



**MALAWI NEWBORN HEALTH PROGRAM
DETAILED IMPLEMENTATION PLAN
FINAL AS REVISED**

**ADVANCING MALAWI'S ROAD MAP TO REDUCE NEWBORN MORTALITY:
REACHING COMMUNITIES AND STRENGTHENING SERVICES AT NATIONAL SCALE**

**COOPERATIVE AGREEMENT: GHS-A-00-06-00016-00
30 SEPTEMBER 2006 – 30 SEPTEMBER 2011**

SUBMITTED BY:

**Save the Children Federation, Inc.
54 Wilton Road
Westport, CT 06880
Telephone: (203) 221-4000
Fax: (203) 221-4056**

CONTACT PERSONS:

**Eric Starbuck, Health Advisor
Carmen Weder, Associate Director, Office of Health**

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ACRONYMS AND TERMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (USAID Global Health project implemented by JHPIEGO in partnership with Save the Children, Futures Group, the Academy for Educational Development, the American College of Nurse-Midwives and Interchurch Medical Assistance)
ACSD	Accelerated Child Survival and Development (UNICEF)
<i>Agogo</i>	Grandparent
ANC	Antenatal Care
BASICS III	Basic Support for Institutionalizing Child Survival III (USAID Global Health project implemented by Management Sciences for Health Management Sciences for Health (MSH) in partnership with John Snow Inc., Academy for Educational Development, Program for Applied Technology for Health, Save the Children, the Manoff Group, and TSL)
BEmOC	Basic Emergency Obstetrical Care
BCC	Behavior Change Communication
CHAM	Christian Health Association of Malawi
C-IMCI	Community IMCI (Integrated Management of Childhood Illness)
COM	College of Medicine
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSTS	Child Survival Technical Support (ORC/Macro)
CT	Connecticut
DC	District of Columbia
DfID	Department for International Development (UK)
DHMT	District Health Management Team
DHO	District Health Office/District Health Officer
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
EBBP	Evidence-Based Best Practice
EHP	Essential Health Package
ESARO	East and Southern Africa Regional Office (UNICEF)
Ekwendeni	Ekwendeni Mission Hospital, Synod of Livingstonia
EmOC	Emergency Obstetrical Care
EU	European Union

FANC	Focused Antenatal Care
FP	Family Planning
FY	Fiscal Year
GAT	Gap Analysis Tool
GNP	Gross National Product
GOM	Government of Malawi
HFA	Health Facility Assessment
HMIB	Health Management Information Bulletin
HMIS	Health Management Information System
HIS	Health Information System
HIV/AIDS	Human Immune-deficiency Syndrome/Acquired Immune Deficiency Syndrome
HO	Home Office of Save the Children, located in Westport, CT
HPN	Health, Population, (HIV/AIDS), Nutrition
HR	Human Resources
HSA	Health Surveillance Assistant
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPT(p)	Intermittent Presumptive Treatment (in pregnancy)
IR	Intermediate Result
ITN	Insecticide Treated Bed Nets
JHPIEGO	Reproductive Health Program affiliated with Johns Hopkins University
JHU	Johns Hopkins University
JSI	John Snow International
KCN	Kamuzu College of Nursing
Km	Kilometer
KMC	Kangaroo Mother Care
KPC	Knowledge, Practice and Coverage
LBW	Low Birth Weight
LQAS	Lot Quality Assessment Sampling
MCH	Maternal and Child Health
MDG	Millennium Development Goal(s)
MICS	Multiple Indicator Cluster Survey
DHS	Malawi Demographic and Health Survey

M&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NBHP	Newborn Health Program
NMR	Neonatal Mortality Rate
NGO	Non-Governmental Organization
OH	Office of Health, Save the Children
OR	Operations Research
ORC	Opinion Research Corporation
PHC	Primary Health Care
PLG	Program Learning Group
PM	Program/Project Manager
PMNCH	Partnership for Maternal, Newborn & Child Health
PMTCT	Prevention of Mother-to-Child Transmission
PO	Project Officer
PS	Principal Secretary (Ministry of Health)
PVO	Private Voluntary Organization
QI	Quality Improvement
RH	Reproductive Health
Road Map	Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity in Malawi
SC	Save the Children Federation, Inc.
SC/Mw	Save the Children Malawi
SMT	Senior Management Team
SNL	Saving Newborn Lives (Save the Children global initiative funded by the Bill & Melinda Gates Foundation)
SO	Strategic Objective
SP	Sulfadoxine+Pyrimethamine (Fansidar)
SWAp	Sector-wide Approach
TA	Technical Assistance
TA	Traditional Authority
TBA	Traditional Birth Attendant

U5MR	Under-five Mortality Rate
UK	United Kingdom of Great Britain and Northern Ireland
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	US Dollar
USG	United States Government
VHC	Village Health Committee
WHO	World Health Organization
WRA	Woman of Reproductive Age
WRASM-Mw	White Ribbon Alliance for Safe Motherhood in Malawi
YR	Year

A. Executive Summary

Save the Children is implementing a five-year Expanded Impact (CS-22) project at the national-level, originally entitled *Supporting Malawi's Road Map to Reduce Neonatal Mortality: Reaching Communities and Strengthening Services at National Scale*, and now known as the Malawi Newborn Health Program (NBHP). The Child Survival and Health Grant Program (CSHGP) intervention is Maternal and Newborn Health (100%), with **focus on the neonate**. The NBHP 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 NBHP 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 and its other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. This includes taking to scale selected newborn health interventions and materials developed and tested by Save the Children in Malawi during the period 2001-05 as part of the global Saving Newborn Lives (SNL) initiative funded by the Bill & Melinda Gates Foundation. SNL2 funding in Malawi continues to generate important evidence related to neonatal care and provides match.

Using the 2007 population projection of 13,187,632, the NBHP beneficiary groups include 3,165,032 women of child bearing age, 456,460 pregnant women, and 44,274 newborns 0-28 days. (During each project year, there will be approximately 500,000 newborns in Malawi.)

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. The NBHP focuses on the main causes of neonatal mortality, *viz.*, infection, birth asphyxia, consequences of prematurity and low birth weight (LBW), and related maternal factors. Together, these account for 89% of all newborn deaths in Malawi.

To carry out this project, Save the Children is partnering at the national level with the MOH, which leads the Road Map process, and its other partners that include UNICEF, WHO, UNFPA, the USAID Mission, the Christian Health Association of Malawi (CHAM), and the White Ribbon Alliance for Safe Motherhood-Malawi (WRASM-Mw). These committed donors and stakeholders combine material and technical resources and expertise for Road Map implementation. Save the Children's primary role is to serve as **reference, catalyst, and technical resource for newborn health** in Malawi.

The NBHP incorporates community-based elements with activities planned in selected district-level settings to generate, test, refine, expand, scale up, sustain, evaluate, document, and disseminate affordable evidence-based approaches and interventions to promote demand for care, discourage harmful practices, build community capacity, and strengthen referral and

community linkages with the formal health system. The **community component** has co-evolved with Government of Malawi's (GOM) growing commitment to newborn health and community approaches; and with MOH policies, plans, and priorities. The Mai Mwana project is an SNL2-funded randomized controlled trial being conducted in Mchinji District by the Institute for Child Health in London and recently funded for completion. The Save the Children Country Office in Malawi plays an oversight role in monitoring and liaising with this important study to extract and disseminate lessons learned for application to MOH district-level and community initiatives. A second SNL2 evidence-generating activity relates to the MOH community-based newborn care package to be piloted in three districts (Thyolo, Dowa, and Chitipa) and ultimately scaled up nationally to 28 districts. Catalytic funds to implement the pilot have been committed by UNICEF, with scale up to be funded through district budgets from the Sector Wide Approach (SWAp) pool funds. Also included in the project's community component is sub-grant support to Ekwendeni Mission Hospital, a CHAM member facility, to refine, document, and package its innovative *agogo* (grandparent) approach for community mobilization and behavior change.

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 health 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.*

Primary contact persons at the USAID/Mission for this project are Catherine Chiphazi, Child Health Specialist, and Lilly Banda-Maliro, Reproductive Health Specialist, both of whom participated in a number of the start-up and DIP process activities. When this DIP document went to press, the USAID Mission's new 5-year strategy and plan for FY07-12 had not yet been made public. The project is, however, fully aligned with the Mission's extant Strategic Objective (SO) 8: *Adopting behaviors that reduce fertility, the risk of HIV/AIDS and improve child health*, contributing to Intermediate Result (IR) 3: *reduced child mortality* and IR 3.4: *improved prevention and management of childhood illnesses and increased use of malaria prevention practices.*

The budget for this Expanded Impact project is \$2,500,000 from USAID, matched \$833,334 (25% match) in non-United States Government funds and in-kind contributions. Ekwendeni Mission Hospital (Synod of Livingstonia) will receive a sub-grant in the amount of \$176,972 (\$124,972 USAID; \$52,000 match from private funds). No applicable changes were made to the budget.

Authors and editors of this DIP are: Karen Z. Waltensperger, Africa Regional Health Advisor; La Rue Seims, SNL Senior Research and Evaluation Advisor, Evelyn Zimba, NBHP Manager; Jeanne Russell, Deputy Country Office Director, Programs; Isaac Chipofya, Deputy Director for Finance & Administration; Sharon Lake-Post, Information and Documentation Specialist; Eric Starbuck, Health Advisor and headquarters backstop; and Carmen Weder, Office of Health Associate Director.

B. CSHGP Data Form

Child Survival and Health Grants Program Project Summary

Apr-11-2007

Save the Children

(Malawi)

General Project Information:

Cooperative Agreement Number: GHS-A-00-06-00016-00
Project Grant Cycle: 22
Project Dates: (10/1/2006 - 9/30/2011)
Project Type: Expanded Impact

SC Headquarters Technical Backstop: Eric Starbuck
Field Program Manager: Evelyn Zimba
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: Catherine Chiphazi

Field Program Manager Information:

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

Alternate Field Contact:

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

Funding Information:

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

Project Information:

Description:

Save the Children is implementing a five-year Expanded Impact project at the national-level originally entitled Supporting Malawi's Road Map to Reduce Neonatal Mortality: Reaching Communities and Strengthening Services at National Scale and now known as the Malawi Newborn Health Program (NBHP). The Child Survival and Health Grant Program (CSHGP) intervention is Maternal and Newborn Health (100%), with focus on the neonate. The NBHP 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 with support from WHO and other donors and launched officially on 30 March 2007. It is the first Road Map in Africa to be officially launched.

Save the Children's NBHP overlaps in time with the Road Map's first two phases (2005-08 and 2009-11) and contributes to achieving its goals, objectives, and targets. As a Road Map partner at the national level, Save the Children cooperates closely with MOH and its other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. This includes taking to national scale selected newborn health interventions and materials developed and tested by Save the Children in Malawi during the period 2001-05 as part of the global Saving Newborn Lives (SNL) initiative funded by the Bill & Melinda Gates Foundation. Gates (SNL2) funding in Malawi continues to generate important evidence related to neonatal care and support project match activities for this project.

Using the 2007 population projection of 13,187,632, the NBHP beneficiary groups include 3,165,032 women of child bearing age, 456,460 pregnant women, and 44,274 newborns 0-28 days. (During each project year, there will be approximately 500,000 newborns in Malawi.)

There are many factors that 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. The NBHP focuses on the main causes of neonatal mortality in Malawi, viz., infection, birth asphyxia, consequences of prematurity and low birth weight (LBW), and related maternal factors. Together, these account for 89% of all newborn deaths. To carry out this project, Save the Children is partnering at the national level with the MOH, which leads the Road Map process. Other key Road Map partners include the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Fund for Population Activities (UNFPA), the USAID Mission, the Christian Health Association of Malawi (CHAM), and the White Ribbon Alliance for Safe Motherhood-Malawi (WRASM-Mw). These organizations, along with other committed donors and stakeholders, are combining material and technical resources and expertise toward Road Map implementation. Save the Children's primary role is to serve as reference, catalyst, and technical resource for newborn health in Malawi.

The NBHP incorporates community-based elements with activities planned in selected district-level settings to test, refine, expand, scale up, sustain, evaluate, document, and disseminate affordable evidence-based approaches and interventions to promote demand for care, discourage harmful practices, build community capacity, and strengthen referral and community linkages with the formal health system. The community component has co-evolved with Government of Malawi's (GOM) growing commitment to newborn health and community approaches; and with MOH policies, plans, and priorities. The community component includes evidence-generating elements (i.e., research, evaluation, operations research) being carried out with matching funds (Gates/SNL2). The first of these is the Mai Mwana project, a randomized controlled trial being conducted in Mchinji District by the Institute for Child Health in London, and recently funded for

completion. The Save the Children Country Office plays an oversight role in monitoring and liaising with this important study to extract and disseminate lessons learned for application to MOH district-level and community initiatives. The second Gates-funded SNL2 evidence-generating activity will be operations research related to the MOH community-based newborn care package to be piloted in three districts (Thyolo, Dowa, and Chitipa), then scaled up nationally to 28 districts. Catalytic to implement the pilot have been committed by UNICEF, with scale up to be funded through district budgets from the Sector Wide Approach (SWAp) pool funds. Partner roles have not yet been delineated, but Save the Children will likely take a lead in monitoring and evaluation in one or more of the pilot districts. Also included in the project's community component is sub-grant support for Ekwendeni Mission Hospital, a Christian Health Association of Malawi (CHAM) member facility, to refine, document, and package its innovative agogo (grandparent) approach for community mobilization and behavior change.

