 (pending availability fo UNICEF funds) • Start working with CCM as they are setting up their systems.	Evelyn	30 December 2009
4.0.4	Outline key action steps that will ensure the institutionalization of the facility and community-based MNC package into the health services delivery system and identify where and how the program can become engaged to ensure this process is underway.	Important	• In progress • Liaise with key partners on that are also involved in CBMNC on how to scale up the package • Development of joint scale up plan with key partners	Evelyn	On going
4.0 5	Identify other program platforms, e.g. CHAM, Catalytic Initiative in 10 districts, new USAID program and most importantly, new districts via government investment.	CHAM has taken it up by so far facilitating one training comprising 6 HSAs from 3 CHAM health facilities using the same module and trainers	• Liaise with key partners that are also involved in CBMNC on how to scale up the package • Development of joint scale up plan with key partners	Evelyn Patrick	On going

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
4.0.6	Partner with other groups working in the health sector such as family planning and adolescent health to continue to raise awareness about MNC and newborn health issues and to raise the program's visibility.	Need for action plan	Opportunity scanning so that we participate in most of these forums and also present our findings and lessons learned	Evelyn	On going
4.0.7	Develop a scale up plan or framework for taking facility and community based MNC package to other districts including the design of a Technical Resource package for facility and community-based MNC service delivery.	Necessary and should start working on it now	• Need to develop a plan on how and who will do it • Identify all partners involved in CBMNC • Come up with a draft scale up plan that is discussed and shared with partners.	Evelyn	2011
4.0.8	Hold regular implementation review meetings with key stakeholders from the MOH, UNICEF, WHO, USAID, the MNBHP and ACCESS districts, zonal health offices, a select number of District Health Officers from the Catalytic Initiative districts, CHAM and, if feasible, a small number of HSAs from program districts.	Already on the plan	• Hold biannual review meetings with partners ie, RHU, implementing districts, zones, UNICEF,UNFPA, etc • Hold quarterly monitoring exercises with partners, i.e. RHU, zonal representatives, 3 districts & UNICEF	Edward	31 December 2009
Process Documentation					
5.0.1	Reflection on activities and milestones from SNL1 that contributed to where the MNBHP should be part of the process documentation plan. In addition, the MNBHP is bigger and broader than the facility and community-based MNC, three-district demonstration project. For example, there are processes that have led to policy change, adoption of new or adapted guidelines, development and use of tools and materials that extend beyond the CBMNC package – all of which are excluded from the current process documentation plan which focuses narrowly on the three-district demonstration project.	Important to do	• Activities and milestones from SNL1 including processes that have led to development of guidelines of change of policies will be documented. Interviews with personnel that were in SNL 1, RHU/MoH & desk review will be some of the processes to be adopted in this documentation exercise	Edward	31 November 2009
5.0 2	There is a need to define the product(s) and the "packaging" of materials the MNBHP wants to have at the conclusion of their activities to document the processes that led to stated successes. This will then inform what must be prioritized in terms of process documentation. The MNBHP and its partners need to define the intended audience, the information this audience needs, and the best means of communicating this information (e.g. how-to manual, case study, document brief etc.).	To be done	• The NBH team should come up with a draft list of things that they want to see at the completion of the program. Seek input from RHU and other partners. Or Edward/George simply ask partners what they would expect at the end of the program. • Upon getting the list, start compiling the priority list/plan, expected audience and the best approaches in communicating	Edward Patrick	15 September 2009 31 November 2009
5.0 3	The MNBHP should begin to write up the preparation phase of the facility and community-based MNC demonstration program. It will be overwhelming if the team waits until the end of implementation.	Noted	• Combine with 5.0.1	Edward	31 November 2009
5.0.4	Missing from the process documentation plan is the "how" and	Noted	• Add the "how" and "who" components in the process	Edward	31 August 2009

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
	the "who". The plan clearly states the sources of information for process documentation and outlines the types of activities that need to be documented for the facility and community-based MNC pilot but it does not designate how the pieces will come together and who is responsible for individual pieces and who is responsible for putting the pieces together.		documentation plan.		
5.0 5	The ACCESS project is replicating the facility and community-based MNC package yet documentation of this replication process is unclear. It will be a huge missed opportunity if the replication of the package is not documented or evaluated in such a way as to compare the outcomes of the three ACCESS districts and the processes that led to those outcomes with those of the facility and community-based MNC demonstration in the three MNBHP districts.	It is necessary and needs informing and involving the ACCESS head from the start.	• Organize a meeting with ACCESS staff and inform on the importance of documentation • Share and discuss the process documentation plans and get input • Include the ACCESS staff on "who" in the plan	Edward	15 September 2009 and on going 30/10/09 30/10/09
• ***Monitoring & Evaluation***					
6.0.1	Ensure that all stakeholders, especially at district level, are aware of the various M&E procedures and systems. A visit to the HMIS officer in Chitipa reflected that he does not know a lot about what is expected of the district in tracking and assessing progress of some aspects of the program. A two-day meeting of the three district DHMT HMIS officers might reinforce understanding and compliance.	Important to do	• Reorient HMIS Officers to the M&E procedures • Invite HMIS officers during the bi-annual review meeting	George	15 August 2009 and on going
6.0 2	Revisit the community mobilization form and include a section that tracks progress in the community mobilization cycle.	Important	• Hold meetings with ACCESS staff and review the community mobilization form	George	30 August 2009
6.0 3	Design a monthly summary sheet for health centers so that they can use data from their catchment areas. Improve use of data for decision making with monthly and quarterly reviews at all levels of program implementation.	To be done	• Design a draft time sheet • Share the sheet with NBH team & partners for comments • Roll out final sheet after getting comments from partners	George	31 October 2009
6.0.4	SC should design CBMNC programmed database that provides summaries so that the district can make better use of the data. Currently, districts cannot make summaries from the existing database and are therefore not using the data they are collecting.	Important data base development in progress	• Design a database • Get comments on the database from Newborn health team and RHU • Take database to the districts and orient them	George	15 August 2009
6.0 5	The M&E plan should have key dates. These key dates are currently in the MNBHP annual plan only.	Important	• Key dates to be put in the M&E plan	George	30 September 2009
6.0.6	Revisit the process indicator matrix and include other HMIS indicators that help track the CBMNC package at the district level.	Important	• Review the process indicator matrix & add HMIS indicators that help track CBMNC package	George	31 October 2009
60.7	There is need to revisit consistency of reporting of some indicators between what is in the proposal for the CBMNC package	Noted	• Review and syncronise what is in the proposal and what is in the M&E plan	George	30 November 2009

No.	Recommendation	SC/MNBHP Comment	Action, (steps, if appropriate), indicator or milestone for completion of action	Responsible institution or person	Timeline for completion
	demonstration and what is in the M&E plan. Similar indicators are indicated as collected monthly in the proposal and quarterly in the M&E plan and vise versa.				
6.0.8	SC should work closely with the national Health Management Unit (HMU) in their review and revision of the HMIS indicators and ensure that all newborn health indicators are consistent with global standards (e.g. the indicator of postnatal care of the newborn is listed as "one week visit" as opposed to the current standard of 24-48 hours). During this process review and amend the *Road Map* indicators that have been met or surpassed.		• Participate in all HMIS meetings especially those involving reviewing of indicators	George	On going till 2011
6.0 9	Look at the sample methodology for the endline survey for the CBMNC package to determine if this can be modified to more adequately capture the impact of the program interventions in specific catchment population as opposed to district-wide measures of impact.		• The endline sample methodology was determined at the same time with the baseline survey. With advice from Simon Cousens, we were given the go ahead of using 30 cluster sampling.	Edward	2011
6.10	Use LQAS sampling methodology for the CS-22 endline in Mzimba as planned to compare changes in the Ekwendeni areas to other parts of Mzimba District without agogo coverage.	Already in the plan Note: this recommendation was previously under Objective 3 but it relates to M&E.	• Start planning for CS-22 endline survey using LQAS	George	2010

1 Community-Based Maternal Newborn Care Program. Draft Monitoring and Evaluation Plan. p.6.

2 CBMNC Package Baseline Survey, Dec/Jan 2008.

3 Shiffman, J and A Kazembe. Generating Political Priority for Newborn Survival in Malawi. 2009.

4 2004 Malawi Demographic and Health Survey. National Statistical Office Zomba, Malawi, and ORC Macro, Calverton, Maryland, USA; December 2005

5 Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa.. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13 978-0-620-37-695-2. ISBN-10: 0-620-37695-3.

Annex 1: Results Highlight – The *Agogo* Approach: A Promising Practice

Funding from USAID/CSHGP allowed Save the Children and its sub-grant partner Ekwendeni Mission Hospital in Mzimba District to take the "*agogo* approach" from an innovative idea to a promising practice in Malawi. At baseline in Mzimba District, only 68 percent of mothers were seen four times or more by a skilled provider; 63 percent were able to produce a maternal card; and 36 percent were able to cite at least two danger signs during pregnancy. Only 57 percent of newborns were dried and wrapped immediately after birth (before the placenta was delivered); only 40 percent were placed with their mothers immediately after birth; and only 48 percent were bathed at least 24 hours after birth. To address the need to communicate knowledge about care-seeking and household best practices for essential newborn care (ENC) in the most effective and culturally acceptable manner, Save the Children has been providing and technical assistance and sub-grant support to the Ekwendeni Mission Hospital (Church of Central Africa Presbyterian, Synod of Livingstonia), a CHAM facility in Mzimba District, since 2004. Ekwendeni's *agogo* approach recruits and trains grandparents to serve as mobilizers for positive change in maternal and newborn health.

Agogo (grandparents) are selected for training because they constitute a **naturally occurring cadre** in the family and community. As elders, they are trusted and listened to in their communities. Grandmothers are close advisors to daughters and daughters-in-law; and grandfathers carry a great deal of influence in the household and in the community especially in terms of decision making. *Agogo* are also gatekeepers and custodians of traditional practices, some of which are harmful to newborns. Communities selected *agogo* for training who were older than 50, had at least one grandchild, were good communicators, knew the traditions, and were respected in their community. Prior to initiation of the sub-grant, Save the Children engaged a consultant (Dr. Judi Aubel, Founder and Director of the Grandmother Project based in Rome) to assist Ekwendeni with a qualitative assessment of the *agogo* strategy to inform the expansion, documentation, and packaging of the approach for dissemination to church groups, national NGOs, and community-based organizations.

Extensive reach During the period of the sub-grant, the Ekwendeni Primary Health Care team trained 4,100 *agogo* (1,635 males and 2,375 females). Of those, 3,090 from the Ekwendeni catchment area received a two-day refresher training; and 1,010 newly-recruited *agogo* from four government-run district health centers received an initial three-day training. These trained *agogo* came from 487 villages, representing 100 percent coverage of the Ekwendeni catchment area and approximately 90 percent coverage of the four government health center areas that Ekwendeni serves under a service agreement with Mzimba District. **Increase in ANC care-seeking** After 15 months of *agogo* implementation, women seeking antenatal care in their first trimester increased by 50 percent. (Baseline value was 40 women per quarter in 10/2007, endline value was 60 women per quarter in 3/2009). **Effective retention and communication of key messages** Six months after being trained, 95 percent of *agogo* could define birth preparedness (saving money for delivery, arranging transport to the hospital, etc); 85 percent could list danger signs for newborn and danger signs during pregnancy; 84 percent could outline the advantages of antenatal care; 83 percent could identify detail immediate care of the newborn. In addition, 8 out of 10 mothers were able to state the health messages communicated by the *agogo* and had discontinued harmful cultural practices associated with delivery and newborn care.
Other results reported by communities Anecdotally, *agogo* reported reductions in newborn mortality in their villages and the following changes in practices: (1) increased seeking of MNH services at a health facility (1st trimester ANC and delivery); (2) more use of maternity waiting homes; (3) a shift from traditional family planning methods to modern methods; (4) exclusive breastfeeding and no longer giving porridge to babies; (5) not giving prelacteal herbal infusions to baby; (6) more use of immunization; (7) no application of any substance to the cord; (8) delayed bathing for up to 3 days; and (9) no longer banishing twins to the bush (out of a belief that livestock would die if the babies stayed in the home).

Annex 2: Malawi Newborn Health Program Presentations (2007-09)

2007

Evelyn Zimba delivered a presentation entitled *Malawi's Newborns:Gaps and opportunities* during the Malawi national PMNCH workshop held 16-19 April 2007 at the Sun N' Sand Holiday Resort in Mangochi. This information provided the basis for identification of priority newborn care activities to be addressed in the Gates-funded PNMCH initiative in Malawi.

Evelyn Zimba, Program Manager, presented on issues and new trends in newborn health at a workshop organized by MOH/RHU for Integration of the Basic Emergency Obstetric and Newborn Care training manual, held on 3–4 May 2007 at Livingstonia Beach Hotel in Salima; and during the follow-up meeting on 20 June 2007 at Cresta Crossroads Hotel.

During the USAID/CSHGP Mini-University workshop held in Baltimore 4-8 June 2007, Evelyn Zimba participated in the MAMAN Bazaar and demonstrated ENC and KMC.

Evelyn Zimba presented on the Malawi Newborn Health Program in a skill-building workshop held at Save the Children in Washington, DC, from 14-18 May 2007 that focused on design of behavior change and community mobilization interventions.

Evelyn Zimba presented on the Malawi CBMNC package scale-up strategy at the SNL Strategic Planning for Scale-up Workshop in Dubai held 18-22 June 2007.

Evelyn Zimba, presented as part of a panel on post-natal care and the CBMNC package at the Women Deliver Conference, taking place 18-20 October 2007 in London, UK. The aim of this global conference was to mobilize high-level commitment to achievement of the fifth Millennium Development Goal (MDG 5) for reduction of maternal mortality in participating countries. The conference brought together some 2,000 people from the global maternal health community, including politicians, international agencies, media, academics, grass-root workers, and activists.

Evelyn Zimba presented on *Malawi's newborns: Gaps and opportunities* during the White Ribbon Alliance Regional Advocacy Workshop held in Malawi in October 2007. During the CSHGP Mini-University workshop held in Baltimore 4-8 June 2007, Evelyn Zimba participated in the MAMAN Bazaar and demonstrated ENC and KMC.

Several members of the NBH team presented at the SNL 2nd Africa Research Workshop, Blantyre, Malawi (12-16 November 2007), including Research & Evaluation Officer Edward Chigwedere who presented results of the formative research conducted in the three learning districts to guide design of CBMNC package.

2008

Evelyn Zimba presented a paper on KMC scale-up at the WHO/AFRO Inter-Country Workshop for Strengthening Neonatal Health in Maternal and Child Health Programs, in Blantyre, Malawi (21-25 January 2008).

Evelyn Zimba presented on results of the Malawi KMC retrospective study at the Priorities on Perinatal Care Conference in Pretoria, South Africa (11-14 March 2008).

Evelyn Zimba and Consultant Anne-Marie Bergh delivered the results of the KMC Retrospective Study conducted in July 2007, followed by a panel discussion, at the Malawi Ministry of Health (MOH)/Reproductive Health Unit (RHU) Dissemination Workshop, Lilongwe (18-19 March 2008).

Health Economist Emmaunelle Daviaud led a workshop on CBMNC costing for the three learning districts, MOH/RHU, and other stakeholders (25 March 2008).

Evelyn Zimba presented a paper on KMC scale-up at the Countdown to 2015: Maternal, Newborn and Child Survival in Cape Town, South Africa (17-19 April 2008).

Evelyn Zimba presented on KMC scale-up at the Save the Children Department of Health & Nutrition Program Learning Group Meeting, held in Easton, MD, USA (19-23 May 2008).

Edward Chingwedze presented on the Malawi NBH Program's plan for process documentation and Evelyn Zimba presented on KMC scale-up on Malawi at the Save the Children/Saving Newborn Lives Program Manager's Meeting, Bangkok, Thailand (July 2008).

Evelyn Zimba presented a poster highlighting results of Malawi's KMC retrospective study and presented as part of a panel at the 1st European Conference on Kangaroo Mother Care and KMC Workshop, Uppsala, Sweden (8-11 October 2008).

2009

Communications Officer Patrick Zgamo presented on the role of media for advocacy in newborn health at White Ribbon Alliance workshop held at Riverside Hotel in Lilongwe on 15 January 2009.

Reuben Ligowe gave a brief presentation on the CBMNC package at the Mai Khanda (formally known as Health Foundation) strategic planning meeting on maternal and newborn health, held at Kambiri Lodge in Salima District, 19-23 January 2009.

Evelyn Zimba presented on the IMCI training manual at a Blantyre meeting, funded by ACCESS, to integrate current trends of PMTCT policy into the BEmONC training module, 2-6 February 2009.

Edward Chigwedere presented on during a Malawi community newborn sepsis management consultative meeting held in Lilongwe, 12 February 2009, convened by MOH and supported by Save the Children.

Patrick Zgamo gave a presentation on newborn health for Day of the African Child during a Children's Parliament Technical Committee at Kalikuti Hotel, 5 May 2009, organized by the Ministry of Gender.

Edward Chigwedere gave a brief presentation on preliminary findings of the mini LQAS survey in Dowa District to district stakeholders (25 May 2009).

M&E Officer George Chiundu presented findings of the mini LQAS survey in Thyolo District (15 June 2009).

Patrick Zgamo gave a presentation on newborn health for the National Children's Manifesto at Kalikuti Hotel on 10 June 2009 during a workshop organized by Ministry of Gender. (Because of Save the Children's advocacy and contributions, the Manifesto now includes a section on newborn health.)

Reuben Ligowe represented Save the Children Malawi at the BASICS conference on *Advocacy to Care for Newborn* in Darker, Senegal, 15-19 June 2009. Reuben presented on KMC in Malawi, participated in a panel discussion, and conducted a demonstration on how to position a baby in KMC. (As a result of this, Save the Children in Tanzania sent a tem member to Malawi to learn more about the Malawi KMC program.)

Evelyn Zimba facilitated a "marketplace" session entitled *Essential childbirth practices for maternal and newborn health and nutrition: AMTSTL and ENC* and gave a demonstration on AMSTL and immediate ENC at the Save the Children Department of Health & Nutrition Program Learning Group meeting held in Norwalk, CT, USA, in late June 2009.

Evelyn presented on the results of the NBHP MTE during a bi-annual review meeting, with participants representing the 6 districts implementing the CBMNC package (Chitipa, Rumphi, Nkhotakota, Dowa, Machinga and Thyolo) that included Zonal Officers, DHOs, IMCI coordinators, and data entry clerks - plus RHU and UNICEF (12 August 2009).

Evelyn Zimba will present on the Malawi CBMNC package to the African Midwives Research Network biennial conference to be held in Dar es Salaam,Tanzania, 30 November-5 December 2009. The theme is "Strengthening health systems to reduce maternal, neonatal and child morbidity and mortality".

Annex 3: Project Management Evaluation

Human resources The MNBH program is fairly well staffed; however, it is a small team and people are stretched. The team currently lacks talent for a robust advocacy effort. There are a number of options to manage this including bringing staff from SNL headquarters to support advocacy efforts, hiring part time consultants in-country to work on advocacy documents; and/or using Save the Children field-based talent, where available. Save the Children/Malawi could also consider bringing on a full-time staff member with a solid background in advocacy and documentation for advocacy. This position will require someone who is a fairly seasoned professional, is a critical thinker, strategic and highly motivated. The team is exploring whether SNL might fund this additional post.

At the same time, if possible, bringing on an additional Program Officer would allow the Program Manager more time to engage with partners from a more strategic position. The fieldwork on this program is immense; particularly in this early implementation phase and with the heightened need for district level engagement and recommendations for zonal engagement. An additional Program Officer could be in place to support the fieldwork including participation in DIP processes, transitioning the ACCESS districts from USAID-funded support, and identifying and troubleshooting implementation issues. This person would work in concert with the two Program Officers currently on staff. Again, the team is exploring whether or not SNL might be able to fund this additional position.

Other issues During 2008, Save the Children and ACCESS identified a series of financial problems with sub-grant compliance on the part of the White Ribbon Alliance for Safe Motherhood (WRASM) in Malawi. Moreover, WRASM-Mw has no active staff at present and no activities on-going. Following a series of discussions with the WRASM-Mw board and the White Ribbon Alliance international headquarters, it was decided to terminate further funding and in-kind support.

No additional human resources, logistical, or other issues were identified during the MTE.

