Save the Children®

Malawi Newborn Health Program
Year 4 Annual Report

Expanded Impact - National Level

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

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Acronyms

ACCESS/MCHIP	Maternal Child Health Integrated Partnership
agogo	Grandparent
ANC	Antenatal Care
CBMNC	Community-Based Maternal and Newborn Care
CCAP	Church of Central Africa Presbyterian
CCM	Community Case Management
CHAM	Christian Health Association of Malawi
COIN	Cost of Integrated Neonatal Tool
CSHGP	Child Survival and Health Grant Program
DIP	Detailed Implementation Plan
EHP	Essential Health Package
EmOC	Emergency Obstetric Care
GOM	Government of Malawi
HMIS	Health Management Information System
HSAs	Health Surveillance Assistants
IMCI	Integrated Management of Childhood Illnesses
IMNC	New Acronym for Essential Obstetric and Newborn Care
KMC	Kangaroo Mother Care
LiST	Lives Saved Tool
M&E	Monitoring and Evaluation
M&E TWG	Monitoring & Evaluation Technical Working Group
MDGs	Millenium Development Goals
MOH	Ministry of Health
MPH	Master in Public Health
MTE	Midterm Evaluation
NBHP	Malawi Newborn Health Program
NGOs	Non-governmental organizations
PMNCH	Partnership for Maternal, Newborn and Child Health
PVO	Private Voluntary Organization
RHU	Reproductive Health Unit
SC Italy	Save the Children Italy
SNL	Saving Newborn Lives
SRH	Sexual and Reproductive Health
SRH TWG	Sexual Reproductive Health Technical Working Group
SSD	Supporting Service Delivery
SWAp	Section Wide Approach
TOTs	Training of Trainers
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

This Annual Report (October 2009-September 2010) covers Year 4 of Save the Children's five-year Expanded Impact (CS-22) project, the Malawi Newborn Health Program (NBHP), implemented at the national-level, with learning activities in several learning districts. The Child Survival and Health Grant Program (CSHGP) intervention is Maternal and Newborn Health (100%), with ***focus on the neonate.*** The Newborn Health Program 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 launched officially on 30 March 2007. The 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 the MOH and its other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. Save the Children's Saving Newborn Lives (SNL) initiative (funded by the Bill & Melinda Gates Foundation) co-funds the Newborn Health Program and supports the three-district pilot of the Community-Based Maternal and Newborn Care (CBMNC) package in the districts of Chitipa, Dowa, and Thyolo, constituting match.

A. Key Progress and Main Accomplishments

Melinda Gates' visit to Malawi and Dowa District In January 2010, Save the Children hosted a visit by Melinda Gates (of the Bill & Melinda Gates Foundation) to Malawi to visit the Malawi Newborn Health Program, co-funded by SNL. Mrs. Gates and her small entourage were accompanied by Evelyn Zimba (Senior Maternal and Newborn Health Program Manager) and Patrick Zgambo (Newborn Health Communications and Media Coordinator) on visits to HSAs who deliver the CBMNC package in Dowa District, the Bwaila Hospital KMC ward, and a Safe Motherhood Sub-Committee meeting in Lilongwe. The success of this visit contributed in part to SNL's negotiating a15-month cost-extension with the Gates Foundation for the Save the Children country office to continue support of the CBMNC package and newborn health in Malawi, through calendar year 2012.

In the fourth year of the Malawi Newborn Health Program, the following highlight some of our main accomplishments:

- **Adoption of the CBMNC Package** The CBMNC package – developed and piloted by Save the Children, UNICEF, ACCESS/MCHIP, WHO, UNFPA and other partners in cooperation with the Reproductive Health Unit (RHU) of the Ministry of Health (MOH) - was officially adopted in February 2010 as a national program after extensive stakeholder consultation. At the district level, new implementation partners and donors are now being directed to implement this national package and no other.
- **National Dissemination of the CBMNC Package** Save the Children partnered with MCHIP to support RHU's dissemination of experiences and lessons learnt from piloting of the CBMNC package in a national workshop held in July 2010.
- **Current Reach of the CBMNC Package in the Learning Districts** During the period 2007-2010, the CBMNC package reached half (47%) of the population of the three learning districts. Additional resources secured from Save the Children Italy is now expanding the scale

of these interventions to saturate the three districts, reaching a projected 85% (1.12 million out of 1.32 million) of the total population. With an expected 15-month cost extension from SNL for the CBMNC pilot, coverage in these three districts could reach nearly 100% by the end of 2012 and benefit approximately 66,160 pregnant women and their newborns annually.

- **Replication of the CBMNC Package beyond the Three Learning Districts** In addition to the three learning districts that Save the Children supports, replication of the CBMNC package is currently supported by USAID-MCHIP in four districts, by UNICEF and its Catalytic Initiative in ten districts; as well as in Partnership for Maternal, Newborn and Child Health (PMNCH) in several additional districts. Save the Children intends to continue working closely with RHU and Road Map partners to support taking the CBMNC package to scale in all 28 districts of Malawi, through strategic engagement and technical support at national and zonal levels. To roll out the CBMNC package countrywide, the districts will require both technical and financial support. Current limitations of resources suggest that scale up is likely to be slow and incomplete. There is also a need to facilitate cross-learning from the experienced learning districts to new districts preparing for uptake of the package and community mobilization. Funding from Save the Children Italy, SNL, and UNICEF for the Catalytic Initiative is expected to ensure a modest level of ongoing support to districts for scale up – but additional funding will need to be leveraged. The USAID bi-lateral procurement for Supporting Service Delivery (SSD) for the Essential Health Package (EHP) – not yet awarded – focused on the need to build on existing maternal and newborn health interventions and may prove to be a further source of support for replication and scale up.
- **Capacity-building for Health Surveillance Assistants (HSAs) in the CBMNC Package**

District	# of HSAs targeted for training in community mobilization & the CBMNC package over the life of the project	# of HSAs trained by the end of September 2010	
		CBMNC	Community mobilization
Dowa	187	171	132
Chitipa	107	142	148
Thyolo	239	264	232
Total	**533**	**578**	**512**

The table above presents progress in the training of HSAs against the targets in the three learning districts match-funded by SNL. In addition to these trainings, Save the Children also trained 25 national trainers for the CBMNC package. This was made possible by supplemental funding from Save the Children Italy and support of the program by government and district partners. As seen in the table, the number of trained HSAs exceeds original targets - partly as a result of Save the Children's continued technical assistance in support of district-level scale up to achieve saturation. Increasing the number of HSAs trained in CBMNC has resulted in increased utilization of health facilities for ANC. Over the past year, district service statistics indicate that ANC utilization increased by about 15%, and facility deliveries increased by about 28%. In these three districts, approximately 84% of deliveries are now taking place with skilled attendance.

- **CBMNC Implementation review meetings** Key stakeholders (MOH, UNICEF, WHO, USAID, Save the Children, MCHIP, Zonal Health Officers, and selected District Health

Officers from Catalytic Initiative districts) held six, monthly implementation review meetings to coordinate efforts, share resources, and align technical details for the CBMNC package.

- **Costing of the CBMNC package** After review of the CBMNC costing tool in July 2009, and with SNL match support, Save the Children engaged a health economist to work with the project team adapting the COIN tool for Malawi. All data are collected and cleaned; and analysis commenced with a draft report expected in late October 2010.
- **Supportive supervision at facility and community level** Save the Children team members conducted all four planned quarterly supervision visits during the reporting period. During the supportive visits at the community level, it was noted that community mobilization activities were not being carried out appropriately. Accordingly, the community mobilization guide was simplified and translated into the local language.
- **Community mobilization** Quarterly supervision visits conducted during the third quarter of 2010 revealed considerable progress in community mobilization, indicating that some communities are mobilizing themselves and providing locally available building materials (such as bricks) to assist in the expansion of health centers in their catchment areas.
- **Scale up of Kangaroo Mother Care (KMC)** During the reporting period, new KMC services were initiated in 20 health facilities (14 hospitals and 6 tertiary/teaching hospitals) throughout the country. National KMC scale up is supported both materially and technically by Save the Children. Essential newborn care and KMC are being practiced by 40 health institutions across the country, including district hospitals, central hospitals and Christian Health Association of Malawi (CHAM) facilities. Already, ten facilities including hospitals and health centers in non Save the Children program districts, have established KMC units. MCHIP (in which Save the Children is a core partner) is also supporting scale up of KMC in its implementation districts and is using materials developed with Save the Children, RHU, and partners. Tutors in nursing institutions have been trained on KMC; and the Malawi College of Health Sciences - a training institution for medical assistants and clinical officers - has incorporated KMC into its curriculum. Save the Children has played a central catalytic and technical support role in establishing KMC as a high-impact, cost-effective intervention to save newborn lives in Malawi.
- **Advocating for standard newborn health indicators into the national HMIS** Malawi's current Health Management Information System (HMIS) still does not include standard newborn health indicators. As previously reported and documented in the Report of the Midterm Evaluation, Save the Children has advocated for the inclusion of these indicators into the HMIS since the Newborn Health Program began in 2006. Since official adoption of the CBMNC into the national program, the HMIS Unit at the MOH has shown proactive interest in incorporating newborn health indicators. Nonetheless, progress toward inclusion of these indicators remains slow due to financial constraints on the part of the HMIS Unit itself. Save the Children has offered to sponsor a meeting, to be held in mid to late October 2010, to review the indicators and plot a way forward. As the process will also involve review of the tools, data flow systems and the actual HMIS database, a consultant has been recruited by Save the Children to assist/guide the development and set up of all the necessary systems.
- **Joint supervision visits** Three out of the expected four joint supportive supervision exercises were conducted during the reporting period. During these visits, partners shared experiences, identified areas requiring attention, and discussed intervention strategies. One joint exercise did not take place because the RHU cancelled due to other national engagements. All parties have subsequently agreed that, should RHU have other commitments and be unable to participate in joint supervision visits in the future, it will request zonal officers (who also take part in these visits) to represent RHU instead of cancelling completely.

- **Bi-annual review meetings** Two RHU bi-annual review meetings were conducted during the reporting period. These activities were made possible with financial support provided by Save the Children.
- **Community KMC** With technical support from Save the Children, the national KMC guidelines were revised to include community KMC. Training of HSAs in community KMC is still ongoing.
- **Packaging of the *Agogo* Approach for Dissemination** The sub-grant to our CHAM partner Ekwendeni Church of Central Africa Presbyterian (CCAP) Mission Hospital in Mzimba District for piloting of the *Agogo* Approach ended in the first quarter of FY10. The process of packaging Ekwendeni's story and lessons learnt is underway. A report documenting Ekwendeni's experiences and lessons learnt (Annex 7) will be packaged with Ekwendeni's training curriculum and report of the original qualitative inquiry, and disseminated in December of this year. The dissemination audience is community-based organizations, church groups, local non-governmental organizations (NGOs), and others interested in engaging grandparents to support promotion of best practices for maternal and newborn health at the household and community levels.
- **Communication** Newborn health in Malawi featured alongside Nepal in the BBC documentary *"Invisible Lives"* in 2010. This important production, aired globally, was facilitated by Save the Children and featured Joy Lawn, SNL Director, Global Evidence and Policy, as its narrator. http://www.who.int/pmnch/topics/newborn/20100126_bbc_newborn_documentary/en/index.html Newborn health and frontline health workers in Malawi were also featured in the Bill & Melinda Gates Foundation documentary production entitled *"Living Proof."* The Malawi Newborn Health Program also counted 24 national newspaper articles, 11 radio news mentions, and four instances of television coverage aired during the same period. Save the Children's 2010 *State of World's Mother Report* featured female frontline health workers and newborn health. Save the Children played a lead technical role in supporting the June 2010 Day of the African Child celebrations with the Government of Malawi and partners.

The Malawi Newborn Health Program continues to move the newborn health agenda forward through active participation on national-level policy-making bodies and strategic engagements with key partners:

- **USAID Health Partners:** Save the Children, as a member of the USAID Health Partners group, participated in all meetings. These meetings provide a forum for the USAID Malawi Mission to share new developments and technical updates regarding USAID funding; and for partners to exchange information and updates.
- **Midterm Section Wide Approach (SWAp) Review** In March, Save the Children participated in this year's SWAp Review, the aim of which was to assess the health sector's midterm performance against the SWAp monitoring and evaluation (M&E) frameworks, annual implementation plan and budget; agree on milestones going forward; and propose key undertakings and actions to be achieved by the next annual review.
- **Safe Motherhood Sub-Committee meetings** Save the Children is a regular participant and continues to serve in a technical leadership role for newborn health on the MOH Safe Motherhood Sub-Committee meetings. The body's aim is to review progress and new developments regarding maternal and newborn health and make recommendations for decisions and actions. During the meeting held in mid-February 2010, among a number of other issues,

the body discussed plans to conduct an Emergency Obstetric Care (EmOC) assessment and established a task force. It also reviewed progress on scale up of the CBMNC package and IMNC trainings with funding from other partners, e.g., UNFPA and WHO.

- **Sexual and Reproductive Health (SRH) Technical Working Group (TWG) meeting** Save the Children was invited to participate in the SRH TWG meeting held in mid March 2010 to discuss progress on the RHU work plan. Among a number of other issues reported at that meeting was that the World Bank was conducting an assessment of maternal and child health services in Malawi. The report of this assessment was disseminated in July.
- **Malawi's EveryOne Campaign** In April 2010, Save the Children partnered with UNICEF, MOH/RHU and the MOH Integrated Management of Childhood Illness (IMCI) Unit to hold a two-day national consultation on the accelerated reduction of maternal, newborn and child mortality in Malawi to achieve the Millennium Development Goals (MDGs) 4 and 5. This consultation was the beginning of a larger advocacy initiative to conceive and carry out a five-year maternal, newborn, and child survival campaign entitled EveryOne and tied to Save the Children's global EveryOne Campaign for newborn and child survival. The national consultation clearly identified as its top priorities for this campaign: national scale up of (1) facility and community-based maternal and newborn care interventions and (2) community case management of childhood illnesses including neonatal sepsis. The priority message *"every newborn baby is a human being with a right to survive"* resonated with the participants at the consultation. Technical assistance for campaign planning was provided by Karen Waltensperger, Africa Regional health Advisor, and Tina Lloren, Africa Regional Nutrition Advisor. A multi-partner ad hoc task force has been set up at the national level to take the planning forward and a launch is planned for mid-October 2010. Among those lending their support and endorsing the campaign in Malawi is the entertainer Madonna.
- **MOH M&E TWG** Save the Children's Malawi Research and M&E Manager, Edward Chigwedere, is now a regular member of the MOH Monitoring & Evaluation Technical Working Group (M&E TWG) led by the HMIS Unit. The M&E TWG serves as a link to the MOH Senior Management Group and Health Sector Advisory group on all issues relating to M&E.

B. Activity Status

Please see Annex 6.

C. Factors Impeding Progress

In addition to the challenges described in Section A above, other factors impeding progress include:

- **Delay in incorporation of community-based sepsis management** As reported in the Report of the Midterm Evaluation, UNICEF did not fulfill its FY07 commitment to fund training of HSAs on the CBMNC package. This led to a delay in the training of HSAs that ultimately resulted in having to postpone the incorporation of community-based sepsis management into the package. Consequently, SNL match funds that had originally been budgeted for community-based sepsis management were reprogrammed to cover the first phase of HSA trainings in the three learning districts. To ensure that plans for community-based sepsis management are not completely abandoned, Save the Children and UNICEF collaborated with the RHU and the IMCI Unit to make community-based management of neonatal sepsis a priority issue for the national consultation on meetings of the MDGs held in April 2010. An ad

hoc task force has been constituted under the RHU involving all partners to take this agenda forward. The task force will present its suggestions for a way forward at a meeting scheduled for October. This will include planning development of the technical guidelines and training materials necessary for integration of community-based management of neonatal sepsis into the existing maternal and newborn health and community case management (CCM) manuals.

- **Health system challenges** Shortage of staff and transport at the district level has also affected implementation of the CBMNC package. HSAs, meant to be based in the community, are at times tasked with the responsibility for facility-based activities. District personnel, due to time constraints and being over-stretched, are able to conduct very little supervision of the package's implementation. These and other factors conspire to make it difficult for HSAs to carry out all expected home visits. In addition, serious delays in the flow of data from HSAs to the district level have been noted. There are a number of activities planned, especially under the EveryOne Campaign, for strong advocacy to convince the Government of Malawi to honor its Abuja 15% pledge and allocate additional needed resources (both financial and human) to the health sector with the hope that some of these problems can be resolved.
- **Integration of the CBMNC task force into the Safe Motherhood Sub-Committee** While consistent with MOH intentions to streamline a plethora of task forces, working groups, and ad hoc committees, integration of the CBMNC task force into the Safe Motherhood Sub-Committee did result in a weakening of the technical focus on the implementation of the package for maternal and newborn care in the community. As a result, discussions on inclusion of standard newborn indicators into the HMIS were delayed. Recently, the Maternal and Newborn Health Core Group was revitalized with monthly meetings, chaired by the RHU, to review progress and propose action plans. Finally, with support from SNL and MCHIP, Save the Children is currently in the process of recruiting a consultant to facilitate the process of review of all indicators, tools and data flow systems for enhanced monitoring and evaluation of maternal and newborn health in Malawi.
- **Management Information System** The management information system for the Newborn Health Program requires further strengthening. The program faced many challenges in ensuring that district-level data are compiled, analyzed and used on a regular basis. There are delays in completing the data entry at the district level, which causes challenges in timely analysis of the data. Save the Children and MCHIP are coordinating with the RHU and HMIS Units to recruit a consultant to review the data flow systems for all maternal and newborn health indicators at the national and district levels.
- **Integration of Community Packages** Save the Children sees as one of the future's greatest challenge the need to integrate the current HSA packages (Essential Health Package, CBMNC Package, curative/CCM) package at the levels of training, delivery, supervision, monitoring, and reporting. As a first step, continued advocacy and technical support is required to integrate the CBMNC package into the basic training package for the HSAs. This will involve addition of the CBMNC modules into the curriculum for HSAs as well as training HSA trainers, facility-based health providers, and district-level support personnel.

D. Technical Assistance Needed and Planned for the Coming Year

- **Preparations for the CSHGP endline survey in Mzimba District** Tanya Guenther, Save the Children's Senior Specialist for M&E in the Department of Health and Nutrition, is expected to visit the program in October 2010 to assist in preparation of the endline survey scheduled for the third quarter of FY11.