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 health services and practices; IR-1: Increased availability of and access to key maternal and newborn care services; IR-2: Improved quality of key maternal and newborn care services; IR-3: Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors; IR-4: Improved policy and enabling social environment for maternal and newborn health.

Location:

Malawi (national level)

Project Partners	Partner Type	Subgrant Amount
Ministry of Health (Reproductive Health Unit)	Collaborating Partner	

General Strategies Planned:

Advocacy on Health Policy

M&E Assessment Strategies:

KPC Survey

Health Facility Assessment

Lot Quality Assurance Sampling

Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

(None Selected)

Groups targeted for Capacity Building:

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

Interventions/Program Components:

Maternal & Newborn Care (100 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Recog. of Danger signs

- Newborn Care

- Post partum Care

Target Beneficiaries:

Infants < 12 months:	593,443
Children 12-23 months:	527,505
Children 0-23 months:	1,120,949
Children 24-59 months:	1,516,578
Children 0-59 Months	2,637,527
Women 15-49 years:	3,165,032
Population of Target Area:	13,187,632

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	148	163	90.0%	15.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	260	300	86.0%	11.0
Percentage of children age 0-23 months whose births were attended by skilled personnel	238	300	79.0%	11.0
Percentage of children age 0-23 months who received a post-natal visit from an appropriate trained health worker within three days after birth	131	300	43.0%	9.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	41	112	36.0%	14.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's Recall)	143	188	76.0%	13.0
Percentage of children age 12-23 months who received a measles vaccination	95	112	84.0%	18.0
Percentage of children age 12-23 months who received DPT 1 vaccination before they reached 12 months	92	112	82.0%	18.0

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 12-23 months who received DPT 3 vaccination before they reached 12 months	83	112	74.0%	17.0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	0	0	0.0%	0.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids	13	110	11.0%	8.0
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	42	81	51.0%	19.0
Percentage of households of children age 0-23 months that treat water effectively	7	33	21.0%	21.0
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period	5	300	1.0%	2.0
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night	184	300	61.0%	10.0
Percentage of children age 0-23 months who are underweight (-SD for the median weight for age, according to WHO/HCHS reference population)	72	262	27.0%	8.0
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	0	0	0.0%	0.0

Comments for Rapid Catch Indicators

The on-line form doesn't seem to have been updated for the Revised Rapid CATCH, e.g., no AMTSL indicators, etc. Also, after each entry, it kept changing to error mode ("Error Executing Database Query"). The KPC Survey was

C. Description of DIP Preparation Process

Lessons learned during start-up and the DIP process

We believe we learned a number of important lessons during the DIP process. We want to share these up-front with reviewers and others thinking about partnering at the national-level:

- ✓ **Our timeline is not necessarily their timeline.**
- ✓ **It's not all about us.**
- ✓ **There are times we need to guide; there are times we need to lead; there are times we need to follow.**
- ✓ **When we work in true partnership, we cannot expect to maintain total control.**
- ✓ **We need to position ourselves to leverage every asset and every opportunity.**
- ✓ **It is critical to keep our eye on the long-term goal and understand the path to get there may have many twists and turns!**
- ✓ **Networking and communication are keys to success.**
- ✓ **We need to work within the system PRO-ACTIVELY.**
- ✓ **Our inputs, whether material or technical, must be strategic.**
- ✓ **We need to have something of value to bring to the table.**

Save the Children's Malawi Newborn Health Program (NBHP) start-up and DIP process have been at times exciting, at times frustrating, and always challenging and rewarding. With SNL2 (our match-funded activity) already in place in Malawi in FY06, we were in a position to carry out a number of pre-award positioning activities that contributed strategically to project start-up. These are detailed in Table 1 below and include: 1) financial contribution (\$75,000) to UNICEF/Malawi to increase sample size and add a mortality module to the Multiple Indicator Cluster Survey (MICS) in order to repeat the NMR measure, and complete cross-tabulations of newborn data; 2) participation in key government working meetings (e.g., community initiatives for districts, new roles for TBAs, the SWAp); 3) participation in working group to integrate the neonate (first two weeks of life) into the national Integrated Management of Childhood Illness (IMCI) program. (These were pre-award investments and not included in the budgeted match).

Malawi's Road Map was officially launched on 30 March 2007, with Save the Children present as a national-level partner. We organized a table display, disseminated communications materials highlighting newborn care issues, and conducted newborn resuscitation demonstrations.

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 requires our working within the system pro-actively, with emphasis on strategic networking and assertive communication. We need to be at the table; and we need to have something of value to bring to the table. That added value is 1) our 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.

Even with a Road Map, we need to understand that the path to our final destination may not always be straight forward or well paved; and that opportunities can and do pop up 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 centrally-funded projects that Save the Children has implemented under the CSHGP is the *shift in locus of control*. When we work in true partnership, we cannot expect to maintain total control.

That being said, we are proud of the project's successful start-up and participatory DIP process. Because this project is *not all about us*, we made a strategic decision to try to meet our own needs by integrating into routine MOH planning activities (e.g., SWAp meeting, MOH/RHU work plan meeting) and by otherwise facilitating opportunities where MOH takes the lead role and we provide material support (e.g., the match-funded community-based newborn care Design Workshop in February). We did not hold our own stakeholders meeting for this project; first, in order to cut down on confusion between our two major funding sources (USAID and Gates); and, second, to avoid calling yet another meeting and taking our partners' valuable time when we are with them so much in other planning meetings. With regard to national task force or technical group, Save the Children is already active on the Maternal and Newborn Sub-Committee of the National Reproductive and Sexual Health Task Force that holds regular meetings; so there was no need to establish a technical working group or advisory body for the project.

During the start-up period, Save the Children collected baseline data, both qualitative and quantitative, to inform program priorities and strategies. All of this data will be shared with partners at the national and district levels.

The Road Map provides a framework and creates a national vision. Save the Children has worked closely with MOH/RHU and other Road Map partners to strengthen relationships and will continue to do so. We have reviewed our goals, objectives/results, and indicators; and have entered into the MOH process of revising targets with RHU and the HIS Unit. Through various stakeholder events and planning meetings, we have strategized with partners on major interventions and have planned and prioritized critical project tasks and activities. This is all part of an on-going process. Role clarification continues as we move forward with memoranda of understanding (MOUs) and sub-grant agreements.

During the first month of the project, we received a visit from USAID (Namita Agravat from CSHGP and USAID Mission representatives) who traveled to Mzimba to visit the Ekwendeni Mission Hospital sub-grant site and observe *agogo* groups in the community. During this visit, we had an opportunity to reiterate and discuss the national scope of the Expanded Impact project, as well as possible emerging opportunities that were re-shaping the project's community component.

The first of our start-up activities – this one related to the Ekwendeni sub-grant in Mzimba District - was a participatory qualitative baseline assessment on the Ekwendeni *agogo* approach, conducted in the field by Judi Aubel (The Grandmother Project). Dr. Aubel brought to bear her wealth of experience working with elder women in community settings on Ekwendeni's

innovative community mobilization and behavior change communication (BCC) approach. Selected highlights assessment results and key recommendations are detailed in the relevant section below. The entire report is found in Annex IV and is now guiding development of the sub-grant agreement with Ekwendeni to refine, expand, document, and package its approach for dissemination to other NGOs, CBOs, and interested districts and communities.

The KPC survey and requirement to collect Rapid CATCH indicators presented a dilemma for us. First, ours is an Expanded Impact project being carried out at the national-level and using national data sources for its M&E plan; and, second, we were in the process of re-aligning and refining our community component in accordance with MOH priorities and plans. In our original application, we proposed to focus more intensively on Mzimba District in the North, in part to achieve synergy with activities in the Ekwendeni catchment area. Several reviewers of the original application questioned the choice of Mzimba District for a range of reasons. Although we did advocate with MOH for the inclusion of Mzimba as a pilot district for the community-based newborn initiative, other districts (Thyolo, Dowa, Chitipa) were ultimately selected. At that point, we determined the most rational course of action was to support the government's decisions and plans for designing and taking to scale a comprehensive community-based newborn care package integrated with ACSD/IMCI.

Because *our timeline is not necessarily their timeline*, at that stage of design, it was inopportune to propose carrying out a baseline KPC survey in one of the three pilot districts. Notwithstanding, it is a requirement of CSHGP to collect Rapid CATCH data. Accordingly, we requested guidance from CSHGP and agreed to conduct the KPC in Mzimba, as discussed during Namita Agravat's CSHGP visit to Malawi in October. The KPC survey was conducted in late January/early February 2007, in cooperation with Millennium Consulting Group. A summary of survey results is found in the relevant section below, along with updated plans for conducting endline measurements. The full report of the KPC survey is found in Annex IV.

Table 1 immediately below details start-up activities and the DIP development process, with dates, numbers of days, partners and NBHP team members involved, methods, and follow-up planned.

DIP review and revision – The DIP review at the Mini-University in Baltimore was attended by Evelyn Zimba, Malawi NBH Program Manager; Fannie Kachale, MOH/RHU Deputy Director; Karen Z. Waltensperger, SC Africa Regional Health Advisor; and La Rue Seims, SNL Senior M&E Advisor. As agreed with CSHGP, DIP revisions were completed by Evelyn Zimba and Jeanne Russell in Lilongwe and Karen Z. Waltensperger in Pretoria, with support and assistance from Sharon Lake-Post in Westport.

Table 1: Project Start-Up Activities

Date(s)# days	Action/Activity	Partners/Stakeholders	Staff	Methods	Follow-up
PRE-AWARD POSITIONING					
March 2006 – 2 wks	NBH Country Visit	MOH, USAID, UNICEF, CHAM	EZ, JR, KZW, JL, JF	Key informant interviews and 1-day stakeholders meeting to review national-level data and prioritize NBH interventions; organized by SC/Mw for MOH with SNL2/Gates funding	
July 2006	MICS	UNICEF, MOH	JL, LS	Contributed financially (\$75,000, SNL2/Gates funds) to UNICEF/Malawi for 2006 MICS to increase sample size, add mortality module, and selected cross-tabulations for neonatal data	Use data for setting NBH program targets with MOH
Aug 2006/ 1 wk	Partnership	MOH, COM, KCN	EZ	Participated in government's 1-week assessment of TBAs new roles	Finalization of report
August 2006	Fundraising (match)	Private donor	SC-HO	Raised \$50,000 from private donor (match) to enhance Ekwendeni's work with <i>agogo</i> approach	Periodic report(s) to private donor
Sept 2006	Exchange visits to Asia for community newborn care package	MOH / RHU UNICEF	EZ, JR, KZW	Collaborated with MOH and UNICEF on South Asia study tours (September/November 2006) for MOH key decision-makers and plans for adapting community home-based newborn care model (SEARCH) for Malawi	Organize and fund (match) MOH Design Workshop
Sept 2006 – Jan 2007/ series of meetings	Community Initiatives Workshop and technical working groups	MOH, UNFPA, COM, KCN CHAM	EZ	Participated in government's 1-week Community Initiatives Workshop and development of district guidelines	Presentation of community guidelines to Safe-Motherhood Technical Working Group
Sept 2007/ 1 wk	SWAp Annual Review	All key stakeholders	EZ	Participated in 1-week SWAp meeting (October 2006)	Milestones for integration of maternal and newborn care package developed

Date(s)# days	Action/ Activity	Partners/ Stakeholders	Staff	Methods	Follow-up
Sept – Nov 2006	IMCI Technical Working Group meetings	MOH, WHO, UNICEF	EZ	Participated in integration of newborn 0-14 days into IMCI and development of IMNCI guidelines	Plans for launch of policy and protocols
POST-AWARD DIP ACTIVITIES					
Oct 2006/ 3 days	Visit to Ekwendeni Mission Hospital	CHAM, CSHGP	EZ, KZW, NA	Formal contact and exploratory visit with sub-grantee partner Ekwendeni; observation of <i>agogo</i> activities in 2 villages	Plan <i>agogo</i> approach baseline qualitative assessment
Oct 2006/ 1 wk	Regional advocacy workshop	WRASM, MOH, USAID, UNFPA	EZ	Participated in White Ribbon Alliance 1-week regional advocacy workshop on Maternal and Newborn Health in Malawi and presented technical update for NBH	
Oct 2006/ 1 wk	Technical assistance for planning operational research	MOH, SNL2, UNICEF	KZW, JR, EZ, DK, MOH, UNICEF /ESARO	Participation in 1-week SNL2 Africa Region Research Workshop in Addis Ababa accompanied by Diana Khonje from MOH/RHU	Plan for MOH community NBC design workshop
Nov 2006/ 2 days	Technical workshop for death audits and social-verbal autopsy	MOH, KCN, WHO, CHAM	EZ	Participated in government's 2-day workshop on development of verbal autopsy guidelines for maternal and newborn mortality	Field test tools in local language
Nov 2006	Courtesy visit for project start-up	MOH	EZ, JR	Formal meeting with new MOH Principal Secretary	
Nov 2006/ 1 wk	Review of Mai Mwana project	ICH (Mai Mwana), MOH/RHU, SC/Mw, SNL2 (DC)	KZW, LS, SW, EZ, MOH/RHU	Conducted review, with SNL2 team, of ICH/Mai Mwana research project in Mchinji District, with attention to dissemination of lessons learned and potential for scale-up	Participate in Mai Mwana monthly meetings for project updates and monitoring
Nov 2006	ACSD/IMCI Approach launch	All line Ministries and key stakeholders	JR, EZ	Participated in national launch of ACSD/IMCI Approach Policy	Collaboration with MOH & UNICEF on operationalization