Annex 4: Work Plan Table

Malawi Newborn Health Program - Five-Year Work Plan (merged and revised) - 1 October 2006 - 30 September 2011
Country Workplan FY07 - FY11

Activity	FY07				FY08												FY09				FY10				FY11				Objective Met	Activity Status
	1	2	3	4	O	N	D	J	F	M	A	M	J	J	A	S	1	2	3	4	1	2	3	4	1	2	3	4		
Program Management																														
Activity 1: Recruit and hire staff	X																												Yes	
Activity 2: Project start-up activities	X																												Yes	
Operational Research																														
Community-based maternal and newborn care																														
Activity 1: Finalize proposal and budget with MOH, UNICEF and 3 districts for community PNC pilot				X																									Yes	
Activity 2 : Finalize tool and conduct Health Facility Assessment				X	X	X																							Yes	
Activity 3: Collaborate with partners to design, conduct and analyze population-based survey in 3 learning districts				X	X	X	X																						Yes	
Activity 4: Finalize design of district pilot (sepsis to come later)					X																									
Activity 5: Contribute to adaptation of MNH training package for HSAs in collaboration with UNICEF and MOH						X	X																						Yes	
Activity 6: Conduct TOT for HSA training package (with UNICEF)											X																		Yes	
Activity 7: Revise and finalise HSA Manual in community MNH												X																	Yes	
Activity 8: Produce HSA community MNH manual												X																	Yes	
Activity 9: Conduct district TOT for HSA community MNH												X																	Yes	
Activity 10: Conduct initial district HSA trainings in community MNH														X	X														Yes	
Activity 11: Hold meeting with RHU to discuss way forward for sepsis and LBW management by HSAs												X																	Yes	
Activity 12: Form small group to lead adaptation process of sepsis management protocol												X	X																Yes	Activity on hold
Activity 13: Design sepsis management protocol															X	X													No	Activity on hold
Activity 14: Assist with development of OR plans and postnatal care protocols on ANC and PNC home visitation, community management of LBW babies and newborn sepsis			X	X								X	X	X	X	X													Yes	Excluding sepsis
Activity 15: Adapt manual for HSAs to manage neonatal sepsis and LBW at the community level																	X												No	Activity on hold
Activity 16: Develop associated job aids																	X												No	Activity on hold
Activity 17: Produce manuals (neonatal sepsis management protocol)																	X												No	Activity on hold

Activity 18: Conduct TOT trainings in neonatal sepsis management																				X									No	Activity on hold
Activity 19: Conduct district HSAs training in neonatal sepsis management																				X	X	X							No	Activity on hold
Activity 20: Support (TA/financing) costing study for community MNH package				X							X	X	X	X															Yes	
Activity 21: With RHU, districts and other key stakeholders, establish and support system for ongoing training/capacity assessement (pre-post tests, training evaluations, trainer assessment checklists) for facility health workers and HSAs			X	X								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	On going
Activity 22: Facilitate/support development of job aids (visit checklists, counseling cards) and supportive supervision at facility and community level										X	X																		Yes	
Activity 23: Support development of IEC/BCC strategies and materials for HSAs community mobilization work with communities				X									X	X	X	X													Yes	
Activity 24: Field test the materials												X																	Yes	
Activity 25: Finalize materials													X																Yes	
Activity 26: Produce IEC materials and disseminate to districts															X														No	Process underway to send for printing
Actvity 27: Orient EHO/HA/CNM/senior HSAs (2 days) in supervision of CBMNH activities															X														Yes	Senior HSAs went through the whole training
Actvity 28: Conduct inventory status of transport for supervision in the 3 learning districts												X																	Yes	
Activity 29: Conduct quarterly joint monitoring/TA support visits to each learning program district				X											X		X	X	X	X	X	X	X	X	X	X	X	X	Yes	On going
Activity 30: Facilitate and participate in partner monthly and quarterly task force meetings for 3 learning program districts		X	X	X									X			X													Yes	
Activity 31: Facilitate and participate in periodic (annual) program reviews and broader information sharing at country level with stakeholders																						X				X			Yes	
Activity 32: Assist in the final revision of community PNC protocols based on learning																X													Yes	
Activity 33: Facilitate continuous learning and scale-up in other districts through ACCESS, UNICEF, and other interested organizations and donors through meetings and information/resource sharing																		X	X	X	X	X	X	X	X	X	X	X	Yes	
Mai Mwana Randomized Controlled Trial																														
Activity 1: Conduct quarterly monitoring of progress on Mai Mwana subgrant			X	X				X			X			X			X	X	X	X									Yes	But on adhoc basis
Activity 2: Conduct quarterly financial monitoring on compliance of Mai Mwana subgrant			X	X									X	X	X	X	X	X	X	X									Yes	
Activity 3: Facilitate annual CHAM & MOH visits to Mai Mwana				X												X													Yes	
Activity 4: Organize/faclitate joint dissemination																								X						Not due

event																													
Activity 5: Assist in publication of results																												X	Not due
Kangaroo Mother Care Retrospective study																													
Activity 1: Conduct KMC retrospective study and come up with recommendations for scale-up with respect to outcomes, operational tools, and efficiencies in terms of staff, training and infrastructure				X																								Yes	
Activity 2: Support development of prototypes to support scale-up (key job aides, wall charts, ward guidelines, monitoring tools, BCC materials)				X																								Yes	
Activity 3: In collaboration with RHU and ACCESS disseminate retrospective KMC study results to key stakeholders				X								X																Yes	
Activity 4: Conduct inventory of pre-service institutions and proximity of KMC centres																X												Yes	
Activity 5: Hold dialogue with facility and training institutions																	X											Yes	
Activity 6: Support establishment of KMC centres																		X	X									Yes	
Activity 7: Discuss with Malawi College of Health Sciences - Training institution for Medical Assistants to call attention to the KMC gap in the training curriculum															X													Yes	
Acyivity 8: Design community KMC strategy and adapt materials												X	X															Yes	
Activity 9: Design prototype materials for HSAs to counsel mothers in community KMC												X	X															Yes	
Activity 10: Facilitate work planning for district KMC scale-up				X								X	X	X	X													Yes	
Activity 11: Provide TA for district KMC scale-up and supportive supervision at facility and community level				X								X	X	X	X	X	X	X	X									Yes	
Activity 12: Participate in annual SNL Africa Research Workshop	X											X								X			X					Yes	
Collaboration and Partnership																													
Activity 1: Raod Map launch activities	X																											Yes	
Activity 2: PMNCH Malawi country plan		X																										Yes	Not regular involvement
Activity 3: Global PMNCH Meeting - REMOVED																													
Activity 4 : Define roles, responsibilites between partners				X																								Yes	Drafted but not signed
Activity 5: MOU/agreement with MOH/RHU												X																Yes	Done as SC and not NBH
Activity 6: MOU/agreement with WRASM-Mw				X																								Yes	
Activity 7: MOU/agreement with UNICEF, MOH, 3 districts (community-based) neonatal care pilot				X																								No	Document written together with partners but not yet signed
Activity 8: Sub-grant agreement with Ekwendeni (*agogo* approach)				X																								Yes	

Activity 9: Participate actively in Maternal and Newborn Sub-committee of RHU Sexual and Reproductive Health Committee	X	X	X	X									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	
Activity 10: Advocate for revised indicators and targets in HIS supportive of newborn health priorities				X																									Yes	On going
Activity 11: Advocate for policies and strategies that reflect consistent and comprehensive indicators and targets for MNH												X			X	X	X												Yes	On going
Actvity 12: Hold meeting with RHU to discuss current list of national newborn health indicators in various national health documents												X					X												Yes	On going
Actvity 13: Revision of maternal and newborn related indicators and targets (through meetings)																	X												No	In progress
Activity 14: Participate in joint planning with MOH, ACCESS and other key stakeholders on maternal and newborn care pre and in-service education			X	X																									Yes	Done through RHU annual work plan
Activity 15: Assess status of pre-service ENC/KMC in partnership with ACCESS				X																									Yes	
Activity 16: Advocate with RHU for revision of postnatal visitation schedule in RH Guidelines currently being finalized				X																									Yes	
Activity 17: Support set-up of system for training assessments and supervision (pre-post tests, training evaluations, assessment checklists and supervision checklist for both trainers and trainees)				X									X	X															Yes	
Activity 18: Advocate with DHMT to post CNMs in communities															X														No	Difficult because of shortage of nurses at facilities
Activity 19: Facilitate/support development of job aides, supportive supervision at national level				X									X	X															Yes	On going
Activity 20: Review/revise health education/BCC materials for use by facility and community health workers (counseling cards, posters, black and white brochures)				X									X	X	X	X	X	X	X	X									Yes	
Activity 21: Attend quarterly meetings to review progress and develop action plans														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	
Activity 22: DevelopH/MIS and indicators (process and quality emphasis) and support district implementation				X									X																Yes	
Activity 23: Participate with all partners in the development of RHU annual work plan		X												X				X				X				X			Yes	
Activity 24: Assist RHU with providing support for annual District Implementation Plan (DIP) by facilitating development of a schedule of DIPs for all the districts and ensure there is representation at all times for maternal and newborn care				X												X				X				X					Yes	But now to be done through Zonal Offices
Activity 25: Participate in DIP development meetings for 7 MOH districts (3 pilot districts, 3 ACCESS districts, and Mzimba)													X								X				X				Yes	This year it was not possible because it coincided with CBMNC package mini survey in preparation for MTR

Activity 26: Work with partners to monitor and ensure adequate equipment and supplies at facility level through DIPs and other donor resources													X				X				X				X				Yes	
Activity 27: Participate in quarterly meetings at national level on MNC, i.e. Health Foundation, Perinatal Care, Women and Children First	X	X	X	X									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	
Actvity 28: Hold discussions with RHU on need for BCI strategy for MNH at facility and community												X																	Yes	Have one in place which focuses mainly on HIV/AIDS. Plan to continue discussions
Actvity 29: Identify partners during Safe Motherhood Meeting who can develop the BCI stratetgy for MNH													X																No	
Activity 30: Hold discussions with WRA and RHU to determine how to move forward and ensure effective implementation of harmonized MNH activities																X													Yes	
Activity 31: Conduct mapping of all programs implementing MNH programs in Malawi																	X												No	WHO was doing a similar activity but unfortunately results have not been shared
Activity 32: Conduct semi-annual coordination meetings (zonal or national?)																	X		X		X		X		X				No	To discuss with RHU on the way forward
Activity 33: Attend partnership meetings on MNCH			X										X				X				X				X				Yes	Sometimes
Activity 34: Attend quarterly White Ribbon Alliance meetings	X	X	X	X									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	But currently facing management problems
Activity 35: In collaboration with MOH and other key stakeholders provide TA/support monitoring visits for scale-up of community-based maternal and newborn care package													X			X			X			X			X			X	Yes	
Activity 36: DIP data review and DIP writing		X																											Yes	
Activity 37: Develop plan of process documentation for MOH/RM partnership				X																									Yes	
Activity 38: Participate in annual SNL Program Manager meetings		X												X				X				X				X			Yes	
Activity 39: Participate in SNL newborn health scale-up meeting		X															X												Yes	
Policy, Advocacy, Networking																														
Activity 1: Policy review and dialogue with RHU (Time TBD with RHU)																														On going
Activity 2: Advocate for revised postnatal visitation schedule				X																									Not yet	Schedule has been changed in RH Standards
Activity 3: Advocate in partnership with MOH and other stakeholders for effective HSAs recruitment				X																									Yes	
Activity 4: Using lessons learned from the 3 OR district advocate for policy review and dialogue on community management of newborn sepsis by HSAs																X				X				X						Activity put on hold
Activity 5: Facilitate revatalization of ENC/KMC TOTs				X																									Yes	

Network by conducting a census of TOTs trained during SNL 1																														
Activity 6: Facilitate advocacy training/capacity building for selected MOH, Civil Society organization, CHAM and professional association members													X																Yes	Done in collaboration with ACCESS
Activity 7: Participate in regional & international global meetings for NBH, i.e., PLG and regional exchange visits			X												X				X				X				X		Yes	
Activity 8: Advocate for the intergration of PNC into mobile clinics																	X												Yes	
Activity 9: Advocate for timely transportation of sick newborns																	X												Yes	Training manual drafted
Activity 10: Advocate for the documentation of MNH BCI strategies													X																No	Discussions underway
Activity 11: Advocate for basic equipment and supplies for ENC/KMC to health facilities in the 3 learning districts																	X												Yes	
Mainstreamed Training, TA Support to MOH Program Management																														
Activity 1: In collaboration with MOH, ACCESS, WHO, UNFPA, UNICEF consolidate and adapt various packages (Safe Motherhood, Life Saving Skills, BEmONC, SNL and KMC) into one standard competency-based package on Essential Obstetric and Newborn Care				X	X	X	X																						Yes	
Activity 2: Using lessons learned from the KMC retrospective assessment provide TA during the harmonization/integration of RHU training manuals				X							X																		Yes	
Activity 3: Facilitate development of a monitoring system for the trainings				X									X																Yes	
Activity 4: Facilitate development of supervision tools during trainings and follow-up sessions				X								X	X																Yes	
Activity 5: Conduct a refresher course of trainers trained under SNL1 (about 30 to be confirmed after census) using the new Essential Obstetric and Newborn Care package				X						X																			Yes	
Activity 6: Co-fund and provide TA for TOT trainings in Essential Obstetric and Newborn care (60)														X															Yes	
Activity 7: Supervise the training sessions to ensure quality														X	X	X													Yes	
Activity 8: Follow-up TOT implementation plans																	X	X											Yes	In progress
Activity 9: Conduct trainings of health workers using the harmonized manual																	X	X	X	X									Yes	
Activity 10: In collaboration with MOH provide TA during roll-out of Essential Obstetric and Newborn Care trainings at district level throughout the country													X				X	X	X	X									Yes	
Activity 11: Co-fund a training session for 15 tutors from health training institutions for effective pre-service compentency based training on Essential Obstetric and Newborn Care													X																Yes	
Activity 12: Conduct follow-up of the trained trainer implementation plans																	X	X	X										Yes	In progress

Activity 13: Provide TA to Mzimba for in-service training of 50 health workers in Essential Obstetric and Newborn Care													X			X													Yes	
Activity 14: Facilitate first follow-up of trainees 6 months post training																		X	X										No	Plans underway
Activity 15: Conduct regular joint supportive supervision of trained trainers																	X	X	X	X	X	X	X	X	X	X	X	X	No	Plans underway
Activity 16: Participate in quarterly meetings to review progress of trainings and develop action plans				X									X			X	X	X	X	X	X	X	X	X	X	X	X	X	Yes	
Activity 17: Produce Harmonized training manuals																X													No	Printing in progress
Activity 18: Support finalization of community mobilization manual															X	X													Yes	
Activity 19: Produce CM Training manuals																X													No	Manual ready for printing
Activity 20: Conduct TOT for HSAs training in CM																X													Yes	
Activity 21: Conduct District HSAs training in CM																	X	X											Yes	In progress
Monitoring & Evaluation, Operations Research, Reporting and Documentation *Monitoring and evaluation*																														
Activity 1: Prepare and submit quarterly financial reports				X	X			X			X			X			X	X	X	X	X	X	X	X	X	X	X	X	Yes	
Activity 2: Prepare and submit annual programmatic reports to CSHGP				X												X				X				X				X	Yes	
Activity 3: Conduct qualitative assessment for agogo strategy	X																												Yes	
Activity 4: Concuct KPC Survey in Mzimba		X																											Yes	
Activity 5: Facilitate HFA in Mzimba district				X												X													No	Mzimba does not have the funds
Activity 6: DIP review at Mini-University			X																										Yes	
Activity 7: Participate in biannual MOH HIS meeting				X												X		X		X		X		X		X		X	Yes	
Activity 8: Conduct participatory mid-term evaluation																			X										Yes	
Activity 9: Conduct endline KPC survey Mzimba Dstrict (LQAS)																										X				Not yet due
Activity 10: Conduct final evaluation of Malawi Newborn Health Program																											X			Not yet due
Activity 11: Finalize set up for process documentation											X																		Yes	In progress
Activity 12: Set up systems for collecting information at national and district level to input into documentation process												X																	Yes	
Activity 13: Collate and write quarterly process documentation report for national and district levels																X													No	Plans underway
Activity 14: Write/develop peer-review articles																												X		Not yet due
Activity 15: Disseminate findings at national and district levels																												X		Not yet due

Activity 16: Compile relevant NB indicators from 2010 DHS preliminary results																												X		Not yet due
Planning and Reviews																															
Activity 1: Participate in biannual SWAp reviews		X		X							X					X		X		X		X		X		X		X	Yes	
Activity 2: Partipate in RHU annual workplan reviews		X								X								X					X		X				Yes	
Activity 3: Submit detailed annual work plan to CSHGP																X				X				X						Yes	
Activity 4: Conduct Country SNL planning exercise for scale-up											X																			Yes	
Ekwendeni Sub-grant																															
Activity 1: Assist Ekwendeni to develop and submit a program description and work plan on *agogo* approach			X	X																										Yes	
Activity 2: Provide TA for the review and revision of BEHAVE messages				X			X																							Yes	
Activity 3: Provide TA during the development of the *agogo* approach training curriculum and other training materials				X	X																									Yes	
Activity 4: Assist Ekwendeni develop M&E and documentation plan				X	X							X	X	X																Yes	
Activity 5: *S*upply Ekwendeni with BCC materials					X																									Yes	
Activity 6: Provide TA to provide training to 1000 agogos and refresher training to 3000 agogos					X	X	X			X	X	X	X																	Yes	
Activity 7: Conduct monitoring visits to Ekwendeni								X				X			X		X	X												Yes	
Activity 8: Conduct 6 months post-training monitoring of the trained *agogos*												X	X	X			X	X												Yes	
Activity 9: Provide TA for process documentation and monitoring of the initiative				X								X																		Yes	
Activity 10: Provide TA for documentation and packaging of *agogo* approach																	X													Yes	In progress
Activity 11: Arrange MOH and CHAM visit to Ekwendeni *agogo* initiative													X																	Yes	USAID Malawi Mission participated in the visit
Activity 12: Print package for dissemination																	X													No	In progress
Activity 13: Support dissemination of experience and manual to stakeholders																	X													No	Plans underway
Activity 14: Provide TA for scale-up by interested stakeholders (faith based groups, local organizations, CBO)																	X	X	X	X	X	X	X	X	X	X	X	X	X	No	Awaiting finalization of packaging of the initiative
Activity 15: Conduct final evaluation of Ekwendeni *agogo* initiative (as part of NBHP participatory Mid-Term Evaluation)																			X											Yes	

Annex 5: Rapid CATCH Table (only necessary if a Mid-Term Evaluation KPC survey was performed)*

Not applicable; no midterm KPC was conducted.

Annex 6: Mid-Term KPC Report (if performed)

No midterm KPC survey was performed.

Annex 7: CHW Training Matrix (September 2009)

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
Chitipa	Health Surveillance Assistant	Government	Paid	97 Community Based Maternal and Newborn Care (CBMNC) Package– including current training 57 trained with SNL funds 40 trained with UNICEF funds	MNH technical issues and skills in: • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
				96 Community mobilization Trained with SNL funds	• Community identification of MNH problems/issues, prioritization of the issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches. • M&E (documentation of the community mobilization activities)
Thyolo	Health Surveillance Assistant	Government	Paid	104 CBMNC Package (including current training) 59 trained with SNL funds 45 trained with UNICEF funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
					periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
				86 community mobilization Trained with SNL funds	• Community identification of MNH problems/issues, prioritization of the issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches. • M&E (documentation of the community mobilization activities)
Dowa	Health Surveillance Assistant	Government	Paid	100 CBMNC Package (including current training) 62 trained with SNL funds 38 trained with UNICEF funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
					(KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
				95 Community mobilization Trained with SNL funds	• Community identification of MNH problems/issues, prioritization of the issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches. • M&E (documentation of the community mobilization activities)
Rumphi	Health Surveillance Assistant	Government	Paid	40 CBMNC Package Trained with ACCESS funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
				40 community mobilization Trained with ACCESS funds	• Community identification of MNH problems/issues, prioritization of the

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
					issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches. • M&E (documentation of the community mobilization activities)
Nkhotakota	Health Surveillance Assistant	Government	Paid	40 CBMNC Package Trained with ACCESS funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
				40 community mobilization Trained with ACCESS funds	• Community identification of MNH problems/issues, prioritization of the issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches • M&E (documentation

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
					of the community mobilization activities)
Phalombe	Health Surveillance Assistant	Government	Paid	40 CBMNC Package Trained with ACCESS funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)
Machinga	Health Surveillance Assistant	Government	Paid	40 CBMNC Package Trained with ACCESS funds	MNH technical issues and skills in:- • Identifying danger signs for pregnant women, newly delivered mothers and newborns • Counseling during antenatal and postnatal periods • Development of birth plan and birth preparation • Essential newborn care including skills in weighing, taking temperature, counting respirations and Kangaroo Mother Care (KMC) for low birth weight (LBW) babies • M&E (Data collection during home visits and data flow)

Project Area (Name of District or Community)	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project and Funding Source	Focus of Training
				40 community mobilization Trained with ACCESS funds	• Community identification of MNH problems/issues, prioritization of the issues, solving the problems and evaluation using the Community Action Cycle (CAC) • Skills in community participatory approaches • M&E (documentation of the community mobilization activities)
Ekwendeni	Grandparents	Naturally occurring cadre (not grantee created)	Volunteers	4000 Agogo (grandparents) Trained with CS-22 sub grant funds	MNH issues including:- • Essential newborn care including skin-to-skin and care for pregnant mothers • Identification of danger signs for pregnant women, newly delivered mothers and newborns • PMTCT • Importance of early ANC, timely health seeking behaviours during labour and delivery and postnatal period • Cultural barriers and promotion of health behaviours • M&E (Data collection during client/home visits and other community activities)

Annex 8: Evaluation Team Members and Titles

External – Team Leader

Judith Robb-McCord, Team Leader

Save the Children – Headquarters and Regional

Karen Z. Waltensperger, Africa Regional Health Advisor
Joseph De Graft Johnson, Maternal and Neonatal Health Advisor, Saving Newborn Lives and ACCESS/MCHIP
Massee Bateman, Director, Saving Newborn Lives (first week)
Nathalie Gamache, Associate Director, Country Support and Coordination Unit, Saving Newborn Lives
Dinah Lord, Communications and Advocacy Advisor, Saving Newborn Lives

Save the Children Country Office – Malawi Newborn Health Program

Evelyn Zimba, Program Manager
Edward Chigwedere, Research and Evaluation Manager
George Chiundu, Monitoring and Evaluation Officer
Patrick Zgamo, Communications Officer
Reuben Ligowe, Project Officer
Maggie Kambalane, Project Officer
Temwachi Nkhono, Project Assistant

University of Malawi, Kamuzu College of Nursing

Abigail Kazembe, Lecturer/Researcher (second week)

UNICEF

Grace Mlava, Program Officer (field visits)

Invited but declined, due to scheduling conflicts

USAID Malawi Mission/DHN Team
Ministry of Health – Reproductive Health Unit

Annex 9: Evaluation Assessment Methodology

The Midterm Evaluation (MTE) of the Malawi Newborn Health Program (MNBHP) was conducted in country from April 20 – April 30, 2009. The MTR team consisted of one external team leader, Judith Robb-McCord; four representatives from Save the Children Saving Newborn Lives program in Washington, DC office, including the SNL Global Director, Dr. Massee Bateman[1]; the Save the Children Africa Regional Health Advisor based in Pretoria; and, four full-time participants from the NBHP staff. The MTE team also benefited from the part-time participation of two other NBHP staff, one part-time external consultant from the University of Malawi/Kamuzu College of Nursing, and one part-time representative from UNICEF. (See Annex 8 for a list of evaluation team members and their titles.) Invitations to participate as members of the MTE team were extended to the USAID Mission and MOH/RHU. Both declined because of time constraints and competing priorities. During the same period, the Mission was hosting a visiting team from Washington, DC - in Malawi to work on the new 5-year strategic country plan for health.

The MTR process included document review, field travel and extensive briefings and discussion with the MNBHP team as well as representatives from partners and stakeholders including the Ministry of Health/Reproductive Health Unit (MOH/RHU), UNICEF, USAID and ACCESS—a USAID-funded maternal and newborn care program operating in three districts in Malawi, in which Save the Children is an active partner.

The MNBHP team in Malawi compiled key documents in advance and had them available for team member use. Documents included the *Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity,* the *IMCI Approach Policy for Accelerated Child Survival and Development in Malawi, June 2006,* the 2004 Demographic and Health Survey, the 2006 Multi-Indicator Cluster Survey, the MNBHP Baseline and Health Facilities Assessment, the USAID Child Survival Health Grants Program (CSHGP) Detailed Implementation Plan and annual program reports, among dozens of others. These documents provided valuable information as to the Government's commitment to maternal and newborn health, the environment in which the program is working, program plans and commitments and accomplishments and challenges to date.

The review team also traveled to the field to meet with District Health Management Teams (DHMTs), health facility personnel, Health Surveillance Assistants (HSAs) and community members. A total of ten MTE team members split into two separate teams and traveled to north (Team 1) to Chitipa and Mzimba, and south (Team 2) to Thyolo and Zomba, over a period of seven and three days, respectively. Following the field trip to Thyolo, a smaller number of team members traveled to Dowa for one day and to Mchinji District, also one day, to visit the Mai Mwana Project team.

Team members met with DHMTs from the districts, hospital and health center personnel, more than sixty HSAs and community members. A tool that was developed prior to the field trips guided interviews and discussion with counterparts. Team members visited each district hospital

[1] Match funding allowed an expanded MTE team.

(Chitipa, Mzimba, Dowa, Thyolo – as well as Zomba Central Hospital) to see Kangaroo Mother Care (KMC) units, and visited seven program-linked health centers.

In Mzimba District, Team 1 met with a group of nearly thirty *agogos* or grandparents and community leaders at the Ekwendeni Mission Hospital, a Christian Health Association of Malawi (CHAM) facility.