- **Community-based sepsis management design/protocol** The Senior Newborn Health Advisor, Steve Wall will provide technical support for the development of the design and management protocol for a small operational research activity on community-based newborn sepsis management to be integrated into the CBMNC package delivered by HSAs. This technical assistance will be supported by SNL match funds.
- **Dissemination of costing report** Save the Children is arranging for a consultant who is a health economist, to come for dissemination of the CBMNC package costing results in the first quarter of calendar year 2011. This will also be covered by SNL match funds.
- **KMC national roll-out** Save the Children is working with the MOH to launch a national rollout of KMC. Stella Abwao, MCHIP/SNL Newborn Health Advisor will provide technical assistance.
- **Newborn health communication strategy and EveryOne Campaign launch** The Malawi Newborn Health program communication strategy and the national Everyone Campaign launch will receive technical assistance from Monika Gutestam, SNL Communications Advisor.
- **Malawi's newborn health policy change timeline** Save the Children is documenting and plans to disseminate contributions of the CSHGP and SNL co-funded Malawi Newborn Health Program to maternal and newborn health achievements in Malawi through a journal publication as part of SNL's "Telling the Story" initiative. SNL Director of Evidence and Advocacy Joy Lawn is assisting in this exercise. (See Results Highlight, Annex 5).
- **Training on the Lives Saved Tool (LiST)** Save the Children's Malawi country office has invited Kate Kerber, SNL's Newborn Health Specialist based in Cape Town, to train the Malawi health team members on use of the LiST.

E. Substantial Changes

There have been no substantial changes to the program description that would warrant modifications to the contract agreement. Project objectives and indicators, intervention mix, specific activities, geographical location, number of beneficiaries and local partners remain the same.

F. Sustainability

The Newborn Health Program in Malawi is entering its fifth and final year of USAID CHSGP funding. As a Road Map partner at the national level, Save the Children cooperates closely with the MOH and its other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. Save the Children supports Malawi's MOH leadership, policies, and strategies - and has created no parallel programs or systems.

As for Save the Children's engagement with newborn health at the national level in Malawi, while phase out is inevitable, SNL has granted a 15-month extension of funding for the three-district CBMNC pilot and national-level support of newborn health. This extension will run from October 2011 to December 2012. In addition, following the success of Melinda Gates' visit to Malawi in January, and the potential of taking the CBMNC package and KMC to scale, Malawi will likely be included in Save the Children's funding application for a third phase of SNL to be submitted to the Bill & Melinda Gates Foundation in the near future. When the Malawi Newborn Health program does phase out, it will leave behind a set of policies, strategies, guidelines, training packages, tools, and systems to support the delivery of quality high-impact interventions for mothers and newborns

at the facility and community levels. All developed in partnership with RHU and key partners, these products will have a lasting effect on newborn health in Malawi.

Based on recommendation from the 2009 MTE, Save the Children has taken a number of steps to strengthen advocacy efforts and reinforce the enabling environment for maternal and newborn health care in Malawi. These activities included:

- Facilitating the MOH to take the lead to identify donors and funding opportunities to support scale up of both the facility and community-based maternal and newborn care packages;
- Introducing the package and materials to the five Zonal Health Offices; providing training, mentoring, capacity building; and working with them to identify opportunities to reach new districts via the zonal platform;
- Engaging with UNICEF and WHO by communicating program results, challenges and ensuring their continued financial and technical engagement in newborn health in Malawi;
- Working with partners to respond to gaps and challenges in selected districts and to more fully inform package scale up;
- Setting milestones/benchmarks for CBMNC package implementation to ensure readiness for incorporation of new intervention component, such as community case management (for children under five) or sepsis management;
- Identifying other program platforms for scale up, e.g. CHAM, Catalytic Initiative in 10 districts, upcoming new USAID bi-lateral, and - most importantly - new districts via government investment;
- Developing a scale-up plan or framework for taking facility- and community-based packages to other districts, including design of a Technical Resource Package for facility and community-based service delivery.

In 2011, the RHU will perform a midterm evaluation of the current Road Map and revise the document. This presents a critical opportunity to share evidence from the three learning districts and KMC, as well as to propose additions or modifications to address gaps in the current Road Map document. Save the Children looks forward to being a key partner in carrying out this process.

G. Specific Information Requested

Not applicable, none requested.

H. Expanded Impact Project Strategy for Contributing to Scale

See Section F above for discussion on **sustainability** and **phase out.**

Save the Children's strategy for contributing to scale in Malawi has been to support the MOH's leadership. As a Road Map partner, we define our primary role as **reference, catalyst, and technical resource for newborn health** in Malawi. To perform this role has required our working within the system pro-actively, with emphasis on strategic networking and assertive communication. We have been at the table at the national level, often the only international private voluntary organization (PVO) to be there, and we are confident that we have contributed something of great value. That added value is: 1) Save the Children's global, regional, and in-country technical expertise in newborn health; 2) long-standing ties to communities and stakeholders in Malawi; and 3) strategic

technical and material inputs for policy dialogue and mainstreamed training, monitoring and evaluation, and scale-up.

To paraphrase from out Detailed Implementation Plan (DIP): Even with a Road Map, Save the Children has learnt that the path to our final destination is not always straightforward or well paved; and that opportunities can and do pop up, or disappear, at any turn or twist. We keep our eye on the final destination (long-term goal) while understanding that we are a fellow traveler on this road; sometimes guiding, sometimes leading, and often following – which is as it should be.

What makes this national-level Expanded Impact project different from other child survival projects that Save the Children has implemented under CSHGP is the ***shift in locus of control.*** When we work in true partnership, we cannot expect to maintain total control. Save the Children provides technical leadership at a national level by integrating into routine MOH planning activities (e.g., SWAp meetings, MOH/RHU work planning meetings, Safe Motherhood Sub-Committee), by facilitating opportunities where the MOH takes the lead role and we provide material and technical support, and by linking Malawi to the global newborn health research and advocacy communities.

I. Management System

All positions under the Malawi Newborn Health Program are filled and the team is fully equipped. Additional funding from Save the Children Italy (SC Italy) allowed Save the Children to add a Program Coordinator position at national level during the past year.

There have also been changes in key Save the Children country office personnel. Michael McGrath joined as new Country Director. A new Senior Health Manager position was created to strengthen national level advocacy efforts and links among Save the Children's health efforts in Malawi. Joby George, a nursing and public health professional with an MPH and significant international PVO experience, was recruited for the post. The job description for the Newborn Health Program Manager was revised to include additional advocacy responsibilities and was reclassified as Senior Maternal and Newborn Health Program Manager.

During the year, Save the Children strengthened its country office financial management systems with the creation of a distinct Grants Management Unit. This has helped to ensure regular and more accurate tracking of progress on expenditures and to identify and address challenges early on. Monthly review of expenditures against budget is carried out with the involvement of both program and finance staff.

J. Local Partner Collaboration and Capacity Building

In addition to our close working relationship with the MOH, CHAM, UNICEF, UNFPA, WHO, USAID, MCHIP, and other international partners (all described above), Save the Children also collaborates with communities, local leadership, faith-based institutions, women's groups, and other community-based organizations through its community mobilization strategy. Via these relationships, some communities are working at identifying maternal and newborn health problems in their communities, and developing and carrying out action plans using locally available resources at the community level.

K. USAID Mission collaboration

Save the Children regularly coordinates with the USAID Mission and other USAID-funded partners. As discussed above, regular program updates are shared during the Health Partners meetings, which also provide opportunities to learn from other Mission-funded initiatives in Malawi. As a core partner in MCHIP, Save the Children is actively involved with other MCHIP partners through weekly meetings held at Save the Children's offices. The Safe Motherhood Sub-Committee meetings chaired by the RHU have also served as a platform for coordination with the Mission and other USAID-funded projects.

Annex 1: M&E Table – Malawi Newborn Health Program (CSHGP)

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	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		MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	31/1,000 live births		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	For which years? 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	Current Status Oct 2010	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	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	93%		95%
		# of pregnant women starting antenatal care	# of estimated pregnant women	Malawi: Health Management Information Bulletin: Annual Report, July 2005-June 2006	Service Statistics	Annual	82%	42%[1]	95%
		# of pregnant women starting antenatal care during the first trimester	# of estimated pregnant women	Malawi: Health Management Information Bulletin: Annual Report, July 2005-June 2006	Service Statistics	Annual	6%	31.3%[1]	15%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	EOP Target
		Total # of antenatal visits	Total # of registrants	Malawi: Health Management Information Bulletin: Annual Report, July 2005-June 2006	Service Statistics	Annual	3	3[1]	4
	TT	# of mothers with live births in previous year given at least 1 dose of tetanus toxoid (TT) vaccine within appropriate interval prior to giving birth	Total # of women surveyed aged 15-49 with a birth in the two years preceding the survey	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	84%		85%
		# 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	Total # of women surveyed aged 15-49 years with a birth in 2 years preceding	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	53%		60%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	EOP Target
		delivered in a health facility	the survey						
	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	MICS 2006 Preliminary Report	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: Annual Report, July 2005-June 2006	Service Statistics	Annual	40%	28%[1]	60%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	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: HMI Bulletin: AR: July 2005-June 2006	Service Statistics (Note: Data Incomplete)	Annual	19%	14.1%[1]	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	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	80%		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%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	EOP Target
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	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	71%		80%
		# of infants aged 0-5 months that are exclusively breastfed	Total # of infants aged 0-5 months surveyed	MICS 2006 Preliminary Report	MICS Survey	Combined MICS/DHS scheduled in 2010	56%		65%
		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%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	Current Status Oct 2010	EOP Target
	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	Governme nt budget allocation to health sector	Government of Malawi budget allocated to health sector	Total Malawi government budget to all sectors including health	Malawi Health SWAp POW/ National Budget	National budget review/SWAP Reviews	Annual budget reviews	11.1%	15.5[2]	15%
	Total allocation to health sector: cost per capita	Government and donor total allocation to health sector (in US $)	Total estimated mid-year population	Malawi Health SWAp POW/ National Budget	National budget review/SWAP Reviews	Annual budget reviews	$7.6	$18[3]	$17.53

*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.

1 HMIS Semi annual bulletin July – December 2009 (Concerns on poor data quality were raised in the report). 2 Malawi Economic Justice Network (2010) 3 Malawi Health Equity Network (2010)

Annex 2: CSHGP Work Plan for FY2011

Malawi Newborn Health Program Detailed Workplan October 1, 2010 - September 30, 2011

1: New/Improved interventions and approaches tested and documented - *not applicable*															
2: Essential newborn care packages tested in alternative settings															
		2010			2011										
	Activities + SubActivities	oct	nov	dec	jan	feb	mar	apr	may	jun	jul	aug	sep	**Activity MGR**	**TA needs**
2.1	**Influence sharing of lessons learned from Mai-Mwana project**														
2.1.a	Hold discussions with Mai-Mwana on holding a joint dissemination of project results				X									Evelyn	
	Influence invitation of Mai-Mwana to MNH forums through RHU to share lessons learned			x			X			X			X	Evelyn	
3: Integration of essential newborn care packages into MCH systems tested/documented															
					2011										
	Activities + SubActivities				jan	feb	mar	apr	may	jun	jul	aug	sep	**Activity MGR**	**TA needs**
3.1	**Training of community health workers**														
3.1.a	Continue district HSA training in CBMNC package in the 3 learning districts	x	x	x		x	x	x	x	x	x	x	x	Rueben	
3.1.b	Continue district HSA training in CM in the 3 learning districts	x	x	x		x	x	x	x	x	x	x	x	Rueben	
3.1.c	Continue district HSA training in CBMNC package in Tyholo and Dowa learning districts				x	x	x	x						Rueben	
3.1.d	Continue district HSA training in CM in Thyolo and Dowa learning districts				x	x	x	x						Rueben	
3.2	**Supervision, Monitoring and evaluation of the learning program**														
3.2.a	Conduct quarterly joint monitoring / TA support visits by partners on the implementation of CBMNC, CKMC and CM in the 3 learning program districts		x				x			x			x	Evelyn	
3.2.b	Conduct monthly M&E support visits to the 3 learning districts and using report generated by the access database identify areas that need urgent supervision	x			x	x	x	x	x	x	x	x	x	Emmanuel	
3.2.c	Conduct monthly TA support visits on the implementaiton of CBMNC, CKMC and CM in the 3 learning districts	x	x	x	x	x	x	x	x	x	x	x	x	Rueben	

3.2.d	Conduct a semi-annual review meeting for the CBMNC package that involve all the 5 Zonal offices to share program information and identify opportunities to reach new districts via the zonal platform			x				x						Evelyn	
3.2.e	Facilitate development and follow-up of core groups to all trained HSAs in the learning districts		x		x	x	x	x	x	x	x	x	x	Reuben	
3.2.f	Quarterly supervision visits at Zonal lever by the M&E Officer at RHU					x			x			x		Joby	
3.2.g	Install the revised M&E system in the 3 learning districts					x								Edward	
3.2.h	Orient district staff and supervisors on the revised M&E system					x								Edward	
3.2.i	Review of Indicators in in the 3 SNL learning districts	x				x			x			x		Edward	
3.2.j	Purchase of Village registers for HSAs in 3 SNL learning districts					x								Edward	
3.2.k	Disseminate costing report					x								Edward	Joy Lawn
3.2.l	Conduct end line KPC survery in Mzimba district									x				Edward	
3.2.m	Conduct end-line survey in the 3 learning districts									x				Edward	Tanya Guenther
3.2.n	Conduct final evaluation of the Malawi MNH Program										x			Edward	Karen Waltensperger
3.2.o	Collate and write quarterly process documentation reports on the facility and CBMNC demonstration program for national and district levels			x			x			x			x	Edward	
3.2.p	Pilot the use of mobile phones for M&E in one district				x	x	x	x	x	x				Edward	
3.2.q	Disseminate Final Evaluation Report												x	Joby	Karen Waltensperger
3.2.r	Contract a consultant to compile "Telling the Story Publication"					x								Evelyn	Joy Lawn
4: Evidence-based essential newborn care documented/promoted at scale															
					2011										
	Activities + SubActivities				**jan**	**feb**	**mar**	**apr**	**may**	**jun**	**jul**	**aug**	**sep**	**Activity MGR**	**TA needs**
Intermediate Result 1: *Availability/Access of routine and emergency newborn care services and supplies increased*															
4.1.a	In collaboration with RHU provide support to facilitate inclusion of CBMNC/CM and IMNH trainings in DIPs by assisting Zonal offices to develop a schedule of DIPs for all the districts and ensure there is representation of partners at all times for maternal and newborn care				x									Evelyn	

4.1.b	Participate in DIP development meetings in 8 MOH districts (3 learning districts, 4 MCHIP districts and Mzimba.					x								Rueben	
4.1.c	Work with partners to monitor and ensure adequate equipment/supplies at facility level through DIPs and other donor resources					x								Evelyn	
4.1.d	Faciltate procurement of NeoNatalie dolls for HBB				x									Evelyn	Steve Wall
4.1.e	Faciltate procurement of KMC dolls				x									Evelyn	
4.1.f	Facilitate national TOT on HBB for IMNH trainers					X								Evelyn	
4.1.g	Facilitate national TOT for addditional IMNH Trainers						x							Richard	
4.1.h	Support district roll out of HBB trainings throughout the 5 zones							x						Richard	
4.1.i	Facilitate establishment of support system for ongoing district H/W trainings / capacity assessment for IMNC trainings that incorporate HBB					x							x	Richard	
4.1.j	Advocate with DHMTs to ensure that all HSAs have the required equipment					x				x				Evelyn	
Intermediate Result 2: *Quality of newborn care services improved*															
4.2.a	Facilitate joint semi-annual follow-up and supportive supervision of trainers and district H/W trained in the IMNC								x					Richard	
4.2.b	Provide TA at zonal level for district KMC scale-up throughout the country			x			x			x			x	Richard	Stella Abwao
4.2.c	As a result of the revision to the M&E system conduct district orientaiton sessions on how to use the revised KMC supervision and data collection tools					x	x	x						Emmanuel	
4.2.d	Provide quarterly supportive supervision visits to all districts implementing KMC	x					x			x			x	Richard	
4.2.e	Finalize and facilitate the roll out of the KMC performance assessment tool					x								Richard	Stella Abwao
4.2.f	In collaboration with MOH/RHU 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		Reuben	
4.2.g	Provide TA during the development and implementation of the community newborn sepsis management in the selected learning districts	x					x			x			x	Evelyn	Steve Wall
4.2.h	Conduct HAS training in community neotal sepsis management - Dowa district					x								Rueben	

4.2.i	Coordinate TA to ensure quality during scale-up of CBMNC / CM to other districts	x	x	x	x	x	x	x	x	x	x	x	x	Reuben	
4.2.j	Facilitate quarterly District level MNCH Stakeholders meetings to review progress and develop action plans			x			x			x			x	Evelyn	
Intermediate Result 3: *Demand for newborn care increased*															
4.3.a	Work with the district to ensure availability of supplies needed for effective CM						x			x			x	Rueben	
4.3.b	Work with RHU to identify other partners to support scale-up of CM						x			x			x	Evelyn	
4.3.c	Support Ekwendeni to identify possible donors to continue the Agogo program and serve as learning site for interested partners			x	x	x	x	x	x	x	x	x	x	Evelyn	
Intermediate Result 4: *Policy environment enabled and resources mobilized for newborn care scale up*															
4.4.a	Participate with partners in the development of RHU annual work plan and other planning cycles to ensure newborn health activities are included				x									Evelyn	
4.4.b	Facilitate and participate in periodic (annual) program reviews and broader information sharing at country level with stakeholders to facilitate scale up of community MNH in other districts			x			x			x			x	Joby	
4.4.c	Facilitate capacity building of the media personnel on MNH issues to facilitate effective information sharing at country level								x					Patrick	Carol Miller
4.4.d	Support National Level Advocacy Activities on MNCS under the EveryOne Campaign plan	x		x		x			x			x		Janet	
4.4.e	Participate actively in quarterly Safe-Motherhood subcommittee meetings of RHU			x			x			x			x	Evelyn	
4.4.f	Participate in quarterly SRH Technical Working Group meetings		x				x			x			x	Joby	
4.4.g	Facilitate and actively participate in MOH HIS meetings annually	x									x			Edward	
4.4.h	Advocate for policies and strategies that reflect consistent and comprehensive indicators and targets for MNH	x					x			x			x	Edward	
4.4.i	Lobby for inclusion of the CBMNC package into the basic HSA training curriculum						x			x			x	Joby	
4.4.j	In collaboration with RHU develop a scale-up plan of MNH / KMC activities that includes HBB				x									Evelyn	
4.4.k	Development and Publication of Advocacy and communication materials (Video, fact sheets,stickers and public service announcements)	x	x	x	x	x	x	x	x	x	x	x	x	Patrick	

4.4.l	Finalize the Linkage of NBH communication strategy and EveryOne Campaign plan	x	x	x		x								Patrick	Monika Gutestam
4.4.m	Attend partnership meetings in MNCH			x				x				x		Evelyn	
4.4.n	Participate in semi-annual SWAP reviews	x						x					x	Joby	
4.4.o	Participate in regional and international meetings for NBH i.e. PLG									x				Evelyn	
4.4.p	Participate in annual SNL Program Managers meeting									x				Evelyn	
4.4.q	Participate in SNL Research Workshop					x								Evelyn	
4.4.r	Provide TA for scale-up of Agogo approach by interested stakeholders			x	x	x	x	x	x	x	x	x	x	Evelyn	Karen Waltensperger
4.4.s	Participate in quarterly meetings at national level on MNC, i.e. Mai Khanda (Health Foundation)			x			x			x			x	Evelyn	
4.4.t	Compile quarterly cost reports			x			x			x			x	Umali	
4.4.u	Compile monthly BVA reports	x	x	x	x	x	x	x	x	x	x	x	x	Umali	
4.4.v	Conduct quarterl finance report review meetings			x			x			x			x	Umali	
4.4.w	Prepare and submit annual programmatic reports to CSHGP (Final Evaluation Report)												x	Edward / Joby	
4.4.x	Develop FY2012 cost extension budget and work plan												x	Evelyn	

Annex 3: Social Behavior Change Strategy for New Partners

Not applicable

Annex 4: Papers or Presentations about Project

National dissemination in Malawi

- **National workshop on Maternal, Newborn and Child Survival, Thyolo, April 13-14, 2010:** Presentations on CBMNC (Thyolo) and Neonatal Sepsis.