Date(s)# days	Action/ Activity	Partners/ Stakeholders	Staff	Methods	Follow-up
Nov 2006	Field visits	MOH, WCF	JR, EZ, SW, KZW	Field visits to WCF, Mai Mwana, and QEH KMC Unit	
Nov 2007	Publicity for advocacy	Visit of German journalist	EZ, JR	Field visits to Bwaila Hospital and Ekwendeni Hospital KMC Units	
Dec 2007	Recruitment and hiring		JR, EZ, HR	Recruitment interviews for NBHP team members	
Dec 2006	Collaboration with USAID Mission	USAID	JR, EZ	Formal meeting with USAID Malawi Mission	To involve USAID during the DIP process
Dec 2006	Partnership visit	MOH	EZ	Formal contacts with Mzimba District Health Management Team	Continue planning discussions
Dec 2006 (3 wks)	Baseline assessment of Ekwendeni <i>agogo</i> approach	CHAM	EZ, JA	Qualitative inquiry using key informant interviews, focus group discussions, observations, etc., and led by Judi Aubel (The Grandmother Project)	Use lessons learned, conclusions, and recommendations for development of Ekwendeni sub-grant
Jan 2007	KPC survey preparations	MOH CHAM, Mzimba District Assembly	EZ, KZW	Meeting with Mzimba DHO and staff and Ekwendeni PHC team in Mzimba	Take forward plans for KPC survey
Feb 2007	KPC survey in Mzimba District	MOH, CHAM, Millennium Consulting Group	EZ, KZW, JR, WT	KPC Survey in Mzimba District	Rapid CATCH and other data to be reported in DIP
Feb 2007	Preparations for Road Map launch	MOH, Road Map partners	EZ	Participated in Road Map start-up meetings (official launch planned for March 30, 2007)	Launch planned for March 30
Feb 2007/ 1 wk	Global SNL Program Meeting	SNL2 (DC), UNICEF	EZ, JR, KZW	Participation in SNL2 (match) Program Managers meeting in Pretoria, RSA; technical updates, working groups; advocacy training	Planning for operations research

Date(s)# days	Action/Activity	Partners/Stakeholders	Staff	Methods	Follow-up
Feb 2007/ 2 days	Global SC Malaria Strategy Meeting		EZ, JR, KZW	Participation in SC Malaria Strategy Meeting (match funded) in Pretoria, RSA; technical updates and strategic planning	
Feb 2007/ 2 days	MOH Design Workshop for community-based newborn care pilot in 3 districts	All key stakeholders in maternal and newborn care	PM, JR, EZ, JL, ST, SW	2-day MOH stakeholder Design Workshop for community-based newborn care; organized and funded (match) by SC/Mw and led by MOH	Formation ad hoc task force to put together package and start implementation of 3 pilot districts
Feb 2007/ 3 days	PNMCH mission meetings on maternal and newborn care	MOH, WHO, UNFPA, UNICEF,	PM, EZ, JR, JL, SW, RL, MK	Participation in PNMCH joint mission from WHO/UNFPA	Follow-up WHO/UNFPA visit planned
Feb 2007	Quality Improvemnt. Workshop	MOH, HF, COM	EZ, RL	Participated in Health Foundation Quality Improvement workshop	
March 2007/1 wk	RHU FY08 Work Plan Meeting	MOH, UNICEF, JHPIEGO, UNFPA, HF	EZ	Participated in development of FY08 annual work plan for RHU	Work plan needs to be operationalized
March 2007	Meeting about RM newborn indicators	MOH	GC, LS	Meeting with the MOH Director of HIS	SC/Mw to participate in national meeting and provide TA
March 2007	“Caps for the Capital”	US Ambassador, MOH, WHO, USAID, CHAM, Mai Mwana, Ekwendeni	PM, JR, KZW, LS, EZ, RL, MK	Donation of 75,000 baby caps to MOH - a symbolic event (PVO funds)	Distribution of caps to MOH and CHAM facilities for KMC units and maternities
4-30 March	DIP writing	NBHP team	KZW, EZ, LS, JR, ES, CW, GC,	DIP Writing	To be defended at Mini-University, June 2007

Date(s)# days	Action/ Activity	Partners/ Stakeholders	Staff	Methods	Follow-up
			RL, MK, SLP		
30 March 2006	Road Map Official Launch	MOH, WHO, UNICEF, USAID, CHAM, UNFPA, others	NBHP team	SC/Mw organized display table for newborn health, distributed BCC materials, conducted resuscitation demonstrations	Participate in all relevant RM activities

CHAM=Christian Health Association of Malawi, COM=College of Medicine, DC=District of Columbia, DHO=District Health Officer, DK=Diana Khonje (RHU), ESARO=East and Southern Africa Regional Office (UNICEF); EZ=Evelyn Zimba, GC=George Chiundu, HF=Health Foundation, HO=Home Office (HQ), HR=Human Resources, ICH=Institute for Child Health, JF=Jennifer Froistad, JL=Joy Lawn, JR=Jeanne Russell, KCN=Kamuza College of Nursing, KZW=Karen Z. Waltensperger, LS=La Rue Seims, MK=Maggie Kambalale, NA=Namita Agravat, QEH KMC=Queen Elizabeth Hospital KMC Unit, MOH=Ministry of Health, PHC=Primary Health Care, PNMCH-Partnership for Maternal, Newborn & Child Health, PM=Paul Mecartney, SC=Save the Children, SLP=Sharon Lake-Post, RHU=Reproductive Health Unit, RL=Reuben Ligowe, RM=Road Map, ST=Shyam Thapa, SW=Steve Wall, WCF=Women and Children First, WT=Worku Tesfera

D. Revisions (from the original application)

This DIP, for an Expanded Impact project at the national level, is in line with what was proposed in the original application. There are no substantive changes in goals and objectives, interventions, or number of beneficiaries. Both budget and work plan have been updated to respond to new opportunities and alignment of community elements with MOH policies, plans, and priorities. Refinements in the project's community component are described in the section above and elaborated in the DIP document.

Budget Amendment - Save the Children is submitting an amended budget to reflect changes in the work plan, including international and regional travel plans, and adjustment of the Ekwendeni sub-grant.

E. Detailed Implementation Plan

1. Program Site Information

a. Map

Please see Annex III for a national map of Malawi.

b. Beneficiary calculations

This Expanded Impact project at the national-level addresses newborns nationally. As the newborn and its mother are seen as a dyad, the project's beneficiaries are newborns and pregnant women. For a healthy newborn, care must begin in pregnancy and continue through delivery and the post-natal period. Secondary beneficiaries are the total population of women of child bearing age, 15-49. They will benefit as the quality of maternal care improves and newborns survive.

The total population of Malawi, 13,187,632, includes 3,165,032 women of child bearing age, 456,460 pregnant women, and 44,274 newborns 0-28 days at the beginning of the project. These

figures, which are projections to 2007 based upon actual counts in the 1998 census, are summarized below:

Table 2: Beneficiary Population

Beneficiary Population Groups	NBHP National Count
<i>Total Population</i>	<i>13,187,632</i>
Women 15-49	3,165,032
Pregnant Women	456,460
Newborns	44,274

Annex XIII specifies how pregnant women and newborns were calculated. In addition, in the annex, beneficiary groups are disaggregated as required and broken down for selected districts in which community-based activities are carried out. At baseline, a total of 101,482 pregnant women and 7,815 newborns 0-28 days old, resided in Chitipa, Thyolo, Dowa, Mchinji, and Mzimba Districts. Mzimba District is further broken down into areas within the Ekwendeni catchment area and the remainder of the district. As all pregnant women and newborns are targeted in this project, the number of beneficiaries does not vary by intervention. It should be noted that there are approximately 500,000 neonates (0-28 days) born in Malawi every year.

Agreed upon beneficiary count - As agreed in the DIP review held in Baltimore in June 2007, the beneficiary count for this project is ~500,000 (pregnant women and neonates). These neonates and their mothers will be reached with:

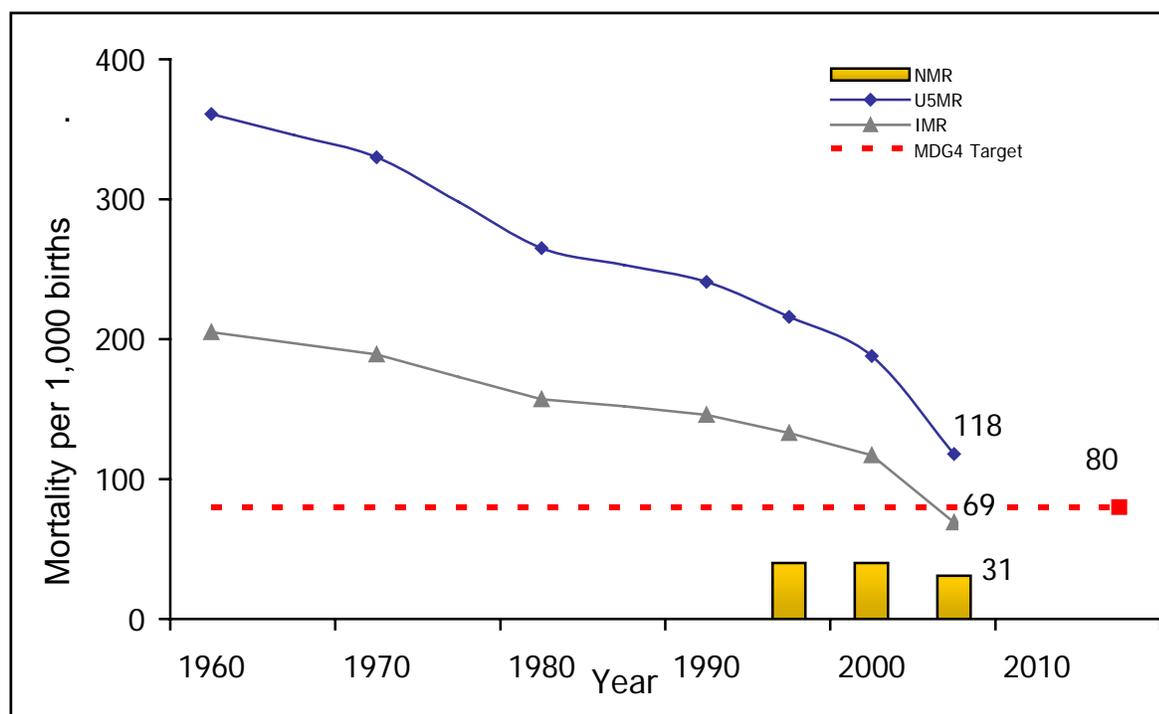
- increased availability of and access to key maternal and newborn care services (increased numbers of HSAs; increased capacity of HSAs and health workers; increased number of facilities better supplied; service delivery better coordinated along continuum of care; stronger and more effective linkages 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).

c. *Health status of mothers and newborns in Malawi*

Encouraging news for Malawi

As our DIP was going to press, the MOH invited Save the Children to participate in a series of working group meetings, requested by UNICEF/ESARO, to document Malawi’s success over the past decade in becoming “one of only three countries in sub-Saharan Africa that has demonstrated remarkable reduction of child mortality rate since 1990, such that attaining MDG 4 is very likely¹”. Without question, GOM commitment to reduction of U5M has been a key factor in that success, along with tetanus elimination, and growing attention and action for maternal and neonatal care. Indeed, the publication *Opportunities for Africa’s Newborns*² (OAN) lists Malawi 7th among eleven sub-Saharan countries where newborns have the lowest risk of dying. Despite this remarkable progress, however, coverage for many key neonatal interventions remains low. According to OAN, if 90% coverage of all essential newborn packages could be achieved in Malawi, up to 8,900 lives could be saved annually, and the range of NMR reduction would be 29-59%.