The team also met with Save the Children ACCESS staff and other representatives from the ACCESS program. With funding from USAID/Malawi, ACCESS is also implementing the MNBHP facility and community-based maternal and newborn care package, including the scale up of KMC, in three additional districts—Machinga, Nkhotakota and Rumphi.

The process afforded MTR team members ample opportunity to probe program achievements and to better understand critical issues that challenge and threaten program success. Interviews with stakeholders at the national, district and community levels allowed team members to gain valuable insight and perspective about the program's pathway for improved maternal and newborn care. Important program milestones and successes as well as gaps were identified and discussed and used to inform the development of recommendations.

While the MTR process was fairly comprehensive, the teams would have benefited from visiting health facilities and HSAs serving even more remote populations. Time and travel distance was a limiting factor. It would have also been useful to meet with more community members or beneficiaries of the program.

Annex 10: List of Persons Interviewed and Contacted during the MTE

No	Partner/ Stakeholder	Position/Title	Name	Date/Time	Email address
1	United Nation Children Fund, P.O .Box 30375, Lilongwe	Country Representative	Carrie Auer	Tuesday 21/04/09 2:00 pm	cauer@unicef.org
2	United Nation Children Fund P.O .Box 30375, Lilongwe	Program Officer	Grace Mlava	Tuesday 21/04/09 2:00 pm	gfmlava@unicef.org
3	United States Agency to International Development, P.O. Box 30455, Lilongwe	HPN Officer	Aly Cameron	28/04/09 – 7:30 am	acameron@usaid.gov
4	United States Agency to International Development, P.O. Box 30455, Lilongwe	Reproductive Health Specialist	Lily Banda - Maliro	28/04/09 – 7:30 am	lbandamaliro@usaid.gov
5	BASICS, P/Bag 398 Lilongwe	Chief of Party	Rudy Thetard Done	28/04/09 08:30 am	rthetard@mw.msh.org
6	Reproductive Health Unit Ministry of Health, P.O. Box 30377, Lilongwe 3 Senior	Technical Advisor	Dr Chisale Mhango Done	27/04/09 – 3:00 pm	cmhango@globemw.net
7	Reproductive Health Unit Ministry of Health, P.O. Box 30377, Lilongwe 3	Deputy Director – Reproductive Health	Fanny Kachale	21/04/09 3:00 pm	fkachale@yahoo.co.uk
8	Ministry of Health, P.O. Box 30377, Lilongwe 3	Head of Pediatrics Kamuzu Central Hospital	Dr Charles Mwasambo	28/04/09 – 3:00 pm	cmwansambo@malawi.net

No	Partner/ Stakeholder	Position/Title	Name	Date/Time	Email address
9	Ministry of Health, P.O. Box 30377, Lilongwe 3	Chief PHC Officer	Edwin Nkhono	27/04/09 – 3:00 pm	Nkhonoemf2001@yahoo.co.uk
10	Mai Khanda, Private Bag B 437, Lilongwe	Director	Ms Agnes Makonda – Ridley		amakonda@maikhanda.org
11	Ministry of Health, P.O. Box 30377, Lilongwe 3	Director of Information Health Management Unit	Chris Moyo	29/04/09 09:00 am	moyochris@gmail.com
12	Ministry of Health Ministry of Health, P.O. Box 30377, Lilongwe 3	IMCI Coordinator	Mr Msona	28/04/09 1: 30 pm	hmsona@gmail.com
13	Zomba Central Hospital P.O. Box Zomba Hospital	Director	Dr Mathias Joshua	24/04/09 10.00 am Done	martiasjoshua@yahoo.com
14	Thyolo District Hospital P.O. Box 21 Thyolo	District Health officer	Dr Beatrice Magomba	22/04/09	beatmat@yahoo.com
15	Thyolo District Hospital P.O. Box 21 Thyolo	IMCI Coordinator	Matola Dauda	22/04/09	mdauda07@gmail.com
16	Dowa District Hospital P.O. Box 25 Dowa	District Health Officer	Violet Kamfonse	27/04/09	haquetwaibu@yahoo.co.uk
17	Dowa District Hospital P.O. Box 25 Dowa	Nursing Officer – Community CBMC Deputy Coordinator	Masumbuko Baluwa	27/04/09	mbukobaluwa@yahoo.co.uk
18	Dowa District Hospital P.O. Box 25 Dowa	IMCI Coordinator	Ephraim Sitima	27/04/09	ephraimsitima@yahoo.com

No	Partner/ Stakeholder	Position/Title	Name	Date/Time	Email address
19	Chitipa District Hospital	Assistant Human Resources	Mr. Frank Chelewani	23/04/09-24/04/09	Not available
20	Chitipa District Hospital	District Health Officer	Mr Jere	23/04/09-24/04/09	
21	Chitipa District Hospital	Acting Matron	Doreen Nyasulu	23/04/09-24/04/09	doreennyasulu@yahoo.com
22	Chitipa District Hospital	HMIS Officer	Mr. Collins Mfungwe	23/04/09-24/04/09	mfungwecw@yahoo.com
23	Chitipa District Hospital	Clinical Officer	Mr. Felix Simbeye	23/04/09-24/04/09	Not available
24	Chitipa District Hospital	Community Nurse	Mrs. Harriet Ndhobvu	23/04/09-24/04/09	
25	Chitipa District - Kameme Health Center	Medical Assistant	Emmanuel Salima	23/04/09-24/04/09	Not available
26	Chitipa District - Kameme Health Center	Environmental Health Assistant (zone supervisor)	Saulosi Kanyinji	23/04/09-24/04/09	Not available
27	Chitipa District - Kameme Catchment Area	Traditional Authority		23/04/09-24/04/09	Not available
28	Chitipa District – Ifumbo Health Center	Medical Assistant (CBMNC master trainer)	Mr Mkandawire	23/04/09-24/04/09	Not available
29	Mzimba District Hospital P.O. Box 131 Mzimba	District Medical Officer	Dr Mwale	28/04/09	
30	Ekwendeni Mission Hospital Livingstonia Synod – The Church of Central Africa Presbyterian P.O. Box 19 Ekwendeni	NBH Coordinator	Rose Gondwe	27/04/09	rosegondwe@gmail.com
31	Ekwendeni Mission Hospital Livingstonia Synod – The Church of Central Africa	Assistant NBH Coordinator	Maggie Munthali	27/04/09	mmunthalie@gmail.com

No	Partner/ Stakeholder	Position/Title	Name	Date/Time	Email address
	Presbyterian P.O. Box 19 Ekwendeni				
32	Ekwendeni Mission Hospital	BCC Coordinator	Alfred Chimaliro	27/04/09	achimaliro@gmail.com
33	Ekwendeni Mission Hospital	Acting PHC Director	Ellie Kapenda	27/04/09	
34	Ekwendeni Mission Hospital	Deputy Matron	Grace Mughogho		
35	Mai Mwana P.O. Box 2 Mchinji	Program Manager	Tambose Phiri	29/04/09	maimwana@malawi.net
36	CHAM-Central	Deputy Director of Health Programs	Lawrence Yobe	29/04/09	lyobe@cham.org.mw
37	CHAM-Central	PHC Manager for MNC Health	Patrick Nayupe	29/04/09	pjnayupe@cham.org.mw
39	Thyolo District Hospital	Safe Motherhood Leader	Albert Mdala		

Annex 11: Project Data Form

Child Survival and Health Grants Program Project Summary

Oct-17-2009

Save the Children

(Malawi)

General Project Information:

Cooperative Agreement Number:	GHS-A-00-06-00016
Project Grant Cycle:	22
Project Dates:	(10/1/2006 - 9/30/2011)
Project Type:	Expanded Impact
SC Headquarters Technical Backstop:	Karen Waltensperger
Field Program Manager:	Evelyn Zimba
Midterm Evaluator:	Judith Robb-McCord
Final Evaluator:	
USAID Mission Contact:	Catherine Chiphazi

Field Program Manager Information:

Name:	Evelyn Zimba
Address:	
Phone:	+2658277091
Fax:	
E-mail:	ezimba@savechildren.org

Alternate Field Contact:

Name:	Jeanne Russell
Address:	
Phone:	+2658206848
E-mail:	jrussell@llmw.savechildren.org

Funding Information:

USAID Funding:(US $): $2,500,000 **PVO match:(US $)** $833,334

Project Information:

Description:

Malawi Newborn Health Program

Many factors contribute to Malawi's high maternal mortality ratio (984/100,000 live births, 2004 DHS), under-five mortality rate (133/1,000, 2006 MICS), and neonatal mortality rate (31/1,000, 2006 MICS), including: 1) low access and availability of quality health care for mothers and newborns, 2) poor recognition of danger signs and 3) inappropriate household practices and care-seeking behaviors; 4) weak social and policy enabling environment; and 5) livelihood challenges. Save the Children's Newborn Health Program – funded by USAID/CSHGP with match from Saving Newborn Lives - focuses on the main causes of neonatal mortality: infection, birth asphyxia, consequences of prematurity and low birth weight, and related maternal factors. Together, these account for 89% of all newborn deaths in Malawi. The national-level Malawi Newborn Health Program supports the government's Essential Health Package (EHP) and Accelerated Child Survival and Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI), including community IMCI (c-IMCI); and is integrated into a multi-year (2005-15) national initiative led by the Ministry of Health (MOH) and guided by The Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity in

Malawi (Road Map), the national framework adopted by the Government of Malawi (GOM) in 2005 and officially launched during this fiscal year (30 March 2007). The Malawi Newborn Health Program overlaps in time with the Road Map's first two phases (2005-08 and 2009-11) and contributes to achieving Road Map goals, objectives, and targets. As a Road Map partner at the national level, Save the Children cooperates closely with MOH Reproductive Health Unit (MOH/RHU) and other international organizations and key stakeholders (including PMNCH, the Partnership for Maternal, Newborn, and Child Health) to expand and mainstream quality neonatal care at all levels of health service delivery. In FY08, these partners will be joined and strengthened by ACCESS, a global project of USAID in which Save the Children is a partner and will play a role in Malawi. The Malawi Newborn Health Program is funded from two complementary sources - the United States Agency for International Development/Child Survival and Health Grant Program (USAID/GH/HIDN/NUT/CSHGP) and Save the Children Saving Newborn Lives (SNL) as match - and integrated as a single program through a merged work plan and unified team functioning. Broadly speaking, SNL match funds are focused on design, development, and evaluation of a community-based maternal and newborn package and operations research/evaluation to generate feasibility evidence for delivery of the package in three learning districts; while USAID/CSHGP funds drive technical leadership at the national level and scale-up activities; including partner coordination, advocacy for policy change and application, and support to the national health management information system (HMIS) to integrate newborn health into existing packages. In addition, SNL funds Mai Mwana, a randomized control trial (RCT) of community-based interventions for newborn care, being carried out in Mchinji District by the Institute for Child Health, University of London.
The Malawi Newborn Health Program - carried out in partnership with MOH, UNICEF, and other key stakeholders - reaches approximately 500,000 neonates (0-28 days) born in Malawi every year and their mothers with:

* Increased availability of and access to key maternal and newborn care services (increased numbers of Health Surveillance Assistants (HSAs); increased capacity of HSAs and health workers; increased number of facilities better supplied; service delivery better coordinated along continuum of care; stronger and more effective linkages between health facilities and community care providers);
* Improved quality of key maternal and newborn care services (improved health worker performance and supervision; more culturally acceptable service delivery);
* Improved household-level attitudes and knowledge of key essential newborn care and related maternal care behaviors (improved communication through multiple channels of key antenatal, delivery, ENC, PNC messages and service information);
* Improved policy and enabling social environment for maternal and newborn health (changed policies; improved standards; re-energized advocacy, networks, community mobilization; increased capacity and engagement of civil society organizations).

To address the many challenges to achieve impact at scale for maternal and newborn health, Save the Children works at the national level and:
* Supports Government of Malawi strategies and integration of maternal and newborn care into existing strategies, programs, and packages, including: (1) Sector Wide Approach (SWAp), (2) Essential Health Program (EHP), (3) Road Map for Accelerated Reduction of Maternal and

Newborn Mortality and Morbidity, (4) Accelerated Child Survival and Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI).
* Generates evidence through implementation research and evaluation on design and delivery of a community-based maternal and newborn care package integrated with the SWAp, EHP, Road Map, and ACSD/IMCI to be taken to scale in all 28 districts of Malawi;
* Partners with the Ministry of Health (MOH), UNICEF, WHO, UNFPA, and other national and international stakeholders in supporting joint planning, review, implementation, and evaluation to reach common goals and objectives;
* Plays a technical leadership role on national-level task forces and working groups in order to ensure quality newborn care all along the household-to-facility continuum of care;
* Engages strategic partnerships at the national level, including: (1) Partnership for Maternal, Newborn, and Child Health, (2) White Ribbon Alliance for Safe Motherhood in Malawi (WRASM);
* Cooperates with the USAID Mission in implementation of ACCESS (Access to Clinical and Community Maternal, Neonatal and Women's Health Services), the USAID global project, as well as with BASICS III (Basic Support for Child Survival), USAID's global flagship project for reduction of under-five mortality;
* Influences national policy through strengthening the enabling environment, including local advocacy capacity (WRASM), and ensuring incorporation of evidence-based best practices into Malawi's policy, norms, and protocols.

The Malawi Newborn Health Program is also partners with Ekwendeni Mission Hospital, a Christian Health Association of Malawi (CHAM) member facility in Mzimba District, to refine, document, and package its innovative agogo (grandparent) approach for community mobilization and behavior change for dissemination to NGOs, faithbased institutions, and community-based organizations.

Goals, Objectives, Results: Road Map Goal: reduced neonatal mortality and morbidity at scale to meet Malawi's Millennium Development Goals (MDGs) by 2015. Strategic Objective: Increased sustainable use of key maternal and neonatal heath services and practices; IR-1: increased availability of and access to key maternal and newborn care services; IR-2: Improved quality of key maternal and newborn care services; IR-3: Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors; IR-4: Improved policy and enabling social environment for maternal and newborn health.

Location:
Malawi (national level)

Project Partners	Partner Type	Subgrant Amount
Ministry of Health (Reproductive Health Unit)	Collaborating Partner	
Ekwendeni Mission Hospital (Synod of Livingstonia)	Subgrantee	$124,972.00
UNICEF	Collaborating Partner	
WHO	Collaborating Partner	

Christian Health Association of Malawi	Collaborating Partner	
White Ribbon Alliance for Safe Motherhood-Malawi	Collaborating Partner	
UNFPA Collaborating Partner	Collaborating Partner	
ACCESS/MCHIP	Collaborating Partner	
Subgrant Total		$124,972.00

General Strategies Planned:
Advocacy on Health Policy

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Lot Quality Assurance Sampling
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:
(None Selected)

Groups Targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
(None Selected)	(None Selected)	(None Selected)	(None Selected)	(None Selected)

Interventions/Program Components:
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)

(CHW Training)
(HF Training)

Maternal & Newborn Care (100 %)
(IMCI Integration)
(CHW Training)
(HF Training)
- Recog. of Danger signs
- Newborn Care
- Post partum Care
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)

Target Beneficiaries:

Infants < 12 months:	**500,000**
Children 0-59 Months	**500,000**

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child.	**0**	**0**	**0.0%**	**0.0**
Percentage of children ager 0-23 months whose births were attended by skilled personnel.	**0**	**0**	**0.0%**	**0.0**

Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall).	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who received a measles vaccination.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age12-23 months who received a DPT3 vaccination before they reached 12 months.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti malarial drug within 24 hours after the fever began.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	**0**	**0**	**0.0%**	**0.0**
Percentage of households of children age 0-23 months that treat water effectively.	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of children 0-23 months who live in a household with soap or a	**0**	**0**	**0.0%**	**0.0**

locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview				
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	**0**	**0**	**0.0%**	**0.0**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population).	**0**	**0**	**0.0%**	**0.0**
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	**0**	**0**	**0.0%**	**0.0**

Comments for Rapid Catch Indicators

IYCF not collected. The on-line form doesn't seem to have been updated for the Revised Rapid CATCH, e.g., no AMTSL indicators, etc. The KPC Survey was conducted in one district, Mzimba, in order to collect Rapid CATCH indicators. NO MIDTERN SURVEY CONDUCTED.

Annex 12: Report of Review of the Ekwendeni *Agogo* Approach

The sub-grant between Ekwendeni Mission Hospital and Save the Children was completed in March 2009. During the MTE, Team 1 spend two days at Ekwendeni to interview staff, community leaders, and grandparents; visit a field site; and measure progress. Its report follows:

In 2004, with funding from SNL1, Save the Children's partner, the Ekwendeni Mission Hospital (Church of Central Africa Presbyterian, Synod of Livingstonia), a CHAM facility, trained nearly 4,000 *agogo*s (grandparents) to be mobilizers for positive change in maternal and newborn health. *Agogo*s were selected for training because, as elders, they are trusted and listened to in their communities. Grandmothers are close advisors to their daughters and daughters-in-law and grandfathers carry a great deal of influence in the household and in the community especially in terms of decision making. *Agogo*s are also gatekeepers and custodians of traditional practices, some of which are harmful to newborns. Communities selected *agogo*s for training who were older than 50, had at least one grandchild, were good communicators, knew the traditions, and were respected in their community.

In order to document and package the *agogo* approach for dissemination, the MNBHP continued to support Ekwendeni's *agogo* approach through a sub-grant from September 2007 to March 2009 (with CS-22 funds). Prior to initiation of the sub-grant, Save the Children engaged Judi Aubel, Founder and Director of the Grandmother Project based in Rome, to assist Ekwendeni with a qualitative assessment of the *agogo* strategy to inform the expansion, documentation and packaging of the approach. During the period of the sub-grant, Ekwendeni staff trained or re-trained 4,100 *agogo*s (1,635 males and 2,375 females). Of those trained, 3,090 *agogo*s from the Ekwendeni catchment area received a two-day refresher training; and 1,010 newly recruited *agogo*s from four government health centers received an initial three-day training. These trained *agogo*s are from 487 villages representing 100% coverage of the Ekwendeni catchment area and approximately 90% coverage of the four government health center areas (Mtwalo health center, Enukweni maternity, Khuyuku health center, Emsizini health center) that Ekwendeni serves under a service agreement with the district. The training package was developed during a workshop with relevant stakeholders in MNH and Save the Children staff co-facilitated the initial trainings.

To assist Ekwendeni with documentation and packaging, Save the Children recruited a post-graduate intern, Melinda Van Zyl (now with Save the Children UK in South Africa) in mid-2008 to assist the Ekwendeni Primary Health Care (PHC) team to document the *agogo* approach. The resulting draft report, "The Ekwendeni *Agogo* Approach: Grandparents as agents of newborn survival" is currently being edited and will be packed with the training and monitoring tools for dissemination to community-based organizations, local NGOs, faith-based, CHAM facilities, and other interested parties.

In March 2009, as the sub-grant ended, Save the Children collaborated with Ekwendeni to conduct a rapid assessment of *agogo* message retention (approximately six months after training). Nearly all of *agogo*s (99%) scored above 50% on message retention.

The MTE team that visited Ekwendeni met with 27 *agogo*s and found that they demonstrate accurate knowledge of key messages and accurate practices for maternal and newborn health. *Agogo*s are educating pregnant and recently delivered women through group and individual counseling. They also use song, poems, and drama. They promote early ANC, delivery at facility, PNC, ENC, recognition of dangers signs, and family planning. For example, one of the male *agogo*s described what to do with a baby born on the side of the road in terms of drying and wrapping the newborn using different cloths for each act. And one of the female *agogo*s did a full demonstration of how to place a newborn in the KMC position. Both male and female *agogo*s refer women to the health facility for ANC, PNC, or follow-up on danger signs but it is the females who will accompany women to the health facility, especially for delivery. Ekwendeni has also extended the *agogo* approach to other areas to include the promotion of HIV counseling and testing and PMTCT.

*Agogo*s report that young people are accepting their messages. They have observed the following change in practices: (1) increased seeking of MNH services at a health facility (1st trimester ANC and delivery); (2) more women going to maternity waiting homes; (3) a shift from traditional family planning methods to modern ones; (4) exclusive breastfeeding and no longer giving porridge to babies; (5) not giving prelactal herbal infusions to baby and insisting on immunization; (6) no application of any substance to the cord; (7) delayed bathing for 3 days; and (8) no longer banishing twins to the bush (out of a belief that livestock would die if the babies stayed in the home).

A monitoring system is in place and the data is flowing with minimal issues. *Agogo*s collect information on pregnancies, deliveries, and post-natal care and record it in a project register (one per village). HSAs collect the *agogo*s' information monthly and submit it to the hospital. In addition, Ekwendeni staff members collect HMIS data from the health centers on ANC and deliveries. In the reports submitted to Save the Children, Ekwendeni concentrates on the HMIS indicators and not the data collected by the *agogo*s. There is no apparent analysis or use of data at community, HSA, or facility level.

Under SNL 1, the program staff reported a lack of supervision in the program which was recognized as a weakness and therefore it was strengthened in the follow-on program. *Agogo*s are supervised by HSAs and the primary health committee chairman at the community level. The Ekwendeni BCC coordinator also meets with *agogo*s as a group using a focus group guide and ensuring the participation of all *agogo*s. Knowledge assessments during supervision are done using the pre/post test as a guide, but no scoring of answers is done. The current monitoring system is not capturing attrition in terms of *agogo*s who are inactive after training, leave the project area, or die.

The group of 27 *agogo*s interviewed, which included village headman, religious leaders, and equal participation from males and females, report having a good relationship with the Ekwendeni Hospital, the primary health chairman who has been trained as a supervisor and provides technical assistance, and the HSA who assisted in the facilitation of trainings, conducts supervision, and compiles *agogo*s' reports for the hospital.

With the end of grant, Ekwendeni does not have funds to continue supervision or additional trainings for the *agogo*s. However, the staff that worked on the program remain part of the hospital's preventive health care team. The supervisory HSA oversight structure and support of community leaders remain. It is anticipated that the changes in social norms will endure and pass from grandmother to mother to daughter and daughter-in-law through cultural channels.

Challenges

- There are numerous organizations that have expressed interest in the *agogo* approach and requested materials from Ekwendeni hospital. However, the Ekwendeni PHC team does not yet have a comprehensive package of materials to share that will ensure quality replication. For the time being they suggest to those interested in the project to visit but few organizations act on this invitation. The dissemination package that SC is helping Ekwendeni put together is intended to fill this gap.
- The trained *agogo*s report that their training was too short. They communicated that they feel the two to three days of training is not enough time to capture all they need to learn on MNH. The men would like more info on PMTCT, KMC and "how babies grow." Women mentioned wanting more training on PMTCT and family planning. Program staff felt the *agogo*s needed more time to learn how to fill in the project registers.
- Ekwendeni PHC staff report that the sub-grant relationship with Save the Children went well, except for the last three months in the grant when a change in a Save the Children accountant led to delays in the transfer of funds.