- **Malawi Ministry of Health (MOH) Reproductive Health Unit (RHU) Dissemination Workshop, Lilongwe, June 7-8, 2010:** NBH Program compiled a presentation on CBMNC and Community Mobilization that was presented by the Deputy Director of RHU, Fannie Kachale and the MCHIP Community MNH Advisor, Anna Chinombo to facilitate buy-in of the package by partners and District Health Management Teams (DHMT).

Southern Africa regional dissemination

- **Africa Newborn Research and Program learning workshop, Addis Ababa, Ethiopia, February 22-26, 2010:** Fannie Kachale, the Deputy Director of the RHU gave a presentation on the progress of the OR on CBMNC and Evelyn Zimba, the MNH Program Manager gave a presentation on KMC Scale-up in Malawi.

- **Continental Conference on Maternal, Infant and Children Health in Africa, Addis Ababa, Ethiopia, April 17-18, 2010:** Evelyn Zimba, MNH Program Manager participated at the AU International Conference of Civil Society Experts Consultation on Maternal and Child Health, which developed a communiqué and joint action plan in preparation for the Africa summit meeting. They also discussed progress on the Maputo Plan of Action (MPoA) on Sexual and Reproductive Health and Rights (SRHR.)

- **The 7th Africa Midwives Research Network (AMRN) Biennial Scientific Conference in Tanzania, Dar es Salaam, November 30-December 5, 2009:** Evelyn Zimba, MNH Program Manager presented a paper on community-based maternal and newborn care (CBMNC) in Malawi.

- **26th Annual International Pediatric Association Congress 2010, Johannesburg, South Africa, August 4-9, 2010:** Evelyn Zimba, MNH Program Manager presented a paper, "Malawi is on track for MDG 4 and has significantly reduced NMR", analysis of changes over time, role of KMC.

- **Helping Babies Breathe (HBB) for Pediatricians at the 26th Annual International Pediatric Association Congress, Johannesburg, South Africa, August 4, 2010:** Evelyn Zimba was invited to assist the facilitation of a training for Pediatricians on Masters of Trainers in Helping Babies Breathe (HBB) during the International Pediatric Association Congress.
- **Saving Newborn Lives (SNL) Africa Regional Technical Assistance Workshop, August 23-September 3, 2010:** Evelyn Zimba gave a presentation on Institutionalization of CBMNC Package - Malawi Experience

Global dissemination

- **Women Deliver Conference, Washington, DC USA, June 7-9, 2010:** Evelyn Zimba, MNH Program Manger gave a presentation on scale-up of CBMNC package in Malawi at the Women Deliver global conference, *Delivering solutions for girls and women.* The conference aimed at proving that maternal and reproductive health needs to be a global priority.

- **Helping Babies Breathe (HBB) Global Experts Training of Master Trainers, Washington, DC, June 14, 2010:** Evelyn Zimba, MNH Program Manager was trained as a Master Trainer in HBB. The Global Implementation Task Force and HBB Principal Investigators served as the faculty for the day-long hands-on training for individuals who would be training other HBB trainers.

- **The 8th International Conference on Kangaroo Mother Care, Quebec City, Canada, June 19-22, 2010:** Evelyn Zimba, MNH Program Manager gave a presentation on Planning and Scaling-up Kangaroo Mother Care in Malawi.

- **Save the Children Health and Nutrition Program Learning Group (PLG) Norwalk, Connecticut USA, June 28-July2, 2010:** Evelyn Zimba participated in Save the Children's annual Program Learning Group for health and nutrition during which she assisted in the facilitation of HBB session.

- **Towards 4+5 Dissemination Conference, London, England, May, 2010:** Edward Chigwedere attended the Towards 4+5 conference that was organized by the Towards 4+5 Research Program Consortium. The conference covered innovative approaches adopted to improve maternal and neonatal health, research on improving health services, discussions on translating research evidence into policy among other areas. Preliminary results of the Mai Mwana project were disseminated at this conference, even though analysis was still ongoing.

Key documents produced (in collaboration with partners) and available:

- Community Mobilization Guidelines translated in local language-Chichewa.
- *"Living Proof"* (Bill & Melinda Gates Foundation documentary).
- *"Invisible Lives"* (BBC documentary).

Annex 5: Results Highlight

Multi-country analysis of change for newborn health: Opportunity for Malawi

Background The Malawi Newborn Health Program - a five-year Expanded Impact project co-funded by USAID/CSHGP and Save the Children Saving Newborn Lives (Bill & Melinda Gates Foundation) - is entering its final year. As a national level partner in Malawi's *Road Map for the Accelerated Reduction of Maternal and Newborn Mortality and Morbidity*, Save the Children cooperates closely with the Ministry of Health (MOH) and other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. Save the Children's primary role is as reference, catalyst, and technical resource for newborn health in Malawi. It works within the system pro-actively, with emphasis on strategic networking and assertive communication. Save the Children is "at the table" at the national level, often the only international private voluntary organization (PVO) to be there, and contributes as added value: (1) Its global, regional, and in-country technical expertise in newborn health; (2) long-standing ties to communities and stakeholders in Malawi; and 3) strategic technical and material inputs for policy dialogue and mainstreamed training, monitoring and evaluation, and scale up.

As this USAID CSHGP project enters its fifth and final year, and Save the Children also enters the final year of its Gate's funding for the second phase of Saving Newborn Lives (SNL), we are conducting a **multi-country analysis of change for newborn health from 2000-2010**. This is being carried out in the 18 countries where SNL is working globally – including Malawi. The analysis looks at what has changed, why it changed, and what more needs to be done for newborn health. Newborn health issues regarding policy change, integration into existing programs and the contribution of various stakeholders will be documented. Save the Children will provide both in-country and external technical support to do the analyses and any other technical needs towards the process. A multi-disciplinary working group in each country will review the analyses and build consensus on how newborn health has changed.

Opportunity for Malawi: This presents a unique opportunity for the MOH and key stakeholders in Malawi to analyze the contributions of efforts invested in improving newborn survival and the data available through various sources. This is seen as a **best practice for a national-level Expanded Impact project** and will put Malawi in a comparative picture with other countries in the region and globally. It will give insight into the future and contribute to plan strategically "what next?" for newborn health. A similar analysis done for child survival in Tanzania and generated critical recommendations for improving child health (Masanja et al, Child survival gains in Tanzania: analysis of data from demographic and health surveys, Lancet 2008). The authors of this article came from a variety of organizations and institutions working in child survival in Tanzania – government, NGOs, research institutes, professional organizations.

Objectives of the analysis (1) To assess change for newborns in Malawi/other countries where SNL is working; (2) to understand what has contributed to the rate of change (e.g., coverage of effective interventions, socio-demographics, health funding, advocacy/policy change); (3) to identify lessons learnt for the future; (4) to suggest a common approach/principles to affect change at scale.

Proposed outputs and timeline (1) A paper in an international peer reviewed journal, either in the Saving Newborn Lives supplement or separately for submission in first quarter of 2011; (2) linked policy briefs to advocate for implementation of existing policies; (3) media and advocacy brief to raise awareness on newborn health issues in Malawi; and (4) a bank of high quality PowerPoint slides for different fora to advocate for newborn health.

Annex 6: Activity Status

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comments
Operational Research *Community-based maternal and newborn care*	Design sepsis management protocol	Not yet on target	Activity was put on hold, development of protocol to be done year 2010 with funds from UNICEF
	Assist with development of OR plans and postnatal care protocols on ANC and PNC home visitation, community management of LBW babies, and newborn sepsis	Completed	OR plans and protocols developed. Sepsis component not included as activity was put on hold
	With RHU and districts and other key stakeholders, establish and support system for ongoing training/capacity assessment (pre-post tests, training evaluations, trainer assessment checklists) for facility health workers and HSAs	On target	M&E system documented, plans underway to review the system
	Facilitate/support development of job aides (visit checklists, counseling cards) and supportive supervision at facility and community levels	On target	Job aides have been developed and currently working on an integrated supervision tool
	Support (TA/financing) costing study for community MNH package	On target	Costing report to be completed this year and dissemination early 2011
	Conduct quarterly joint monitoring/TA support visits to each learning program district	On target	On going, monitoring and supervision reports available
	Facilitate and participate in partner monthly and quarterly task force meetings for 3 learning program districts	On target	Task force integrated with Safe Motherhood Sub-committee meeting since early 2009. SC still a key member of the sub-committee
	Facilitate and participate in periodic (annual) program reviews and broader information sharing at country level with stakeholders	On target	On going, minutes documented
	Assist in the final revision of community PNC protocols based on learning	Completed	Initial protocols documented subject to further revisions at the end of the learning program
	Facilitate continuous learning and scale-up in other districts through ACCESS, UNICEF, and other interested organizations and donors through meetings and information/resource sharing	On target	MOH mandated all partners interested in community MNH to use the national CBMNC package. Currently scale-up in progress

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comments
			through MCHIP, CHAM, WHO, UNICEF and UNFPA
Mai Mwana Randomized Controlled Trial	Organize/facilitate joint dissemination event	Not yet on target	Further discussions with Institute for Child Study and Mai Mwana required
	Assist in publication of results	On target	Activity planned for FY 2011
Kangaroo Mother Care Retrospective study	Design community KMC strategy and adapt materials	Completed	National KMC guidelines revised and documented
	Design prototype materials for HSAs to counsel mothers in community KMC	Completed	To use counseling cards developed under CBMNC package
	Facilitate work planning for district scale-up	Completed	Facilitated development of district work plans for KMC scale-up
	Provide TA for district scale-up and supportive supervision at facility and community level	On target	On going
	Participate in annual SNL Africa Research Workshop	On target	Participated
Collaboration and Partnership	Participate actively in Maternal and Newborn Sub-committee of RHU Sexual and Reproductive Health Committee	On target	Copies of minutes available
	Advocate for revised indicators and targets in HIS supportive of newborn health priorities	Not yet on target	Still under discussion a national meeting planned October 2010
	Facilitate/support development of job aides, supportive supervision at national level	Not yet on target	Job aids documented. Development of integrated supervision tool in progress
	Attend quarterly meetings to review progress and develop action plans	On target	On going, participate in quarterly reviews through Safe Motherhood Sub-committee meetings
	Develop H/MIS and indicators (process and quality emphasis) and support district implementation	Completed	For district level implementation done. But still advocating for inclusion of key newborn indicators in the national HMIS
	Participate with all partners in the development of RHU annual work plan	On target	On going activity but 2010 not done due to problem of funds at RHU
	Assist RHU with providing support for annual District	On target	On going done through Zonal

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comments
	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		Offices
	Participate in DIP development meetings for 7 MOH districts (3 pilot districts, 3 ACCESS districts, and Mzimba)	On target	Participated in 3 pilot districts and Mzimba
	Work with partners to monitor and ensure adequate equip/supplies at facility level through DIPs and other donor resources	On target	In collaboration with UNICEF gaps are identified and key MNH equipment is included in the annual procurement by UNICEF
	Participate in quarterly meetings at national level on MNC, i.e. Health Foundation, Perinatal Care, Women and Children First	On target	Participated in an Open Day activities for Health Foundation
	Attend partnership meetings on MNCH	Not yet on target	Participate on ad hoc basis
	Attend monthly White Ribbon Alliance meetings	Not yet on target	Was initially on target but WRA program activities have been suspended until further notice
	In collaboration with MOH and other key stakeholders provide TA/support monitoring visits for scale-up of community-based maternal and newborn care package	On target	Reports available
	Participate in annual SNL Program Managers meetings	On target	Participated
Policy, Advocacy, Networking	Policy review and dialogue with RHU	Completed	Participated in SRH policy review and final copy developed
	Advocate for revised postnatal visitation schedule	Not yet on target	National HMIS meeting scheduled for October 2010
	Advocate in partnership with MOH and other stakeholders for effective HSAs recruitment	Not yet on target	Discussions in progress
	Using lessons learned from the 3 OR district advocate for policy review and dialogue on community management of newborn sepsis by HSAs	Not on target	The activity was postponed and sepsis protocol development re-scheduled for September 2010
	Participate in regional & international global meetings for NBH, i.e., PLG and regional exchange visits	On target	Participated in Africa Midwives Research Network Conference, Women Deliver conference, KMC

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comments
			International conference, PLG and International Pediatric Congress
Mainstreamed Training, TA Support to MOH Program Management	Facilitate development of a monitoring system for the trainings	Completed	M&E system in place
	Facilitate development of supervision tools during trainings and follow-up sessions	Not yet on target	Partners still working on an integrated tool for supervision
	Supervise the training sessions to ensure quality	On target	Spot checking continues on regular basis
	Follow-up TOT implementation plans	On target	Reports available
	In collaboration with MOH provide TA during roll-out of Essential Obstetric and Newborn Care trainings at district level throughout the country	On target	Reports available
	Conduct follow-up of the trained trainer implementation plans	On target	Reports available
	Provide TA to Mzimba for in-service training of 50 health workers in Essential Obstetric and Newborn Care (now called IMNC)	Completed	30 health workers trained using IMNC training manual. The district had been promised further funding by WHO to train additional 30 health workers which did not materialize
	Facilitate first follow-up of trainees 6 months post training	Not yet on target	Plans underway to conduct it in November 2010
	Conduct regular joint supportive supervision of trained trainers	On target	On going reports available
	Participate in quarterly meetings to review progress of trainings and develop actions plans	On target	On going
M & E, Operations Research, Reporting and Documentation *Monitoring and evaluation*	Prepare and submit quarterly financial reports	On target	Reports available

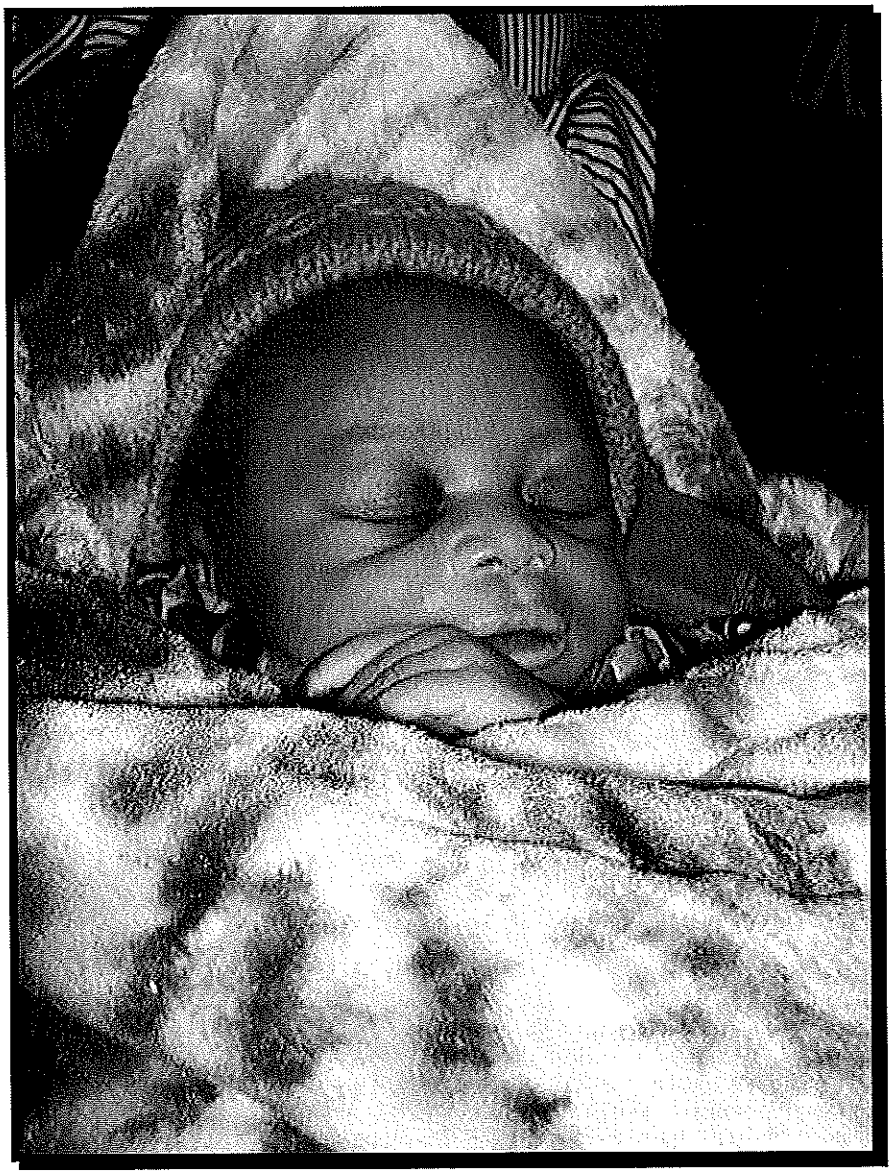
Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comments
	Prepare and submit annual programmatic reports to CSHGP	On target	
	Facilitate HFA in Mzimba district	Not on target	Activity dropped by mutual agreement with district
	Participate in biannual MOH HIS meeting	On target	Meetings held irregularly due to funding problems
Planning and Reviews	Participate in biannual SWAp reviews	On target	Reports available
	Participate in RHU annual work plan review & planning cycle	On target	This year not yet done due to funding problems at RHU
	Submit detailed annual work plan to CSHGP	On target	Work plans available
Ekwendeni Sub-grant	Provide TA for documentation and packaging of agogo approach	Completed	Approach documented
	Print package for dissemination	On target	Process underway
	Support dissemination of experience and manual to stakeholders	On target	Dissemination planned for December 2010
	Provide TA for scale-up by interested stakeholders (faith based groups, local organizations, CBO)	On target	On going

Annex 7: Agogo Report

THE EKWENDENI *AGOGO* APPROACH

Grandparents as agents of change for newborn survival

DRAFT – October 2010



Melinda Van Zyl, Rose Gondwe, Evelyn Zimba

THE EKWENDENI *AGOGO* APPROACH

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THE EKWENDENI *AGOGO* APPROACH

PLEASE NOTE: THIS IS STILL A DRAFT AND IN THE PROCESS OF BEING EDITED, FORMATTED, AND PACKAGED WITH OTHER KEY DOCUMENTS FOR DISSEMINATION. PLEASE DO NOT CITE.