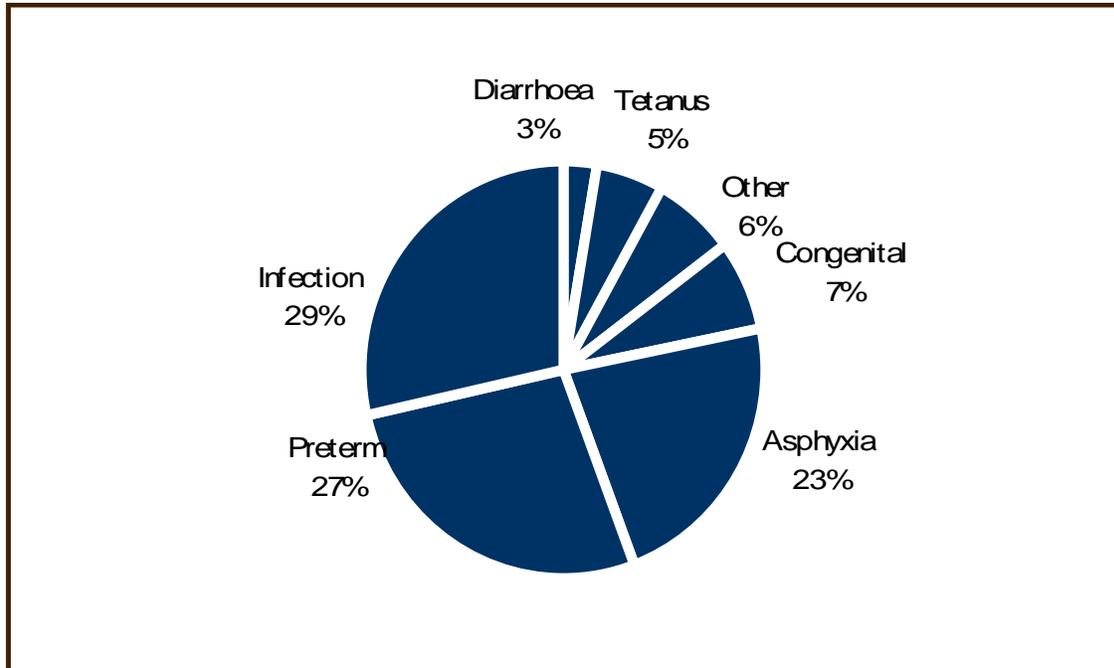
Figure 1. Malawi Rate of Progress to MDG 4 (updated by Kate Kerber from *Opportunities for Africa’s Newborns*)



Globally, three causes - infections, birth asphyxia, and complications of preterm birth and/or LBW - account for 88% of neonatal deaths,³ (89% in Malawi⁴, 94% including tetanus), with deaths in the first week due largely to prematurity and birth asphyxia. Analyses in the 2005 *The Lancet Neonatal Series*⁵, led by Save the Children (SNL) and partners - including WHO, UNICEF, and major academic institutions - concluded that basic, cost-effective interventions currently exist that could prevent up to 72% of neonatal deaths⁶. According to OAN, if 90%

coverage of all essential newborn packages could be achieved in Malawi, up to 8,900 lives could be saved annually, and the range of NMR reduction would be 29-59%.

Figure 2. Malawi Estimated Causes of Neonatal Deaths (updated by Kate Kerber from *Opportunities for Africa's Newborns*)



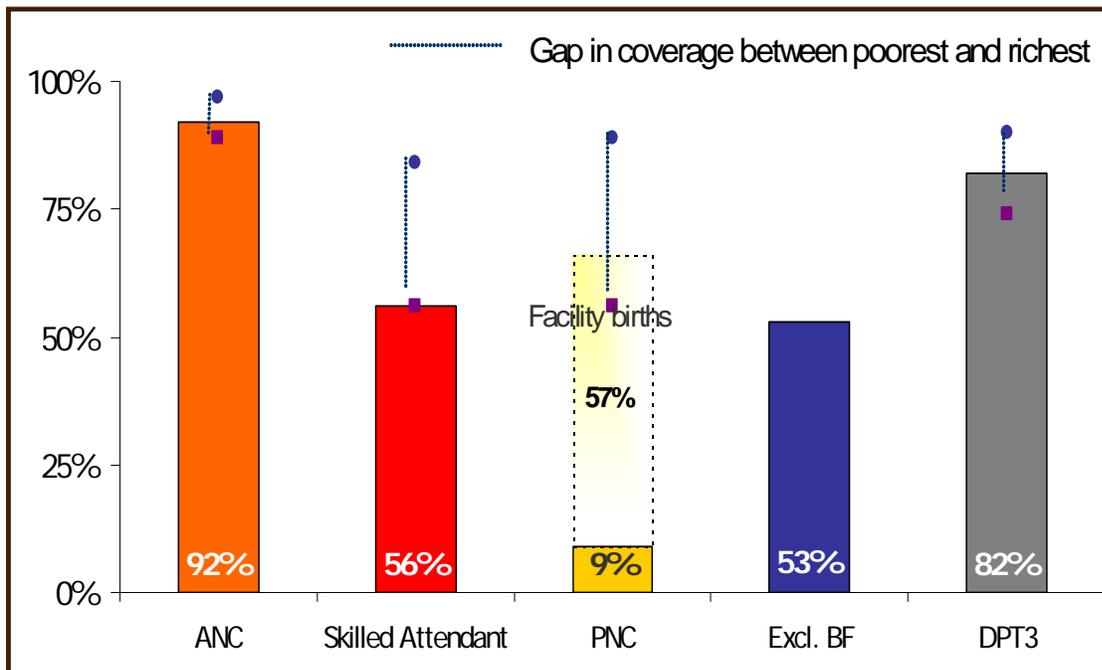
The 2004 DHS reports a maternal mortality ratio of 984/100,000. Adolescent pregnancies account for approximately 25% of all births and 20% of maternal deaths in Malawi. Lifetime risk of maternal death is estimated at 1:7, one of the highest globally, with underlying causes including early childbearing and high fertility rate. The total fertility rate (TFR) in Malawi has declined from 7.6 births per woman twenty years ago to 6.0 as reported in the 2004 DHS. Twenty-eight percent (28%) of currently married women 15-49 are using a modern method of contraception. Overall, nearly half (45%) of women 15-49 years in Malawi are anemic. Ninety-three (93%) of pregnant women in Malawi receive at least some ANC from a health professional. However, far fewer make the four recommended visits or receive all elements of the focused ANC (FANC) package, the high-impact elements of which include intermittent presumptive treatment for malaria, de-worming, iron supplementation, and one-on-one Prevention of Mother-to-Child Transmission (PMTCT) counseling. A majority of mothers (92%, 2004 DHS; 93% 2006 MICS) received at least one prenatal care visit, but only 57% (2004 DHS) completed the recommended four visits. HIS data from MOH shows that those registered for antenatal care completed an average of three visits. Most received at least one dose of TT (84%), but TT2 during the last pregnancy was only 66% (2004 DHS). Only 21% of those delivering outside of a facility report receiving post-partum care (2004 DHS). Looking at the components of antenatal care, as a proxy for quality of services, the large majority of women were given iron (79% 2004 DHS; 80% 2006 MICS) and anti-malarial drugs (81% DHS).

In rural areas, where 80% of Malawians live, nearly three-quarters of births take place at home or in the community without skilled attendance. Country-wide, 57% (2004 DHS) of all births

take place in health facilities, a statistic that has remained constant for the past decade. Because of severe staff shortages, even those deliveries that take place in health facilities are not necessarily attended by a skilled attendant.

The ENC package for health workers is not widely-applied, nor has the ENC module yet been incorporated into the standard Safe Motherhood training package being used to train providers at the facility-level. In many facilities, it is common practice to bathe newborns immediately, increasing risk of hypothermia. Despite the Baby Friendly Hospital Initiative (currently covering only seven facilities), infants are not always put immediately to the mother's breast. During the critical first week of life, few mothers and neonates are examined for danger signs; and most new mothers are not supplemented with vitamin A during the post-partum period to replenish depleted stores or enrich breast milk. The 2004 DHS results show that only 75% of infants less than two months are exclusively breastfed, and pre-lacteal feeds are common. Complementary feeding is commonly introduced at an early age. Among children under two months, 11% are given water, and 8% have received complementary foods. Forty-two percent (42%) of Malawian household have at least one mosquito net; but 80% of women 15-49 and more than 70% of children under five are not protected from mosquitoes, as reported in the 2004 DHS.

Figure 3. Malawi Coverage along Continuum of Care and Equity (updated by Kate Kerber from *Opportunities for Africa's Newborns*)



HIV/AIDS and malnutrition: HIV/AIDS and related diseases are now the leading cause of adult mortality in Malawi. Approximately 16% of all adults are HIV-positive, and more than a third of all Malawian children under 15 have lost at least one parent to the disease⁷. The total estimated number of people living with HIV/AIDS in Malawi exceeds 800,000⁸. The HIV/AIDS

prevalence rate is highest in the Southern and Central Regions of Malawi, where food insecurity and vulnerability are also most intense. Chronic malnutrition rates in Malawi are amongst the highest in the world. The 2004 DHS estimate of stunting in children under five is 48%, and nearly half of those children (22%) are severely stunted. Five percent of children are wasted, and 22% are underweight. This is virtually the same as reported in the 1992 and 2000 DHS, indicating no improvement in child nutritional status over the past decade.

d. *Other factors that influence health*

Demographic, socio-economic, and cultural characteristics: Malawi is a landlocked country of Southern Africa, located at the southern end of the Rift Valley; bordered by Tanzania, Zambia, and Mozambique. Malawi's total surface area is 118,484 square kilometers (kms), of which approximately 80% is land. Lake Malawi, about 475 kms long and running down Malawi's eastern boundary with Mozambique, accounts for most of the remainder. Malawi's estimated population of over 13 million people and overall population density of 89 persons per square km (231 per square mile) make it one of the most densely populated countries of Africa. Females comprise 51% of the total population, of whom 42% are of reproductive age (15-49 years). Eighty-five percent (85%) of the population lives in rural areas, with the urban population having grown significantly over the past decade.

The country is divided into three administrative regions (Southern, Central, and Northern). Malawi's main commercial center is the industrial city of Blantyre in the South; the seat of government is the city of Lilongwe in the Central Region; and the city of Mzuzu serves as the administrative and commercial headquarters of the North. The Southern Region is the largest in terms of size and population. Malawi has a total of 28 districts, 13 of which are in the Southern Region, nine in the Central Region, and six in the Northern Region. Each District comprises several Traditional Authorities (TAs) that are in turn composed of villages, the smallest administrative unit in Malawi. Officially recognized traditional leaders include Group Village Headmen and Village Headmen, mostly but not exclusively male. Malawi's nine main ethnic groups are Chewa, Nyanja, Lomwe, Yao, Tumbuka, Sena, Tonga, Ngoni, and Ngonde (Nkonde). Chichewa is the national language; and English the official language of Malawi. Tumbuka serves as language of common communication in the North; Yao is widely-spoken on the shore of Lake Malawi; and Lomwe and Sena are common in parts of the South. Approximately two-thirds of the population identify themselves as Christians (belonging to the Catholic Church and various Protestant denominations); one-fifth of the population is Muslim. Other Malawians practice animism and other traditional beliefs.

In July 2007, Malawi will commemorate 43 years of independence and just over 13 years of multi-party democracy. Despite this long period of self-rule, the country continues to perform poorly in many of its critical sectors. Malawi is among the world's poorest countries, ranked 166/177 on the 2006 Human Development Index⁹. Malawi is primarily agricultural, with 54% of its workforce engaged in farming, animal husbandry, fishing, and forestry. Principal crops are maize, sugarcane, fruits, vegetables, and peanuts. Major exports include tobacco, tea, sugar, and peanuts. The Malawian economy depends on substantial inflows of economic assistance from the International Monetary Fund (IMF), World Bank, and other multi-lateral organizations and bi-lateral donor nations. Sixty-five percent (65%) of the population is characterized as living below the poverty line on less than USD \$1 per day and unable to meet daily consumption needs; and

more than half of the population is food-insecure. The country's current food-security crisis results from several recent years of poor weather (droughts and floods), poor government policy, reliance on ineffective agricultural practices, and dependence on maize. This is all exacerbated by the impact of HIV/AIDS which is progressively eroding the lives and livelihoods of all Malawians, but especially rural dwellers.

Social structure, cultural practices, key household and care-seeking behaviors¹⁰: Kinship, marriage, descent, and inheritance patterns are underlying building blocks of social structure, with implications for familial reciprocities, power relationships, gender dynamics, and intra-familial decision-making. While a large part of Southern Malawi retains its matrilineal roots, and Northern Malawi is typically patrilineal, tremendous variation is found within districts and traditional authorities. As in much of sub-Saharan Africa, traditional Malawian social structure is in a state of transition, with the classic patterns of kinship, marriage, and inheritance blending and changing. Social change is a dynamic response to internal pressures and external influences, including population, migration, organized religion, colonial history, migrant labor, urbanization, the HIV/AIDS pandemic, education, economic development, media communications, and other socio-economic factors.