Recommendations

- Assist Ekwendeni with developing a PowerPoint presentation that can be used to promote the *agogo* approach with CHAM, district and national health meetings to disseminate this successful approach.
- Continue assisting Ekwendeni with the packing of reports, materials and tools in a "how-to" guide that can be shared with partners.
- Support Ekwendeni in proposal writing and scanning and identifying funding opportunities and possible donors to continue to supervise, monitor and re-train *agogo*s as well as to serve as a learning site for interested partners.
- As planned, use LQAS sampling methodology for the population-based CS-22 endline (KPC) in Mzimba to compare changes in the Ekwendeni areas to other parts of Mzimba District without *agogo* the benefit of coverage.

Annex 13: Ekwndeni Final Report

FINAL REPORT

DRAFT

EKWENDENI AGOGO APPROACH PROGRAMME

GRANT NUMBER 10346

2nd AUGUST 2007 TO 31st MARCH 2009

Submitted by

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OUTLINE OF FINAL REPORT

TABLE OF CONTENTS

1. ACRONYMS/ABBREVIATIONS

ANC	Antenatal Care
BBA	Born Before Arrival
CBDA	Community-Based Distribution Agent
DHO	District Health Office
ENC	Essential Newborn Care
F	Female
HCT	HIV Counseling and Testing
HSA	Health Surveillance Assistance
IEC	Information, Education, Communication
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
M	Male
NND	Neonatal Deaths
PHC	Primary Health Care

2.0 EXECUTIVE SUMMARY

Ekwendeni Hospital through SNL funding in 2004 introduced the agogo approach with an aim to improve health care seeking behaviour of pregnant women and newborns. The strategy used the agogo to influence mothers and their newborns to go for medical treatment early when there is any health problem related to pregnancy and newborn. Undocumented evidence showed significant improvement in health care seeking behaviour of mothers and newborns.

It is against this background that in 2007 Ekwendeni, with funding from Child Survival (CS-22) grant through Save the Children, thought of refining, defining and documenting the role of grand parents in the prevention of maternal and newborn morbidity and mortality. Grand parents have inherent role of advising the young mothers on issues related to pregnancy and childbirth. It is only when the grandparents have good information that they will be able to advise accordingly.

In this second phase of the approach Ekwendeni thought of developing a training manual for the agogos using the loose materials that they used to orient the agogos during the first phase. Content in the training manual include normal pregnancy, antenatal care, danger signs during antenatal, labour and delivery, immediate care of the baby and Kangaroo mother care. Agogos that were oriented in the first phase were refreshed using the manual and they also recruited 1000 new agogos who were trained using the manual. Refresher took two days per session while training took three days per session.

After the curriculum was developed mapping exercise of the agogos was done. This was necessary to make sure how many agogos that were trained in the first phase are still available and working. Out of the 4000 that were trained initially 3000 were identified during the mapping exercise. These underwent a refresher training using the training manual. During the training, the agogos were very grateful with what they were being taught, They were able to explain why they were doing some of the harmful cultural practices e.g. when a woman is having convulsions, they said it means, the woman has multiple partners as a result they were ill-treating her so that she should not have multiple partners again and this woman was never taken to any health facility. But with the introduction of the agogo approach, these agogos have realized the importance of taking the women with convulsions to the hospital and they now know the causes of those convulsions.

These agogos promised to change their bad practices because now they have the knowledge. They said once they reach home, they would no longer practice bad behaviours that promoted deaths of mothers and neonates. One agogo commented that those women who will deliver after these trainings are lucky because the agogos are now equipped with new ideas which are really practical and there is nothing which can stop them from changing the culture as they are the owners of the villages and the owners of culture too.

Supervision of agogos was key to this program. The primary supervisor of the agogos was a Health Surveillance Assistant (HSA) who was also oriented on the approach. Program level supervisors were also making visits to the agogos just to make sure that they are able to follow what they were taught during training. Another major reason why supervision was intensified was the fact that these are old people despite the knowledge gained and required coaching for them to master the skills. During supervision they were grateful with the visitation and requested for more visits to their communities.

As a matter of enforcing the skills, IEC materials were distributed to the agogos which they used during counseling of the pregnant mothers. The IEC materials, which were distributed, had messages on danger signs during pregnancy, birth preparedness and kangaroo mother care.

Since the whole idea of carrying out this approach for the second time was to refine, define and document the role of grand parents in the prevention of maternal and neonatal morbidity and mortality assessment of the program was done from 16th to 20th February 2009.

The report highlights major accomplishments of the program, challenges faced during implementation, recommendations and the lessons learnt during the implementation of the agogo approach.

3.0 INTRODUCTION

Background

Traditional practices and beliefs regarding pregnancy and newborn care are widely observed in the catchment area of Ekwendeni and beyond. While some of these may be beneficial or at least harmless, others contribute to poor maternal and neonatal health. In some areas, the mother and the baby undergo a traditional confinement period of seven to ten days after delivery until the baby's umbilical cord falls off. Babies are not always dried or warmed immediately soon after birth, or they may be washed before being put to the breast. Some of the newborns between one week and three months are fed with water and water mixtures which can greatly increase chances of infections and contribute to poor health and development. Some traditional beliefs prevent women from disclosing pregnancy and seeking antenatal care at the earliest stage.

Among the different villages in the catchment area, there are some variations in decision-making and health care seeking behaviour that affects the demand of services. Men, for instance, are the key decision-makers regarding where a pregnant woman should go for delivery. Mother-in-laws and grandparents also play a greater role in decision-making about seeking care for newborns once an illness is recognized while women in other communities follow a complex process that involves the extended family members on both sides.

It was to this background that Ekwendeni in 2004 with funding from Saving Newborn Lives phase 1 (SNL 1) thought of working with grand parents taking advantage on the fact that agogo influence decision-making and practices related to maternal and neonatal health in their communities.

The agogo program started due to high neonatal and maternal death rates caused by harmful cultural practices. The strong support for the involvement of agogo in maternal and neonatal health activities from both community members and Ekwendeni staff stems from the fact that the agogo strategy builds on cultural roles and responsibilities of the agogo. At both the household and community levels, agogo influence decision-making and practices related to maternal and neonatal health. By acknowledging the role of the agogo as family advisors and teachers, the strategy has been a strong source of motivation for them to be more involved in community programs.

The program showed significant improvement in health care seeking behaviour of maternal and newborns but it lacked documentation as evidence for the improvement in the care seeking behaviour. Then in 2006 with funding from Child survival (CS-22), Ekwendeni thought of refining, defining and documenting the best practices in the agogo approach which can be shared to other interested stakeholders or communities in Malawi.

Goal.
The goal of the project was to reduce maternal and neonatal morbidity and mortality in Ekwendeni catchment area.

Objectives.

- To facilitate positive behaviour change that promotes maternal and newborn care and survival among grand parents (Agogo)
- To document success stories, challenges and positive behaviour changes in the community aimed at reducing maternal and neonatal morbidity and mortality rates in Ekwendeni catchment area.
- To come up with a standardised training curriculum for the agogo that can be adopted by Malawi government.

Project description.
The project aimed at refining, defining and documenting the role of the agogo in the prevention of maternal and newborn morbidity and mortality. The project started with a census of the old agogo who were trained by Ekwendeni through SNL 1 project funding, and development of a curriculum for agogo training. Out of the 4000 old agogo trained during SNL1, 3000 agogo were refreshed using the developed curriculum. These came from Ekwendeni catchment area and an extra 1000 new agogo from outside Ekwendeni catchment area were also trained.

4.0 MAJOR ACTIVITIES AND ACCOMPLISHMENTS

4.1 MANAGEMENT ISSUES

- Recruitment of staff and staff retention
    - 1 BCC Officer was recruited for the project.
- Management meetings
  Planned meetings
    - 12 meetings were planned for the entire project life but only 11 were conducted.
- Other administrative issues
    - Vehicle maintenance has been done when need arisen.
    - Office supplies have been bought.

4.2 START UP ACTIVITIES

Manual development
Development of the manual for agogo training was the first thing to be done in July 2007. It took place at Ilala lodge in Mzuzu. The following participated in the development of the manual: Representatives from CHAM, Ekwendeni College of Nursing, Save the Children, Ekwendeni team and Mzimba DHO. After the meeting, the manual was written and circulated to the development team for comments and later revised accordingly.

The manual was also piloted using the first training of agogos in October 2007 and followed up on the group in December 2007. The follow up visit was to qualitatively assess knowledge retention and activities of the agogo in the community.

Mapping
Mapping and registration of agogo was done in September 2007, in order to know how many agogos trained in the SNL 1 were still available and how many new agogos were to be included. It was a very exciting exercise as many agogos showed interest to participate in the program.

4.3 ORIENTATION OF HSAs
Orientation of HSAs from outside Ekwendeni catchment area was conducted from 12th to 13th December 2007. The team from save the children came to assist orienting these HSAs. The team comprised of Maggie Kambalame, George Chiundu and Reuben Ligowe. 42 HSAs were oriented on what agogos have been trained in, and what they are expected to do in their communities and how they are going to be assisting these agogos. They were also oriented on how to fill the report forms. A second group of HSAs was oriented from 28th to 29th February 2008 and these were from within Ekwendeni catchment area. They were 28 in total.

4.4 AGOGO TRAINING
The initial training sessions of the agogos started on 10th October 2007 and ended on 1st December 2007 and the refresher course sessions started on 17th march 2008 and ended on 26th August 2008. Nurses, clinicians and HSAs from Ekwendeni facilitated the trainings. A total of 3000 agogos from within Ekwendeni catchment area were refreshed and 1000 agogo from outside catchment area were trained. Each session of the initial trainings was for three days while each refresher course session was for two days and it was conducted in two classes per session with an average of 40 agogos per class. The training was just theory.

Mode of training and content
The training was theory and participatory where by agogos were given chance to explain what they know before giving them new information. This made them feel respected as a result the lessons became easily acceptable. Most of the topics were done through group work in order to give chance to agogos to express themselves freely and they also asked questions when they were not clear with certain issues. Many agogos showed interest in this type of approach. Due to short training period (two or three days), the knocking off time was prolonged in order to cover more topics.

The curriculum was designed such that the training covers four modules. Module one aims at assisting grand parents to gain knowledge on maternal and newborn health status in Malawi and inform them about their role to enable them participate in maternal and neonatal care at community level.

Module two aims at equipping grand parents with knowledge, skills and attitude necessary for promoting, and advocating for care during pregnancy and after delivery and at community level.

Module three aims at equipping grand parents with necessary basic knowledge, skills and attitudes in essential newborn care (ENC) in order for them to be able to support mothers and newborns in the community.

Module four aims at equipping grand parents with knowledge, skills and attitudes on how to care for LBW / preterm babies and KMC so that they can properly support mothers who have LBW babies.

Issues of data collection, monitoring and linkages with HSAs for supervision and support were taught and discussed at the end of the training. Agogos were given hard cover books per village for

documentation of their work. This was done to generate data of their activities as the main reason for the program was to document the process, agogo work and its lessons.

Pre-test and post-test

In order to assess if agogos are getting knowledge out of the trainings, a pre/post test was designed and given to each trainee before (pre test) and after (post test) the training. The test was given through oral questioning, asking agogos individually and let them explain what they know or understand because most of the agogos were illiterate.

Results of the pre-test, ranged from 6% - 76%, were withheld until after the completion of the post-test, which, Results ranged from 6% - 100. Most of the agogos showed that they had increased their knowledge through the trainings.

SUMMARY FOR AGOGO TRAINING RESULTS

Scores	**Pre-Test**				**Post- Test**			
	Male	**%**	**Female**	**%**	**Male**	**%**	**Female**	%
0 -20%	**214**	**5**	**321**	**8**	**184**	**5**	**88**	2
21 -40 %	**590**	**15**	**495**	**12**	**243**	**6**	**200**	5
41 -60%	**593**	**15**	**643**	**16**	**456**	**11**	**598**	**15**
61 -80%	**439**	**11**	**705**		**553**	**14**	**806**	20
81 -100%	**0**		**0**		**400**	**10**	**472**	12
Total	**1836**		**2164**		**1836**		**2164**	

Echoes from agogo during training
We wish we were trained earlier; most of our grandchildren would have been saved.

4.5 AGOGO COMMUNITY ACTIVITIES

The agogos formed clubs according to their villages, soon after their training. They have days when they meet and discuss different topics and burning issues, sometimes with the assistance from the HSAs. They also have specific days where they meet the community, mostly once a weak. They teach and counsel the community in MNH and other health related issues. They do this through health talks and discussions, songs and drama performances.

Most of the agogos perform drama together with the already existing drama groups in their communities. They perform the dramas at the antenatal and under five clinics and sometimes they are given chance to give health talks. Others disseminate information through songs and this attracts the community members. The most encouraging thing is that even the children are able to sing these songs.

They are also doing door to door visitation to make sure all the women are counseled and assisted as an individual or as a couple. Usually the female agogos would counsel both the woman and the man but the male agogo counsels the man only because of culture which says a woman should not talk to the father in law as a way of respect.

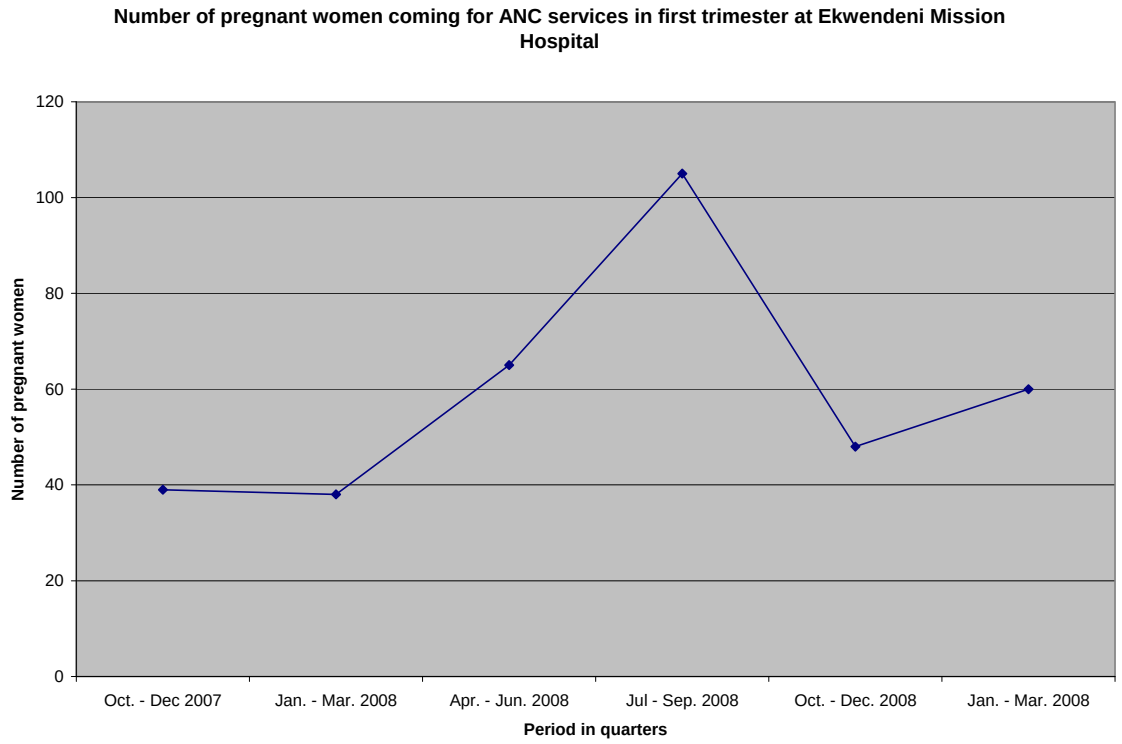
Another major activity the agogos are doing is to escort mothers to the hospital when in labour or when a woman has danger signs or the baby is sick. The agogos are trying hard to discourage home deliveries by telling the women to await labour at the hospital.

Some agogo participate in other health related activities, like village health committees, CBDAs and some are HTC promoters, and this makes them become more active.

4.6 PROGRAM CONTRIBUTION TO KEY MNH ACHIEVEMENTS

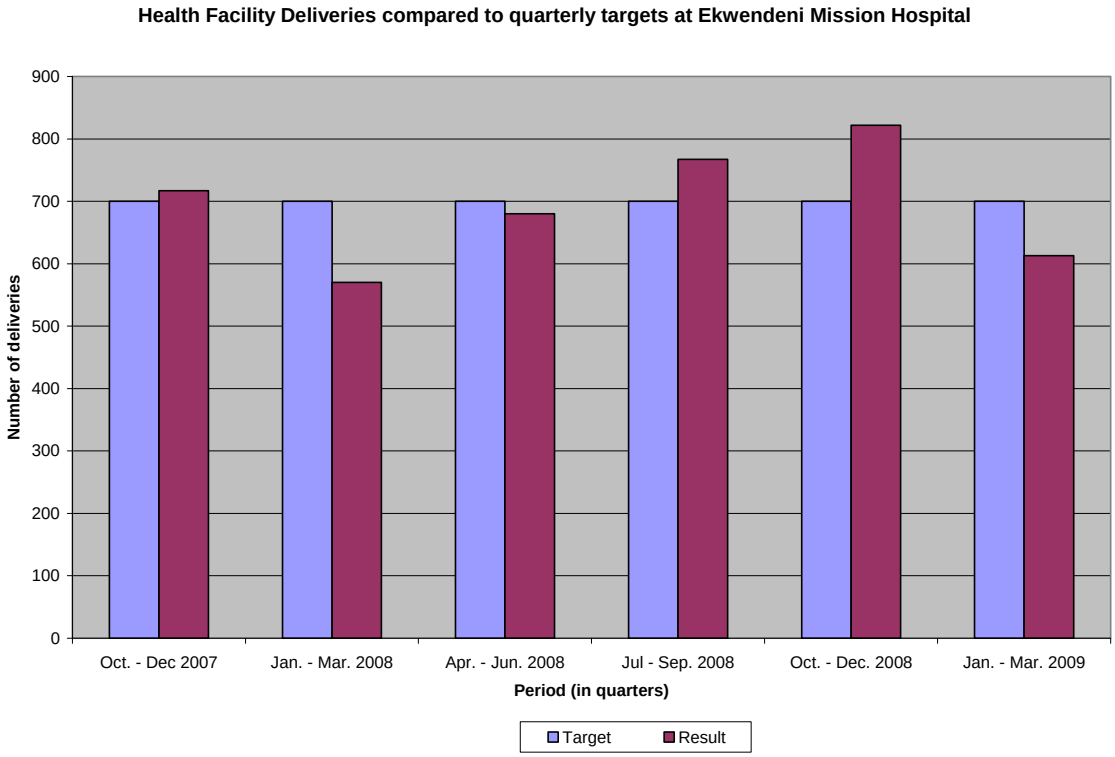
Antenatal services

Ekwendeni Mission Hospital and its surrounding health centers have noticed increased use of antenatal services by pregnant women. However, number of pregnant women coming for first antenatal visit during first trimester is still low although improving. During the period of the agogo approach program, Ekwendeni Mission Hospital has attended to 355 pregnant women starting ANC in first trimester as elaborated in the graph below.



Health Facility Deliveries

Health facility deliveries have improved in all the facilities with more women coming before expected date of delivery (EDD), to wait for labor in waiting shelters. For instance, Ekwendeni Mission Hospital alone, which had set its quarterly target of deliveries at 700 and to a total of 4200 deliveries in the period of the program, had actually assisted 4169 deliveries. The chart below details quarterly deliveries against the targets.



5.0 MONITORING AND EVALUATION

5.1 SUPERVISORY VISITS

Supervisory visits were done outside and within Ekwendeni catchment area. Agogos were supervised on quarterly basis by their Health Surveillance Assistants (HSAs) who were oriented to the program. The HSAs were also providing support to agogos in documentation and linking them to health facilities.

Apart from the HSA's quarterly supervision, the program team from Ekwendeni was visiting the agogos and their communities for supportive supervision and periodic assessments on knowledge and activities of agogos in the communities. A total of 2694 agogos have been supervised by the program team. Most of the agogos are still having the knowledge they gained during training, and are really assisting women in the communities very much by referring them to deliver at the hospital. They also refer mothers and babies with danger signs and for postnatal check up.

At least 8 out of 10 mothers from each area visited, were able to say what the agogos are doing and information they are disseminating in the communities especially on newborn care, and mentioned some harmful cultural practices which they have stopped as a result of agogo work. Some of the harmful practices that have stopped include the sending of mothers and babies to the bush when

they deliver twins or when they deliver by breech. The mothers explained how the agogos have improved their lives by assisting them during pregnancy and after delivery, for example, agogo have, been advising them on newborn care especially on exclusive breastfeeding, identification of newborn danger signs and the importance of one week postnatal check up.

During the supervision, IEC materials were distributed so that the agogos can use when counseling women. A total of 1100 IEC materials were distributed. The IEC materials which were distributed had messages on danger signs during pregnancy, birth preparedness and kangaroo mother care.

As mostly supervision was done qualitatively through discussions, on 30th May 2008, Ekwendeni team visited Chimbongondo, Elangeni and Mkamaumoza areas to mainly assess knowledge retention by agogos through focus group discussions (FGDs). It was noted that most agogos still remembered much of the information and disseminated right information to their communities.

Supervision summary

	Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Total
Number of supervisory visits made to agogos by program team	1	7	4	8	6	5	31
Number of agogos supervised by program team	45	325	155	1130	675	364	2694

5.2 DATA QUALITY ASSESSMENT (DQA)

As a requirement of USAID, Malawi Mission, and in order to improve on quality of data the program reports on, a data quality assessment exercise was done on 23 – 24 May 2008. One area, Kavula, was sampled and visited for data verification and validation. The team comprised of George Chiundu and Reuben Ligowe, representatives from Save the Children and Ekwendeni program team.

The team first reviewed the indicators to assess whether they are valid, reliable, precise, and whether they are reported timely and data is safeguarded from unauthorized changes. Data flow was discussed with an aim of identifying and ironing out weaknesses of the system.

Data was then reviewed and data from Kavula area extracted. This data was checked against the data at sources, HMIS data from the area's health centre and agogo data from their registers.

Apart from checking data for DQA, the team discussed with the agogos about their work and how they can go around the challenges they were facing.

5.3 AGOGO POST TRAINING ASSESSMENT

Agogo assessment was done from 16th to 20th February 2009 in some of the communities within and outside Ekwendeni catchment area by Save the Children and Ekwendeni staff. The assessment was done in 10 randomly sampled areas, with two objectives as follows:

- To assess how much knowledge agogo were able to retain from the training after a minimum period of six months.
- To assess activities being conducted in the communities by agogo.

The assessment included, in depth interviews and focus group discussions. The results were very impressive because it showed that many agogos are active in their communities. 80% of the agogos could remember at least 75% of materials taught to them during training. The most remembered areas of training included birth preparedness (95%), danger signs for newborn (86%), danger signs during pregnancy (86%), advantages of antenatal care (84%) and immediate care of the newborn (83%).

It was noted during the assessment that the work of the agogo have led to improvement in behaviors and practices in the community and the agogo and their local leaders reported to have noticed improvement in women's health and their families in the community due to agogo work. The local leaders reported reduction of maternal and neonatal deaths in their areas.

5.4 DOCUMENTATION

The data collected by agogos is really assisting this program to know how agogos are performing and how effective they are in the communities, and the challenges they are facing. It will also assist other people in case of replication.