EXECUTIVE SUMMARY

Ekwendeni grandmothers celebrate their grandchildren. Photo by Melinda Van Zyl.

Since 2004, Ekwendeni Church of Central Africa Presbyterian (CCAP) Mission Hospital and Save the Children have partnered in community mobilization efforts to lower maternal and neonatal mortality in the Ekwendeni catchment area, located in Mzimba District of Northern Malawi. Recognizing the valuable social credibility and decision-making status traditionally held by grandparents, or *agogo* in local communities, the Ekwendeni Hospital and Save the

Children developed the *Agogo* Approach, an implementation strategy that trained grandparents to advise new mothers on antenatal and essential newborn care. Since the training of the first grandparents in 2004 under the first phase of Save the Children's Saving Newborn Lives (SNL) initiative in Malawi, hospital staff have noted a steady decrease in newborn mortality in the hospital catchment area paired with an increased demand for antenatal and neonatal services at the hospital and its outreach clinics. Since the initial trainings, grandparents have actively shared relevant information about newborn health through songs and lectures with members of their communities. Through record-keeping, they have engaged themselves in monitoring the health of pregnant women in their villages and urged them to seek antenatal care at the correct intervals.

Named after the original Tumbuka translation for "grandparents," the *Agogo* Approach's achievements make a compelling case for the implementation of behavior change strategies that respect and build on existing social structures and relationships in order to reduce neonatal and maternal mortality. The success and apparent sustainability of the *Agogo* Approach prompted the creation of this document. It is written to help guide local community-based organizations and church groups, local non-governmental organisations, and other civil society outreach initiatives wishing to replicate the *Agogo* Approach as applied at Ekwendeni. Although care has been taken to provide generic guidelines that might easily be translated to other environments, different cultural contexts may naturally dictate modifications to project planning.

1. CONTEXT

1.1 Maternal and newborn health in sub-Saharan Africa

An estimated minimum of one million babies in Africa die within their first four weeks of life (Lawn and Kerber, 2006), while approximately 500 000 women die annually from complications and conditions during pregnancy and childbirth (Howard-Grabman, 2007). This is particularly significant for sub-Saharan Africa, where many countries are struggling to make

the progress required for achieving the Millennium Development Goals (MDGs) by the 2015 deadline. The Millennium Development Goals most relevant to the *Agogo* Approach are MDG 4 (reduce by two thirds the mortality rate of children under five) and MDG 5 (reduce by three quarters the maternal mortality ratio). In the case of MDG 4, newborn mortality deserves to be singled out and targeted due to the increasingly large proportion of under five deaths that occur during the first four weeks of life (Lawn and Kerber, 2006).

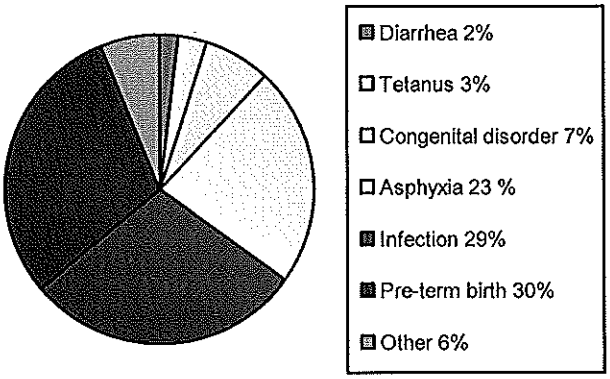


Figure 1. Main causes of neonatal deaths in Malawi in 2006

In Malawi, recent statistics show that 22 percent of deaths in children under five occur during the neonatal period (the first 28 days of life) from causes that are readily prevented or treated in the industrialized world (United Nations, 2008).

The Ekwendeni *Agogo* Approach endeavors to reduce the number of newborn deaths in Malawi's northern Mzimba district by changing the health care seeking behavior of mothers at the community level. The Approach teaches mothers healthy practices that address the causes of newborn fatalities (see Figure 1).

1.2 History and demographic context

Functioning under the Synod of Livingstonia, Ekwendeni CCAP Mission Hospital serves a catchment area of approximately 600 square kilometers with a population of roughly 100,000, including referrals from outside its catchment area

The community that Ekwendeni serves is divided into collections of small villages comprising seven to 288 households. Villagers in this rural area practice subsistence farming, and housing is mostly of traditional construction. Socio-economic challenges include poverty, inadequate access to transport, poor roads and meager finances dictated by the success of seasonal crop harvests.

Five government health centers on the perimeter and just outside of Ekwendeni's catchment area provide basic health services that include maternal and antenatal health. The health

centers refer patients needing surgery or more specialized treatment to Ekwendeni Mission Hospital. Areas within the catchment have each been allocated a health post, attended by a Health Surveillance Assistant who delivers a package of promotive and preventive services and functions as the link between communities and government health services.

Before the *Agogo* Approach was initiated, most births in the Ekwendeni catchment area took place at home, without the assistance of skilled birth attendants, and many newborn deaths occurred, often as a result of harmful traditional practices. While some traditional practices common in the villages were relatively harmless or indeed beneficial, others were contributing directly to the risk of neonatal death. The use of traditional medicine to accelerate labor was common practice, leading to injury and even death in many young mothers. Babies who were born prematurely often died before reaching the hospital due to lack of transportation. Mothers who did manage to get to the hospital in time for the delivery were mostly ill-prepared . Families in Malawi are responsible for providing many of the supplies necessary for a clean delivery; but mothers often did not bring along anything other than a *chitenje* (a traditional brightly-patterned piece of cloth) with which to wrap the newborn. Babies born at home were not always be warmed or dried after birth, and were often bathed before being put to the mother's breast, exposing them to risk of hypothermia. Instead of immediate and exclusive breastfeeding, newborns were often given water or other liquid mixtures, increasing chances of infection as well as contributing to poor health and development in general. In some cases, husbands discouraged wives from seeking antenatal care out of fear of being tested for HIV.

Although many villages were situated in relative proximity to at least one health centre, it was clear that mothers and newborns were not benefiting from the complete range of services at their disposal, and that the demand for such services needed to be stimulated. In many cases, mothers did not access services because they did not recognize dangers signs during pregnancy, and were unaware of the importance of regular antenatal visits.

1.3 Needs and conceptualization

The Ekwendeni Hospital Primary Health Care staff believed a certain amount of behavior change would have to occur if the newborn mortality rate in the area was to be reduced. Success would depend on:

a) Mobilization of the community's mothers to improve their careseeking behavior when it came to newborn and maternal health; and

b) Changing harmful practices related to traditional beliefs.

Between 2001 and 2006, Ekwendeni Hospital - as a partner organisation to Save the Children and its SNL initiative - implemented a set of facility-based and community-based activities related to newborn health in its catchment area. Initially, programs focused almost entirely on women of reproductive age. Focusing on young mothers, however, did not result in sufficient behavior change to produce a significant reduction in newborn mortality. The Ekwendeni staff recognized this as due to the importance ascribed to traditional roles within Tumbuka families in Mzimba District.

Being a area of patrilineal kinship structure, it is customary for paternal grandmothers, or mothers-in-law, to actively influence the care of mothers and newborns, with particular significance for pregnant women or first-time mothers (Matinga, 2002). A rapid qualitative assessment of cultural factors related to newborn health carried out in 2001 by Save the Children's Africa Regional Health Advisor emphasized this:

"Whether a household is matrilineal or patrilineal, it is the grandmothers and other elder female relatives who commonly serve as key household advisors in all matters concerning care of the pregnant woman, neonate and new mothers, particularly with a firstborn child. Senior women also serve as first-line gatekeepers for care seeking and influence male relatives' decision-making (Waltensperger, 2001).

The shift from focusing on mothers to involving grandparents as active role players and agents of change occurred when the Ekwendeni team decided to capitalize on the traditional

decision-making status of elders to influence community perceptions and beliefs regarding essential newborn health care. In the words of Kistone Mhango, Primary Health Care Coordinator at Ekwendeni CCAP Mission Hospital:

"At the outset of the project the focus of the behavior change activities was on working with the village health committees and drama groups composed of younger people. There was no discussion of involving grandparents. But as time went by we realized that certain persons were missing, the agogo. We realized that they are the ones who teach the do's and don't's to younger women. We realized that our programs with communities would have more impact if the agogo were involved" (Aubel, 2006).

THE AGOGO APPROACH IN BRIEF

In an attempt to reduce risk for maternal and newborn mortality in the Ekwendeni catchment area in northern Malawi, staff at the primary health care unit of the local mission hospital collaborated with Save the Children to conceptualize a community-level behavior change approach that would incorporate the traditional role of grandparents, or "agogo," as decision-makers in matters concerning newborn care. The Agogo Approach enlisted the help of village headmen to recruit the most influential grandparents from local villages, who then received two days of training in best practices for maternal health and essential newborn care.

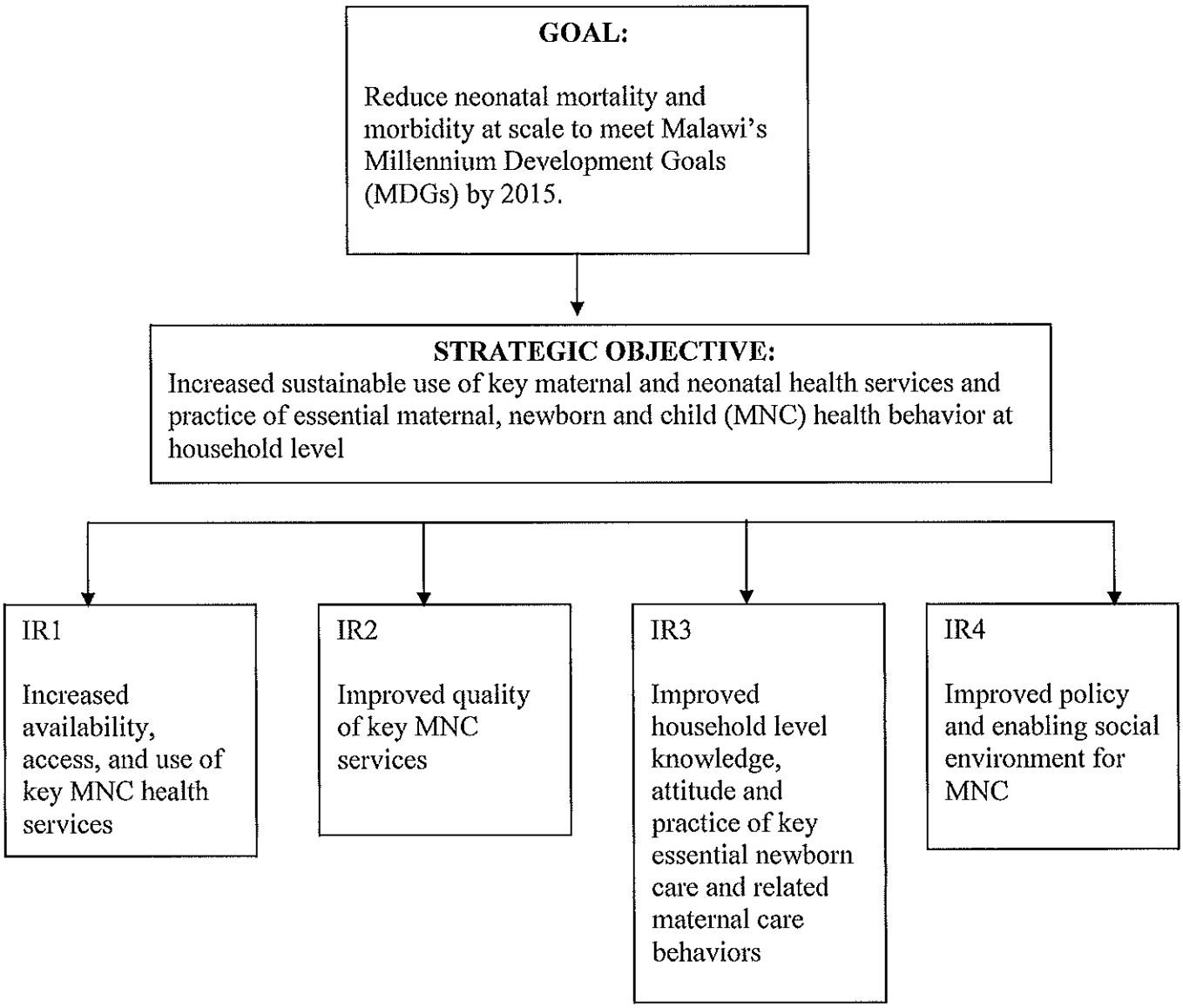
Upon returning to their villages, the grandparents resumed their traditional advising role and promoted essential newborn care practices based on the knowledge they had gained during training. They dismissed harmful traditional practices (that had sometimes prevailed for generations before training) and acted as agents of behavior change in teaching mothers and fathers new ways of caring for newborns and pregnant women. Grandparents of each village kept an "agogo register" to record the names and details of newly pregnant mothers in the neighborhood. The agogo register enabled grandparents to monitor the progress of pregnancies in the village.

Pregnant women received frequent home visits from their local grandparents, who counselled them about the importance of regular antenatal visits. Grandparents paid more frequent visits to first-time mothers and mothers who had had previous problems. Often they accompanied mothers to the health centre or hospital when the time for delivery arrived.

Villagers in the Ekwendeni catchment area reported to have noticed a reduction in the number of maternal and newborn deaths since the project's inception in 2004.

1.4 Goal, objectives and results framework

The Ekwendeni *Agogo* Approach feeds into Save the Children's Malawi Newborn Health Program, funded by the United States Agency for International Development (USAID) Child Survival and Health Grant Program (CSHGP) and Save the Chilren SNL. The results framework for this overarching program is laid out as follows:



The goal of the *Agogo* Approach corresponds directly to the goal of Save the Children's Malawi Newborn Health Program. The specific objectives of the Agogo Approach are:

- To involve grandparents to facilitate positive behavior change that improves maternal and newborn care and survival;
- To document success stories, challenges and positive behavior changes in the community aimed at reducing maternal and neonatal morbidity and mortality rates in Ekwendeni catchment area;
- To develop a standardized training curriculum for the *agogo* (grandparents) that can be adopted by other organisations wishing to replicate the approach.

1.5 Grandparents as agents of behavior change

Despite their widely recognized status in many rural African communities as sources of wisdom and advice, elders are often ignored in the design of community interventions or outreach projects aimed at effecting behavior change. Waltensperger (2008, p2) argues that "behaviour change strategies promoting best practices in infant and young child feeding frequently target young mothers exclusively, underestimating the roles of community norms, complex household decision-making dynamics, and influential matriarchs who may be giving contradictory advice."

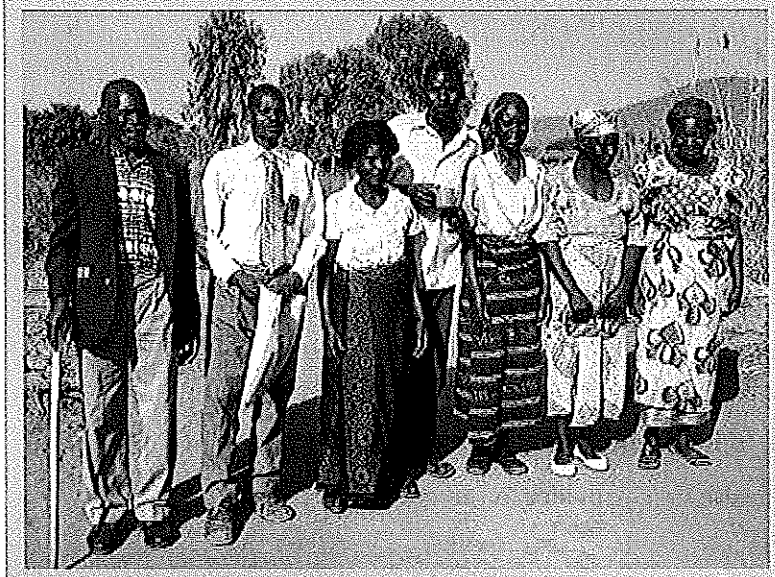
Yet projects that have engaged senior women as social resources and development partners have led to more successful outcomes. A participatory education strategy that utilized networks of senior women in Senegal found measurable positive changes in grandmothers' knowledge of nutrition and in their advice to younger women, as well as improved household feeding practices (Aubel et al., 2001). Similarly, a maternal and newborn health project implemented by Helen Keller International under a Save the Children SNL sub-grant in Mali in 2001/2 utilized senior women and traditional community leaders to promote changes in social norms related to household practices for birth preparedness and newborn care. The project's final evaluation reported significant changes in the attitudes and practices for the majority of project indicators, specifically among grandmothers (Waltensperger, 2008).