Whether a household is matrilineal, patrilineal, or transitional, it is 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 mother, particularly with a firstborn child. Senior women also serve as first-line gatekeepers for care-seeking and influence male relatives' decision-making. Even armed with accurate knowledge about best practices, young mothers confront the powerful barrier of social norms. When a senior woman in authority (e.g., mother or mother-in-law) gives child-rearing advice contrary to best practices, the young mother may be powerless to contradict or resist.

Significance of a newborn life: In order to understand familial motivation and decision-making, and to construct and communicate effective messages, it is imperative to understand beliefs and practices related to the significance of newborn life in the cultural context. In the Malawian worldview, whether boy or girl, a child is considered God's gift and family wealth. Notwithstanding, different ethnic groups measure the significance and loss of newborn life differently. In some, an infant only becomes a human being and member of the community upon reaching some biological or social milestone (e.g., naming, loss of umbilical cord, sitting, weaning from mother's breast). A baby that dies before that milestone is reached may not be grieved for or buried in the same way as an older child. In much of Malawi, the infant is counted as a person and member of the community soon after birth and almost always by the time the umbilical cord has dropped off. Of a baby that is stillborn or that dies shortly after birth, one says that "God did not want us to live with that child", "It is "God's will", or "The water spills, but the glass remains", the latter an acknowledgement of maternal capacity to bear other children.

Antenatal practices: In Malawi, it is widely considered bad luck to make birth plans or delivery preparations or to contemplate complications or obstetrical emergencies. In traditional belief, pregnancy is recognized as a time of great danger for mother and baby. Out of fear of malevolence by witchcraft or sorcery, women often do not disclose a pregnancy until it becomes evident. Because of this, ANC is rarely sought in the first trimester and often not until late in the second. In the Southern Region, for first pregnancies, traditional wisdom about pregnancy and

childbirth is passed on through initiation ceremonies. Special initiation advisors, usually elder women in the village, instruct young expectant mothers about matters of hygiene and what to expect and how to behave. As characteristic in initiation, behavioral norms and respect are emphasized, with girls being told to conduct themselves “properly” at health facilities or toward TBAs, to follow instructions, be cooperative, and not aggravate providers by crying or shouting. Danger signs and possible obstetric complications are usually not described out of fear of provoking the same. Consequently, young pregnant women are reluctant to ask questions of health workers and ignorant about what kinds of questions to ask.

Intra-familial decision-making and care-seeking: Intra-familial decision-making processes can be very complex, particularly in matrilineal areas. A mother with an ailing infant, for example, may first go to her own mother (the baby’s grandmother) to ask advice. Thereafter, she (the baby’s mother), or her husband (the baby’s father), might go to the mother’s maternal uncle, who might in turn seek the counsel of the mother’s father (the baby’s maternal grandfather). These maternal relatives would then discuss the matter and make a decision about care seeking. In patrilineal areas, a husband’s sister might “stand in” for an absent husband. In the typical rural Malawian household, it is usually a senior woman (e.g., mother-in-law or maternal grandmother) who manages maternal, newborn, and child health issues. Her counsel is sought for advice and problems, and it is she who acts as gatekeeper, referring the matter to the male head of household (e.g., grandfather, maternal uncle, or grandfather) for final decision.

Childbirth beliefs and practices: Certain cultural beliefs may discourage families from delivering in health facilities. In some districts of Malawi (e.g., along the eastern lakeshore), it is believed possible to determine with certainty the paternity of a child only if a baby is born at home or with a TBA. Throughout Malawi, it is commonly believed that difficult labor can result from infidelity on the part of the wife, or strained relationships between the wife and her husband’s relatives. In a home or TBA-assisted delivery, the difficulty of the labor can be observed and its “meaning” understood. Some families are convinced that facilities - with their modern equipment, instruments, injections, and transfusions – could “cover up the truth”. This same belief held by untrained TBAs might make them reluctant to intervene or refer complicated deliveries out of fear of upsetting family dynamics or interfering with “the will (or punishment) of God”. Delivery and handling of placenta are important considerations for families in choosing home-, TBA-, or facility-delivery.

Immediate newborn care: In traditional practice, newborns are not routinely put immediately to their mother’s breast. A newborn is usually left unattended on the ground, away from its mother and exposed to hypothermia or injury, until the placenta is delivered. Until the placenta is delivered, no one touches the newborn out of fear of contamination. Newborn practices may vary from TBA to TBA, and community to community. In the Southern Region, when the baby is delivered, the cord is cut and tied; the infant washed in water containing traditional herbs, wrapped, then put to its mother’s breast only once she has bathed and put on clean clothes. Traditionally, the cord is tied in two or three places and cut by the grandmother (maternal mother or mother-in-law), or TBA, using a “clean” sugar cane peel or other cutting implement, such as a knife, if available. Preparations of pumpkin flower juice, ash, crushed charcoal, charred maize cob, cow dung, or soil may be applied to staunch the blood and seal the stump.

Breastfeeding beliefs and practices: Traditional beliefs that colostrum is “bad”, “bitter”, “pus-like”, or “toxic” are common and serve to discourage immediate breastfeeding. During the interval between birth and the flow of “real milk” from the mother’s breast, newborns are typically given water, infusions with traditional herbs, raw maize flour and water, cooked watery porridge, or tinned or condensed milk. In some ethnic groups, especially in matrilineal areas, a newborn may be put to the breast of its maternal grandmother “to teach it how to suck”. A majority of mothers sleep with their infants and carry them wherever they go, so feeding on demand and frequent feeding are common practices. Introduction of watery maize porridge, usually with added sugar, begins in some communities at a few weeks or one month. Reasons commonly cited by mothers and grandmothers for early introduction of other foods include “not enough breast milk”, “the baby was crying for food,” “the baby was hungry.”

e. Current status and quality of health system

Formal health system: Nearly all health care services are provided by three main agencies: MOH (60%), CHAM (37%), Ministry of Local Government (1%), and the balance by private-sector institutions, and military and police health facilities. The formal health system has three levels of care: the primary level comprising health centers, health posts, dispensaries, and rural hospitals; the second level made up of district and CHAM hospitals; the tertiary level including central hospitals and one private hospital with specialist services. Malawi’s health system is grossly under-resourced, and facilities often ill-equipped and short-staffed. Wards are over-crowded; newborns sometimes put two to an incubator; only six facilities country-wide currently offer KMC¹¹; maternities lack basic equipment and capacity for newborn resuscitation; and, outside of specialist facilities, health workers are largely untrained in management of the sick newborn.

Per capita expenditure for health is approximately USD \$5^{12, 13}, 9% of Malawi’s annual budget, and inadequate for delivery of basic quality primary health care services. The Road Map notes that the cost of delivering an “Essential Health Package” of evidence-based and cost-effective health services would cost a minimum of USD \$17.53 per capita per year, not feasible under current conditions. Perhaps most critical: Malawi’s well-trained health care professionals (e.g., medical doctors, registered nurses) are highly sought after and recruited by countries in the UK, North America, and elsewhere in the English-speaking world; and, tragically, many health workers are succumbing to HIV/AIDS. The human resource crisis is further weakening a struggling health care delivery system. Malawi has made an attempt to fill the health worker gap with trained community-based Health Surveillance Assistants (HSAs) who receive six weeks training and carry out surveillance, data-collection, data-consolidation, and health education activities in the communities. The current government plan is to double the number of HSAs. Currently, the ratio of HSA to community residents is 1:2000. Increasingly, HSAs are recognized as important community resources and are being recruited and trained for additional duties by the local government, NGOs, and others, e.g., in HIV/AIDS prevention counseling, breastfeeding coaching, PMTCT, community case management of childhood illness. However, expansion of HSA training and duties has not been coordinated or recognized at the central level and presents a concern that these community-based agents are being spread too thin. This is a critical issue to implementing newborn care at the community level, as MOH has made the decision to have its community-based newborn care package, to be piloted in three districts, delivered by specially-trained female HSAs.

On the positive side, in 2006, Malawi's national IMCI program incorporated the neonate 0-14 days old, a technical process in which Save the Children participated. The Road Map was officially launched on 30 March 2007; and the MOH/RHU FY08 work plan is rich in newborn health interventions, many of which are attracting donor support. Of particular note are plans to begin training a cadre of community midwives and attention to new roles for traditional birth attendants (TBAs) that include improved referral and possibly newborn care. The USAID global ACCESS project will be starting up activities at the end of this fiscal year; and PMNCH will be assisting in improving maternal, newborn, and under-five health through funding to WHO/UNFPA. In addition, EU/WHO funding is coming into the country with resources to support maternal and newborn care, especially basic emergency obstetric care (BEmOC); and Africa Development Bank funding is going into the SWAp earmarked for a range of maternal and neonatal care activities.

Informal health sector: As in most sub-Saharan African countries, Malawi has a flourishing informal health sector that includes TBAs, herbalists, traditional practitioners, itinerant injectionists, spiritual healers, and commercial drug vendors. In both rural and urban settings, health care is typically sought from the informal sector, before, during, and after seeking care from hospital or health center. Families frequently chose to use traditional practitioners over the formal health care system because of proximity and perceived quality of care issues. Herbalists and healers may be considered more affordable, accessible, welcoming, attentive, and culturally sensitive than trained health workers. Health facilities may be regarded as distant, dirty, and demeaning. Many TBAs operate out of community-built birthing huts where the atmosphere may appear cleaner, quieter, and more caring and supportive than in the maternity. Although active in most communities, TBAs are not currently incorporated into the formal health care system, and most are untrained and unequipped; although some receive support through District Health Management Teams (DHMT) and/or local or international non-governmental organizations (NGOs). It is, therefore, not unusual to find TBAs and health center staff having positive reciprocal relationships where TBAs provide ANC, counseling, and referral; assist deliveries (sometimes in the maternity); perform post-partum visits; and are in turn supervised by trained health workers. As mentioned above, in 2006, the MOH/RHU began exploring new roles for TBAs through a series of working groups and community visits in which Save the Children participated. The partners will be working on drawing up guidance and developing training materials in FY08; and a funding commitment from WHO/EU will enable UNFPA to work in three districts to train TBAs in case finding and incentivized referral. In addition to TBAs, other traditional practitioners specialize in problems of pregnant women, newborns, and post-partum mothers. These providers have yet to be enumerated, studied, and engaged into formal relationships with the health system.

f. Disadvantaged, high risk, under-served groups and those living in extreme poverty

In Malawi, the excess NMR for the poorest vs. the least poor has been calculated at 24%¹⁴. There are pockets of Malawians living in extreme poverty to be found country-wide, and particularly in the central and southern regions. The Save the Children/Malawi Country Office is working in a number of these areas with targeted interventions in food security, community therapeutic care for malnourished children, HIV/AIDS home-based care, and support for orphans and vulnerable children. Equity is a key concern of Save the Children and will be taken into account in all planning and operationalization.

g. Opportunities, linkages, and complementary activities

Partnership for Maternal, Newborn, and Child Health (PNMCH): Malawi was designated a **priority country** by the Global Partnership for Maternal, Newborn and Child Health (PMNCH), following its New York launch on 12 September 2005. PMNCH, of which SC is a founding member, was formed to accelerate progress in achieving MDGs 4 and 5, which call for major reductions in maternal and child mortality by 2015. Malawi's priority designation has already led to new opportunities. Through a recent grant to WHO/UNFPA, PMNCH is making available funds in the amount of \$7 million over three years available for each of three sub-Saharan African countries (Malawi, Mozambique, Burkina Faso) for national- and district-level activities to reduce maternal and U5 mortality. It is anticipated that \$2.3 million per year will go into Malawi. A joint WHO/UNFPA planning mission visited Malawi the week of 14 February 2007 and met with all stakeholders, including Save the Children. In addition, members of that same WHO/UNFPA mission participated for a half day in the MOH Design Workshop for a community-based newborn care package that Save the Children organized and match-funded. The PMNCH effort is in its initial stages, and several ideas are on the table. Save the Children will participate in program planning and advocate to ensure the newborn is not forgotten. The NBHP team will provide an update at the DIP review at the Mini-University in June.

EU/WHO/GOM Partnership on Making Pregnancy Safer: On 14 February 2007, this European Union/WHO/GOM partnership was launched and presided over by the Hon. Majorie Ngaunje (MP), Minister of Health. The intent of the partnership is to prioritize reproductive health within the MOH's current initiatives through "six signal functions that need to be in place to save women's lives". The partnership will work to 1) ensure adequate resources are available with the MOH budget to support implementation of the Road Map; 2) Prioritize in-service training on basic EmOC for all enrolled nurses, registered nurses, and medical assistants, with priority given to all health center based staff; 3) make the "six signal functions" compulsory for pre-service training; 4) Prioritize the deployment of staff with basic EmOC skills to rural health facilities and target those with these skills to receive the rural incentive scheme within the MOH Emergency Human Resources Program; insist that a budget line be put into place at the district level for safe motherhood. Expected results of the EU/WHO/GOM partnership are: 1) enough staff with the midwifery skills, in the right place, in the right numbers, who are motivated to stay; 2) communications and transport to facilitate emergency referrals; 3) responsive BEmOC service; 4) communities that take responsibility for each mother's and child's health and well being. This partnership will focus on three district settings (Ntcheu, Nkhota Bay, Zomba). Save the Children will liaise with the partnership and MOH/RHU to ensure that adequate attention is paid to the newborn.