This data is usually collected by the HSAs from agogo but sometimes when the BCC officer goes for supervision he collects it. The data is first checked by the HSA who makes sure it has been filled correctly before it is sent to Ekwendeni Hospital for entering since some agogos have problems in filling the data.

If there are any serious problems, they are addressed in time to avoid recurrence if possible e.g. when a neonatal or maternal death has been reported, a neonatal /maternal death audit is done together with the family/community involved to prevent it from happening again.

Data flow is good from agogos to Ekwendeni hospital, but there are some problems in the areas where there are new recruited HSAs who are not oriented on agogo activities.

Jonathan Hubschman from America, a representative from Save the Children and Ekwendeni team visited some of the areas from 5th -7th March 2008. The main aim of his visit was to take photographs of agogo activities, some of which could be used locally for documentation. A lot of photographs were taken and agogos were very happy to have their activities captured on camera.

Documentation technical assistance

With an aim to strengthen program documentation, an intern from South Africa, Melinda Van Zyl, visited Ekwendeni from 5th August to 29th August 2008. Her main aim of the visit was to assist Ekwendeni team on documentation of agogo activities including success story writing, data presentation and reporting. She was also an extra pair of hands in the communities during

supervisions. She visited the following communities during her stay in Ekwendeni: Chimbongondo, Zombwe, Ng'ongo, Kapondero, Khuyukuyu, and Enyezini.

Among her activities she managed to:

- Provide technical assistance to Ekwendeni team on writing success stories and case studies.
- Review the program M&E system and made recommendations
- Produced an information sheet about agogo program which included lessons learnt
- Assisted in producing charts for program reporting.

In her information sheet that she compiled for agogo approach, she noted the following successes:

- Villagers are reporting a visible decrease in the number of mothers and newborns who die in their communities.
- The demand for antenatal care has been stimulated, with more mothers attending their first visit within the first trimester of pregnancy than before.
- Mothers are making use of the maternal shelter at the hospital to await the start of labor, and are better prepared for birth thanks to transport arrangements made on their behalf by grandparents.
- The maternity ward at the hospital serving the Ekwendeni catchment area is experiencing a surge in the number of patients who come to deliver at hospital; so much so that they have had to add a new ward with ten additional beds.
- Babies born prematurely in villages no longer arrive at hospital in cardboard boxes smothered with blankets; but are being transported in the Kangaroo Mother Care position (see photograph) and have a much higher survival rate as a consequence.
- Harmful traditional practices have been replaced by good practice in villages where agogos are active, and many patients that in the past would have been treated with traditional medicine are instead being referred to hospital or health centers.
- A free flow of information has resulted from trained agogos to other members of their communities. Children can be found to sing along to the words of songs about good practice in essential newborn care, and agogos actively seek out opportunities to disseminate information.

As a follow up to the documentation support given by Melinda, she visited Ekwendeni again with George Chiundu, Newborn Health M&E Officer on 18th and 19th September 2008 for data management and reporting training of program staff. The training focused on issues of data collection, flow, entry and storage. The team was also trained on data presentation and reporting for quarterly and annual reports as well as interpretation as a step towards data use.

5.5 PROGRAM LEARNING AND SHARING

On 14th December 2007, a team from Save the Children and Ekwendeni visited Kafulufulu which is one of the areas where agogo have been trained. The team was very impressed with live testimonies from the agogos who were able to say everything which they learnt and this showed that there was retention of knowledge. This was part of piloting and learning the best way of training the agogos and approach in the community. The team was satisfied with the approach in the community and knowledge retention by agogos which meant the mode of training was good.

On 10th August 2008, representatives from ministry of Health, USAID and Program Manager for newborn Health Program, Save the Children visited Ekwendeni to see what agogos are doing in the communities after training them. They had a chance of visiting agogo in Mkamaumoza area, one of the service level agreement areas outside Ekwendeni catchment area. They were amazed with what they saw because it gave them a good understanding of the strength of agogos in promoting better practices in the community.

Save the Children's Regional Health Advisor, Karen Waltensperger, Save the Children's Africa Regional Health Advisor, visited Ekwendeni from 20th to 22nd August 2008 and she had a chance of seeing agogos in action in the community. She was much impressed with what she saw and she encouraged the agogos to continue the good work.

6.0 CONSTRAINTS / CHALLENGES

The program faced the following constraints or challenges:

- Inadequate funds for supervision.
- Inadequate time for agogo training.
- A number of newly recruited HSAs in some areas who have no idea about agogo activities, and this delays data collection from the agogo and there is no proper supervision of the agogo by the HSAs.
- Reluctance of some couples to be visited by agogos from other villages thinking they might be witches
- Death of some agogos in some areas affecting agogo work.

7.0 RECOMMENDATIONS

The program faced the following constraints or challenges:

- There is need to increase agogo training period for each session to ensure that they are gaining enough knowledge as most of them are illiterate and learn at a slow pace, knocking off late makes agogo become more tired and bored.
- Enough funds need to be available for frequent supervision to take place, as these are old people who need frequent follow ups.
- There is need to continue documenting activities done in the community.
- There is need to train some more agogo especially in service agreement areas.
- There is need to orient the newly recruited HSAs so that they are aware of what agogos are doing in their communities and their role as HSAs in the agogo activities.

8.0 LESSONS LEARNED

- The traditional decision-making role played by grandparents in certain cultures is a powerful and effective instrument for bringing about behavior change.
- Villagers in very rural, traditional communities readily replace harmful traditional practices if they come to understand the benefit of new behavior.
- Engaging village headmen to select and recruit agogos instantly increases project credibility and community ownership.
- Drama, songs and poems create momentum for dynamic and natural flow of information.
- Agogo activity improves inter-generational communication within communities.

- Frequent supervision of agogos really makes them become more active and confident as they are reminded frequently.
- Documentation in every activity is very vital and helps others to know what the project has done.

9.0 ATTACHMENTS: PLANNED ACTIVITIES

PERIOD	PLANNED ACTIVITIES	ACTIVITIES DONE	ACTIVITIES SHIFTED	REASONS FOR SHIFTING
2007 3rd quarter	Curriculum development	Curriculum development	None	_
	Mapping exercise	Mapping exercise		
2007 4th quarter	Train 1000 agogo from outside catchment area	Train 1000 agogo from outside catchment area	None	_
		Orientation of 42 HSAs	_	_
	Conduct 3 project meetings	3 project meetings conducted	_	_
2008 1st quarter	Refresher training for agogos	422 agogos refreshed	_	_
	Supervision of trained agogos	325 agogos supervised	_	_
	Distribute 500 IEC materials	300 IEC materials distributed		Inadequate materials
	Conduct 3 project meetings	3 project meetings conducted		
2008 2nd quarter	Refresher training for agogos	2187 agogo refreshed		
	Supervision of 500 trained agogos	155 agogo supervised		Rains in some areas
	Distribute 150 IEC materials	50 IEC materials distributed		Inadequate materials
	Conduct 3 project meetings	3 project meetings conducted		
2008 3rd quarter	Refresher training for 391 agogos	391 agogo refreshed		

PERIOD	PLANNED ACTIVITIES	ACTIVITIES DONE	ACTIVITIES SHIFTED	REASONS FOR SHIFTING
	Supervision of 1000 trained agogos	650 agogo supervised		
	Post training assessment for agogo	_	agogos Post training assessment for agogo	To fit Save The Children program
	Conduct 1 project meeting	1 project meeting conducted		
2008 4th quarter	Conduct 1 project meeting	1 meeting conducted		
	Supervision 1000 of trained agogo	675 agogo supervised		Cultivating season
	Distribute 500 IEC materials	200 IEC materials distributed		Inadequate materials
2009 1st quarter	Conduct 1 project meeting	1 meeting conducted		
	Supervision 800 of trained agogo	364 supervised		Rains in some areas
	Distribute 300 IEC materials	100 IEC materials distributed		Inadequate materials
	Post training assessment for agogo	124 agogo assessed		

10.0 SUCCESS STORIES

Tamala Manda's Story

Tamala Manda delivered at home a preterm baby boy at 33 weeks gestation. During delivery her mother in law was away and came back a day later only to find out that Tamala has delivered a preterm baby and is happily nursing the baby at home. Had it not been for the advice of her mother in law to take the baby to the hospital, she would have obeyed to the villager's advice and continued nursing the baby at home which would have led to hypothermia there by increasing neonatal deaths. Tamala's mother in law advised her to carry the baby in kangaroo position when going to the hospital. She arrived at the hospital with her baby in that position.

Tamala's mother in law is a trained agogo from Emsizini area. She is one of the many active agogos who are really assisting mothers in the communities in caring for newborns.

This is the first time for Tamala to have a baby and to carry a baby in kangaroo position was difficult for her in the first few days. Her mother in law was always by her side to assist her carry the baby until she was used. She was very happy with the method and she accused those villagers at home for wanting to kill her preterm baby by not bringing her to the hospital. She has promised that next time she delivers a preterm baby she will not hesitate to bring the baby to the hospital in kangaroo position. The midwife who received Tamala was very happy with the way the baby was carried and praised the agogo for what she did to Tamala.

Memory's Story

In the photo, Memory with her baby and the trained agogo

Memory delivered a healthy baby boy. It is her second baby. She and her husband lives far away from their relatives. Their land lady is a trained agogo. Had it not been for the initiative of the land lady to take her to hospital she would have delivered at home and bleed to death. Memory was in labour at home and her husband had no money for transport. They are tenants who have just come. The land lady assisted memory by taking her own money and brought memory to the hospital. As soon as they arrived at the hospital memory delivered a baby who failed to breathe at birth but the midwife who attended to her assisted the baby to breathe and the baby survived. Memory bled a lot but she survived because she was transfused. If this trained agogo was not around what could have happen to memory and her baby? It would have been another maternal and neonatal death had it not been for the agogo's advice and initiative.

Ester's Story

Ester Soko delivered a healthy baby girl. Had it not been for the advice of her mother-in-law, she would have acted on villagers' recommendations and taken traditional medicine to accelerate labor, a practice which can lead to complications and which annually causes the death of many healthy African babies just like Ester's daughter. Ester's mother-in-law is a trained agogo, a venerable grandparent from her village in Malawi's rural Chimbongondo area, who in 2007 received critical training in matters concerning essential newborn healthcare from staff at Ekwendeni mission hospital, in a program funded by Save the Children and USAID. Now acting as local advisors on matters relating to pregnancy and newborn health, thousands of other agogos like Ester's mother-in-law are helping to lower the newborn mortality rate in Malawi through their influence as decision makers in the community. Fortunately for Ester, her mother-in-law discouraged ill-advised use of traditional medicine and referred her to Ekwendeni hospital instead, where her granddaughter was safely delivered by means of vacuum delivery. Hospital staff who attended the birth were adamant that the little girl would have been yet another neonatal fatality had it not been for the agogo's advice.

Martha Kayuni's Story

Martha Kayuni delivered a preterm baby on 12/03/09 at 34 weeks gestation. She is a tenant but her neighbor is one of the trained agogos. Two days prior to delivery she complained of abdominal pains to her land lord who said she needs to take some local medicine to stop her from delivering a preterm baby.

This trained agogo came to see Martha after she heard that she has been complaining of abdominal pains, fortunately she arrived as Martha was about to take the medicine which was brought to her by the land lord. The trained agogo told Martha not to take the medicine which may be harmful to the baby but instead should go to the hospital for assistance. This agogo escorted Martha to the nearest health centre and an hour later she delivered.

The health centre staff referred Martha and her baby to Ekwendeni hospital for kangaroo care. The baby is growing fast and doing well. Had it not been for the advice of the agogo, Martha would have acted on the land lord's recommendations and took the local medicine which would have harmed the baby there by increasing neonatal deaths. The trained agogos are really assisting the program to reduce the neonatal deaths.

Annex 14: A Report on the Results of the Mini LQAS Survey for the 3-District Demonstration of the Community-Based Maternal and Newborn Care Package Conducted in Preparation for the Midterm Evaluation

Background

The Malawi Ministry of Health (MOH) Reproductive Health Unit (RHU) - in partnership with Save the Children, UNICEF and other partners – is conducting a three-year programme of work that is developing, implementing and evaluating the feasibility, cost and outcomes of a scalable strategy of high impact interventions to improve key maternal and neonatal practices and health care coverage in the three districts of Chitipa, Dowa, and Thyolo.

The goal of this programme is to reduce maternal and neonatal mortality in Malawi. This is being done through delivering an integrated package of community-based high impact interventions for mothers and newborns by Health Surveillance Assistants (HSAs) and linked with community mobilisation and health system strengthening, in the context of the Essential Health Package (EHP) and Accelerated Child Survival Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI) framework in Malawi.

This package is managed and implemented within the prevailing structures and staffing of the MOH and the three districts' health management teams. Trained HSAs have been implementing the CBMNC program in the 3-districts since August 2008. Realising the importance of assessing whether trained HSAs are reaching mothers and neonates as expected in the program, and in preparation for the maternal & newborn health mid term review, a mini survey was conducted. Thirty eight (38) mothers (from 2 selected catchment areas) that had delivered after a HSAs in that specific catchment area was trained in CBMNC were randomly selected and interviewed in each of the 3-districts.

Justification for the mini survey

During the development of Save the Children, Newborn Health program's DIP for the period 2006 – 2011 a mid term review of the program in the second quarter of 2009 was one of the planned activities. Among the NBH activities in Malawi is the CBMNC pilot package which, as earlier noted, is implemented within the prevailing health system structures. Implementation of the CBMNC package started in August 2008. Since implementation of this package is within the prevailing health system structures, data entry of all the data that is collected by the HSAs is supposed to take place at the district level. Unfortunately the flow of filled forms from the HSAs to the district was not going on as fast and as smooth as expected. Not much data had therefore reached RHU or Save the Children before March 2009. It therefore became very difficult ascertaining how the package was being rolled out in the 3 districts. Since this was important information for the mid tern review, a survey to assess progress in implementation of this package in the 3 districts was found necessary.

Broad aim of the mini survey

To assess the extent to which trained HSAs had started rolling out the CBMNC package in the 3 pilot districts.

Specific objectives

1. To assess coverage of ANC services being offered by HSAs as part of the CBMNC package in the 3 pilot districts.
2. To assess coverage of PNC services being offered by HSAs as part of the CBMNC package in the 3 pilot districts.

METHODOLOGY

Target Population

Mothers who delivered after a HSA in their catchment area had been trained in CBMNC were interviewed.

Sampling Method & Sample Size

Lot Quality Assurance Sampling (LQAS) was used in the sampling of the interviewed mothers. A total of 118 mothers were interviewed.

Selection of Catchment Areas

Catchment areas that had all HSAs trained in CBMNC were randomly selected in Dowa and Chitipa & Thyolo. Interviews were conducted in Bvumbwe and Mikolongwe catchment areas in Thyolo, Bowe and Chankungu in Dowa and Kaseye and Misuku in Chitipa. HSAs in the catchment areas where the interviews were conducted were **all** trained in the package between August and December 2008.

Selection of respondents

A list of the villages and total population in each catchment area was provided before the study started. Using the LQAS method the total number of interviews to be conducted in each village was established. A guide from each district was picked to assist in the identification of the villages where interviews were supposed to be undertaken. Upon getting to the villages where interviews were supposed to be conducted, each team would go to the centre of the village, spin a bottle and head towards the nearest household where the bottle pointed. Screening for a mother with a child aged less than 5 months was then undertaken. If there were more than two mothers at a household who were eligible for interviewing, only one mother was randomly selected. After finishing an interview at a household, we moved to the next household directly opposite the kitchen door/entrance of the household where the interview was conducted or where screening took place till we got the required number of interviews in each village.

Data collection

A structured questionnaire was developed for data collection. The questionnaire was tested before it was used in the field. Nine (9) HSAs (3 from each district) were hired as research assistants/interviewers for this exercise. All the hired HSAs had not been trained in the CBMNC package. The interviewers were trained on the sampling method, interviewing techniques and oriented to the questionnaire before they started collecting data.

Data entry and analysis

A data entry clerk was hired to enter filled forms. Data analysis (using SPSS) and data tabulation was done by Edward, George and the NBH team.

PRESENTATION OF RESULTS

Background Information

Table 1 below presents the distribution of interviewed mothers by district. A total of 19 interviews were conducted in each catchment area except in Bowe and Chankhungu where 20 and 22 interviews were conducted respectively. All the interviewed mothers had babies whose age range was between 0 – 5 months.

Table 1. Distribution of interviewed mothers by catchment area and district

District	Catchment Area	# of Interviews Conducted	Percent
Dowa	Bowe Health Centre	20	16.9
	Chankhungu Health Center	22	18.6
Thyolo	Bvumbwe Health Centre	19	16.1
	Mikolongwe Health Centre	19	16.1
Chitipa	Kaseye Health Centre	19	16.1
	Misuku Health Centre	19	16.1
	Total	**118**	**100.0**

ANC Visitation

Table 2 Distribution of mothers who were visited by a HSA during pregnancy

			Whether visited by a HSA during pregnancy?		Total
			Yes	No	
District	Chitipa	Count	30	8	38
		% of Total	25.4%	6.8%	32.2%
	Dowa	Count	36	6	42
		% of Total	30.5%	5.1%	35.6%
	Thyolo	Count	12	26	38
		% of Total	10.2%	22.0%	32.2%
Total		Count	78	40	118
		% of Total	66.1%	33.9%	100.0%

As shown in the Table 2 above, 66% of the interviewed mothers reported that a HSA visited them when they were pregnant. Of the 34% that reported that they were never visited by a HSA, the majority (22%) were from Thyolo. LQAS tabulation on coverage of visits by HSAs during pregnancy, as noted in the Table 3 below, reflects a similar trend where Mikolongwe and

Bvumbwe had below average coverage compared to the other catchment areas in Dowa and Chitipa respectively.

Table 3

District	Indicator: Mothers that were visited by a HSA during pregnancy		Number Correct	Average Coverage Estimate	Total Respondents	Decision Rule (using LQAS table)	Equal to or above average
Dowa	Bowe HC		17	70%	20	12*	Y
	Chankhungu HC		19		22	13	Y
Thyolo	Bvumbwe HC		2		19	11	N
	Mikolongwe HC		10		19	11	N
Chitipa	Kaseye HC		16		19	11	Y
	Misuku HC		14		19	11	Y

* Alpha or beta errors ≥ 10%

Respondents were also asked when HSAs first visited them when they were pregnant. As presented in the graph below, most visits were during the second and third trimester. It should however be noted that this information does not give a true presentation on whether HSAs are indeed visiting mothers well beyond the first trimester because this study targeted mothers who delivered after an HSA had been trained. It is therefore likely that when most mothers were still in the first trimester, these HSAs had not yet been trained.

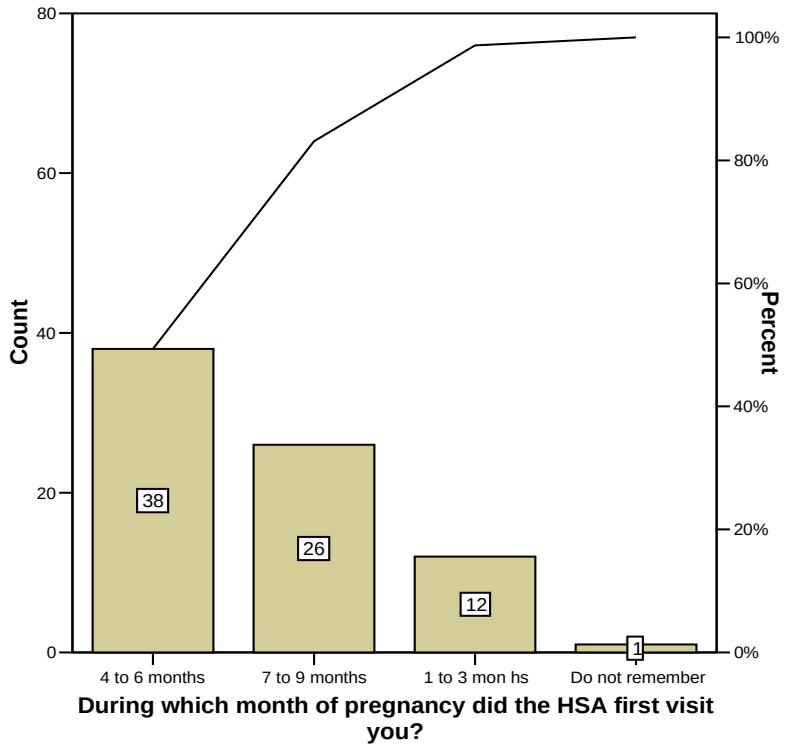


Figure 1

Under the CBMNC program HSAs are expected to visit mothers 3 times during pregnancy. This study explored the number of times HSAs in the 3 pilot districts are visiting pregnant mothers. As shown in the table below, only about 20% of the mothers reported being visited 3 times with about 76% reporting a visit from an HSA once or twice. Interestingly, about 4% of the mothers reported that they were visited by an HSA four times. Again this information should be taken with caution given the duration HSAs had been trained and when this evaluation was conducted.

Table 4

District		Number of times HSAs visited a pregnant mother during her last pregnancy				Total
		Once	Twice	Three times	4 or more times	
Chitipa	Count	9	12	4	3	28
	% of Total	11.8%	15.8%	5.3%	3.9%	36.8%
Dowa	Count	17	10	9	0	36
	% of Total	22.4%	13.2%	11.8%	.0%	47.4%
Thyolo	Count	6	4	2	0	12
	% of Total	7.9%	5.3%	2.6%	.0%	15.8%
Total	Count	32	26	15	3	76
	% of Total	42.1%	34.2%	19.7%	3.9%	100.0%

As shown in the pie chart below (Figure 2), nearly all the interviewed mothers (98%) reported that they had sought ANC at a health facility. The study however did not assess how many times they sought ANC care at a health facility.

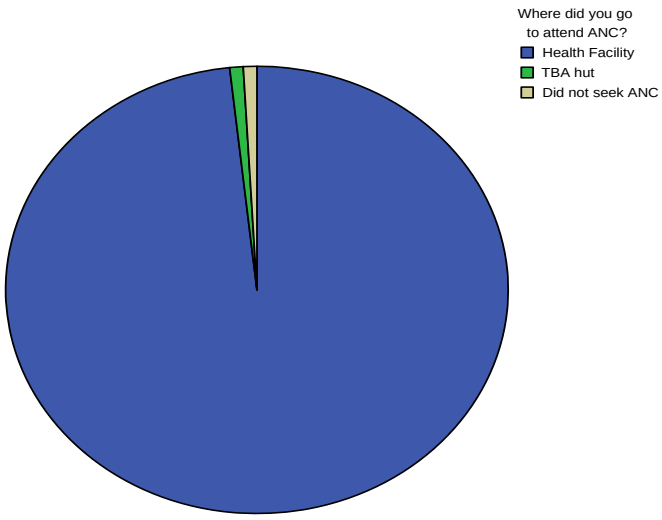


Figure 2

Delivery and Postnatal Visitations

The study also explored where mothers are delivering in the three districts. As shown in the Table 5 below, the majority of mothers (78%) reported that they delivered at a health facility. About 17% of the mothers however reported delivering at home. Around 50% of the mothers reporting home deliveries were in Dowa.