International development programs should recognize grandmothers as potentially powerful allies in the improvement of child health through the establishment of good practice and healthy behaviors in the communities they influence. In addition to exerting a certain amount

of influence in the community, elders are often a good source of information about traditional practices and beliefs. This is significant because past maternal and child health programs have found that community members are often more motivated to participate in programs that value and build on traditional practices while promoting targeted changes (Waltensperger, 2008).

LEADERS IN NEWBORN HEALTH:

THE AGOGO FROM KHUYUKUYU



The agogo from Khuyukuyu area in Ekwendeni have wasted no time since receiving their training in 2008. To qualify for training, an agogo needed to be over 50 years of age, trustworthy and respected in his or her community, a recognized role model, and have grandchildren.. Upon returning to Khuyukuyu, the trained agogoagogo, now well versed in essential basic newborn and maternal healthcare, took the initiative to schedule weekly meetings on Wednesday afternoons at 2 o' clock, which are attended by pregnant mothers from the various communities in the area. AgogoAgogo approach pregnant mothers and invite them to attend, where they receive critical information about maternal health and newborn care. At the meetings, they are further informed about the benefits of delivering in a facility with skills attendants urged to plan ahead and leave for the health centre or hospital well in advance of the start of labor. New mothers are assisted and often accompanied by agogo when they leave for the planned place of birth. The Khuyukuva community believes that the information agogo have shared with pregnant mothers has already saved the lives of several newborn babies from their area.

2. PROJECT IMPLEMENTATION

2.1 Essential components

The successful implementation of the *Agogo* Approach involved the following components.

ESSENTIAL COMPONENTS OF THE EKWENDENI *AGOGO* APPROACH					
Stakeholders	Costing	Human resources	Community resources	Intellectual capital	Accommodation and transport

2.1.1 Stakeholders

The stakeholders are an important component of the *Agogo* approach, and should be clearly delineated. They include community members, funders, the external organization in charge of an overarching program (if relevant), and any health care provider in the community who would be affected by implementation of the project.

The Ekwendeni *Agogo* Approach was developed by Ekwendeni Mission Hospital, first as part of Save the Children's Saving Newborn Lives I initiative, and later under a sub-grant from Save the Children's Malawi Newborn Health Program, funded by SNL and the USAID Child Survival and Health Grant Program (CSHGP) in Washington, DC.

Stakeholders in developing the Ekwendeni *Agogo* Approach included:

- Newborn babies from the targeted villages in the hospital catchment area;
- Mothers who were counseled, advised and accompanied by *agogo*;
- Husbands who received counseling and advice from *agogo*;
- Village headmen, who took an active interest in ensuring participation;

- Traditional birth attendants from the targeted villages who, if not trained as *agogo*, were visited and advised by *agogo* on a regular basis;
- *Agogo* from villages not targeted for training, who were visited by trained *agogo* and initiated in the knowledge of good practice regarding essential newborn care;
- Young girls in the villages who were counseled by *agogo* on family planning and the dangers of extramarital sex;
- Hospital staff at the maternity ward to whom mothers and babies were referred;
- The project team from the primary health care unit at Ekwendeni Mission Hospital, including the Director of Primary Health Care, the Project Coordinator, Assistant Coordinator, Accounts Assistant, Behavior Change and Communication Officer and the Project Driver;
- The nursing staff who conduct regular antenatal clinics in the villages, to whom mothers were referred by *agogo* for antenatal check-ups;
- The Save the Children Country Office staff in Lilongwe who provided technical and material support;
- The USAID Child Survival and Health Grant Program and Saving Newborn Lives that co-fund Save the Children's Malawi Newborn Health Program.

2.1.2 Costing

A comprehensive list of expenses for the Ekwendeni *Agogo* Approach is available as an appendix to this guide, but a summary of financial inputs is below:

- **Salaries**

  The Project Coordinator, Assistant Coordinator and Accounts Assistant were already employed by Ekwendeni Mission Hospital; only two staff members were paid under the sub-grant, BCC officer and the Project Driver;

- **Training and behavior change and communication (BCC) materials**

  A small set of BCC materials in the form of posters and flyers were designed and printed to raise awareness and improve behaviors related to danger signs during pregnancy;

- **Training expenses**

  For their training, *Agogo* were accommodated at the Mission for a night and given refreshments at the training sessions; they also received transport that necessarily involved

fuel costs and vehicle rental. Costs were budgeted according to the Synod of Livingstonia's current guide to the costing of training amenities and arrangements in Malawi;

- **Project transport budget**

This included means of transport such as a bicycle or small motorcycle for the BCC Officer, fuel for field and supervision visits, truck rental and fuel for transporting *agogo* to and from training, vehicle maintenance costs. (Ekwendeni used a vehicle already in its possession that had been purchased under the first phase of Saving Newborn Lives.)

- **Recording equipment**

In the case of Ekwendeni, a small camcorder was procured to facilitate documentation of success stories and project events;

- **Office equipment**

A computer and printer; a photocopy machine;

- **Office expenses and documentation costs**

Photocopy machine maintenance, paper for recording forms, printing costs, a bulletin board, etc.

The Ekwendeni AgogoApproach team from the hospital's Primary Health Care Department: (From left to right) Mac Honde (project driver), Alfred Chimaliro (BCC officer), Rose Gondwe (Project Coordinator) and Maggie Munthali (Assistant Coordinator).

2.1.3 Human resources

The success and sustainability of any community newborn health initiative is a function of the dedication, enthusiasm and competence of the people involved in its implementation. Human resources for the Ekwendeni *Agogo* Approach included project staff and community members, especially grandparents, who became voluntary trainers of other grandparents in the community.

The staff at Ekwendeni Hospital's Primary Health Care Department are experienced community workers with excellent communication skills. They have the advantage of being associated with a hospital that had already delivered a considerable number of effective community-based interventions, ranging from nutrition to malaria prevention. For that reason, the staff enjoyed a significant amount of credibility with traditional leaders, elders, and community members from the outset of the implementation of the *Agogo* Approach.

Some project staff members were already on Ekwendeni Mission Hospital's payroll, employed either by the Primary Health Care Department or nurses in the wards. They therefore did not receive extra compensation for functioning within a primary health project that was essentially within their scope of work. Both the Project Coordinator and Assistant Coordinator worked full-time in the hospital's maternity ward, where they gauged targeted indicators of project success (for instance, how many mothers were delivering in hospital after being accompanied there by trained *agogo*) and observed needs or limitations as the project progressed. They also wrote success stories and documented case studies for reporting purposes. The Accounts Assistant functioned as the accounts resource person on other primary health care initiatives, and therefore took on the accounts management of *Agogo* Approach activities as a part of his routine responsibilities.

Table 1 depicts project staff and their duties as implemented in the Ekwendeni *Agogo* Approach.

Table 1. **Essential project staff required for successful implementation of the *Agogo* Approach**	
Position	**Duties and responsibilities**
Project coordinator	• Train staff • Provide input for *agogo* training • Supervise daily project activities • Supervise subordinate staff daily • Compile reports • Submit reports to primary health care director, donors and relevant authorities • Chair staff project meetings • Authorize movement of project funds • Organize and make local purchases for project related activities where appropriate • Assure timely ordering of relevant equipment and commodities • Monitor and assure quality of newborn care • Attend meetings/workshops related to project • Make suggestions for project improvements and design future project proposals • Accompany BCC officer on some supervision visits to *agogo* in communities
Assistant Project Coordinator	• Assist project coordinator • Assist in training activities • Conduct health talks and distribute IEC materials • Assist in compilation of reports • Implement project activities • Attend hospital and community meetings • Attend workshops / conferences • Stand in for project coordinator on supervision visits with BCC officer if the former can't attend
Behavior Change Communication oOficer	• Make visits to villages to encourage and oversee *agogo* • Convert information from the *agogo* registers to electronic format • Interpret information from *agogo* registers to inform target indicators • Prepare findings (through graphs, narratives, tables etc) for quarterly reports • Report to project coordinator on project activities • Write monthly or quarterly reports • Attend community meetings • Capture primary data in the community with the camcorder

	• Document, publicize and disseminate information to relevant stakeholders • Ensure that HSAs in the communities have blank forms on which to record data from *agogo* registers
Accounts Assistant	• Record all financial transactions of the project • Monitor the budget • Prepare payment vouchers
Project Driver	• Drive staff for project related activities • Keep vehicle in good running order (conduct regular fuel, oil, tyre pressure checks) • Report any vehicle trouble immediately to project coordinator • Keep vehicle clean and tidy

Table 2 depicts human resources from the community whose roles are vital to successful implementation of the *Agogo* Approach.

Table 2. **Community participation required for successful implementation of the *Agogo* Approach**

Position	**Duties and responsibilities**
Grandparents (Number is relative to the size of a village or area served; villages in the Ekwendeni catchment area ranged in size from seven to 288 households. On average, five to seven grandparents were selected per village.)	• Attend training at the health center or hospital; • Provide advice on matters related to pregnancy, birth and essential newborn care to members within their own families, and second, to other community members; • Identify and record the names of pregnant women in the community in an *agogo* register, and maintain the register throughout the pregnancy until the first post-natal visit and the eventual health of the newborn; • Use the *agogo* register for monitoring pregnant women in the village, providing guidance and encouragement to ensure that they attend antenatal visits at the correct times; • Promote birth preparedness among the women in their village, and help make arrangements for transport to hospital in time for delivery; • Encourage hospital deliveries and if necessary accompany women to the maternity ward; • Inform villagers about the dangers of harmful traditional practices and use influence and new knowledge to promote behavior change in this regard; • Counsel husbands who may at first disagree with new ideas • Present the *agogo* register to the local HSA on a monthly basis for transcription to HSA reporting form

Village headmen (Each village in Ekwendeni has one village headman)	• Attend the *agogo* training; • Select *agogo* from his village to attend training; • Monitor the process within his village, and act if a problem is identified; • Mediate when a husband or community member rejects the advice of *agogo* and insists on perpetuating harmful traditional practices
Health Surveillance Assistant (HSA) (Each area in Ekwendeni has one HSA who acts as a link between the community and the local health services)	• Attend an orientation session on the *Agogo* Approach • Transcribe the information on the *agogo* register to the HSA reporting form used by the BCC officer (see appendix), and deliver this form once a month to the BCC officer at the project office; • Communicate feedback, questions or problems from *agogo* to the BCC officer

2.1.4 Community resources

Social capital marks the single greatest community resource without which the implementation of the *Agogo* Approach (or any approach that advocates behavior change through mobilization of community members) would simply not be possible. The existence of an intact traditional family structure with an established social hierarchy provides a valuable channel along which behavior change messages may be passed. The traditional decision-making role of grandparents seems to predispose significant receptiveness on the part of their younger family members, notably daughters and daughters-in-law who by tradition are expected to look to mothers and mothers-in-law for advice regarding pregnancy, birth and newborn care.

Another community resource was the Ekwendeni hospital, demonstrating that the *Agogo* Approach most effectively functions within the framework of existing health programs. The proximity of a hospital or even a small health center with a skilled birth attendant provides a facility to which *agogo* can refer mothers for delivery, as well as access to medical personnel who can intervene in the case of complications. Naturally, the better equipped the health facility, the greater reduction in newborn deaths. Though basic, the hospital at Ekwendeni was equipped with a small surgery, a basic neonatal intensive care room (one small room, closed off from the general neonatal ward, with one incubator), an isolation room for newborns with

infectious diseases and a room where Kangaroo Mother Care was practiced by mothers of low-birth weight babies or premature newborns.

2.1.5 Intellectual capital

The intellectual capital accompanying the Ekwendeni Hospital was another factor in the project's capacity for success. Intellectual capital at the hospital took the form of trained clinicians, nurses and primary health care practitioners who performed routine lifesaving activities such as caesarian sections and resuscitations, and who in some cases had already had previous project experience. Additionally, nurses and lecturers from the local nursing college participated in training sessions or acted as trainers.

Intellectual capital was also used to design the training regimen for *agogo*. The *agogo* training manual was compiled by a team of experts from Save the Children's Malawi Country Office staff,, Ekwendeni Hospital, Ekwendeni Nursing School, St. John's Nursing School, Kamuzu College of Nursing and the Malawi Ministry of Health The training manual included a generic curriculum on basic yet essential preventive care for mothers and newborns, and covered topics such as the timing of antenatal visits, birth preparedness, danger signs during pregnancy or birth, postnatal care and Kangaroo Mother Care (KMC). The *Agogo* Training Manual used at Ekwendeni can be found as an appendix to this guide.

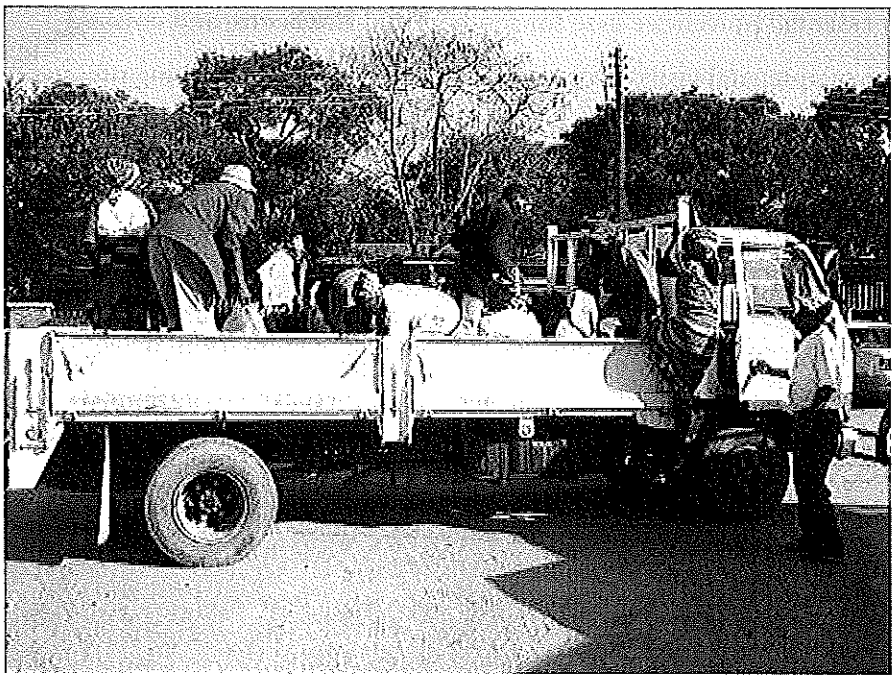
Training sessions with grandparents from the targeted community also supplied important information about local traditional beliefs and practices influencing maternal and newborn health..Staff at local health centers and health surveillance assistants (HSAs) contributed information about local newborn health practices. They may very well be aware of exactly what behavior needs to change, but may in the past have felt powerless to reach the whole community.

2.1.6 Accommodation and transport

Accommodation and transport for the *agogo* was based on the preference to train *agogo* at the Ekwendeni hospital. One night's accommodation and transport to and from a central point

near their villages were provided for *agogo* attending the training sessions at the hospital. While in some settings it might be appropriate (and maybe less costly) to train *agogo* at a central village close to their homes, project staff at Ekwendeni felt that *agogo* would be motivated by the perception that they were important guests of the hospital. This did in fact seem to elevate the importance they attached to their role as guardians of newborn health in their villages, and also reinforced their credibility as experts with villagers who may have had their doubts. Moreover, it proved to be a more practical arrangement than sending out the training team into the village, as this was constituted mostly of nurses and hospital workers whose presence at the hospital was not expendable for two consecutive days. Having the *agogo* at the hospital also meant that they were able to become acquainted with the maternity ward and observe at first hand practices such as Kangaroo Mother Care which they would be advocating.

If the *agogo* lived too far from Ekwendeni, a truck would pick them up at a central point close to their villages on the first morning of training, and drop them there again on the second afternoon after completion of the sessions.



AgogoAgogoAgogo climbing aboard the truck providing transport back to their villages after the completion of a training session at Ekwendeni in August 2008.

2.2 A step-by-step guide to implementing the *Agogo* Approach

2.2.1 Obtaining community buy-in

The interest and commitment of community members were vital to the success of the *Agogo* Approach. Even though the primary health care unit at Ekwendeni Mission hospital had already gained the trust of the community through earlier projects in the area, steps were taken to promote community interest and ownership during the initial stages of the *Agogo* Approach, including soliciting feedback from community members.

Once a needs assessment had been done, proposals submitted and funding secured, the cultivation of community ownership started in earnest, when the project staff identified the specific villages from which *agogo* would be trained. Staff contacted village headmen in each village (by letter, in the case of Ekwendeni) to convey the objectives and intentions of the project. If the headman approved of the project, he would suggest *agogo* in his own village to be trained. Engaging the village headmen as the first level decision-makers in the process gave the project credibility, and in most cases facilitated participation and boosted interest among Ekwendeni *agogo* and community members.

Figure 2. Basic steps in the implementation process

STEPS FOR IMPLEMENTATION	CONTINUOUS M&E	
1. Project staff decide on villages to be targeted.	**Project team conducts and documents supervision**	**Ongoing documentation (agogo registers; data compilation; report writing; success stories; case studies etc.)**
2. The BCC officer communicates with village headmen to introduce the project and obtain community buy-in.		

3. Project staff refine training material and plan training.		
4. The BCC officer communicates training details to *agogo* through Health Surveillance Assistants (HSAs).		
5. The project team and/or additional trainers train *agogo* and orientate HSAs.		

2.2.2 Interpreting baseline data and setting target indicators

Baseline data for the *Agogo* Approach were gleaned from data collected during 2002 in Mzimba district. Staff identified eight key target indicators to evaluate quarterly in order to monitor project progress (see Table 3 in the section on monitoring and evaluation of the *Agogo* Approach).