USAID/ACCESS: ACCESS core funds have been accessed to build district level capacity through training 540 health care providers in Basic Emergency Obstetrical Care (BEmOC) under the FY08 MOH/RHU work plan. A stakeholders meeting is being organized, and Save the Children will participate. Moreover, the USAID Mission is buying into the global ACCESS project through field support. As this DIP was going to press, representatives from ACCESS had arrived in-country and were engaged in a series of exploratory meetings, including with Save the Children (an ACCESS partner). Among ideas under discussion are additional support for KMC

and community skin-to-skin. ACCESS and Save the Children will collaborate closely and intend to forge strong linkages between programs. Save the Children has advocated for support of KMC and other newborn care activities in Mzimba District where we have baseline data from our KPC survey, and where there are five hospitals (1 central, 1 district, 3 CHAM), only one (Ekwendeni) having a KMC unit. The NBHP team will report on decisions taken, plans in progress, and Save the Children's role, if any, at the time of the DIP review in June.

ACSD/IMCI: In late 2006, the GOM launched *the Integrated Management of Childhood Illness for Accelerated Child Survival and Development (ACSD) in Malawi*¹⁵. Endorsed by all line Ministries, the policy was formulated in the context of major reforms such as decentralization of operational decisions to local assembly and community levels, the SWAp to Health (and Essential Health Package [EHP] therein), and recognition of the variety of partners and sectoral approaches essential for child survival, growth, and development. The IMCI Approach Strategy for ACSD in Malawi provides guidance and standardization to the implementation of IMCI, including c-IMCI. It includes three primary components: Component 1: Improvement in case management skills of health workers; Component 2: Improvement in the health system to deliver essential drugs and supplies; and Component 3: Improvement in family and community practices for child survival, growth and development. In Malawi, neonatal care, pediatric HIV/AIDS care, and Prevention of Mother-to-Child Transmission (PMTCT) have been incorporated into IMCI modules. Component 3 of IMCI, often called Community- or c-IMCI, includes multi-sectoral dimensions addressing child protection, livelihoods, early childhood development, education, and social welfare.

More than 10 districts (including Thyolo, Dowa, Chitipa, and Mchinji) have been selected in partnership with UNICEF for accelerated roll-out and scale up of ACSD/IMCI. The national ACSD/IMCI program is supported by the SWAp and thus larger policy and funding frameworks that include the UK Department for International Development (DfID), the World Bank, WHO, UNICEF, and others. UNICEF is providing districts with funding and technical support for the development of implementation plans, costing, and start-up activities. Other donors, as well as international and local NGOs, are encouraged at all levels to embrace and support the implementation and scale-up of the ACSD/IMCI interventions. Design of the MOH community-based newborn care package to be piloted in Thyolo, Dowa, and Chitipa is within the ACSD/IMCI framework and consistent with the EHP.

The Health Foundation: The Health Foundation (a UK consortium that includes the Institute for Child Health, Institute for Health Care Improvement, and Women and Children First) is carrying out a 3-year program (with possibility of 2-year extension) in three districts (Kasungu, Lilongwe, and Salima) with the aim of improving the quality of maternal and neonatal health services at the facility level. Local representatives of the Health Foundation participated in the MOH Design Workshop for the community-based newborn care package held in February. Save the Children will remain in regular contact with the Health Foundation to explore ways that we can link and partner to achieve impact at scale.

Women and Children First (WCF): WCF is a British NGO (and a partner in The Health Foundation project described above). It began operations in Malawi in 2006 and is currently active in Ntcheu and Salima Districts, with funding from a foundation supported by the UK Lotteries. Working in collaboration with the DHMTs, WCF is implementing a "lite" version of

Mai Mwana, focusing on women's groups, in a low resource setting closely linked with district health services. WCF participated in the MOH Design Workshop for community-based newborn care in February. Save the Children maintains regular communications with WCF and will assist in identifying opportunities to share its documentation, lessons learned, and results in the Road Map context.

White Ribbon Alliance for Safe Motherhood in Malawi (WRASM-Mw): WRASM-Mw, a Road Map partner, is a local, voluntary, civil society coalition of organizations and individuals combining forces with the following goal: *to raise awareness among policy leaders, donors, and the community through advocacy and social mobilization on the need to make maternal and neonatal health a priority agenda for all Malawian women through: 1) advocacy; 2) forming alliances; 3) broadening the coalition; 4) acting as a catalyst for action.* Since its inception in Malawi, Save the Children has supported WRASM-Mw and currently contributes office space, utilities, and transport to the small but growing membership organization. Under this project, Save the Children will work with WRASM-Mw to renew and expand the newborn health advocacy role it played under SNL1. The relationship will be formalized in an MOU and vendor agreement to collaborate on selected activities, especially the Road Map advocacy plan. Token funding has been set aside in the project budget for additional support to WRASM-Mw to access telephone service for communications and enable it to collaborate on advocacy activities to be detailed in the MOU. A copy of the completed MOU will be provided by the NBHP team at the DIP review in June.

2. Summary of Baseline and Other Assessments

Save the Children's Expanded Impact NBHP is national in scope, with a community component comprised of selected activities (including operations research) carried out in five district settings in all three administrative regions of the country. As previously stated, at the national level, the major beneficiary groups, at the beginning of the project, include 456,460 pregnant women and 44,274 newborns 0-28 days old. These figures are projections to 2007 based upon actual counts in the 1998 census. This population is the same as that originally proposed.

Baseline assessments for this project include:

- Review and extraction of data from national population-based surveys and MOH/HIS service statistics;
- health facility assessments (HFAs);
- a 30-cluster knowledge, practice and coverage (KPC) survey;
- district-level training assessments;
- qualitative assessment of the Ekwendeni *agogo* approach for evaluation and planning purposes.

We also have available the following baseline documents developed under SNL1. These include:

- Formative research study conducted in four districts by Save the Children's SNL1 program in August-November 2002 to inform prior newborn programming;
- State of the World's Newborns: Malawi¹⁶, a national newborn health situational analysis also developed under SNL1.

a. Baselines and other assessments

National population-based data and service statistics were extracted from key sources, primarily the Multiple Indicator Cluster Survey (MICS 2006), Demographic and Health Survey (DHS 2004), and the MOH Health Management Information Bulletin (HMIB). As the NBHP is Expanded Impact and national in scale, the project seeks to impact upon practices, use of services, and survival of newborns that can be measured at the national level.

During FY06, Save the Children (SNL2) contributed financially to the Malawi MICS in order to (1) add a module to take a repeat measure the Neonatal Mortality Rate (NMR), (2) increase the sample size to improve the accuracy of data collected at the district level, (3) add questions on postnatal care, and (4) cross-tabulate data relevant to newborns. Previously, under SNL1, Save the Children also successfully advocated for an indicator of postnatal care within 3 days to be added to the 2004 DHS. In late April 2007, NBHP's M&E Officer will represent Save the Children at an important national meeting being held to harmonize HIS indicators, especially with the national Road Map, and to revise indicator targets. All these efforts will improve the quality of data available to monitor improvement through the HIS on an annual basis and evaluate results (outcomes and impact of interventions) at the end of the project. Annual changes, however, may reflect improvements in the HIS as a result of refinement of the system, and improved HIS capacity, as much as real changes in the indicators.

Indicators being tracked at the national level are organized according to the project's results framework's intermediate results. Unlike district-level programs, the national newborn program can track data being collected at the impact or goal level. The neonatal mortality rate has been measured at 27/1,000 in the 2004 DHS (for the five year period 1999-2004) and 31/1,000 in the 2006 MICS survey (for the preceding two-year period). One reason Save the Children contributed financially to the MICS survey was to provide a second estimate of the neonatal mortality rate as the 2004 DHS figures appeared to be unreasonably low and to show an atypical pattern compared to other sub-Saharan African (SSA) countries. Using DHS data, the NMR as a proportion of the U5MR (133) is only 21%; while the SSA average for sub-Saharan Africa is 25%. We believe that 31/1,000 is the more reasonable baseline. Using the MICS data, the NMR as proportion of the U5MR (118) is 26%, closer to the SSA average. Our goal – consistent with the GOM's - is to reduce the neonatal mortality rate to 25/1,000 at the end of the project, scheduled to be measured in a combined MICS/DHS survey in 2010.

Considering increased availability, access, and use of key services, most (92% DHS; 93% MICS) received at least one prenatal care visit, but only 57% (DHS) completed the recommended four visits. (This is fairly consistent with district-level data collected by the project in the Mzimba KPC survey and discussed below.) The HIS shows that those registered for antenatal care completed an average of three visits. Most received at least one dose of TT (84%), but TT2 during the last pregnancy was only 66% (DHS). The majority delivered in a health facility (57% DHS; 54% MICS). The percentages delivered by skilled attendants was nearly identical; although it is known in Malawi that, due to severe staffing constraints, delivering in a health facility is no guarantee of being delivered by a skilled attendant. Only 21% of those delivering outside of a facility report receiving post partum care (DHS). Looking at the

components of antenatal care, as a proxy for quality of services, the large majority of women were given iron (79% DHS; 80% MICS) and anti-malarial drugs (81% DHS).

Considering household knowledge, attitudes, and practices for key essential newborn care and related maternal care behaviors, most (71% MICS) are exclusively breastfed from 0-3 months. This percentage decreases at 0-5 months (56% MICS) and at 0-5 months (53% DHS). About two-thirds (69% DHS) of newborns were breastfed within one hour of birth. Only a small proportion (15% DHS) of pregnant women slept under an insecticide-treated bednet the night preceding the survey. About half spaced their last pregnancy 36 months or more after the immediately preceding pregnancy.

Health facility assessments (HFAs) are planned for July-August 2007 in public hospitals nationwide. HFAs will be conducted by MOH and funded by the World Bank; and their emphasis will be malaria. MOH, however, wants to include maternal and newborn care in the facility assessments,¹⁷ and Save the Children is working with the RHU to ensure that the newborn is well represented in the HFA. In fact, Save the Children has previous experience in Malawi (i.e., Mangochi District) in conducting HFAs sensitive to maternal and newborn care. The instrument developed and used in Mangochi under SNL1 includes equipment for newborn resuscitation, delivery and cord care, the labor ward and nursery, infection prevention, reagents, and drugs needed by newborns. Recently, SNL2 headquarters staff has been working with ORC/MACRO to add newborn content to the Service Provision Assessment (SPA) instrument, which will also be provided to the Malawi HIS Director when finalized. Other instruments, including that developed by Child Survival Technical Assistance (CSTS) and recommended by CSHGP will be reviewed for sensitivity to newborn needs.

In order to satisfy the CSHGP requirement to collect data for Rapid CATCH indicators, a **population-based 30-cluster KPC survey** of mothers of children 0-23 months was conducted in Mzimba District in February/March 2007. The survey included all questions for Revised Rapid CATCH indicators, as well as key Maternal and Newborn Care questions drawn from the KPC 2000+ and from the Minimum Activities for Mothers and Newborns (MAMAN) questionnaires.

The survey was carried out by the Millennium Consulting Group with participation by staff from Save the Children, Ekwendeni Hospital, and Mzimba District Health Office (DHO).

Authorization to conduct the survey was obtained from the Mzimba District Commissioner and approved by the National Statistics Office in Zomba, as required.

The questionnaire was administered in Tumbuka by interviewers trained for five days. Sampling clusters were selected by cumulating the populations of census enumeration areas and selecting 30 by applying a sampling interval. A village within each of the enumeration areas was then selected that was in the center of the area. Next, households were selected by going to the center of that village, spinning a bottle, counting all houses on an imaginary line from the center of the village to its boundary, and selecting a household at random among those counted. Subsequent households were selected by going to the third nearest household on the right-hand side of the main entrance of the previous household until 10 interviews were conducted in each cluster.

There were no refusals.

As Ekwendeni Hospital, in Mzimba District, will receive a sub-grant and is planning a program of activities to refine, document, and package its *agogo* approach in its catchment area within

Mzimba District, the Newborn Health Program's **endline survey** will use Lot Quality Assurance Sampling (LQAS) methodology to compare five supervision areas: (1) an area where Ekwendeni has been working with *agogos* for some time and where the *agogos* will receive refresher training and supervision under this sub-grant project, (2) an expansion area in Mzimba District where new *agogos* will be trained, and (c) at least three additional areas within Mzimba District where no *agogos* are trained. Coverage measures obtained using the LQAS methodology, as long as there are at least five supervision areas, are comparable to those obtained through 30-cluster methodology. The confidence interval using LQAS is only slightly narrower (about +/- 7 rather than +/- 10 at 50% prevalence). Dr. Joseph Valadez who developed the LQAS method states in his trainings that measures obtained using the two different methods can be compared. The endline KPC will be useful in assessing outcomes in the communities applying the *agogo* approach. Not only will the knowledge, practices, and coverage of mothers of newborns be assessed at the beginning and end of the project, the outcome in areas with and without *agogo* training can be ranked at endline using LQAS.