Table 5

District			Place of delivery				Total
			Health Facility	TBA home/hut	Home	Other	
	Chitipa	Count	28	1	5	1	35
		% of Total	24.6%	.9%	4.4%	.9%	30.7%
	Dowa	Count	31	1	10	0	42
		% of Total	27.2%	.9%	8.8%	.0%	36.8%
	Thyolo	Count	30	3	4	0	37
		% of Total	26.3%	2.6%	3.5%	.0%	32.5%
Total		Count	89	5	19	1	114
		% of Total	78.1%	4.4%	16.7%	.9%	100.0%

As shown in the Table 6 below, average coverage of postnatal visits by HSAs was 60% across the six catchment areas. Again postnatal care home visits coverage remained above average coverage in Dowa and Chitipa and below average in Thyolo.

Table 6

	Indicator: Mothers & newborns that were visited by a HSA after delivering	Number Correct	Average Coverage Estimate	Total Respondents	Decision Rule (using LQAS table)	Equal to or above average
Dowa	Bowe HC	17	60%	20	9*	Y
	Chankhungu HC	20		22	10	Y
Thyolo	Bvumbwe HC	1		19	9	N
	Mikolongwe HC	7		19	9	N
Chitipa	Kaseye HC	13		19	9	Y
	Misuku HC	12		19	9	Y

* Alpha or beta errors ≥ 10%

We also explored when postnatal home visits were conducted by HSAs. The first home visit was conducted within 1- 30 days after delivery. It should however be noted that it is mothers that reported delivering at a health facility (76%) who reported being visited by an HSA within the 1 - 30 days range. It should however be noted that it is unclear whether the first day of visit for health center deliveries refers to the first day after delivery or after discharge. All the interviewed mothers that delivered at a TBA (6%) had the first visit from the HSA between 4 and 15 days

and those that delivered at home (18%) were visited for the first time within a 1 – 7 days range. These home visits after delivery were however not as frequent as expected. As shown in Table 7 below, most of the interviewed mothers (61%) reported that they were only visited once with only about 5% reporting they were visited 3 times. None of the interviewed mothers in Thyolo received 3 postnatal visits.

Table 7

			How many times did the HSA visit you within the first week of your baby's birth?					Total
			Once	Twice	Three times	None	Do not remember	
District	Chitipa	Count	7	8	4	0	4	23
		% of Total	10.4%	11.9%	6.0%	.0%	6.0%	34.3%
	Dowa	Count	30	4	2	0	0	36
		% of Total	44.8%	6.0%	3.0%	.0%	.0%	53.7%
	Thyolo	Count	4	1	0	3	0	8
		% of Total	6.0%	1.5%	.0%	4.5%	.0%	11.9%
Total		Count	41	13	6	3	4	67
		% of Total	61.2%	19.4%	9.0%	4.5%	6.0%	100.0%

Areas counseled/discussed about the baby during the PNC visit(s)

All trained HSAs in the implementation areas are expected to counsel mothers on a number of issues whenever they go for home visits. Tables 8 and 9 below present the areas HSAs discussed/counseled mothers on both about the mothers themselves and the babies.

Table 8. Areas discussed/counseled on about the baby

Areas discussed/counseled on the baby	Percentage (N70)
Immunization	28%
Newborn danger signs	29%
Seeking PNC from health facility	14%
Breastfeeding	38%
General Health of the newborn	17%

Table 9. Areas counseled/discussed about the mother

Issues discussed/counseled on	Percentage (N70)
Family planning after LAM	14%
Proper breastfeeding	27%
General health of the mother	23%
Seeking PNC at health facility	38%
Danger sign for the mother	17%

The study also explored what the HSAs are doing to the baby during PNC visits. Table 10 below shows what the HSAs did. Taking weight and temperature and examining the baby were the

commonest procedures undertaken by the HSAs. Checking the cord and counting respirations were not reported by most of the interviewed mothers.

Table 10

What the HSA did to the baby	Percentage (N70)
Took temperature	54%
Weighed the baby	70%
Counted respirations	24%
Checked the cord	30%
Examined the baby	57%
Referred baby to health facility	4%

Conclusion

In general, there is commendable coverage of the package in Dowa and Chitipa. The study however indicates some shortcomings in Thyolo disitrict where coverage was noted below average most of the times. This therefore calls for more attention to be paid in Thyolo in as far as implementation of the package is concerned. It should also be noted that whilst there is commendable coverage in Dowa and Chitipa, a closer look at the implementation of the package as prescribed - especially conducting all the three PNC visits within one week and coverage of different activities at each visit, it should be noted that there remain some more work to be done.

Annex 15: Malawi Newborn Survival Report

Generating Political Priority for Newborn Survival in Malawi

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Abstract

Newborn survival is a major problem in Malawi, as approximately 16,000 babies die in the country each year in their first month of life. Health professionals in Malawi have paid a great deal of attention to the policy and technical challenges surrounding newborn survival. They have paid less attention to how political attention for the issue might be enhanced. This study analyzes the extent to which newborn survival has emerged as a political priority in the country, and challenges those concerned with the issue face in enhancing priority.

We find that the newborn survival policy community has made considerable progress in building attention in the very short time period the issue has been on the Malawian policy agenda. However, political attention is far from institutionalized, and could diminish if not cultivated. We identify three challenges this community faces as it seeks to enhance attention. First is building cohesion and leadership within this community so that it can become a more potent force for promotion of the issue. Second is identifying an effective public positioning of the issue that will convince political leaders that newborn survival is worthy of their attention and resources. Third is expanding the base of political support for newborn survival beyond the small network of largely technically-oriented and already convinced health professionals, to include politicians and civil society organizations.

Introduction

With a national neonatal mortality rate of 33 per 1000 births (National Statistical Office and UNICEF 2008), approximately 16,000 babies in Malawi die in their first month of life. Over the past decade a number of organizations in the country have made progress in addressing this problem. Their work has led to greater knowledge surrounding the biomedical causes of neonatal mortality, the technical interventions necessary to prevent these deaths, and the social and cultural factors that contribute to the problem.

Addressing newborn survival also has a political dimension. Even if we know the biomedical causes of neonatal mortality, can ascertain that levels remain high and are able to identify effective interventions, there is no guarantee that political leaders will take action, as they are burdened with thousands of issues to consider each year and have limited resources to deal with these problems. Political scientists have termed this the challenge of generating political priority: ensuring that political leaders consider an issue to be worthy of sustained attention, and back up that attention with the provision of financial, human and technical resources commensurate with the severity of the problem. In this paper we consider the political rather than the biomedical or technical dimensions of the issue of newborn survival in Malawi.

We employed a process-tracing methodology for this study, a qualitative case study approach involving analysis of multiple sources of information in order to minimize bias and establish common patterns of causality (Yin 1994). In the second half of 2008, we conducted 23

interviews in Malawi with individuals involved with newborn survival in government, civil society, development partner and academic institutions. In addition, we collected and reviewed approximately 75 documents, including health and other surveys, government policy documents, donor reports and published research on Malawian neonatal mortality. We also visited implementation sites. We then analyzed the interview transcripts and documents to assess the level of political priority and analyze the factors behind the emergence of policy attention.

We employ a framework on the determinants of political priority for health initiatives published in the international medical journal *The Lancet* in 2007 (Shiffman and Smith 2007). The framework consists of four categories of factors: the power of involved actors, the ideas they use to position the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself.

We find that political attention for newborn survival in Malawi is growing, due in part to the effectiveness of the Malawi newborn survival policy community in promoting this issue. Given that the issue is relatively new in the country – only over the past eight years has it emerged as a meaningful governmental concern – progress in generating political attention has been quite significant and likely exceeds that in most other sub-Saharan African nation-states with high neonatal mortality.

This being said, our aim in this study is not to dwell on successes but to highlight shortcomings, in order that policy community members might deliberate on these and devise ways to surmount

them. In Malawi, political attention is far from secure or institutionalized, and policy community members face a number of challenges in building political attention. Among these are:

(1) Defining the boundaries of and building cohesion within the newborn survival policy community

(2) Determining how the issue of newborn survival should be positioned publicly

(3) Finding ways to expand political attention beyond the small group of largely technically-oriented professionals who are committed to the issue

In the sections that follow, we describe the framework, analyze the state of political priority for newborn survival in Malawi with reference to this framework, and point to challenges individuals and organizations concerned with newborn survival in the country may need to address in order to enhance political attention for the issue.

The Analytical Framework

Researchers have sought to understand why initiatives pursuing social and political change succeed or fail in attracting political support. They have investigated several kinds of collective action efforts, including international networks on issues such as climate change (Keck and Sikkink 1998; Finnemore and Sikkink 1998; Haas 1992; Florini 2000); social movements for causes such as civil rights (McAdam et al. 1996; Tarrow 1998; Johnston and Noakes 2005; Snow et al. 1986); and policy communities that aim to place particular issues on national agendas (Sabatier 1998; Kingdon 1984; Baumgartner and Jones 1993). A central concern in collective

action research is the role of power: the power of actors involved with the issue; the power of the ideas used to define and describe the issue; the power of political contexts to inhibit or facilitate political support; and the power of certain characteristics of the issue, such as the number of deaths a particular problem may cause, to inspire action.

These four elements – the power of actors, the influence of ideas, the nature of political contexts and characteristics of the issue itself – form the foundation of the framework on the determinants of political priority for collective action initiatives (table 1). Initiatives are more likely to attract political support if they share certain features in each category.

Actor power

The first element is actor power. Initiatives differ in the strength of the actors that compose them, in the quality of linkages among these actors, and in the collective capacity of the actors to confront opponents (Buse, Mays and Walt 2005; Reich 1995; Brugha and Varvasovszky 2000). Among the factors that influence initiative acquisition of political support are policy communities (factor 1), the network of individuals and organizations linked by a central concern for the issue. These communities include, among others, civil society leaders, non-governmental organizations, government officials, bilateral donors, members of UN agencies, other international organizations and academics. Policy communities that agree on basic issues such as how the problem should be solved are more likely to acquire political support than those divided by such issues, as politicians will be more likely to listen to the former as authoritative sources of knowledge. The emergence of respected leaders embraced by the community (factor

2) facilitates coalescence and gives direction to the initiative. UNICEF's former director James Grant, for instance, is often cited as an example of such a leader. Strong guiding institutions (factor 3) - organizations or coordinating mechanisms with a mandate to lead the initiative - are also critical. Initiatives may start through informal associations or as projects inside formal organizations, but if they are to thrive, they must build their own enduring institutions (McAdam et al. 1996). Ongoing competition among concerned organizations to control the issue may hamper the creation of these structures. The Task Force for Child Survival and Development formerly led by Grant has been noted as a particularly effective guiding institution for the cause of child health. Finally, initiatives are more likely to generate political support if they link with grassroots organizations in civil society pushing for attention to the issue (factor 4), rather than remain confined to select members of a policy community. Pressure from grassroots AIDS activists on national governments and on international organizations, for instance, has helped to increase government and donor attention for the disease in developing countries.

Ideas

Ideas also shape political support for initiatives. The role of ideas in politics has inspired considerable research (Finnemore and Sikkink 2001; Harris and Siplon 2007) grounded in recognition that material influences alone cannot explain all actor behavior and that actors interpret the world around them in very different ways. The central ideational variable in collective action research is the 'frame': the way in which an issue is understood and positioned publicly (Snow et al. 1986). Any issue can be framed in multiple ways. For instance, HIV/AIDS has been framed as a public health problem, a development issue, a humanitarian

crisis and a threat to security (Berman 2001; Prins 2004). Some frames resonate more than others, and different frames appeal to different audiences. Finance ministers, for instance, may be more likely to respond to frames that emphasize the economic costs of a health problem, while health ministers may pay more attention to frames that focus on public health benefits and losses. Frames that resonate *internally* (factor 5) unify policy communities by providing a common understanding of the definition of, causes of and solutions to the problem. Frames that resonate *externally* (factor 6) move critical audiences to action, particularly the political leaders who control the resources that initiatives need.

Political contexts

The political contexts in which actors operate also exert considerable influence on political support levels (Leichter 1979; Grindle and Thomas 1991; Walt and Gilson 1994). Actors may have little control over these contextual factors, but they must take them into account if they wish to develop effective strategies. Many elements of political context matter, but two are key. First are policy windows (factor 7). These are moments in time when conditions align favorably for an issue, presenting advocates with particularly strong opportunities to reach international and national political leaders (Kingdon 1984). Policy windows often open following major disasters (such as a tsunami), discoveries (a new vaccine) or forums (global UN conferences). The Millennium Development Goals, for instance, have facilitated the opening of policy windows for some of the causes included. A second critical element of context is the governance structure for the sector (factor 8) – the set of norms (shared beliefs on appropriate behavior) and the institutions that negotiate and enforce these norms. For instance, international treaties, laws

and declarations exist for many sectors, including trade, the environment and health, often with an international organization or set of organizations in charge of their enforcement. In some sectors, these structures work well; in others, they are dysfunctional. Several studies have expressed concern about the increasingly fragmented structure of global governance for health, with many organizations competing for power, constantly shifting priorities and no single organization or set of organizations with the power to coordinate (Walt 2001; Lee et al. 1996).

Issue characteristics

Finally, the nature of the issue itself shapes political priority. Some issues are intrinsically easier to promote than others (Keck and Sikkink 1998; Stone 1989). Problems easily measured are more likely to gain political support than ones that are not, as policy-makers and advocates will have information to confirm the severity and monitor progress (factor 9). For instance, studies providing credible evidence of high population growth and fertility rates interacted with other factors in the 1970s and 1980s to convince political leaders in many developing countries that they had population problems requiring attention. Problems that cause significant harm, as indicated by objective measures such as numbers of deaths, are more likely to attract resources than those that do not, as policy-makers will perceive the former as more serious (factor 10). Problems with relatively simple, inexpensive, evidence-based solutions will be easier to promote than those without these features, as policy-makers prefer to devote resources to issues that they think they can address effectively and cheaply (factor 11). Cheap and effective vaccines, for instance, have helped generate political attention for child immunization.

No factor is likely necessary or sufficient for political support: some initiatives that have not attracted political priority possess a number of these characteristics and some initiatives that have received political attention lack several. For instance, HIV/AIDS presently attracts considerable political support despite extensive contention within its global policy community, and polio eradication continues to receive substantial resources despite the disease's small global burden compared to many other conditions. Conversely, chronic diseases such as cardiovascular conditions, cancer and diabetes, certain communicable diseases such as pneumonia, and a number of risk factors such as malnutrition attract few global resources despite causing high morbidity and mortality.

These cases notwithstanding, existing research on collective action provides evidence that, other things being equal, each factor enhances the likelihood an initiative will receive priority. A policy community is more likely to generate political support for its concern if it is cohesive, well-led, guided by strong institutions and backed by mobilized civil societies; if it agrees on solutions to the problem and has developed frames for the issue that resonate with political leaders; if it takes advantage of policy windows and is situated in a sector with a strong governance structure; and if it addresses an issue that is easily measured, high in severity and has effective interventions available. In such a situation, actor power, ideas, political contexts and issue characteristics all work in favor of the initiative.

Table 1: Framework on determinants of political priority for collective action initiatives

Category	Description	Factors shaping political priority
Actor power	The strength of the individuals and organizations concerned with the issue	1. *Policy community cohesion*: The degree of coalescence among the network of individuals and organizations centrally involved with the issue
		2. *Leadership*: The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause
		3. *Guiding institutions*: The effectiveness of organizations or coordinating mechanisms with a mandate to lead the initiative
		4. *Civil society mobilization*: The extent to which grassroots organizations have mobilized to press political authorities to address the issue
Ideas	The ways in which actors understand and portray the issue	5. *Internal frame*: The degree to which the policy community agrees on the definition of, causes of and solutions to the problem
		6. *External frame*: Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	7. *Policy windows*: Political moments when conditions align favorably for an issue, presenting opportunities for advocates to influence decision-makers
		8. *Governance structure*: The degree to which norms and institutions operating in a sector provide a platform for effective collective action
Issue characteristics	Features of the problem	9. *Credible indicators*: Clear measures that demonstrate the severity of the problem and that can be used to monitor progress
		10. *Severity*: The size of the burden relative to other problems, as indicated by objective measures such as mortality levels
		11. *Effective interventions*: The extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement, and inexpensive

Political Priority for Newborn Survival in Malawi: An Assessment

Milestones in attention for newborn survival in Malawi

The central policy document for newborn survival in Malawi is the Road Map for Accelerating the Reduction of Maternal and Newborn Mortality and Morbidity, promulgated in 2005 and officially launched in 2007 (Ministry of Health, Republic of Malawi 2005b). Its objective is to increase use of key maternal and neonatal health services and practices, with the goal of enabling the country to significantly reduce levels of maternal and neonatal mortality. The Road Map followed on a 2003 African Regional Reproductive Health Task Force meeting calling on countries to develop national plans for accelerating maternal and newborn survival (Partnership for Maternal, Newborn and Child Health 2006). Malawi was the first African country to adopt such a national program. The Road Map also followed a national assessment of obstetric care facilities, organized by the Ministry of Health's Reproductive Health Unit with support from UNFPA, UNICEF and WHO (Ministry of Health, Republic of Malawi, 2005a). The report revealed that while the country had almost double the number of WHO recommended comprehensive emergency obstetric care (EmOC) facilities, it had only two percent of basic EmOC facilities, with very uneven geographical coverage (Ministry of Health, Republic of Malawi, 2005a).

The Road Map itself is integrated into the cornerstone of Malawi national health policy, the 2004-2010 Program of Work for the Sector Wide Approach (SWAp), which seeks to harmonize national health development efforts and integrate government and donor work. At the heart of

the program of work is the Essential Health Package, a set of health services intended to address the country's most acute health problems. Newborn survival is included on this list as part of reproductive health.

Explicit national attention to newborn survival in Malawi only emerged in the early 2000s. This attention had both domestic and international antecedents. Discussion of high neonatal mortality rates in the country shaped parts of the National 2001 Reproductive Health Policy (interview no. 7). The government was also a signatory to the Millennium Development Goals, and embraced MDG 4 calling for a two-thirds reduction in child mortality by the year 2015 (Ministry of Health, Community Health Sciences Section 2007). Also in that year, Save the Children USA initiated its Saving Newborn Lives program in the country, and in 2002 produced an in-depth situation analysis of newborn health in Malawi (Saving Newborn Lives 2002). Save the Children has continued to serve as a source of technical knowledge, policy development and advocacy for newborn survival at national and local levels, building capacity for newborn care, influencing behavior change, and developing curricula for nursing schools, among its many activities.

Newborn survival has also become a centerpiece of several other national policy documents and initiatives. After African Union heads of state met in Libya in 2005 and declared their commitment to achieve the fourth MDG, the government of Malawi endorsed a policy for accelerated child survival and development in 2006. The government adopted a Five-Year Strategic Plan for Accelerated Child Survival and Development (ACSD), with the aim of scaling-up high impact interventions for children and mothers (Ministry of Health, Community Health Sciences Section 2007). In addition, the government has embraced the Integrated

Management of Childhood Illness approach that also aims to support the achievement of the child survival MDG (Ministry of Health, National IMCI Unit 2006). Beyond this, Malawi is a priority country of the global Partnership for Maternal, Newborn and Child Health, and received a grant of $7 million over three years to reduce maternal and under-five mortality.

An influential event that shaped subsequent intervention strategy in Malawi was a 2006 study tour to India sponsored by UNICEF for Ministry of Health policy-makers, where they observed a highly successful home-based neonatal care package in Maharashtra state (interviews no. 6, 9, 12, 18). Save the Children subsequently sponsored a design workshop, in partnership with the Ministry of Health and UNICEF, to develop a package of interventions tailored to the Malawian context.

Actor power and newborn survival in Malawi

As the discussion above suggests, a number of organizations in Malawi address newborn survival. These include: government units (especially the Ministry of Health's Reproductive Health and Integrated Management of Childhood Illness units and the Ministry of Women and Children); United Nations agencies (United Nations Children's Fund; United Nations Population Fund; World Health Organization); international non-governmental organizations (especially Save the Children); domestic non-governmental organizations (CHAM); bilateral and multilateral donor agencies (USAID; the African Development Fund); and several organizations of a hybrid character (White Ribbon Alliance; Mai Khanda, formerly known as Health Foundation; USAID's ACCESS program). Within each of these organizations one or more

individuals considers newborn survival to be part of his or her portfolio of responsibilities, although only a handful of these individuals identifies the newborn to be his or her sole focus (interviews no. 1,3,5,6,7,8,11,12,15,16,17,18,19,20,22). There are also a number of pediatricians and nurses outside these organizations in Malawi who have a strong concern for the issue of newborn survival. As a group, these individuals form the newborn survival policy community in Malawi - the network of persons and organizations with a shared concern for the issue. Collectively they and the organizations they work for bring a high level of technical competence to and deep concern for newborn survival.

They and their predecessors in these organizations are among the key actors responsible for bringing newborn survival to the Malawi policy agenda. Several developments indicate that the issue holds a place on the government agenda. First, newborn survival interventions are included as an element of reproductive health in the Essential Health Package (EHP) – a list of health services to be provided across the country to address the major sources of death and illness in the country. Second, the government has embraced the Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity, a multi-year program led by the Reproductive Health Unit. In addition, several other country-wide initiatives include neonatal mortality reduction as a priority even if that is not their sole focus. These include the Accelerated Child Survival and Development (ACSD) program and the Integrated Management of Childhood Illness (IMCI) policy.

This being said, the policy community faces several challenges in building additional political attention for the issue. First, composed largely of health and public health professionals, the

policy community is predominantly technical rather than political in orientation. Some members have made efforts to target politicians for support. For instance, on January 30th, 2009 the White Ribbon Alliance organized a meeting for aspiring parliamentarians in advance of the general election in order to secure their commitment for budget support for maternal and neonatal survival. This being said, no one in the policy community is a politician, and there has not yet been a comprehensive, sustained effort in the political arena or within civil society in order to broaden the base of political support for newborn survival.

Second there are some concerns about cohesion. Members know one another and some formal coordination mechanisms do exist (for instance, most of these organizations are members of the Safe Motherhood Sub-Committee of the Sexual and Reproductive Health Working Group of the Ministry of Health, organized under the Reproductive Health Unit). However, respondents express some worry about the quality of coordination:

> In order to figure out what is going on you have to go to every single individual and have a meeting with them and…slowly put it all together….. we do not know as much as we should about what each other are doing and there is a lot of duplication (interview no. 12).

> Each of these partners has got its own agenda. When they work together it's not because they want to solve a common problem, much as they may say they want to contribute; it's about us making a name out of it; about us being visible (interview no. 3).

Some respondents point to a harmonized manual for care as a potential means of both bringing about better care and improving policy community cohesion. However, they also note coordination problems with this project:

> We have developed a curriculum for the newborn… [Organization X] also has its own curriculum for the newborn…because of those I could say there will be duplication of efforts and also confusing the providers at implementation level, because maybe one provider will be trained by [organization X]; maybe another provider will be trained by the training manual developed by [organization Y] (interview no. 17).