2.2.3 Developing and refining training materials

An experienced team of public health experts from a variety of organizations and institutions working in maternal and newborn health developed a training manual for the *Agogo* Approach .The team included representatives from Ekwendeni Hospital, Ekwendeni Nursing School, St. John's Nursing School, Kamuzu College of Nursing, the Malawian Ministry of Health and Save the Children. Designed to "equip grandparents with basic knowledge, skills and attitudes that will enable them to promote, support, (and) advocate quality maternal and neonatal care at the community level to assist in the reduction of maternal and newborn mortality" (*Agogo*

Training Manual, p1), the training manual consisted of four training modules to be taught over two days. The training manual is included as an appendix to this guide, but can be modified or refined for similar projects as needed.

2.2.4 Recruitment of grandparents

The behavior change communication officer led the recruitment of *agogo*. Together with the project coordinator and assistant coordinator, he first identified villages where *agogo* would be selected and then invited village headmen to participate in the project. Once the village headmen of targeted villages accepted, they selected the *agogo* from their villages who were respected community leaders and who would be most interested in making a success of the project. While almost all discretion in the selection process was left to the village headmen, the selected *agogo* had to meet the following additional criteria:

- be over 50 years of age (to ensure that they commanded respect)
- have grandchildren of their own (to maximize credibility)
- be role models

In addition, knowing how to read and write (for keeping *agogo* registers) was an added advantage .

The village headmen communicatd the names of the recruited *agogo* to the local health surveillance assistant (HSA) or the BCC officer, who in turn communicated the dates and details of scheduled training sessions to the village headmen. In most cases, the village headmen participated in the training.

2.2.5 Training

According to the objectives listed in the *Agogo* Training Manual, training during the *Agogo* Approach aimed to enable grandparents to

- utilize their culturally defined roles as teachers and guides in the community to provide advice regarding good practice in maternal and newborn care;

- take a leading role in the promotion of beneficial cultural practices and discouraging harmful practices in the community;
- participate actively in other community health programs by disseminating maternal and newborn care messages;
- collaborate with members of the primary health care unit in reporting and documenting maternal and newborn care issues within their catchment area.

2.2.5.1 Logistics of agogo training

The *agogo* training lasted two days, with two modules per day--one in the morning and one in the afternoon. The project team was responsible for logistics, with the BCC officer and the driver organizing transport, the project coordinator ensuring timely access to funds for fuel costs, refreshments and one night's accommodation for *agogo* (if necessary) and the assistant coordinator or project coordinator making the necessary accommodation arrangements. A conference room in the primary health care building at Ekwendeni was the venue for the training, but any space that will comfortably accommodate a trainer and 40 grandparents should suffice. When more than 40 *agogo* were recruited (often as many as 80 *agogo* were selected from an area containing many small villages), two conference rooms were used, and two training sessions ran concurrently. The sessions started as soon as all *agogo* had arrived (around 8 AM), paused for a short tea break in the morning, and then ran until lunch, which lasted for an hour and a half. After lunch, *agogo* attended the afternoon session, which ended around 5 PM and included refreshment (a bottle of soda) halfway through.

2.2.5.2 Pre- and post-tests

Grandparents took two written tests during the training,,although other forms of assessment may be preferred in groups where the majority of grandparents are illiterate. The tests were administered in the local Tumbuka language, and grandparents who had trouble reading or writing were assisted by student nurses who acted as scribes.

The first test, administered as a pre-test before the first day's activities,,asked *agogo* to answer a few general questions related to good practice in maternal and newborn health. The second

test, administered as a post-test upon completion of the second day's activities, evaluated the extent of collective learning that had been achieved during the training and confirmed that individual *agogo* leaving the training possessed the necessary knowledge to convey medically sound advice.

While a fixed curriculum was followed, trainers were mindful to include information on specific needs or misconceptions that became apparent during discussions or during marking of the pre-test.

Grandfathers listen attentively during an agogoagogo training session at Ekwendeni Mission Hospital. Trained grandfathers have been found to participate as actively as grandmothers in giving advice related to essential newborn care and often take it upon themselves to arrange practical matters such as transport to hospital before delivery.

2.2.5.3 Course content

Day 1 – Module 1 (morning session)

The first module familiarized *agogo* with the maternal and newborn health situation in Malawi and reaffirmed the hospital's recognition of tham as leaders in newborn health at community level. Group discussions explored the traditional role of grandparents in making decisions about newborn health. Active participation allowed hospital and project staff to hear about the traditional practices related to newborn. Finally, trainers introduced grandparents to the concept of the *Agogo* Approach and explained what would be expected of them.

Day 1– Module 2 (afternoon session)

On the afternoon of the first day, grandparents learned about maternal care, including antenatal visits, birth preparedness, danger signs occuring during pregnancy or after delivery, care-seeking, postnatal care and family planning. *Agogo* also discussed cultural practices related to maternal care. This particular discussion constituted a vital part of the training by increasing ownership, stimulating participation and informing course content.

Day 2 – Module 3 (morning session)

Day 2 began with intensive learning about essential newborn care. The grandparents learned about care after delivery, immunizations, exclusive breastfeeding, postnatal care and danger signs to look out for in a newborn baby. Cultural practices surrounding care of the newborn were discussed, and grandparents learned new behaviors with which to replace potentially harmful practices.

Day 4 - Module 4 (afternoon session)

The last session of the *agogo* training focused on the care of low birth weight babies and Kangaroo Mother Care (KMC). Grandparents had ample opportunity to practice KMC techniques with a low birth weight baby .

Although the training manual outlined the use of registers in the first module, training staff at Ekwendeni found it more useful to cover this later in the training, when *agogo* had a clear idea of what would be expected of them. They therefore used the second session on the last day to teach grandparents how to use the *agogo* registers to monitor mothers and newborns in their villages.

Kangaroo Mother Care at Ekwendeni Hospital. KMC regulates the body temperature and heart rate of pre-term newborns or babies with a low birth weight. AgogoAgogoAgogo are trained to implement KMC and to support and train

2.2.5.4 Training method

The *agogo* training method was participatory and interactive. New skills, such as Kangaroo Mother Care, were taught in a hands-on way, through pair and group activities. Posters or leaflets depicting examples of maternal danger signs or dangerous conditions in newborns were used if available. Grandparents shared knowledge, discussed opinions and asked questions, and many *agogo* who could write preferred to take notes for later reference. Question and answer, repetition and testing reinforced correct responses or behaviors, and role plays or case studies provided an element of fun. All activities were conducted with respect, and trainers were mindful that the training represented a two-way learning experience: the *agogo* contributed as much knowledge as the trainers did.

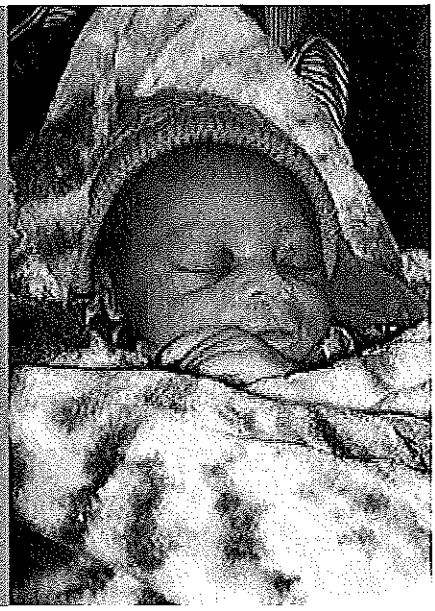
2.2.5.5 A note on cultural practices and traditional beliefs

Trainers were sensitive to grandparents' feelings and listened attentively without condemning any cultural practices or beliefs, or correcting them prematurely.. It was crucial to the success of the project that grandparents felt respected throughout the training, and that when the

disadvantages of harmful practices were pointed out and explained, it was done without seeming patronizing or judgmental. At the same time, trainers praised and reaffirmed beneficial traditional practices. In addition, information provided by grandparents during the training sessions often informed project implementation or even dictated small adaptations to the training curriculum, as some harmful cultural practices differed between villages

SAVED BY A MEETING

Elliness,, a young woman near Khuyukuyu, was expecting her first baby. She heard about the newborn health information sessions held by agogo in her village and started attending. When Elliness suffered from convulsions (preclampsia) later in her pregnancy, the agogo arranged transport to hospital and discouraged local villagers from banging pots and pans around her ears as a local belief would have them do. . Tthanks to the agogo' quick action and careful monitoring, Elliness's baby was delivered and received specialized care at hospital and survived.



2.2.5.6 Orientation of health surveillance assistants

The health surveillance assistants (HSA) from the areas where *agogo* received training were informed of the grandparents' training and future activities. While the HSA could have been included in the *agogo* training sessions, Ekwendeni hospital found it useful to rather host a one day orientation to the *Agogo* Approach for all HSAs in the hospital catchment area. The goal of the orientation was to make HSAs aware of the extent and details of grandparents' activities in communities so that they could provide support if needed. They also learned about the *agogo* register, since they would have the responsibility of copying information from the register to a reporting form on a monthly basis and delivering this to the behavior change communication officer at the hospital. As the link between government health services and the community, HSAs were important representatives of the *Agogo* Approach, and were responsible for raising awareness among other health workers or authorities. The HSA from each area was the

communication link between the BCC officer and the *agogo*, and needed to be accessible in case the *agogo* had questions or comments for the project staff.

2.2.6 The use of agogo registers

In order to obtain current data about the mothers who were reached by the *Agogo* Approach, *agogo* carried an *agogo* register in which they recorded the names and progress of pregnant mothers in their village. *Agogo* decided whether they needed more than one register in the village, where it would be stored and who would be directly responsible for it. *Agogo* recorded the following information in the registers:

- Mother's assitned identification number (or a number by which the village kept count of how many mothers had been entered on the register)
- The village name
- Mother's name
- Mother's physical address
- The time in gestation that the mother started antenatal care
- The place (clinic/health centre) where the mother started attending antenatal care
- Whether the mother was referred (by an *agogo*)to the hospital or health centre during pregnancy
- If she was referred to hospital by an *agogo*, the reason for such a referral
- Place of delivery
- Date of delivery
- Was the mother referred to a health centre or hospital by an *agogo* during labor? (In case of an unforeseen home delivery)
- The reason for such a referral
- The place she was referred to
- Was the newborn referred to hospital or a health centre for postnatal care?
- Reason for referral
- Date of the newborn's first physical examination

- Did the mother take the baby for postnatal services at 6 weeks of age (immunizations as well as family planning advice)
- Was the baby referred to hospital for a check-up at a later stage?
- The reason for the referral
- Place referred to
- Survival status of the baby
- Cause of death (in the case of newborn death)
- Date of death
- Status of the mother
- Cause of death (in case of maternal death)
- Date of death

Information on the *agogo* register was updated, if necessary, on a daily basis, and *agogo* frequently visited pregnant women at home to keep up with changes in mothers' health status. The *agogo* register further served as a calendar to remind *agogo* to send mothers for antenatal visits, postnatal check-ups and immunizations.. The *agogo* provided their local health surveillance assistants with access to the register on a monthly basis, so that the HSAs could copy information from the register to the HSA reporting form and then deliver the form to the BCC officer at the hospital or field office. It was the responsibility of the BCC officer to ensure that HSAs had a supply of blank reporting forms to record data from the *agogo* registers. A copy of the HSA reporting form can be found in Appendix

2.2.7 Monitoring and evaluation

A Performance Monitoring and Evaluation Plan (PMP) for the *Agogo* Approach (see appendix) was drawn up by staff from the Save the Children Country Office in Malawi, and the project team at Ekwendeni submitted quarterly progress reports to the Save the Children country office.. Target indicators were developed from district baseline data, continually assessed by the BCC officer, who used HSA reporting forms and HMIS (government) data from local health centers, and entered into a database. Indicators were designed to provide feedback on

the mothers and newborns benefiting from the approach, Table 3 depicts the target indicators and sources of information used to measure them.

Table 3. Target indicators for monitoring progress and achievements of the Agogo Approach

INDICATOR TITLE	SOURCE OF INFORMATION
Percentage of pregnant women starting antenatal care during the first trimester	HMIS government data
Percentage of deliveries conducted by skilled birth attendant	HMIS government data
Percentage of women receiving post partum care within one week of delivery	HMIS government data
Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal and/or newborn health and nutrition care through CSGHP-supported programs [Disaggregated by gender]	Training reports or records of *agogo* training as kept by project staff
Number of women and babies referred to health facility by *agogo*	*Agogo* registers
Number of supervisory visits made to *agogo* by project team	Project documentation (such as supervision reports)
Number of *agogo* followed up six months after training	Project documentation (such as activity reports or supervision reports)
Percentage and number of *agogo* with 50% knowledge retention at six months follow-up	Post-tests or focus group discussions conducted during supervisory visits

Frequent supervision visits from the project team featured prominently in the project's monitoring plan. In Ekwendeni area, HSAs acted as immediate supervisors of *agogo* and assisted in documenting *agogo* activities in the villages. The project team scheduled supervision visits so that every group of trained *agogo* received a visit within six months of training at the

most. The visits were conducted through focus group discussions led by members of the project team (the project coordinator, assistant coordinator and the BCC officer). Twelve was the preferred maximum number of *agogo* in a focus group, as project staff needed as much individual interaction with *agogo* during supervision visits as possible to ensure that all *agogo* were still conversant in matters related to the training curriculum, to gather information about community activities initiated by the *agogo* and to ensure that *agogo* registers were updated correctly and regularly. See Appendix for the supervision checklist.

In addition to monitoring the performance of *agogo*, supervision visits served as an opportunity to refresh *agogo* knowledge about essential maternal and newborn health care. The project staff also gave valuable feedback and motivation, often through news from the hospital or health centers (if the advice from the *agogo* was leading to more hospital deliveries, for instance). Success stories were shared at supervision visits and documented by the project staff for later inclusion in quarterly reports to funders.

Young mothers as a group often received supervisory visits. Conversations or focus group discussions with them provided valuable information on agogo activities in their community.

The mothers pictured at right were advised and supported throughout their pregnancies by trained agogo. Once the program began, none of the women had a stillbirth, and all of the newborns are now growing into healthy babies and toddlers.

2.2.8 Documentation

Project staff gathered success stories, photographs and even video records to document the activities of the *Agogo* Approach. A camcorder was included as an essential procurement for the *Agogo* Approach, and project staff were trained in its use and encouraged to take it along to all project related activities.

Important documentation included:

- minutes of all meetings by project staff
- minutes or records of village health meetings related to *agogo* activities
- reports of supervision visits
- reports of field visits
- electronic database incorporating data from *agogo* registers
- any other records of referred cases
- monthly and/or quarterly reports as needed
- success stories of how the project has benefited mothers and newborns
- any other documentation as dictated by the specific monitoring and evaluation plan
- midterm and final evaluations

A special bulletin board was created in the maternal and newborn health office of the primary health care unit at Ekwendeni hospital as a visual platform for the *Agogo* Approach's activities and achievements. This facilitated documentation and motivated project staff to write success stories and take photographs of activities, while at the same time providing visitors and potential funders with project details.

3. PROJECT OUTCOMES

3.1 Changes in behavior

The *Agogo* Approach resulted in widespread behavior change in communities living in and around the Ekwendeni catchment area. Shortly after the first training was conducted and the first group of *agogo* became active in their communities, home deliveries decreased and the maternity ward at Ekwendeni hospital became busier, the result of more mothers being referred or choosing to deliver at the hospital. The maternal shelter outside the hospital gates, where mothers came to await the birth of their babies, was a constant hub of activity, with *agogo* and mothers cooking meals and staying until after the baby was born. As encouraged by the *agogo*, mothers also increasingly sought care at the hospital after recognizing potential danger signs.

The last *agogo* training session, in July 2008, coincided with the addition of 10 new beds and a new wing to the maternity ward, a concrete testimony to changed perceptions regarding the safety of home deliveries. The number of mothers having their first antenatal visit within the first trimester of pregnancy was also on the increase. Both hospital staff and villagers observed a visible reduction in the number of newborn deaths, and mothers said they no longer felt forced to have large families.

Table 4 (on page 74) documents some of the main changes in behavior that occurred as a direct result of *agogo* activity in the communities in Ekwendeni catchment area.

GRANDPARENT SAVES NEWBORN FROM HARMFUL PRACTICE

Esta Soko is the proud mother of 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 that can lead to complications and death. Esta's mother-in-law had received critical training in matters concerning essential newborn health care from staff at Ekwendeni mission hospital, in a Save the Children project funded by USAID. Fortunately for Esta, 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 another neonatal fatality, due to prolonged labor, had it not been for the agogoagogo's advice.

Now acting as local advisors on matters relating to pregnancy and newborn health, thousands of other agogoagogoagogo like Esta's mother-in-law are helping to lower the newborn mortality rate in Malawi through their influence as decision makers in the community.

3.2 Resulting information flow

The extent to which information on healthy maternal and newborn practices was shared in communities after *agogo* were trained indicated the potential sustainability of the *agogo* approach. The training sessions attended by *agogo* were designed to enhance their traditional roles as decision-makers, empowering them to give advice that would result in the sound health of babies born to their daughters or daughters-in-law. During the training sessions, grandparents were encouraged to find creative ways of sharing their knowledge with members of their families and communities.

Supervision visits revealed a variety of dissemination efforts designed and implemented by *agogo*. In most cases, trained grandparents from a village would come together upon returning from training to discuss and plan how to communicate messages of good practice to women, girls and husbands in their community. Their subsequent efforts took many forms: in some areas, *agogo* composed songs that would encourage good practice; for instance, about danger signs to look out for during pregnancy. These songs were sung widely in the community, and it

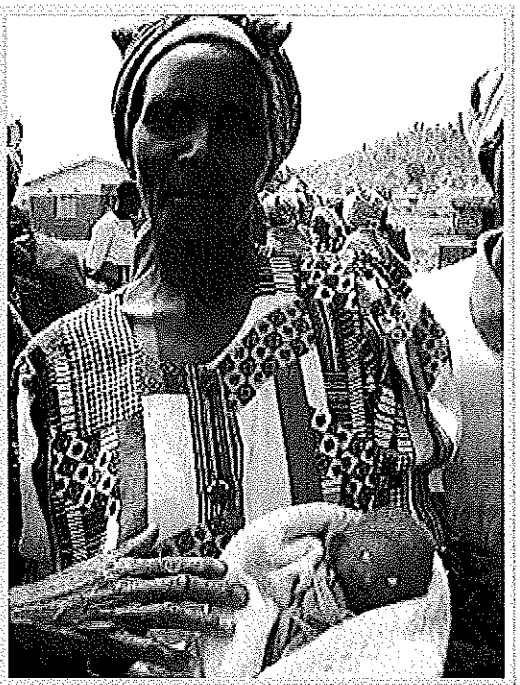
was clear on field visits that the information perpetuated by the songs was flowing freely; even small children knew the words and sang loudly about danger signs that would signal the necessity of a hospital visit.