The findings from the baseline survey are described briefly below, along with a discussion of how the results inform program priorities. The complete KPC survey report is included in Annex IV.

KPC results: As the project promotes the concept that the mother and newborn are a dyad, and that a healthy mother is necessary for a healthy infant, the KPC survey covered the continuum from antenatal care through delivery and postnatal care. The survey found that at least one antenatal care visit was universal in Mzimba District. Nearly all mothers (96%) had had at least one antenatal care visit by a skilled attendant prior to the birth of her youngest child. Only two-thirds (68%), however, had received the government-recommended four visits. A program emphasis will be to increase the proportion of women who complete the recommended four visits for focused antenatal care (FANC).

The quality of the antenatal care visits appears high with the large majority having been appropriately counseled. Most received counseling on delivery preparations (97%), immunization (96%), breast feeding (94%), and child spacing (94%); and the large majority (89%) were counseled on danger signs during pregnancy. Surprisingly, although counseling on danger signs was relatively high, only 36% could recall two or more danger signs during pregnancy. Similarly, only 29% could report at least two neonatal danger signs. The quality of counseling may need to be improved. Most (96%) received or bought iron supplements while pregnant. All had received at least two TT shots at some point in their lives, and 75% had received TT2 or more while pregnant with their youngest child. Most (87%) took anti-malarials during pregnancy (intermittent presumptive treatment).

Access to a health care facility was high, with 86% residing within 5 kilometers or one hour of a facility. The majority (79%) gave birth at a health facility with a skilled attendant, much higher than the Malawi average of 57% (DHS, 2004). Most (93%) had a clean cord cut, not surprising with such a high facility birthrate.

Essential newborn care, to be emphasized in this program, clearly has room for improvement. More than half of the mothers (52%) bathed their baby within 24 hours. Only 57% dried and wrapped their baby immediately after birth. More than half of newborns (60%) were not placed

with their mother immediately after birth. Most importantly, very few mothers delivering at home and their babies received a checkup within 3 days after delivery. Of the 39 mothers who delivered at home, only five (13%) received a checkup within three days; and only three of their newborns received a checkup during the crucial three-day period when most newborn deaths occur. Only half (48%) breastfed their babies within one hour; and only 36% were exclusively breastfeeding in the 24 hours preceding the survey.

While some Rapid CATCH indicators are for older children and do not apply to the newborn, the project will be collecting data in the Rapid CATCH for some indicators that it does not expect to be able to influence directly but which nonetheless have an impact upon neonatal health and survival. These indicators include:

- Birth interval of at least 24 months after the previous child: 91%
- Active management of third stage of labor: 58%
- Vitamin A supplementation: 76%
- Childhood immunizations: 88%-95% (see table below)

Table 3: Baseline Indicators for the Knowledge, Practice and Coverage (KPC, Malawi Newborn Health Program, Mzimba District, February/March 2007

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREQUENCY	PERCENT
B. CHILD SPACING				
Q8	percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	163	148	91%
C. MATERNAL AND NEWBORN CARE				
ANTENATAL CARE				
Q14	percentage of mothers with children age 0-23 months who got antenatal care by a skilled health attendant prior to the birth of her youngest child	300	289	96%
Q15	percentage of mothers with children age 0-23 months who were seen by a skilled health attendant at least 4 or more times during the pregnancy of her youngest child	300	203	68%
ANTENATAL COUNSELING INDICATORS				
Q16	percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on delivery preparations	289	281	97%
Q16	percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on breast feeding	289	272	94%
Q16	percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on child spacing	289	273	94%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
Q16	percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on immunization	289	276	96%
Q16	percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on danger signs during pregnancy	289	258	89%
TETANUS TOXOID INDICATOR				
Q17-20	percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child	300	300	100%
Q18 Is reporting on this really required? (I don't get it)	percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations WHILE pregnant with their youngest child	300	225	75%
Q20 Is reporting on this really required? (I don't get it)	percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations BEFORE the pregnancy of their youngest child	300	260	87%
MATERNAL HEALTH CARD POSSESSION INDICATOR				
Q21	percentage of mothers with children age 0-23 months with a maternal card (interviewer confirmed)	300	190	63%
INDICATOR FOR ACCESSIBILITY TO THE HEALTH FACILITY				
Q22-24	percentage of mothers with children age 0-23 months who reside within 5 kms from a health facility OR are able to get to a health facility within 1 hour	300	257	86%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
INDICATOR FOR KNOWLEDGE OF MATERNAL DANGER SIGNS DURING PREGNANCY				
Q25A	percentage of mothers with children age 0-23 months who know at least two danger signs during pregnancy	300	108	36%
Q25B	percentage of mothers with children age 0-23 months who would first seek care from a health facility when they have danger signs during pregnancy	300	292	97%
IRON SUPPLEMENTATION INDICATOR				
Q26	percentage of mothers with children age 0-23 months who received or bought iron supplements while pregnant with the youngest child	300	287	96%
INDICATOR FOR PLACE OF DELIVERY				
Q27	percentage of mothers with children age 0-23 months who gave birth in a health facility	300	238	79%
	percentage of mothers with children age 0-23 months who gave birth at home	300	39	13%
INDICATOR FOR SKILLED DELIVERY ASSISTANCE				
Q28	percentage of children age 0-23 months whose births were attended by skilled personnel	300	238	79%
INDICATOR FOR CLEAN CODE CARE				
Q29-30	percentage of children age 0-23 months whose delivery involved use of a clean birth kit or whose cord was cut with a new razor blade	300	280	93%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
INDICATOR FOR ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR (AMSTL)				
Q31-33	percentage of children age 0-23 months whose birth involved AMSTL by skilled birth attendant	238	138	58%
DRYING AND WRAPPING INDICATOR				
Q34-35	percentage of newborns who were dried and wrapped with warm cloth or blanket immediately after birth (before placenta was delivered)	300	171	57%
PLACEMENT AT BIRTH INDICATOR				
Q36	percentage of children age 0-23 months who were placed with the mother immediately after birth	300	121	40%
FIRST BATH INDICATOR				
Q37	percentage of children age 0-23 months whose first bath was delayed at least 24 hours after birth	300	145	48%
INDICATOR FOR POST-PARTUM; NATAL VISIT				
Q38-40	percentage of mothers of children age 0-23 months who received a post-partum check up by an appropriate trained health worker within three days after the birth of the youngest child	300	123	41%
Q38-40	percentage of mothers of children age 0-23 months who received a post-partum check up by an appropriate trained health worker within three days after the birth of the youngest child - HOME DELIVERY	39	5	13%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
Q41-43	percentage of children age 0-23 months who received a post-natal check up by an appropriate trained health worker within three days after birth	300	131	44%
Q41-43	percentage of children age 0-23 months who received a post-natal check up by an appropriate trained health worker within three days after birth - HOME DELIVERY	39	3	8%
INDICATOR FOR KNOWLEDGE OF NEONATAL DANGER SIGNS				
Q44	percentage of mothers of children age 0-23 months who are able to report at least two known neonatal danger signs	300	88	29%
D. BREASTFEEDING/INFANT & CHILD FEEDING				
Q45-48	percentage of children age 0-23 months who were put to the breast within one hour of delivery and did not receive prelacteal feeds	300	145	48%
Q49-52	percentage of infants age 0-5 months who were exclusively breast fed in the last 24 hours	112	41	37%
E. VITAMIN A SUPPLEMENTATION				
Q53-54	percentage of children age 6-23 months who received a Vitamin A dose within the last 6 months	188	143	76%
F. CHILD IMMUNIZATIONS				
	percentage of children age 12-23 months who received a measles vaccination	112	95	85%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
Q55-Q57				
Q55-Q56	percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	112	92	82%
Q55-Q56	percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	112	88	79%
G. MALARIA				
Q58-Q59	percentage of mothers of children age 0-23 months who took an effective anti-malarial drug during the pregnancy with the youngest child	300	263	88%
Q60-Q64	percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	300	7	2%
Q65-Q68	percentage of children age 0-23 months who slept under an insecticide treated bed net the previous night (Q68 <=6)	300	184	61%
Q65-Q68 (Malawi protocol calls for treatment of bednet within past 12 months)	percentage of children age 0-23 months who slept under an insecticide treated bed net the previous night (Malawi Protocol – Q68 <=12)	300	191	64%
H. CONTROL OF DIARRHEA				
Q69	percentage of children age 0-23 months with diarrhea in the last two weeks who received an oral rehydration solution and/or recommended home fluids	110	13	12%

QUESTION #	DESCRIPTION OF INDICATOR	TOTAL	FREOUENC Y	PERCENT
Q69-Q72	percentage of children age 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements	110	0	0%
I. ARI/PNEUMONIA				
Q73-Q76	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	81	42	52%
J. WATER AND SANITATION				
Q77-Q78	percentage of households of children age 0-23 months that treat water effectively	33	7	21%
Q79-Q82	percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the last 24 hours	300	5	2%
K. ANTHROPOMETRICS				
Q83	percentage of children age 0-23 months who are under weight (< -2 standard deviations for median weight for age according to WHO/HCHS reference population)	262	72	28%

In August-November 2002, under SNL1, Save the Children completed a major **qualitative study (formative research)** in four districts - Mulanje, Phalombe, Mangochi, and Mzimba - in order to inform behavior change communication (BCC) activities. The overall objective of the research was to identify behaviors and practices that could either adversely affect or improve the care of newborns among households, communities, and service providers. The study included 48 focus group discussions and 35 in-depth interviews conducted over a three-week period with well-trained facilitators and interviewers. The research addressed eight principle elements of essential newborn care, including: 1) antenatal care, 2) actions taken to address antenatal danger signs, 3) birth preparedness, 4) delivery with trained/skilled personnel, 5) early postpartum contact for mother and baby 6) proper cord care, 7) thermal management, and 8) actions taken to address danger signs for newborns. A full report is available.¹⁸ Below is a summary of key findings.

Highlights of the qualitative findings: Most women were aware of the major components of antenatal care. Iron tablets were in short supply at health centers, however, and some women received less than the recommended number of tablets when pregnant. With respect to Intermittent Presumptive Treatment of malaria during pregnancy (IPTp), some women did not take the recommend two doses of Fansidar (Sulfadoxine+Pyrimethamine [SP]) for fear of aborting. Some women also failed to get TT injections because it was painful or because of rumors that the shots could make a woman sterile. Many women found it difficult to have four antenatal care visits, and many sought care only late in the pregnancy. One of the barriers to seeking care early was that pregnant women waited until they were certain of the ‘settling down’ of the pregnancy, which they understood is a period beyond which they were unlikely to miscarry. Women also delayed care because of discourteous treatment by midwives at health care facilities.

Knowledge of danger signs during pregnancy and childbirth was greater than during the post-partum period. Women in the Ekwendeni catchment area in Mzimba were more aware of danger signs than women in other districts studied. Regarding birth preparedness, most respondents recognized the importance of preparing emergency transport plans and putting money aside, but due to poverty, the need for food and farm inputs often surpassed the importance of savings for contingencies. Some families did not prepare because of the uncertain outcome of the pregnancy, especially of the survival of the newborn.

Barriers to facility delivery included long distances to the facility for some women, bad treatment by midwives, and stories about delivering at facilities without trained or skilled attendance. Although many women were aware of proper cord care, few practiced it due to the cultural practice of confining women within a sleeping hut until the cord drops off. Women therefore used substances felt to quicken the cord dropping off. Findings suggested that women would find the use of methylated spirit on the cord acceptable.

Most women did not go for post-natal care until four to six weeks after delivery. (The current government recommendation is at 7 days and 6 weeks; a policy we are working to change.) Few saw the benefit of a post-partum check up for the mother, although more saw the benefit for the newborn. As mentioned, women were less aware of danger signs after the birth than before or during the birth. Delays in seeking care were also due to the perception that conditions improve on their own. With regard to thermal management, it is common practice to bathe the neonate soon after birth, and there is little understanding about the need for delay to prevent

hypothermia. Many said that no health worker had ever explained to them why the first bath should be delayed.

In December 2006, a **participatory qualitative assessment** on the Ekwendeni *agogo* (grandparent) approach was carried out for the project by Judi Aibel (The Grandmother Project). The purpose of this study was to assist the Ekwendeni Primary Health Care (PHC) team to assess the strengths and weaknesses of its *agogos* with a view to inform activities to be carried out sub-grant to define, refine, expand, document, package, and disseminate this innovative approach for community mobilizations and behavior change. The assessment found that grandmothers and grandfathers play complementary but gender-specific roles related to maternal and neonatal health at the household level. Grandmothers (e.g., mothers-in-law in largely patrilineal Mzimba) are the direct advisors of young women and direct care-givers of young children. If problems arise, senior women are the *first-line decision-makers* about what should be done and advise not only younger women but also their husbands and sons. Grandfathers usually play a more distant but supportive role with regard to issues related to pregnancy and newborn care and take on a more active role when extra resources are required. When there are special needs or problems, grandfathers may be called upon to mobilize resources, transport, etc. The assessment concluded that the *agogo* approach has strengthened the knowledge of both grandmothers and grandfathers and, in so doing, has reinforced their complementary support for pregnant women and newborns.