A third issue concerns a perceived need to clarify the role of the government in coordinating newborn survival activities, particularly with respect to policy-making and implementation. One respondent notes, for instance:

> The government has limited funding and most activities are supported by development partners. This puts them in an awkward situation. Each agency goes in with an idea and they are forced to adopt the idea (interview no. 20).

A mid-term review of the Malawi Sector Wide Approach suggests that the nature of government-donor interactions is a concern not just for newborn survival but for a multitude of health issues:

> With regards to providing and promoting strategic programme direction, there is a worrying view expressed by some senior MOH staff that even though the POW remains the national health strategy, should any development partner offer to provide services outside the framework of the POW and EHP, the Ministry is unable to say 'no', and must accept what is on offer. Such a viewpoint would indicate that MOH staff may not feel empowered to prioritise interventions and not hold development partners to account when they stray too far away from agreed strategies and work plans (Carlson et al. 2008).

An implication here is that there are difficulties surrounding leadership. There is no strong institutional leadership: no organization in the country regularly bringing together the network of actors concerned with newborn survival. Also, there is no personal leadership: no senior figure that has taken this up as a personal issue, worked to create a cohesive policy community and to push the political system to act.

One consequence of these policy community challenges is that outside this community the level of concern for the issue is limited. Few senior government officials or politicians pay much attention to the issue (a Speaker of Parliament being a notable exception) (interview no. 22). No Ministry outside of the Ministry of Health has a strong concern for newborn survival, and even within that Ministry attention is largely concentrated in the Reproductive Health Unit and to a lesser extent the Integrated Management of Childhood Illness Unit. Few parliamentarians know much about the issue, and even the parliamentary committee on health does not identify it to be a

priority (interview no. 10). Also, with the possible exception of the White Ribbon Alliance which is an organization dependent on donor support, and the Malawi Health Equity Network, no civil society group with an advocacy orientation presses the government on the issue (interview nos. 4, 11, 13, 22).

Ideas and newborn survival in Malawi

Both the internal frame - the way policy community members understand the definition of, causes of and solutions to the problem - and the external frame - how they portray the problem to external audiences in order to attract their support - may pose some problems and require attention. Policy community members understand the problem of newborn survival in different ways. Also, while some individuals and organizations in the policy community have considered external framing, the community does not appear to have come together to consider or generate consensus on positioning. Policy community members may therefore not be communicating a unified position concerning why newborn survival deserves attention, nor understand what political leaders think about the issue, hampering their ability to convince these leaders of the issue's importance.

The ways in which policy community members speak about newborn survival indicate their different understandings of the nature of the issue. At the same time, these differences offer seeds for a useful discussion on framing. Several themes emerge from policy community discourse: the value of linking the issues of maternal and newborn survival; the usefulness of connecting reduction of neonatal mortality to the national aims of lowering infant and child

mortality; the relationship of newborn survival to problems of high fertility; the broader public health benefits of enhancing health system capacity to save newborn lives; and the inherent dignity of the life of the newborn.

Many members of the policy community see the issues of maternal and newborn survival to be inextricably linked. As one respondent notes:

> I find it difficult to separate; you know how can you talk about the newborn without talking about their mother and their nine months of pregnancy? (interview no. 12)

A UN official agrees and expresses concern about the way the UN engages these issues:

> The mother and baby cannot be separated. The baby is there because of the mother, so all these divisions of the UN – [one] has the mandate to look after the mother and [another] after the baby…doesn't make a lot of sense because the mother and the baby are one (interview no. 15).

The same respondent also provides a public health rationale for linking the two issues:

> If you can reduce maternal deaths the result [reduced neonatal mortality] will follow automatically.

Another respondent offers a political reason for making this link:

> When you have got such high maternal mortality rates…not only is it important to be looking at the mother but also politically you don't want to compartmentalize yourself…or you could lose credibility (interview no. 12).

Some also connect the issue to child survival. For instance, the five-year strategic plan for Accelerated Child Survival and Development in Malawi offers a reason for focusing on neonatal mortality (Ministry of Health, Community Health Sciences Section 2007):

> As the under-five mortality rate and the infant mortality rate are getting lower, neonatal mortality is taking a larger proportion of these deaths.

And an interviewee notes:

> For Malawi, child health, infant mortality and maternal mortality are big things and the newborn is very much linked to those two broader issues. There is a high need for reducing infant mortality (interview no. 21).

Several respondents connect the issue to problems of high fertility and population growth:

> Neonatal issues cannot be looked at in isolation…there are also links even to issues of population, issues of family planning… As long as population is growing at alarming rates the resources will never be enough (interview no. 4).
>
> The more pregnancies [women] have the more dangerous it will be…we would rather they take care of this newborn and maybe who knows with family planning we may be able to actually say this is the total fertility rate that we want as a country….As a country, we are not happy with our total fertility rate, which is at 6.3; we would want to drop it to 4.9 (interview no. 6).

A report on newborn survival in Malawi (Saving Newborn Lives 2002) suggests an additional reason to prioritize the issue - its broader public health benefits:

> Another argument for promoting neonatal health is economies of scale, that some of the neonatal interventions would have an impact on improving the health of the general public. Programs that will improve antenatal care and related newborn outcomes also reach the broader public.

A prominent theme in the way the policy community speaks about the issue is sadness concerning the fatalism and invisibility that surrounds the death of a newborn:

> Culturally, the newborns are not treated as another human being…. The neonate is not talked about or treated as people, the way a one-year old or two-year old is…When a neonatal death has occurred in the village, it is not considered as a death (interview no. 3).
>
> Most communities think [the] death is acceptable because that is how God has made it…this is the will of God (interview no. 1).
>
> The tendency is not to name babies until two to six weeks because parents are afraid that the baby will die. We would rather if they die [they do so] without a name: it is not as painful (interview no. 8).
>
> The culture says the newborn is a thing and not a human being. Even the death of a newborn is not something that will make the community go crying…it is like it was born and just passed (interview no. 1).
>
> Even the term 'kupita padera' it's like you haven't yielded anything at all…when a newborn dies (interview no. 2).

Underlying these comments seems to be a concern that the death of newborn has become accepted as a fact of life, not only among communities but also among many policy-makers. The issue does not create a sense of alarm. Respondents express an insistence that apart from any broader social aims, this issue should generate concern because it is a matter of human dignity;

the life the newborn must be valued in and of itself. As an excerpt from a report puts it (Saving Newborn Lives 2002):

> From a humanitarian perspective, every life should be valued and cherished. What kind of precedent is set turning a blind eye to the needs of a newborn?

In sum, the policy community has yet to agree on why this issue is important; nor has it discovered an effective external positioning. A major challenge is to find issue frames that will resonate with political leaders. Doing so may require shaking policy-makers from their complacency – de-normalizing the issue by moving it from the realm of the everyday to a crisis that is unacceptable and can be surmounted. This demands discovering ways of unsettling political leaders surrounding the gravity of the crisis. The themes mentioned by policy community members – the connection with maternal mortality, the contribution to child mortality, the effects on population growth, the impact on development, the issue of human dignity – offer seeds for a discussion the policy community needs to have in order to generate consensus on internal and external framing.

Political contexts and newborn survival in Malawi

Several factors concerning political context shape attention to newborn survival in Malawi. The newborn survival policy community does not have full control over these factors; however, it must take them into account in order to devise effective political strategy. Three factors are particularly influential: the country's embrace of international commitments to child survival; its nascent multi-party democracy that creates the political space for advocacy surrounding social problems; and weak bureaucratic and health systems capacities that hamper the development of sub-national political attention and the delivery of technical interventions to the grassroots.

As noted above, a set of international agreements has created global political momentum for the reduction of child survival. The most notable are the Millennium Development Goals, and in particular MDGs 4 and 5 on child and maternal survival. The Government of Malawi has publicly declared its commitment to the MDGs, and has embraced a set of internationally-influenced initiatives, including the Road Map, the Accelerated Child Survival and Development program and IMCI, all of which invoke MDG goals. These international agreements and the Malawian government embrace of these commitments enhance the advocacy environment for newborn survival in the country.

The national political context also has changed in a positive way for newborn survival. At independence Malawi had a multi-party system, but this disappeared in 1966, and Malawi experienced nearly three decades of single party rule under Dr. Hastings Banda. In 1993 multi-party democracy returned to Malawi and in 1994 elections for the President and parliament were held (Patel and Svasand 2007). Since then three further presidential and parliamentary elections have been held. The multi-party system exhibits instability and is far from institutionalized; however, Malawi has experienced far less political turmoil in recent years than many other Sub-Saharan African states. Under the single party system few civil society organizations were allowed to exist, and any overtly political organizations were repressed. Although civil society organizations have not had full freedom in the multi-party period and state-civil society relations have been tense (in 2001 for instance the state enacted a restrictive NGO act intended to curtail the actions of these organizations), the space for civil society to organize and press the government is far greater than it was prior to 1994.

The political opening has created favorable conditions for the development of political attention for social and health issues. It has forced ruling parties to be more attentive to social concerns in order to sustain their hold on political power. It also has enabled civil society organizations, formerly banned or severely restricted under the single-party regime, to proliferate. While civil society organizations involved in health are not numerous or powerful, a number have emerged and are increasingly vocal. It is conceivable now, as it was not a decade and a half ago, that robust civil society organizations could emerge and coordinate with or press the government to address reproductive and child health issues, including newborn survival.

If international attention and political liberalization favor the possibility for developing priority for social issues such as newborn survival, weak bureaucratic and health systems capacities continue to pose problems toward that end. Even as the government and the newborn survival policy community develop credible national strategies for neonatal mortality reduction, they face considerable constraints in carrying out their plans at the grassroots. One problem is the country's severe human resource constraints in the health sector, limiting the capacity to deliver effective interventions. As of the mid-2000s the country had only one doctor per 45,662 people according to the Ministry of Health, significantly below the WHO average ratio of 1 per 10,000 (Ministry of Health, as reported in PSI HIV/AIDS Southern Africa Project Report). There was only one nurse per 3,500 people, compared to one per 1,000 for Africa as a whole, and 95% were urban-based, leaving rural areas severely under-served. Also, there was a major shortfall of health surveillance assistants. The EHP targets required 12,615 HSAs; yet there were only

several thousand employed in the health sector. Moreover, many health personnel need strengthening in key competencies for newborn care (Save the Children, Malawi 2008).

In addition, the Ministry of Health has had problems communicating and disseminating the national health plans that do exist, including the Road Map. For instance, one study found that only 20 of 45 facility managers surveyed had heard of the Essential Health Package, and among health center managers, only one third knew of the EHP (Mueller, Lungu, Acharya and Palmer 2008). And as some respondents note:

> Implementation is the problem because they can issue orders but if they are not able to see what is happening at the facility it will be a problem (interview no. 17).
>
> Safe motherhood coordinators who are health workers at the district… would actually tell you that they don't know about the Road Map…The document was sent to those facilities but… people may take the documents and put them on the shelf without disseminating (interview no. 6).
>
> We may have 40 to 50 people invited to a meeting and it's not possible to call each and every health worker to orient them (interview no. 6).
>
> We have beautiful plans in the SWAp, essential health package, the Road Map for maternal health. We know what is supposed to be done but sometimes we don't do it (interview no. 17).

Decentralization creates further complexities for implementation. In 1998 and 1999 the government issued acts on decentralization and local government that created 40 local assemblies and devolved some administrative authority to the district level (Patel and Svasand 2007), decentralizing oversight over health services to these assemblies (PSI HIV/AIDS Southern Africa Project Report). While in theory these reforms should make officials more responsive to local health needs, they also create a dilemma for newborn survival: local officials may not care about the issue and therefore ignore it. As one respondent puts it: "sometimes it's difficult for the Ministry [of Health] to influence what plans the district have come up with (interview no. 17)."

These problems surrounding implementation and bureaucratic capacity cannot be solved simply through technical interventions and getting the right information to the right people: they are also political challenges. Addressing these issues requires finding ways to ensure not just that national but also district and local political officials and government civil servants consider newborn survival to be an issue worthy of attention and resources – that is, making sure that these officials see it in their interest to prioritize building health worker capacity and to implement the Road Map as an authoritative guide for neonatal and maternal mortality reduction.

Issue characteristics and newborn survival in Malawi

Several characteristics of the issue of maternal survival have long posed barriers for its advocates: maternal deaths are not as numerous as those caused by a number of other high burden conditions; accurate measurement of maternal mortality is difficult technically; and the interventions to avert maternal death are not as simple as those for some other conditions (Shiffman and Smith 2007). Malawi is unusual in being one of only a handful of countries where maternal mortality ranks among the country's higher health priorities.

Newborn survival compares favorably with maternal survival on these issue characteristics. Studies have established conclusively that neonatal mortality in Malawi is high and a leading contributor to under-five mortality; means of measuring neonatal mortality with reasonable accuracy do exist and have been employed in the country; and knowledge surrounding the interventions necessary to avert newborn deaths is growing rapidly.

There are sufficient data available to ascertain that Malawi has a significant problem with neonatal mortality. The 2004 Malawi Demographic and Health Survey (MDHS) found a neonatal mortality rate of 27 per 1,000 live births (National Statistical Office & ORC Macro 2005). A 2006 MICS survey found a higher rate of 33 for the two years preceding the survey (National Statistical Office and UNICEF 2008). Save the Children contributed financial resources to this survey out of concern that the MDHS figure represented a pattern atypical in Africa, with neonatal mortality only 21% of under-five mortality, compared to a Sub-Saharan African average of 25% (Save the Children 2007). The 2006 MICS survey data confirmed that neonatal mortality represents a significant portion of under-five mortality in the country – 26%. Moreover, trends indicate decreases in under-five and infant mortality rates but stagnation in neonatal mortality (National Statistical Office and UNICEF 2008), creating an imperative to address newborn survival if Malawi hopes to achieve MDG goals.

Knowledge surrounding the interventions necessary to avert newborn deaths is growing rapidly. Several interventions aimed at reducing neonatal mortality have been put in place at global as well as national levels. The SEARCH Project in India reported a fall of 62% in neonatal mortality (Bang et al 1999). As noted above, several elements of this project has influenced Malawian efforts. Recent analysis in the Lancet Neonatal Series concluded that basic, cost effective interventions currently exist that could prevent up to 72% of neonatal deaths (Darmstadt et al 2005).

In Malawi, SNL introduced Essential Newborn Care in 2001. Essential newborn care was intended to promote the quality of newborn care to improve the survival of neonates at facility and community levels. Thereafter several interventions have been instituted such as PMTCT, Kangaroo Mother Care, FANC, BemOC, IPTp and exclusive breastfeeding.

Challenges in Augmenting Political Priority for Newborn Survival in Malawi

If we consider the state of political attention for newborn survival in Malawi with reference to the framework, we see a mix of facilitating and inhibiting factors. With respect to actors, the policy community is very strong technically and its efforts have enhanced attention for the issue considerably over the past decade. On the other hand, the community is not as cohesive as it could be, and there is some confusion surrounding leadership. Also, civil society coordination with and pressure on government to address the issue is only beginning, and not yet strong. With respect to ideas, the community has yet to come together to develop a cohesive understanding of the problem (the internal frame), and how the issue is to be positioned publicly (the external frame) remains unresolved. With respect to political context, international attention to the issue and the government's embrace of international commitments such as the MDGs, as well as the emergence of multi-party democracy, all favor the development of political attention for the issue. On the other hand, decentralization and weak bureaucratic capacity present challenges for developing political attention at sub-national levels and for ensuring the delivery of services. With respect to issue characteristics, reasonably credible indicators, reliable data on the severity of the problem, and emerging technical knowledge on a set of interventions that can address newborn survival all favor promotion of the issue.

This review points to three primary challenges the policy community faces in building political attention for newborn survival in Malawi, above and beyond policy, technical and social challenges such as devising effective national plans and local guidelines for the care of the newborn, expanding the skills of healthcare providers and altering community behavior and attitudes. These challenges invoke all four categories of the framework: they speak to how actors could use ideas and take advantage of political contexts and issue characteristics to enhance political attention for newborn survival. We discuss each of these three challenges below.

Strengthening the policy community itself

The Malawi newborn survival policy community is a primary agent for generating political attention for the issue. Over the past decade it has made progress toward that end. However, it has yet to fully take advantage of its potential, due to ambiguities concerning its boundaries and problems with cohesion.

An unresolved issue is how the community understands its boundaries, and what boundaries would most benefit the promotion of the issue (and any issues that ought to be linked with newborn survival). That is, is there value in having a policy community focused solely on the issue of newborn survival, or does this community need to include a wider membership and understand itself more expansively, say, as a maternal-newborn survival policy community or a community with an even broader mandate? We have used the term 'newborn survival policy

community' in this report to refer to the network of individuals and organizations with a shared concern for the issue. However, the findings reveal that few individuals or organizations focus solely on that concern, and a number of individuals may question the value of having such a narrowly defined community. They believe that the newborn is inextricably linked to the mother and ought not to be separated out as a stand-alone issue. Those who form this network may need to pay more explicit attention to the problem of boundary definitions, as greater clarity may be needed in order to develop a coherent community identity and advance political attention for the issue and any linked issues.

Policy community members also acknowledge problems of cohesion, which is an issue directly connected to boundary definition. Those in the network state that they are not fully aware of what one another is working on, and they perceive there to be inadequate leadership and coordination among themselves. These problems raise a number of questions. How could this network better share information? What kinds of structures are necessary for better coordination on the issue? What kind of leadership systems and forums are necessary on newborn survival and any linked issues in order to ensure that the network is working in tandem to expand attention and resources for these causes?

This network is potentially quite influential. Composed predominantly of health and public health experts, it commands respect that derives from its high level of expertise and involvement in a problem of a humanitarian nature. This respect could be translated into political influence: that is, policy community members could have the ear of senior political officials, ministers, parliamentarians and others. The extent to which this technical authority will translate into

political influence will depend on the initiative and creativity of members of the community itself in finding ways to build effective leadership, create institutional structures that allow members to work in tandem, and (see next section) frame the cause in a strategic way.

Developing effective issue frames

While individual organizations have considered the question of framing, the policy community has not done so collectively. Developing an effective external frame is critical because it is a primary means of convincing political leaders that the issue of newborn survival is important and deserves their attention and resources.

Devising a public positioning for the issue that resonates with national and local political elites is not a simple exercise that can be done in the course of an afternoon, delivered by a handful of external communication experts or imposed by global leaders who already have decided how their organizations should frame the issue. Frame development is a complicated process, and frames that may work in some countries and cultures may be entirely ineffective in another. The national policy community needs to engage in a careful deliberative process that involves at least three steps:

1. The specification of a set of political and social leaders whose support is crucial to advancing the cause of newborn survival.

The more clearly the targets are specified, the more effective a framing strategy is likely to be. For instance, to take an example of one target: 'parliamentarians' is too broad, and in any case the support of all parliamentarians is neither feasible nor necessary. The question is which parliamentarians? Presumably the issue would benefit from the support of the parliamentary committee on health and specifically the head of that committee, who presently pay very little attention to the issue. A parliamentary speaker has already expressed sympathy for the issues of maternal and newborn survival: what would convince him to engage the issue more vigorously? Which other committees, and specific parliamentarians, are critical for advancing the issue, and most likely to work on the issue actively if convinced of its importance? Similar questions need to be asked about officials surrounding the president, government ministries beyond the Ministry of Health, civil society organizations, district assemblies, and other institutions.

2. The accumulation of specific information concerning how these leaders presently view the issue, if they think about it all.

Promoters of an issue are more likely to develop effective frames if these flow from accurate information concerning how the targets perceive the issue. It is a mistake for policy community members to presume they know what perceptions these targets hold: often, policy community members do not even fully understand *one another's* perceptions on the issue (the fact that Malawi newborn survival policy community members express a multitude of reasons concerning why the issue is important indicates that this point may be true of this particular policy community). Acquiring this information demands in-depth, carefully

planned conversations with at least a subset of potential targets, and careful analysis of this information to identify themes. Particularly important is information on (a) any beliefs these targets hold concerning why the issue should not be a priority, and (b) beliefs they hold concerning what would make a health issue important to them (i.e. because it slows economic growth? because it kills many people? because it makes the country look bad in the international arena? and so forth).

3. A set of policy community meetings to devise frames for the issue that (1) are likely to resonate with these targets and (2) do not fundamentally violate the beliefs of the policy community itself.

Armed with information about who should be targeted and how these individuals likely perceive the issue, the policy community is then in a much better position to develop frames that will alter existing beliefs and convince targets that the issue is important and worthy of resources and action. Different targets may require different messages: finance ministers may, for instance, be more responsive to arguments that emphasize cost-effectiveness and economic growth; public health officials to arguments that focus on population health and lives saved; civil society organizations to arguments surrounding the rights of vulnerable citizens.

Policy community members should also take into account their own beliefs in the process. They will be unenthusiastic about promoting a particular framing if it fundamentally violates their own strongly held beliefs concerning why the issue is important. At the same time it is

critical they avoid a common danger in framing: taking the issue's importance to be self-evident. Often policy communities feel so passionate about the issue that they simply cannot understand why others do not feel the same way. However, rarely do external audiences share those beliefs or sense of the self-evident nature of the issue's importance. The attitudes of external audiences will change only if their pre-existing beliefs are respected and taken into account in the development of frames.

In sum, to expand political support the policy community will need to deliberate collectively on framing to come to an evidence-based consensus on effective public positionings of the issue. If they do not, they risk speaking with a cacophony of voices that will serve only to confuse the targets they seek to convince.

Expanding the base of political support

The findings reveal that the base of support for neonatal mortality reduction has expanded over the past decade. However, it is still narrow. This issue is a strong concern only for a small number of actors in the country: certain parts of the Ministry of Health and Ministry of Women and Children; several UN agencies; USAID; Save the Children; and several other health-oriented organizations. Given the humanitarian nature of the issue, few political actors are likely to say openly that the issue is 'unimportant' and not deserving of attention. However, statements are easy to make and matter less than concrete action and resource provision. Measured on those terms the issue does not have extensive support at the most senior political levels, in other ministries, in parliament, and among civil society organizations. As a result, issue sustainability

becomes a concern: one wonders what would happen should the small network of actors concerned with the issue shift their attention over time to other health issues (as so often occurs among organizations involved in health)? Would the issue drop from the policy agenda?

Strengthening policy community cohesiveness and finding effective issue frames are first steps toward expanding the political base, and ultimately toward institutionalizing attention within the national political system. With a strong policy community and frames that resonate with political elites, the network will be in a position to cultivate alliances with actors who could substantially expand attention to and resources for neonatal mortality reduction, and who could sustain attention and resources across time. A particular need is to find one or more senior political allies who might advance this issue in parliament, other ministries and around the president's office. Some senior politicians might be willing to take this up as a means of acquiring political capital for themselves. Newborn survival is an unaddressed issue at the national level and may present an opportunity for a politician seeking an issue that could bring him or her political capital.

It should be noted that cultivating alliances is not only a national issue but also a sub-national concern. Decentralization of political power has put greater authority into the hands of local assemblies, local political leaders and local health officials. Even if national leaders are convinced of the issue's importance, decentralization and weak bureaucratic capacity mean that they cannot simply order local officials to carry out their priorities. Local officials themselves must come to value the importance of neonatal mortality reduction.