In yet another area, *agogo* arranged to meet weekly with pregnant mothers and young girls from the community. At these meetings, the *agogo* discussed not only the information received at the training ("to keep our memories fresh"); they also spoke to pregnant mothers about issues such as the necessity and timing of antenatal visits, danger signs, good practices with which to replace traditionally harmful ones, and family planning. These messages reached families in nearby villages where *agogo* had not been trained, as friends who heard about these efforts encouraged their own daughters and daughters-in-law to attend the meetings, with the result that more mothers started following correct procedures to ensure a safe delivery and a healthy newborn.

The creation of dramas was another favorite way of sharing information with communities, and community members turned up in great numbers to view dramas staged by *agogo*. In addition to staging dramas, some agogo took it upon themselves to go from village to village in

LIFESAVING VILLAGE THEATRE

The agogo from Chimbongondo area in Mzimba district in northern Malawi received training during March 2008. Now they regularly stage drama productions for communities in their area, incorporating humor and props (see the doll fashioned out of clay which stars as a newborn in the drama) into scenarios to which villagers can relate, in an effort to bring home messages about essential newborn healthcare. A typical plot depicts the sharing of advice with an expectant couple. The "husband" is against the idea of antenatal visits due to the HIV testing that might take place, but with great effort and antics on the part of the elderly actors - much to the delight of the audience - is counseled and persuaded by the actors playing the role of agogo. The drama proceeds and includes practical advice regarding birth (at hospital) and breastfeeding, as well as Kangaroo Mother Care. Dramas are enthusiastically attended by young and old, and play an important role in altering misconceptions and changing harmful behavior.



Right: A grandmother holds a clay doll which she uses in the dramas staged by agogo.

areas where agogo had not been trained to deliver lectures about the dangers of certain traditional practices. Agogo seemed to be motivated by the sentiment that the message they had received should remain as a legacy to future generations after they were gone.

'We teach the whole community, because in future we will not be there to teach."

Towards the end of the project, several factors indicated that a natural flow of information had been established in the communities served by trained grandparents:

- Hospital deliveries had increased, even for mothers who had not been advised by *agogo*, but who had friends that had been referred to hospital and who had passed on the information.
- Children and young people in villages were aware of the details surrounding maternal and newborn care, thanks to dramas and talks by *agogo*.
- Children were singing the words to the songs about the curriculum, meaning that the next generation already knew more about sound preventive practices than their parents had before *agogo* were trained.
- During supervision visits, young girls said they had been advised on family planning matters, and that they felt that the *agogo* were sometimes more accessible if they needed someone to talk to or had questions related to sexual health.
- The frequency of meetings, discussions and the general activity of *agogo* emphasized a dynamic flow of information within the community.
- Qualitative and quantitative indications that objectives were being achieved pointed to the emergence of natural channels of information on the topic of essential newborn health and promised a sound measure of sustainability.

Figure 3. How maternal and newborn health information flowed because of the *Agogo* Approach

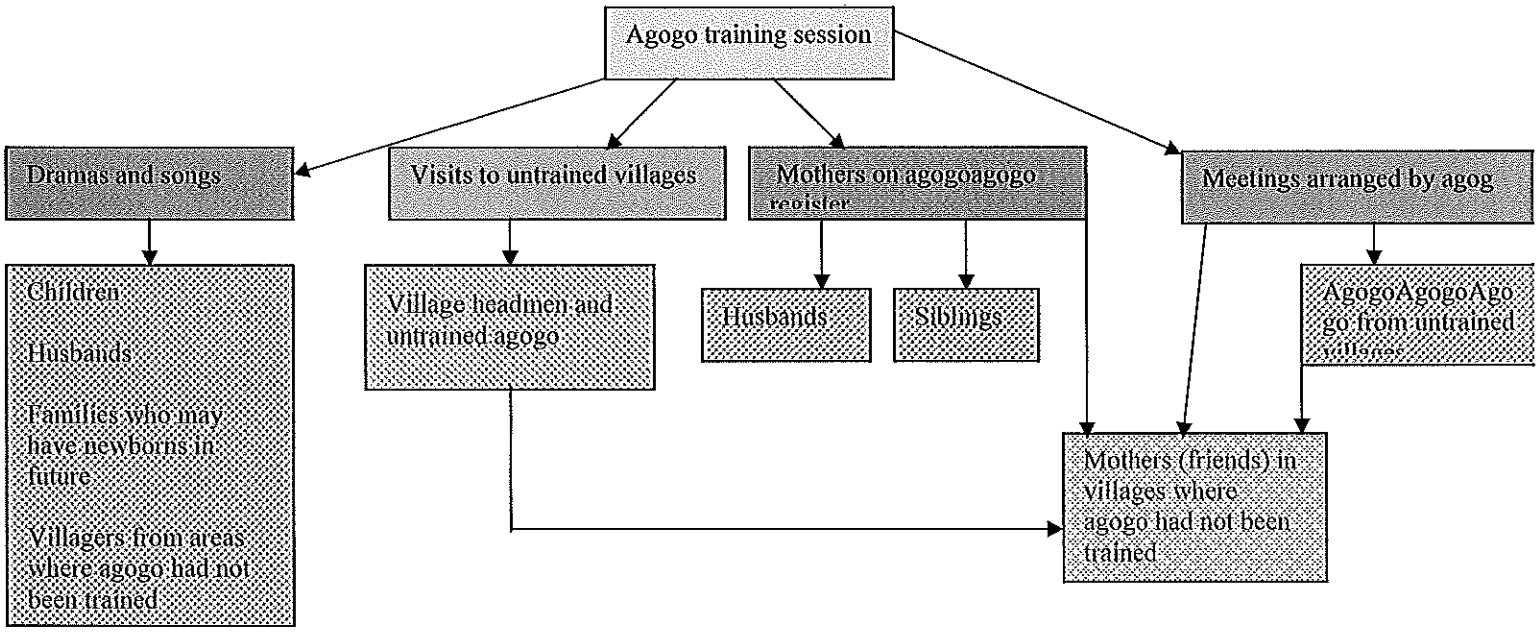


Table 4. Positive changes in behavior occurring as a direct result of agogo activity in Ekwendeni

Past behavior	Consequences	New behavior
Following a birth, some villagers believed that a husband should leave the home for a certain period of time.	This was reported to encourage infidelity and likely lead to the spread of HIV and sexually transmitted infections.	Grandparents now discourage this behavior in their communities, teaching husbands and wives that both belong in the home after a baby has been born.
The birth of twins or a breach delivery used to be interpreted as a sign of abnormality, and following either of these events, some villages would banish a mother and her babies to the bush, leaving food out for her but not encouraging any contact with her until the babies were older.	In most cases, babies would fail to survive due to extreme conditions and hypothermia.	Mothers are encouraged to deliver at hospital, and are welcomed back in the village afterwards regardless of the baby's status. The birth of twins is no longer interpreted to be a negative event. Grandparents distribute information regarding the dangers of exposing babies to extreme conditions.
Traditional medicine was given to accelerate labor.	Maternal injury; newborn deaths; high rate of birth asphyxia.	Mothers are referred to hospital for delivery; agogoagogoagogo are advising against the use of traditional medicine for acceleration of labor.
Women delivered at home instead of a health centre.	Higher incidence of newborn and maternal deaths due to inappropriate medical interventions in the case of complications.	Women are accompanied to maternal shelters to await delivery at the health center or hospital.
Premature babies born in the village would be bundled in blankets and placed in a cardboard box for transportation to the hospital.	High incidence of newborn deaths.	Mothers wrap babies in a skin-to-skin position as taught by agogoagogoagogo. The babies' heart rates and temperature are thus regulated and many more babies survive.
Preclampsia (convulsions) used to be treated by banging pots and pans or making a very loud noise around the patient's ears.	Endangerment of the unborn baby; newborn or maternal death in worst-case scenarios.	Mothers are taken to hospital where they receive the required medical care.
Babies were bathed immediately after birth.	Hypothermia; infections.	Babies are born in hospital; if born in the village, they are dried and only bathed after 24 hours have elapsed.

4. LESSONS LEARNED

> "The most fertile source of insight is hindsight."
>
> - *Morris Kline, Mathematics: The Loss of Certainty.*

The first implementation of any project is bound to render ways in which it could be improved upon a second time round. Although the *Agogo* Approach proved exceptionally effective and promising as a community level strategy involving the elder members of society, a number of project particulars were adapted and improved upon during the course of the project life, while still others are included here because they represent aspects that, if approached differently or reconsidered, may prove more effective in future applications.

Measuring mortality

The programmatic challenges of measuring significant changes in mortality in smaller community populations are well recognized by organizations that have implemented health programs aimed at improving newborn and maternal health (Howard-Grabman, 2007). A good qualitative measure can be obtained by asking questions about newborn mortality in the country during the first training session for *agogo*. Because grandmothers in Tumbuka culture are the authorities on newborn life and death, they are sometimes the only community members -other than the mothers themselves- who can convey an accurate picture of the number of newborn deaths in a particular village during a given year, since many "silent" deaths go uncounted as villagers often do not mourn or acknowledge stillbirths or babies who die in the first week of life. If asked how many mothers or babies were lost in the last year, grandparents from one area or village could discuss the matter and provide a relatively reliable number that may prove useful in later years if very area-specific data is required.

Duration of training

Agogo frequently requested that the duration of training be extended to more than two days. The reason, according to some, was that they found the amount of information overwhelming, and they were concerned about remembering it all. While in principle there would be no problem with longer training sessions, even one extra training day per group would elevate the project cost (due to accommodation expenses) and significantly extend the project duration. In addition, supervisors reported that *agogo* retained information very effectively when they engaged in internal meetings and were actively giving advice on a continuous basis. Advice and good practice taught from the *agogo* curriculum was integrated and reached a status of almost cultural significance in villages very quickly following training, which meant that *agogo* who were actively advocating good practice on a daily basis did not seem to be in any danger of forgetting, as many *agogo* professed. A suggestion here would be to ensure that supervision visits were also used as opportunities to refresh *agogo* memories about the details of good practice.

Supervision and training should run concurrently

The implementation of the *Agogo* Approach at Ekwendeni involved many groups of *agogo* that were trained over the course of more than a year. The full time involvement of project staff in training activities meant that supervision of groups did not start until all groups were trained. This led to some *agogo* practicing as advisors for more than half a year following training without receiving any supervision visits during that period of time. Taking this challenge into consideration, the team considered the idea of limiting the behavior change officer's involvement in training sessions, so that he or she is free to conduct supervision visits when their timing needed to coincide with training sessions. Regular supervision visits are vital for motivating *agogo* and ensuring that they are promoting accurate information, best practices, and confidently fulfilling their roles.

Training of project staff

Despite their high level of competence and extensive experience in implementation of community projects, all members of the project team were not equally confident in using technological equipment such as the necessary computer applications or camcorder. A quick training session set them right but would have been better timed had it taken place at the start of project. Other training that proved useful to team members included data handling and writing success stories and reports to sponsors.

Supervision of process documentation

Many program implementation teams do not have training or experience in sophisticated process documention. If process documentation is required by the donor, or needs to be generated for any particular reason other than monthly or quarterly feedback to donors, the donor or sub-granting organization should do an assessment and provide orientation and training to fill gaps.

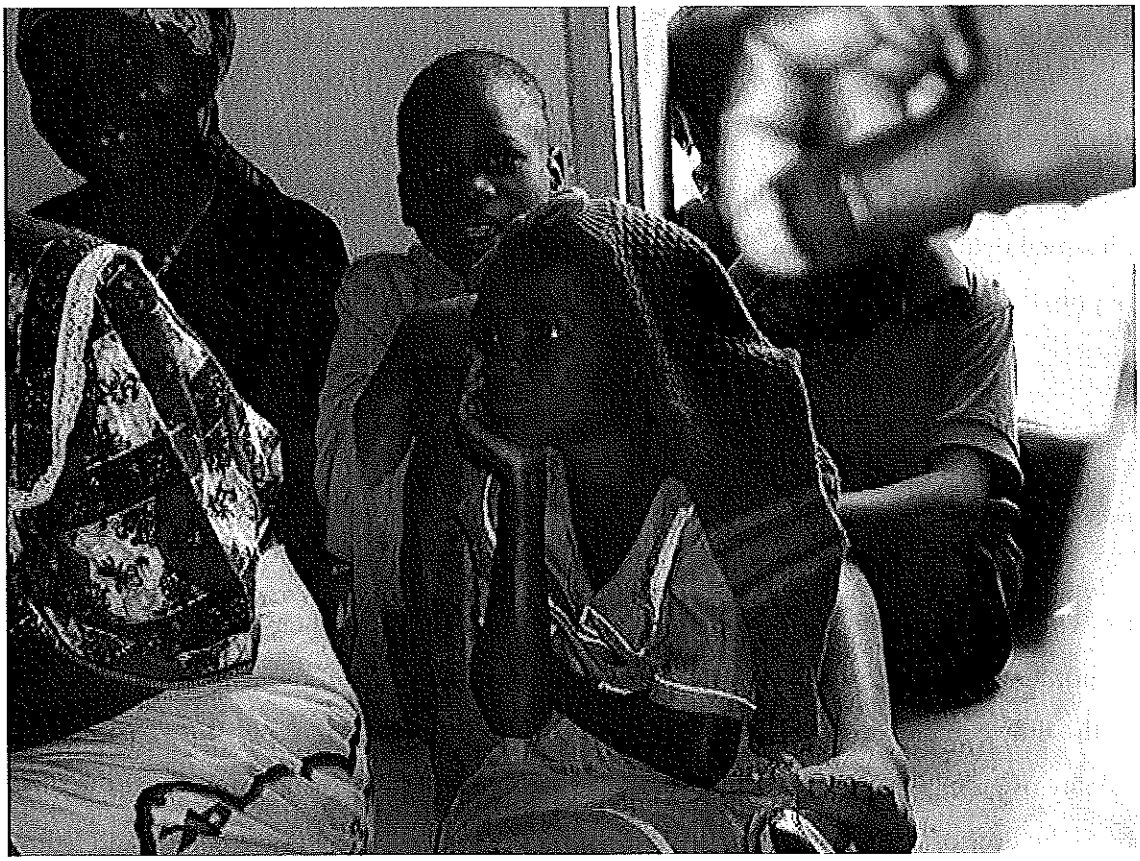
Raising awareness in communities that were not targeted for training

While grandparents were not trained or required to visit villages beyond their own to teach what they had learnt, some chose to do so for the benefit of the greater community. Others talked to friends in "untrained" villages about what they had learned. Therefore, broad awareness should be raised about the *Agogo* Approach in the surrounding project area to increase the *agogo*' credibility as trained advisors. In some cases, elders from unfamiliar villages hesitated to believe the contrary ideas (contrary to traditional belief and practice) put forth by the *agogo* and resisted change.

Translate songs

The *agogo*' songs or poems should be translated into English for use in other projects or to showcase them to the international community. The songs and poems represented an ageless

and indispensable communication technique and served as a means of recognizing for the innovation and enthusiasm of the the grandparents .



A little girl watches spellbound as agogo from her village teach through drama and song.

5. CONCLUSION: SUSTAINING NEWBORN CARE

Certainly the aim of any maternal and newborn health project is to achieve an improved health status that continues beyond the project's end. Such a status can only hope to be achieved if behavior change is integrated with daily life and acquires cultural significance.

In the *Agogo* Approach, grandparents – in their role as customary decision-makers and traditional advisors- provide an open and culturally appropriate channel of communication into Tumbuka society through which the causes and potential solutions for maternal and newborn mortality could be targeted and addressed. Empowering grandparents with essential

knowledge about maternal and newborn health care enabled them to catalyze and mobilize the rest of their communities to reduce newborn deaths. The *Agogo* Approach naturally engaged the participation of mothers and husbands because they were traditionally receptive to grandparents' advice.

Community participation is an accepted precondition to sustainable behavior change. It is also a function of the stimulated demand for health care services (antenatal visits, postnatal check-ups, hospital deliveries, etc.) created by *agogo* activity within a specific community. The more the supply-demand cycle for newborn health services improves, the greater and more established the capacity for sustained change in health-seeking behavior amongst mothers in the targeted area.

Mothers who were advised by *agogo* gained an improved understanding of their own health needs, as well as that of their newborns. These new mothers are the grandmothers of the future. They now culturally inclined to learn and accept advice from their own mothers and grandmothers and will repeat that advice later to their own daughters and daughters-in-law when the time comes for them to take decisions for a new generation of newborns. Enriching the quality of grandparents' existing repertoire of advice strengthens their credibility as family heads in the eyes of a younger generation increasingly influenced by modern ideas - and helps protect the integrity of a very important traditional family structure that has already been lost in too many African urban settings.

The trained *agogo* in Ekwendeni are proof of the enormously important role that can be played by Africa's elders in the protection of its most precious and vulnerable resource: its newborns.

APPENDICES

Appendix A.....Ekwendeni *Agogo* Training Manual

Appendix B.....Health surveillance assistant reporting form

Appendix C.....Performance Monitoring Plan

Appendix D.....Supervision visit checklist

Appendix E.....Budget

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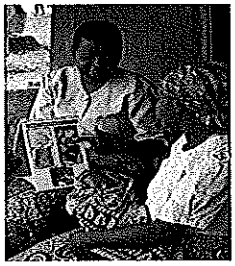
Annex 8: Women Deliver Presentation

Scale-up of Community Based Maternal and Newborn Care (CBMNC) Package in Malawi

Presented at the Women Deliver Conference

9th June 2010



Evelyn Zimba, Program Manager

Save the Children - Malawi Newborn Health Program

USAID

Save the Children.

Outline

- Background
- CBMNC Package
- Methodology
- Progress
- Challenges
- Conclusion

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Related Health Indicators

(DHS 2004 & MICS 2006)

Maternal mortality ratio per 100,000 live births	807
Stillbirth rate per 1,000 total births	39
Annual number of stillbirths	22,200
Neonatal mortality rate per 1,000 live births	33
Annual number of neonatal deaths	18,900
Proportion of newborns born with LBW	20%
Infant mortality rate per 1,000 live births	69
Under 5 mortality rate per 1,000 live births	118

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Malawi CBMNC package

- The CBMNC package is implemented in partnership with MOH Reproductive Health Unit (RHU), Save the Children, UNICEF, USAID-MCHIP, WHO, Norwegian Church Aid, UNFPA
- Save the Children's Malawi Newborn Health Program is co-funded by USAID CSHGP and Saving Newborn Lives

- The program started in 2007 with a 3-year learning program (OR) implemented in three districts to evaluate the feasibility, cost and outcomes of a CBMNC package
- Followed by a scale-up program in 6 districts
- In the pipeline are now 5 additional districts

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Objective of CBMNC package

- To contribute to the reduction of maternal and neonatal mortality in Malawi by:
  - Improving care for pregnant women, recently delivered mothers and newborns along the hospital-to-household continuum of care
  - Strengthening facility-based services by training of personnel using IMNC manual and provision of equipment & supplies
  - Promotion of MNH services through community mobilization (CM) and structured home visits by MOH employed community health workers called Health Surveillance Assistants (HSAs)

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Guiding Principles of CBMNC package

- HSAs undergo a 10 days CBMNC and 8 days CM training.
  - Promote community MNH services through CM and counsel pregnant women, recently delivered women and their newborns on the importance of attending ANC clinic, birth preparedness, clean delivery, delivery by skilled attendant, ENC, identify and classify mothers and newborns with danger signs and refer
  - Conduct home visits three times during pregnancy, within 24 hours of childbirth, at 3 and 8 days post-delivery

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Milestones

- MOH learning visit to India in 2006
- Design workshop - February 2007
- Training of HSAs in CBMNC & CM (2008-ongoing)
- Government mandates all partners interested in CMNH to use the CBMNC package (2010)

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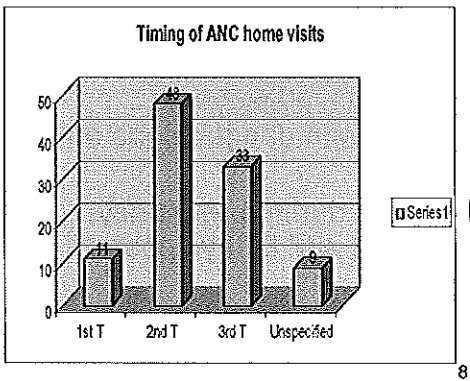
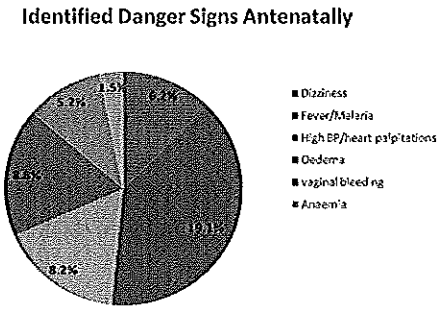
CMNH Results: Antenatal

- **5398 women in 7 districts received antenatal home visit by HSAs**





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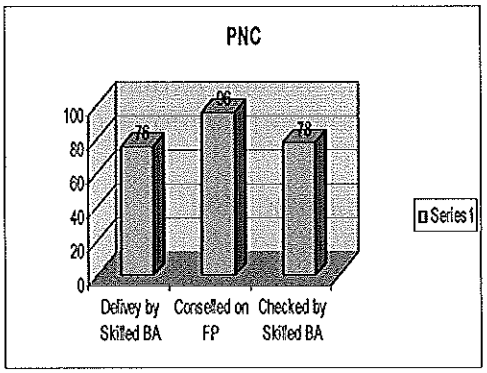
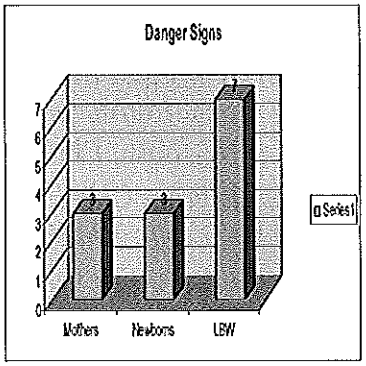
CMNH Results: Postnatal

3415 mother/infant pairs visited at home by HSAs





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Challenges

- Transportation to conduct home visits and for supervision
- Trainings happening at a slow pace
- Delays in flow of data to central point
- Most women hide their pregnancies during the first trimester for fear of witchcraft
- Overwhelming demand at health facility for labour and delivery services. This has created more work for midwives and strain resources at health facility
- Inadequate resources for scale-up in other districts

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Conclusion

- Midterm evaluation of the 3 learning districts showed that it is feasible to equip HSAs with knowledge and skills on MNH to identify and counsel pregnant women, recently delivered women and their newborns through structured home visits. LQAS to assess HSA coverage of home visits: ANC 70%, PNC 60%
- Home visits by CHW have led to improved MNH household care-seeking practices
- Structured HSA home visits should be adopted and scaled-up to improve MNH services

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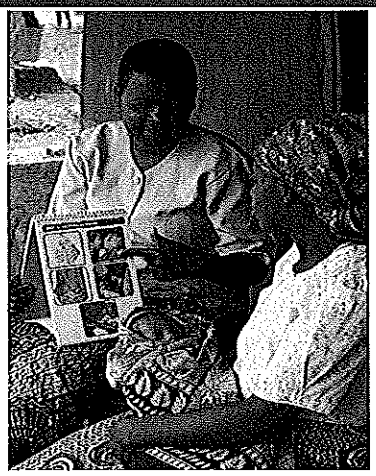
Thank you



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Annex 9: KMC Scale-up Presentation

Planning and Scaling up Kangaroo Mother Care in Malawi

KMC Conference
Quebec, Canada
June 21st, 2010

For more information
Contact: Evelyn Zimba, SC Malawi
ezimba@savechildren.org

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Outline

- Why KMC in Malawi
- KMC scale up; Partnership and government leadership
  - Where we are coming from
  - Retrospective assessment
  - Moving to scale
  - Resource mobilization and advocacy
  - Challenges

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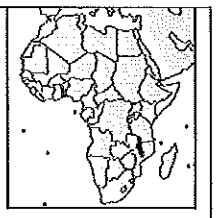
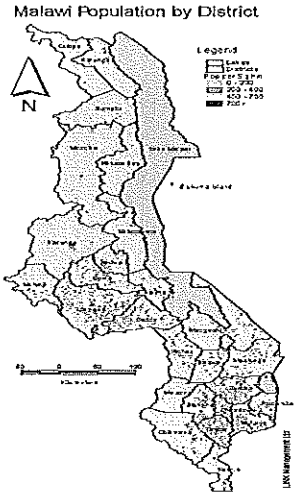
Map of Malawi





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Newborn Health Situation in Malawi

- Neonatal mortality rate: 33/1000 live births
- Low birth weight rate: 20%
- 43% of babies born at home
- Preterm births: one of the leading cause of newborn deaths

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KMC in Malawi – Why?

- Prior to late 1980s, LBW babies were nursed away from mothers in locally made incubators, a wooden box with a light bulb below the mattress for heat and babies stayed in the nursery 2 to 3 months if they survived
- Inadequate staff to care for and monitor babies
- Congestion in the nurseries

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Where we are coming from…

- From 2002-2006, MOH/RHU and Save the Children, with support from Saving Newborn Lives (SNL) and USAID CSHGP, and with other partners initiated first scale-up - Key accomplishments:
  - National KMC guidelines
  - Road Map – KMC included
  - KMC established in 6 additional hospitals
  - KMC training manual and BCC materials developed
  - 18 trainers and 274 health workers trained
  - KMC incorporated into midwifery pre-service curricula
- The major question that remained was how to get to wider scale and reach all families with small babies?
- Retrospective assessment was conducted to inform the way forward

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Retrospective Assessment

- Key question: could KMC be scaled up to all district hospitals?
- Key findings - Opportunities were there to expand but required:
  - More partnership and government ownership
  - Integration of KMC into MNH services
  - Establishment of a community follow-up system
  - Development of an effective M&E system to monitor quality of implementation

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Moving to Scale: *KMC in national documents*

- Facility, ambulatory and community KMC incorporated into MNH manual for health workers —modular KMC training and more focus on implementation — government endorsed for nation-wide use
- Community and ambulatory KMC incorporated into the community based maternal and newborn care (CBMNC) training manual for Health Surveillance Assistants (HSAs)
- National KMC guidelines revised to incorporate community and ambulatory KMC

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Moving to Scale:
KMC training

- In partnership with MOH/RHU, Save the Children, MCHIP, WHO, UNICEF, UNFPA
  - 298 health workers have been trained
  - 130 HSAs trained in ambulatory and community KMC
  - 15 Tutors trained in KMC

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Moving to Scale:
KMC service delivery

- Government plan for KMC in all district hospitals; 30 hospitals and 6 health centers have active KMC units – including 20 of 29 government-run district hospitals
- Continuous on-site facilitation and support is promoted
- Joint supervision by partners done quarterly
- Community and ambulatory KMC implementation piloted in 7 districts
- Data collection/flow continues to be an issue that partners are working to address.
- Two newly developed hospitals include special KMC wards

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Moving to Scale: *M&E and research*

- **Monitoring and evaluation**
  - Draft M&E system for tracking practices and quality of services at national level developed
  - Registers and monitoring forms distributed
  - Revision of integrated supervision tool to incorporate ENC/KMC is underway
- **Implementation research**
  - Malawi (MoH, SC and UNICEF) program is piloting community newborn care package that includes community KMC

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Resource Mobilization & Advocacy

- Dissemination of KMC Retrospective Assessment report
- TA provided during district planning (DIP) to provide guidance on the establishment of KMC
- KMC BCC materials reproduced for nation-wide distribution
- Sensitization of local leaders on ambulatory and community KMC through district executive meetings
- KMC included in MOH/RHU national dissemination meeting July 2010
- KMC success stories shared with prospective donors
- Media products developed in the past year; Living Proof and BBC video documentary
- Grace and baby Tumtumfwe visit Washington and tell their story

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Challenges in Scale up of Facility-based KMC

- **Human resources – staffing**
  - Insufficient nursing and clinical supervision
- **Implementation and follow-up**
  - Poor quality of documentation especially on feeding and vital signs
  - Congestion of babies in small KMC rooms
  - Lack of commitment by districts to fund scale-up
  - Lack of appropriate follow-up systems especially for defaulters

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Challenges Addressed

- Patient attendants to counteract staff shortages
- Close supervision to new KMC sites for documentation
- Development of M&E system underway for tracking practices and quality
- Mothers practice KMC in other rooms e.g. PNC ward for bigger babies so that KMC rooms are left for very small babies or intermittent KMC for those in nursery wards
- Development of Community follow-up system in progress
- With RHU, working with districts not yet implementing KMC

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Annex 10: Child Survival and Health Grants Program Project Summary

Oct-23-2010
Save the Children
(Malawi)

General Project Information

Cooperative Agreement Number:	GHS-A-00-06-00016
SC Headquarters Technical Backstop:	Karen Waltensperger
SC Headquarters Technical Backstop Backup:	Karen Waltensperger
Field Program Manager:	Evelyn Zimba
Midterm Evaluator:	Judith Robb-McCord
Final Evaluator:	
Headquarter Financial Contact:	Carmen Weder
Project Dates:	10/1/2006 - 9/30/2011 (FY06)
Project Type:	Expanded Impact
USAID Mission Contact:	Catherine Chiphazi
Project Web Site:	

Field Program Manager

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Grant Funding Information

USAID Funding: $2,500,000 **PVO Match:** $833,334

General Project 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, faith- based 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.

Project Location

Latitude: -15.31	**Longitude:** 35.10
Project Location Types:	Urban Peri-urban Rural
Levels of Intervention:	District Hospital Health Center Health Post Level Home Community
Province(s):	--
District(s):	Malawi (national level)
Sub-District(s):	--

Operations Research Information

OR Project Title:	Community Based Maternal and Newborn Health Operations Research
Cost of OR Activities:	$959,665
Research Partner(s):	Ministry of Health, UNICEF, WHO, UNFPA, MCHIP and other partners
OR Project Description:	The Community Based Maternal & Newborn Care (CBMNC) programme seeks to reduce maternal and neonatal mortality in Malawi. The program is being done through the delivery of an integrated package of community-based high impact interventions for mothers and newborns delivered 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. The specific objectives of the programme are: 1. To improve access, availability and quality of existing *facility-based maternal and newborn care* in the three programme districts. This is being done through strengthening existing maternal, newborn, and child health (MNCH) packages such as focused antenatal care (FANC), Basic Emergency Obstetric

Care (BEmOC) and IMCI, and specifically ensuring that high impact interventions to reduce neonatal mortality are initiated or strengthened at facilities, including neonatal resuscitation, kangaroo mother care (KMC), and care of ill babies at referral centres, particularly neonatal sepsis case management.

2. To increase access and availability of *community-based maternal and newborn care*. This is being done through developing and implementing a package, including training and supervision tools, job aids for home visits and related supply kits, for use by HSAs, and implementing this package with links to community IMCI (c-IMCI), FANC, routine postnatal care, nutrition, immunisation and other key preventive care packages within the EHP.

3. To increase *community knowledge and use of* key maternal and newborn health behaviours and demand for care. This will be done by complementing formal health system initiatives at community and facility level with proven community mobilization approaches to improve maternal and newborn care in the community.

4. To develop, implement, refine and evaluate an algorithm for diagnosis and referral of *neonatal sepsis* by HSAs. This will be informed by the recent learning of other community-based interventions for the treatment and/or referral of neonates with sepsis, and will be developed during Year 1 and implemented in Years 2 and 3. If treatment of neonatal sepsis with antibiotics by HSAs is to be added, a proposal addendum for this component of the programme will be submitted to the National Health Sciences Research and Ethics Committee (NHSRC) prior to initiation.

This programme is managed and implemented within the prevailing structures and staffing of the MOH and the three district health management teams. UNICEF, Save the Children, and other partners provide technical and financial support to support the planning, implementation, capacity building and monitoring and evaluation of the programme.

Partners

Ministry of Health (Reproductive Health Unit) (Collaborating Partner)	$0
Ekwendeni Mission Hospital (Synod of Livingstonia) (Subgrantee)	$124,972
UNICEF (Collaborating Partner)	$0
WHO (Collaborating Partner)	$0
UNFPA (Collaborating Partner)	$0
Christian Health Association of Malawi (Collaborating Partner)	$0
White Ribbon Alliance for Safe Motherhood-Malawi (Collaborating Partner)	$0
ACCESS/MCHIP (Collaborating Partner)	$0

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Group interventions Interpersonal Communication Mass media and small media
Health Services Access Strategies:	Emergency Transport Planning/Financing Addressing social barriers (i.e. gender, socio-cultural, etc)
Health Systems Strengthening:	Quality Assurance Supportive Supervision Task Shifting Developing/Helping to develop clinical protocols, procedures, case management guidelines Developing/Helping to develop job aids Monitoring health facility worker adherence with evidence-based guidelines Providing feedback on health worker performance Referral-counter referral system development for CHWs Community role in supervision of CHWs Development of clinical record forms Review of clinical records (for quality assessment/feedback) Coordinating existing HMIS with community level data Community input on quality improvement
Strategies for Enabling Environment:	Create/Update national guidelines/protocols Advocacy for revisions to national guidelines/protocols Stakeholder engagement and policy dialogue (local/state or national)

	Advocacy for policy change or resource mobilization Building capacity of communities/CBOs to advocate to leaders for health
Tools/Methodologies:	BEHAVE Framework Rapid Health Facility Assessment LQAS Mobile Devices for Data Collection Lives Saved Calculator

Capacity Building
(None Selected)

Interventions & Components
(None Selected)

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health
There is no data for this project for this operational plan indicator.
Number of People Trained in Child Health & Nutrition
There is no data for this project for this operational plan indicator.
Number of People Trained in Malaria Treatment or Prevention
There is no data for this project for this operational plan indicator.

Locations & Sub-Areas

Total Population: 724,873

Target Beneficiaries

	Malawi - SC - FY06
Children 0-59 months	123,228
Women 15-49 years	166,720
Beneficiaries Total	289,948

Rapid Catch Indicators: DIP Submission

				Sample Type: 30 Cluster
Indicator	**Numerator**	**Denominator**	**Percentage**	**Confidence Interval**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	**148**	**163**	**90.8%**	**15.3**
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**260**	**300**	**86.7%**	**11.2**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**238**	**300**	**79.3%**	**11.1**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth	**131**	**300**	**43.7%**	**9.3**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**41**	**112**	**36.6%**	**14.3**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**143**	**188**	**76.1%**	**13.9**
Percentage of children age 12-23 months who received a measles vaccination	**95**	**112**	**84.8%**	**18.3**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**92**	**112**	**82.1%**	**18.2**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**83**	**112**	**74.1%**	**17.9**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated	**7**	**300**	**2.3%**	**2.4**

with an effective anti-malarial drug within 24 hours after the fever began				
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	**13**	**110**	**11.8%**	**8.8**
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	**42**	**81**	**51.9%**	**19.1**
Percentage of households of children age 0-23 months that treat water effectively	**7**	**33**	**21.2%**	**21.0**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**5**	**300**	**1.7%**	**2.1**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**184**	**300**	**61.3%**	**10.4**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**72**	**262**	**27.5%**	**8.3**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**0**	**0**	**0.0%**	**0.0**

Rapid Catch Indicators: Mid-term

				Sample Type: 30 Cluster
Indicator	**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 age 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 three days after birth	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: card verified or 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 DTP1 according to the vaccination card or mother's recall by the time of the survey	0	0	0.0%	0.0
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	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	0	0	0.0%	0.0

with an effective anti-malarial drug within 24 hours after the fever began				
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 age 0-23 months who live in households with soap at the place for hand washing	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**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 the WHO/NCHS reference population)	**0**	**0**	**0.0%**	**0.0**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**0**	**0**	**0.0%**	

Rapid Catch Indicators: Final Evaluation

Rapid Catch Indicator Comments

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 MIDTERM SURVEY CONDUCTED.