In sum, a key challenge for the policy community is to think systematically about political strategy, in much the same way it has thought about policy guidance, technical interventions and community mobilization strategies. Doing so is critical to ensuring sustainability of attention, particularly if global and national issue priorities shift.

Conclusion

We have presented results on factors shaping the state of political attention for newborn survival in Malawi. The evidence reveals that this attention has grown over the past decade, but that priority is far from institutionalized. A network of actors with strong technical knowledge stands behind the issue, but these actors confront several challenges in expanding and institutionalizing priority. These include strengthening the capacity of the network itself to conduct advocacy, developing a framing for the issue that resonates with political elites, and expanding the political base of actors that back the issue. It is possible for newborn survival to be institutionalized as a political priority in Malawi, but this will require explicit political strategizing by the policy community itself.

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Annex 16: Additional Background Articles

The Daily Times: Bringing Better Care Closer, September 22, 2009

The Daily Times: Old Tools, New Solutions: Benefiting from 'Agogo', June 25, 2009

The Daily Times: Kangaroo Mother Care: Saving Malawi's Babies, June 16, 2009

Bringing bet

A visit to [illegible] one of the [illegible] places in Chitipa [illegible] the [illegible] battle with maternal and neonatal mortality. A recent visit to Chitipa recently shows that several interventions have made a difference. Community Based Maternal and Newborn Health is one of them, CLIFTON KAWANGA writes.

LET THEM COUNT —The project implemented in Chitipa has increased the chances of survival for the children within the critical first week of life. On the knowledge imparted to the communities has benefited would-be mothers who now visit health facilities to deliver.—Picture by [illegible]

AT 23, Maria Mlwaghi from Nthalire in Chitipa, is healthy and already a mother of three.

At some point when she was expecting her second child, she feared she was to become a "statistic" of Malawi's raging battles with maternal and neonatal mortality.

Maria nearly died two years ago after complication in child bearing at a Traditional Birth Attendant (TBA). Tolerated by age-old customs and culture of bearing children at a TBA and not seeking any antenatal services brought her to the brink when at a TBA, her child slid into an abnormal position and she could not give birth.

For Maria, 48 hours of gruelling labour and bitter concoctions from her husband's witchdoctor gave in to nothing. Then followed the slow, pounding and painful trip to Chitipa District Hospital to seek help.

At the hospital, the child was found to have slid across its birth path (transverse position). This is often best resolved by skilled medical attendants.

At least she lived to tell the tale. Her baby boy did not. He is a statistic.

Malawi has a population of nearly 13 million people and it is one of the poorest countries in the world, ranking 166 out of 177 on the Human Development Index (2008) and with a per capita GDP of $160. Nearly 85 percent of the population lives in rural areas and 65 percent of the population is defined as poor and unable to meet daily consumption needs.

Despite substantial progress over the last several years, maternal, child and neonatal mortality rates are still high. Although the Maternal Mortality Ratio (MMR) declined from 1,120 per 100,000 live births in 2000 to 807 in 2006, it remains one of the highest in the world. That is according to the Malawi National Statistics Office (NSO) through the Multiple Indicator Cluster (MICS) Survey released in 2006.

The Neonatal Mortality Rate (NMR), at 33 per 1,000 live births, results in the death of 18,900 newborns annually and accounts for 26 percent of under-five mortality. Many neonatal deaths take place at home and are not recorded or counted therefore the NMR is suspected to be higher.

"Clearly, in order to reach the country's Millennium Development Goal 5 targets and save more under-5 lives, more substantial reductions in neonatal mortality will be essential," reasons Evelyn Zimba, Programme Manager for Save the Children's Maternal and Newborn Health programme.

But where and why is the country making neonatic losses?

The Multiple Indicator Cluster (MICS) survey released in 2006 suggests that main causes of neonatal deaths in Malawi are infection (30 percent), asphyxia (22 percent) and preterm birth (30 percent). Anywhere from 60-80 percent of these deaths are in low-birth weight babies, mostly preterm.

"The first week of life is the most critical for the neonate with 50 percent of deaths occurring within the first day and 75 percent within the first week. Further, there is a large urban/rural disparity in neonatal mortality. In the urban, NMR is 23/1,000 on average while in rural areas it is 35/1,000," adds the report.

Existing interventions

RECENT analyses in The Lancet, a reputable global neonatal publication [illegible] offers hope by concluding that basic, cost-effective interventions currently exist for countries like Malawi that could prevent up to 72 percent of neonatal deaths.

It is hypothesised that, if rural families were able to achieve the same levels of neonatal mortality as urban families, the annual number of neonatal deaths would be cut almost in half.

It is against this background that the Reproductive Health Unit of the Malawi Ministry of Health in collaboration with Unicef and Save the Children with financial support from USAID and the Bill and Melinda Gates Foundation started an operations' research project called Community Based Maternal & Newborn Health in Chitipa, Thyolo & Dowa with the goal of reducing maternal and neonatal mortality in Malawi.

Together, the three districts comprised more than 280,000 women of reproductive age, 210,000 children under the age of five and more than 61,000 births annually.

"The project seeks to improve access, availability and quality of community-based and facility-based Maternal and Newborn Health (MNH) care," says Zimba.

Apart from that, the project further seeks to increase community knowledge, participation and mobilisation on key MNH behaviours and demand for MNH services from duty bearers at community and national level.

Under Community Mobilisation, health surveillance assistants (HSA) sensitise communities in their catchment areas on MNH issues, the importance of seeking MNH care from health facilities and mobilise the community in identifying the causes of the MNH issues and strategies on how to deal with them.

Zimba says that the entry point for community dialogue is the Traditional Authority in close collaboration with the Village Development Committee (VDC) and the Group Village Headmen. In each community, volunteer community workers are responsible for initiating community dialogue on MNH issues in collaboration with community leaders.

They engage natural community structures around efforts to improve knowledge, social norms and behaviours on MNH. HSAs are actively involved.

Community Mobilisation activities are determined by the communities and encourage facility births, emergency preparedness for transport, establishment of mothers support groups, and efforts to increase the involvement of men in maternal, newborn and child health issues.

At household level, the project is implemented through delivering an integrated package of community-based interventions aimed at reducing maternal and neonatal mortality and morbidity.

The interventions are delivered through community based HSAs who are first trained in the Community-Based Maternal and Newborn Care Package.

After training, HSAs identify and register and track pregnant women in their community. They conduct one prenatal home visit in the first three months of pregnancy where they counsel would-be mothers and their partners to seek prenatal services throughout pregnancy.

The HSAs also counsels the would-be mothers and their partners on [illegible] knowledge and Behaviour Change Communication (BCC) that promotes prenatal and postnatal care seeking behaviours and timing, birth preparedness, facility delivery, clean delivery, family planning, immediate and exclusive breastfeeding, skin-to-skin thermal care, hygiene, cord and skin care, nutrition, care-seeking behaviour, insecticide treated nets (ITN) and danger signs to look out for during pregnancy, postnatal and in newborns.

"Mothers are specifically encouraged to attend antenatal clinic within the first three months of pregnancy and also to eventually delivery in a health facility. It is crucial to receive the right information in this way to combat maternal and neonatal mortality. We believe it is further important to complete the antenatal visits," stresses Zimba.

Benefits of antenatal care

FIRST with a progressing but unpleasant report card, the government has equally been pressing communities to seek health facility antenatal care within the first three months of pregnancy.

Among women aged 15–49 who gave birth in the two years preceding the 2006 survey, 97 percent of women received at least one antenatal care.

Only 33 percent of women receive postnatal care while only a quarter of children receive a health check-up within 6 weeks of birth.

Says an optimistic Zimba: "We believe if mothers seek antenatal services where the right knowledge and preparation is enhanced and deliver in health facilities under skilled attendants, we might greatly reduce the risk on

THE DAILY TIMES, Tuesday, September 22, 2009

ter care closer

pregnant women and newborns".

At national level skilled attendance at birth, critical for both the mother and newborn, is only 54 percent with 46 percent born at home, says the MICS report of 2006.

Zimba adds that it is also particularly crucial for pregnant women to access antenatal care particularly in the wake of HIV/Aids in Malawi.

With one of the highest HIV prevalence rates in the world at an estimated 14 percent of the adult population and approximately 20 percent of pregnant women, Mother-to-child transmission (MTCT) is the primary mode of acquisition of infection for children and the second most common cause of HIV in the country.

"Preventing maternal to child transmission of HIV is currently being scaled up by the state but we need these mothers to come in early so that critical decisions are made," he says.

In the Community Based Maternal & Newborn Health Project, the HSA also conducts three postnatal visits within the first week after a woman has delivered where they counsel on the importance of postnatal care for both the mother and the baby.

At present, postnatal care coverage within 2 days of birth is estimated at 37 percent, 100 percent of facility births and a [illegible] for 9 percent for home births. Predictably, postnatal care visits are more commonly done by older women, women residing in urban areas, more educated women and women in the highest wealth [illegible].

In the Community Based Maternal & Newborn Health Project, the home visits are done alongside community health system strengthening in the context of the Essential Health Package (EHP) and Accelerated Child Survival Development (ACSD) Strategy for Integrated Management of Childhood Illness (IMCI) framework in Malawi.

"Here, capacity of staff and health facilities are enhanced to meet both demand and quality of care on maternal and neonatal care. We are talking of both skills development of health workers and provision of equipment for MNH," adds Zimba.

To date, the three districts have trained 381 HSAs who are implementing the programme.

Preliminary results are showing change.

Recently, [illegible] gave birth to a baby girl. She was visited by an HSA in her area throughout her pregnancy. [illegible] she attended all [illegible] antenatal visits to the health facility.

"I realised I did not do the right thing at first. After the HSA visits, I attended clinics at [illegible]. I decided to come here early as I am determined never to risk my child's or my life again," she said.

A visit and interview at the waiting bay of the maternity ward of Chitipa District Hospital indicates women from Wenya, [illegible] and the other distant places of Chitipa come to deliver early and at a hospital.

District Nursing Officer for Chitipa Doreen Nyondo says despite incomplete coverage of the whole of her district by the Community Based Maternal & Newborn Health Project's critical interventions, positive trends on maternal and neonatal deaths and behaviours are emerging and as she put it, "its not an accident".

The critical part, she said, is that through the project, the HSAs bring key messages on maternal and newborn care to the home and this is crucial for people who have to walk long distances to health facilities. She adds that the vigilance brought by the registering of pregnant women and the prenatal and antenatal visits enable identification of complications earlier and faster thereby reducing the risk of danger for pregnant women, mothers and neonates.

Nyondo said: "When we go out to the villages, we find that their HSAs really visit their clients and at the hospital here there has been a surge in antenatal visits within the first trimester; early arrivals before labour and hospital deliveries. Incidentally, the programme is mostly from the areas being covered by the Community Based Maternal & Newborn Health Project. Its not rocket science but truth is there is no accident in this happening."

Perhaps she has a point.

[illegible]—Reductions in neonatal mortality will be essential.

Old tools, new solution: Benefiting from 'agogo'

Some communities regard grandparents as old tools whose value can only be appreciated in the museum. Yet these old tools have proved to be a futurum of new solutions. While some people unfairly treat these grandparents, the communities in Ekwendeni have discovered agogo's real value; CLIFTON [illegible]WANGA looks at [illegible]ir role in reducing neonatal deaths.

In some communities, being an old man or old woman is a crime; the penalty one pays for being old ranges from disrespect to mental torture that degrade their human dignity.

Yet in communities like those around Ekwendeni hospital, the old men and old women are prized as they are the reason neonatal deaths have decreased.

The figures are encouraging. In 2006, there were 60 neonatal deaths recorded at the hospital, 51 in 2007 and 39 in 2008. Official neonatal mortality rate is 33 deaths per every 1,000 births in the country.

Until the implementation of the project, the problem [illegible] growing in the area. Agogo Approach was the missing piece to help reduce neonatal deaths.

Ekwendeni in Mzimba, where the project is being implemented, is home to many rural villages that for the most part are far removed from hospitals and health facilities. Roads in this area are often poor or impassable due to heavy rains.

"The survival of babies delivered in the villages is often endangered by serious logistical obstacles in the way of reaching a hospital in time if complications set in or specialised help is required," says Evelyn Zimba who is programme manager of Save the Children's Newborn Health (SNH) Programme.

At national level, Ministry of Health says 45 percent of newborns are born at home or at a traditional birth attendant (TBA).

Zimba, an expert in newborn health, says neonatal deaths in Malawi occur mainly due to infections, prematurity and asphyxia and about 75 percent of the neonatal deaths occur in the first seven days of a child's life despite the fact that these conditions are manageable or treatable.

Recognising the potential influence exerted by grandparents on practices relating to birth and newborn health, Save the Children has been supporting Ekwendeni Mission Hospital in their quest to utilise grandparents as mobilising agents of behaviour change within the communities.

"Before 2004, the number of newborn deaths in the area was further increased by traditional practices harmful to healthy development and maternal deaths due to pregnancy related causes were not at all uncommon.

"Babies born prematurely in the village and hastily brought to the local mission hospital at Ekwendeni were often dead on arrival, for lack of proper transportation or as a result of hypothermia," says Rose Gondwe who is coordinator of the project in Ekwendeni.

The inclusion of the elderly in this project means there is readily available advice given to the mothers.

"Many babies died in the villages because danger signs failed to be recognised by mothers or traditional birth attendants," says 59-year-old Isabel Ngwira who has assisted a lot of women in the communities since the project started.

Ngwira says: "We have been empowered by the training that was offered that is why we are better placed to assist the mothers in our community."

According to Gondwe, the project's specification of a grandparent, locally known as agogo, is someone from 50 years and above and should be strong enough physically.

"There are a lot of male agogos who have been trained. They are now well aware of what happens with the newly born babies which was not common before this programme was implemented," she says.

In Ekwendeni catchment area, there are about 4,000 trained agogos.

The approach requires the agogos to identify expectant women and advise them on the importance of starting antenatal visits early, says Gondwe.

Martha Chiumia, 24, got help from Ngwira to give birth to her third child.

"There were complications with the first and second births. I never visited the hospital until a month before the day of delivery.

"This time it was easy because I was visiting the hospital regularly and the timing was perfect," says Chiumia who first gave birth when she was 18 years old.

Ngwira says, traditionally, the appropriate age for a mother to give birth is 25 years. Early pregnancy so often causes complications during delivery.

According to Gondwe, primary healthcare staff at the local mission hospital launched an initiative to reduce the number of maternal and newborn deaths in the hospital catchment area, targeting young mothers with information dissemination sessions emphasising the importance of antenatal care and the benefits of delivering at the hospital.

Yet traditionally, Gondwe says, family structures in Tumbuka culture meant that the new information was subjected to scrutiny and subordinated to cultural beliefs held by village elders who are used to traditional decision makers regarding matters of birth and newborn care.

"As a result, no meaningful behavioural change occurred," says Gondwe adding that the situation has since changed with the involvement of the grandparents.

The programme, which was initially funded by the Bill and Melinda Gates Foundation and subsequently by the United States Agency for International Development (USAID) through Save the Children's Child Survival Project in Malawi, provided three-day training sessions for grandparents from more than 42 communities between 2004 and 2008.

"During the training, horizontal dialogue and negotiation of knowledge happened in a non-judgemental environment, affording hospital and project staff a valuable opportunity for gaining insight into traditional practices while providing suggestions and information geared towards behavioural change," says Maggie Mumbwe who is assistant coordinator of the project.

The training curriculum covered essential aspects of maternal and newborn health, equipping grandparents with lifesaving knowledge regarding the timing of antenatal visits, danger signs to look out for in pregnant mothers and newborns, exclusive breastfeeding, family planning, birth preparedness and postnatal care.

Mumbwe says grandparents further received instruction in documenting details of pregnant mothers in their villages.

"An Agogo Register in which grandparents record details regarding each pregnancy in the village not only enables close monitoring of pregnant mother's health but also acts as a reminder to prompt or guide her to attend antenatal visits at the correct time," she says.

When the time for a mother's delivery draws close, says Mumbwe, grandparents from her community make arrangements for transport to hospital before labour starts and often a grandmother accompanies her to the maternal shelter at Ekwendeni to await the delivery.

To break the barrier that threatened the success of the project in its earlier stages, they deliberately targeted individuals who would influence behavioural change.

"The headman of every village receiving training was included among those trained, as were many TBAs from the area. In an effort to include project ownership amongst the main stakeholders in the village," Gondwe says.

Health surveillance assistants underwent orientation so that they could play a supportive role and reinforce behavioural change.

However, knowledge alone would not result into success.

Trained grandparents from target areas within the hospital catchment have come up with different innovative ways of distributing knowledge within their communities and a free flow of information is occurring within target areas.

"Some have created songs, incorporating important information such as the danger signs to look out for during pregnancy.

"Others travel from village to village, instructing mothers-to-be, untrained agogos and young girls on the benefits of hospital deliveries and antenatal care, as well as on the disadvantages of certain harmful traditional practices prevalent in the area," Gondwe says.

As the country aims to meet MDG 4, which is reducing by two thirds the mortality rate of children under five by 2015, the Agogo Approach has proved to be one of the [illegible] Malawi towards that goal.

NGWIRA —We have been empowered by the training

CHIUMIA—The timing was perfect.- Pictures by Clifton Kawanga

> "There are a lot of male agogos who have been trained. They are now well aware of what happens with the newly born babies which was not common before this programme was implemented

Kangaroo Mother Care: Saving Malawi's babies

Today, Malawi joins the rest of the world in commemorating the Day of the African Child under the theme 'Strengthening the Laws and Systems to Protect Children.' ***CLIFTON KAWANGA*** explores a system that may just save the country's babies.

ZIMBA — It is a low-cost and resource-efficient method —Photo by Clifton Kawanga

EFFECTIVE – A mother at Bwefa KMC providing warmth to newly born baby

EVERY year in Sub-Saharan Africa, an estimated minimum of one million babies die within their first four weeks of life. Malawi as one of the sub-Saharan Africa countries is no exception and the progress towards Millennium Development Goal 4, which is "reducing by two thirds of the mortality rate of children under five by the year 2015, is complicated by the high number of preterm births that occur every year.

Malawi's official neonatal mortality rate at 33 deaths per every 1,000 live births is a figure that even the most optimistic of the country's health workers, bureaucrats, technocrats and statisticians silently and logically do not necessarily believe in.

The statistics is mainly questionable because most births in rural Malawi occur in villages using often hazardous traditional methods and unskilled attendants. At national level, the Malawi Ministry of Health (MOH) says 43 percent of newborns are born at home or at a traditional birth attendant (TBA). As a result, it is highly likely that many newborn deaths are unrecorded.

"Those newborns born at home often remain secluded with their mothers for about seven to 10 days after birth so that traditional rituals are performed," says Rose Gondwe a Midwife at Ekwendeni Mission Hospital.

Statistically, suggests the World Health Organization, 75 percent of neonatal deaths worldwide occur as a result of complications in the first seven days of a child's life and often from unmanageable or treatable conditions.

"One major complication that often arises in Malawi is that newborns are not provided with adequate warmth to enable them to survive and they develop complications which are often fatal. If this can be managed, the rate at which newborns die can significantly be managed' says Gondwe.

In different parts of Malawi, certain cultural values and customs have seen newborns being exposed to home-made "hot water bottles" that have in some instances ended up providing unregulated and horrendous heat for newborns.

"The situation is particularly critical in preterm births," adds Gondwe.

Preterm babies have a low birth weight, and are especially at risk of infections and hypothermia, or dangerously low body temperature.

In countries such as Malawi, where medical personnel are few, a lack of access to specialised care and equipment means that babies born preterm have hardly any chance of surviving and thriving. Babies born unexpectedly at home in rural areas are most at risk as a result of poor road conditions and lack of warmth during transportation to hospital. Many preterm babies in rural areas die on the way to hospital, due to hypothermia.

MOH estimates that preterm births account for 20 percent of all newborn deaths in Malawi.

"These small babies need extra care and warmth, and incubators often are not available in Malawian health facilities," she adds.

It is against this background that Ministry of Health in partnership with Save the Children with financial support from Unicef and the Bill and Melinda Gates Foundation are promoting Kangaroo Mother Care (KMC) in the country.

KMC is an easy and inexpensive method which very effectively makes use of skin-to-skin contact to improve very small newborns' chances of survival. A baby with low birth weight is strapped skin-to-skin to the mother's chest with a chitenje, wearing only a nappy and warm hat or cap. This promotes warmth and regulates the baby's temperature, encourages weight gain and uptake and duration of breastfeeding and reduces infections. The reason that this approach is inexpensive; KMC can effectively be applied in home, community and hospital settings.

KMC can also involve the father or any surrogate mother available to provide warmth.

First introduced in the 1990s, KMC has gradually been implemented in a number of districts in Malawi.

"KMC has been shown to be more effective than incubator care for stable small babies. It is a low-cost and resource-efficient method that encourages early discharge and requires less nursing staff as the mother does most of caring and only needs to be taught and observed," says Evelyn Zimba, Programme Manager at Save the Children's Newborn Health (NBH) Programme.

Zimba states that studies have shown that children put on KMC are likely to feel more connected and comfortable with their surrogate mothers.

Rachael Chima from Chimaopa has a 12-day-old on KMC at Bwefa. She agrees with the scientific theory.

"My child cries less on KMC than when placed in the incubator. I think there is some truth to the idea," she says.

Apart from providing technical assistance in supporting scale up of KMC facilities countrywide, Save the Children and other partners have been striving to make KMC a top policy agenda issue in combating neonatal mortality in Malawi.

So far the signs and frameworks seem promising.

The Malawi government has clearly recognised how crucial KMC is in its effort to reduce child mortality and morbidity by two thirds from its commitment to the Millennium Development Goals. It has also highlighted KMC as one of the strategies in the Scaulised Roadmap for reduction of maternal and neonatal 'mortality and morbidity.

Despite obvious success, progress in spreading the method has been slow.

"Evidence in KMC sites indicates improved neonatal survival and reduced hospital stay as compared to incubator care. To date there are 22 health facilities providing KMC in Malawi," she adds.

Save the Children, Unicef, Access and other partners are now making concerted efforts to reach more districts in Malawi with KMC.

Since 2002, Save the Children has been involved in scaling up the application of KMC in Malawi.

Says Zimba: "Save the Children, through Child survival and Save Newborn Lives programme is currently working with Ministry of Health to scale up KMC services in Malawi. Training of service providers has already started."

In order to reach to more service providers, a facility based training approach that uses an Integrated Maternal and Neonatal Care training manual compiled in a modular form is being used in order to avoid taking away the few health workers available in the health facilities and at the same time to make sure that more health workers are trained at once, all in an effort to achieve MDG 4.

On the other hand, Zimba, a veteran maternal and neonatal professional, remains adamant that the only way Malawi can reach the promised land as far as MDG4 is concerned is if the country reduces unnecessary neonatal deaths.

"For all the progress we have made, it is clear we need to cut down on these unnecessary neonatal deaths," she says.

In light of this year's Day of the African Child theme of *'Strengthening the Laws and Systems to Protect Children,'* she may not be far off to demand that KMC be in the top drawers of government policy.

That way, Malawi's newborns might just count.