The assessment identified strengths of Ekwendeni's *agogo* approach as:

- Basis of culturally-defined roles and relationships
- Inherent motivation of *agogos* to learn
- Training of *agogos* at Ekwendeni Hospital rather than in village setting
- Community organization and leadership in the Ekwendeni catchment area
- Village Health Committee (VHC) collaboration with and support for *agogos*
- *Agogo* participation in drama performances on newborn and other topics
- Dancing to songs on priority newborn topics
- Use of culturally appropriate posters and brochures

Weaknesses were:

- Very limited monitoring and supervision
- Very limited documentation
- Limited focus on positive cultural roles and practices

The study made detailed recommendations that are guiding development of the Ekwendeni sub-grant agreement. Please see Annex IV for the final report of this qualitative assessment.

As the Ekwendeni sub-grant activity will involve extensive training of *agogos*, a formal **training assessment** of the program will be done. This will be done using the four levels recommended by Kirkpatrick¹⁹:

- Participants reaction to the training, e.g. length, logistics, methods
- Pre-test of *agogo* knowledge just prior to training, post-test of knowledge at the completion of training, and post-test of knowledge after six months for retention
- Use of learnings in the community: supervision visits and interviews about barriers to using new knowledge, and

- Assessment of changes in the community through a KPC survey using LQAS methodology, described above.

In addition to the KPC survey, the pre- and post-test comparisons are particularly important in assessing the results of the agogo intervention.

b. Disease surveillance data: Neonatal sepsis and tetanus

Reliable data on cases of neonatal sepsis and of birth asphyxia in Malawi are unavailable. Although the Ministry of Health officially reports neonatal sepsis cases as part of its health management information system (HMIS), very few cases are captured. These two conditions, along with complications of prematurity, normally account for the majority of newborn deaths.

As neonatal tetanus is a disease for which the World Health Assembly has called for total elimination, hospitals and clinics are more diligent in reporting the cases seen at facilities. It is unknown how many cases die quietly at home. A total of 271 neonatal tetanus cases were recorded nationally in the fiscal year 2006, or 0.48 cases per 1,000 live births. This is a decrease from 511 cases in fiscal year 2005. Efforts are needed to increase coverage for tetanus toxoid (TT) from 84% for TT1 and 66% for TT2 in order to ensure early elimination of the disease. Based upon the relatively low TT2 coverage, it is likely that many cases of neonatal tetanus are not being detected and reported.

The table below shows neonatal tetanus cases and cases per 1,000 live births by district. The majority of cases were reported in Lilongwe (27 cases), Blantyre (148 cases), and Nsanje (29 cases). Of the five districts with more intensive community-based newborn activities (shaded in the table), Dowa ranked sixth highest of 26 districts with 10 cases reported in fiscal year 2006. One case was also reported in Chitipa District.

Table 4: Neonatal Tetanus Cases per 1,000 Live Births, July 2005-June 2006

District	Live Births	Neonatal Tetanus Cases	Cases/1,000 births
Chitipa	732	1	1.4
Karonga	3,560	3	0.8
Nkhata Bay	4,236	0	0.0
Rumphi	7,380	0	0.0
Mzimba	16,513	0	0.0
Kasungu	9,217	7	0.8
Nkhotakota	3,850	0	0.0
Ntchisi	3,250	6	1.8
Dowa	7,937	10	1.3
Salima	5,660	12	2.1

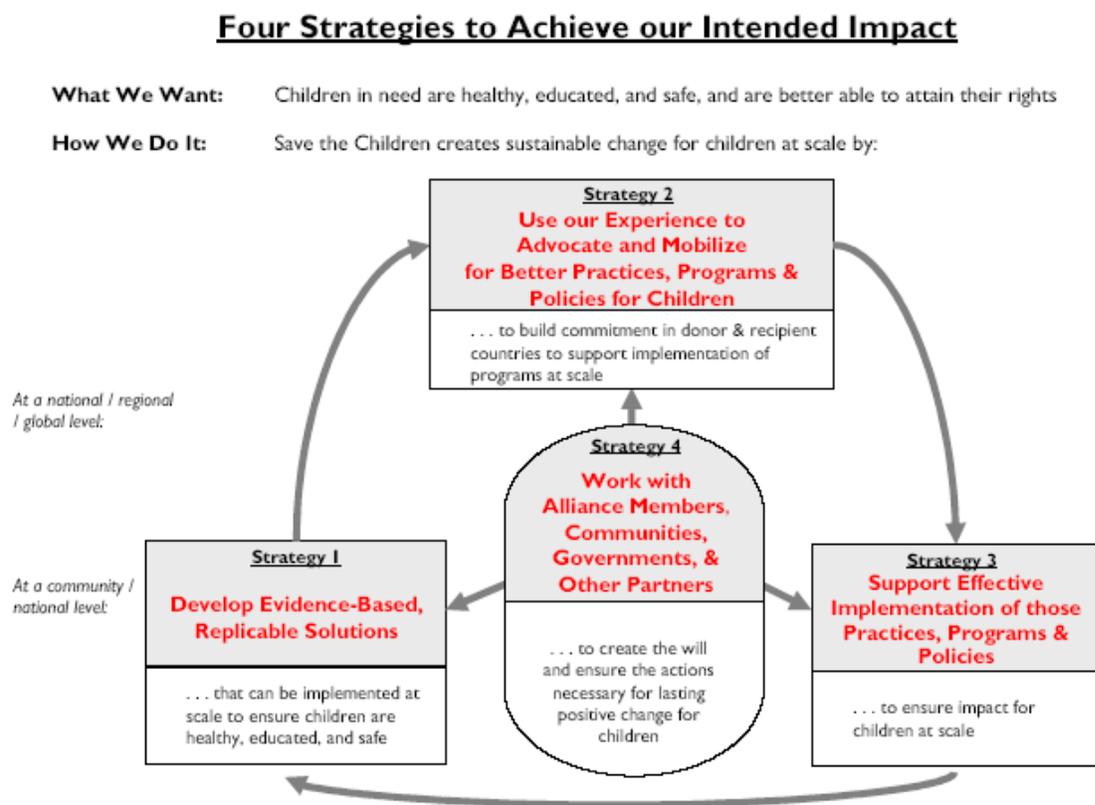
District	Live Births	Neonatal Tetanus Cases	Cases/1,000 births
Lilongwe	28,128	27	1.0
Mchinji	8,164	0	0.0
Dedza	9,266	6	0.6
Ntcheu	10,350	14	1.4
Mangochi	9,818	2	0.2
Machinga	10,886	3	0.3
Zomba	14,334	0	0.0
Chiradzulu	6,531	1	0.2
Blantyre	18,084	148	8.2
Mwanza	1,324	0	0.0
Thyolo	9,900	0	0.0
Mulanje	10,492	1	0.1
Chikwawa	8,030	0	0.0
Nsanje	7,201	29	4.0
Phalombe	3,729	0	0.0
Balaka	4,946	1	0.2
Malawi	223,518	271	1.2

3. Program Description

OVERALL PROGRAM STRATEGY

This Expanded Impact Newborn Health Program uses Save the Children’s global *four mutually-reinforcing strategies*²⁰ (below) for implementation of the NBHP. How these four strategies relate to the intervention-specific approach for newborn health is described in detail in the section below.

Figure 4. Four Strategies to Achieve our Intended Impact



The NBHP is a five-year Expanded Impact project at the national-level originally entitled *Supporting Malawi’s Road Map to Reduce Neonatal Mortality: Reaching Communities and Strengthening Services at National Scale*. The Child Survival and Health Grant Program (CSHGP) intervention is Maternal and Newborn Health (100%), with **focus on the neonate**. The NBHP 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 with support from WHO and other donors and launched officially on 30 March 2007. It is the first Road Map in Africa to be officially launched.

Save the Children's NBHP overlaps in time with the Road Map's first two phases (2005-08 and 2009-11) and contributes to achieving its goals, objectives, and targets. As a Road Map partner at the national level, Save the Children cooperates closely with MOH and its other key stakeholders to expand and mainstream quality neonatal care at all levels of health service delivery. This includes taking to national scale selected newborn health interventions and materials developed and tested by Save the Children in Malawi during the period 2001-05 as part of the global Saving Newborn Lives (SNL) initiative funded by the Bill & Melinda Gates Foundation. Gates (SNL2) funding in Malawi continues to generate important evidence related to neonatal care and support project match activities for this project.

As described in sections above, there are many factors that 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.

The NBHP focuses on the main causes of neonatal mortality in Malawi, *viz.*, infection, birth asphyxia, consequences of prematurity and low birth weight (LBW), and related maternal factors. Together, these account for 89% of all newborn deaths.

To carry out this project, Save the Children is partnering at the national level with the MOH, which leads the Road Map process. Other key Road Map partners include the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Fund for Population Activities (UNFPA), the USAID Mission, the Christian Health Association of Malawi (CHAM), and the White Ribbon Alliance for Safe Motherhood-Malawi (WRASM-Mw). These organizations, along with other committed donors and stakeholders, are combining material and technical resources and expertise toward Road Map implementation. Save the Children's primary role is to serve as **reference, catalyst, and technical resource for newborn health** in Malawi. To perform this role requires our working within the system pro-actively, with emphasis on strategic networking and assertive communication. We need to be at the table; and we need to have something of value to bring to the table. That added value is 1) our 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.

Working in Partnership: The NBHP is integrated into the Road Map, follows the MOH lead, collaborates with Road Map partners, and mainstreams neonatal care at all levels of the health care delivery system. Save the Children contributes to supporting, improving, expanding, and taking to scale a set of strategies, interventions, and services determined by MOH and partners. In order to ensure engagement of key stakeholders throughout the life cycle of the project, Save the Children will (1) identify key stakeholders from all relevant sectors and groups (ministries, academic institutions, professional organizations, PVOs, NGOs, and other civil society groups; (2) involve stakeholders in task forces and other working groups to achieve consensus on key constraints or barriers and key questions or knowledge gaps that need to be addressed, (3) ensure participation of key representatives in planning monitoring strategies and operations research; (4) invite stakeholder representatives to take part in field and monitoring visits to Mai Mwana,

Ekwendeni, pilot district for the community-based newborn care package, and other demonstration sites; (5) invite stakeholder representatives to participate in events designed to address use of results (e.g., regional dissemination workshops); (6) document and share results in formats tailored to each stakeholder audience; (7) disseminate globally published results of national studies actively to stakeholder audiences; and (8) assure participation of other development partners throughout the process, and especially in efforts to influence policy, practice, and mobilization of resources.

The NBHP incorporates community-based elements with activities planned in selected district-level settings to test, refine, expand, scale up, sustain, evaluate, document, and disseminate affordable evidence-based approaches and interventions to promote demand for care, discourage harmful practices, build community capacity, and strengthen referral and community linkages with the formal health system. The **community component** has co-evolved with Government of Malawi's (GOM) growing commitment to newborn health and community approaches; and with MOH policies, plans, and priorities.

The community component includes evidence-generating elements (i.e., research, evaluation, operations research) being carried out with matching funds (Gates/SNL2). The first of these is the Mai Mwana project, a randomized controlled trial being conducted in Mchinji District by the Institute for Child Health in London, and recently funded for completion. The Save the Children Country Office plays an oversight role in monitoring and liaising with this important study to extract and disseminate lessons learned for application to MOH district-level and community initiatives. The second Gates-funded SNL2 evidence-generating activity will be operations research related to the MOH community-based newborn care package to be piloted in three districts (Thyolo, Dowa, and Chitipa), then scaled up nationally to 28 districts. Catalytic funds to implement the pilot have been committed by UNICEF, with scale up to be funded through district budgets from the Sector Wide Approach (SWAp) pool funds. Partner roles have not yet been delineated, but Save the Children will likely take a lead in monitoring and evaluation in one or more of the pilot districts. Also included in the project's community component is sub-grant support for Ekwendeni Mission Hospital, a Christian Health Association of Malawi (CHAM) member facility, to refine, document, and package its innovative *agogo* (grandparent) approach for community mobilization and behavior change. (Ekwendeni's behavior change strategy is described in Section 4 below.)

Building Capacity: Through responsive technical assistance, joint planning, inputs into curricula and training, mentoring, monitoring, supportive supervision, M&E, documentation and analysis, and use of data for decision-making, Save the Children will build capacity of MOH, CHAM, and other partners to plan and implement high-impact maternal and newborn health services. In addition, Save the Children has budgeted to provide MOH with expert technical assistance on priority topics over the course of the 5-year project. Illustrative MOH technical assistance needs in support of the Road Map include: Management of Birth Asphyxia; Management of the Sick Newborn; Community-Based Management of LBW Newborns ("skin to skin" or KMC); Perinatal and Maternal Death Audits at First Level Facilities; Strengthening HIS and M&E. However, because TA needs to be jointly planned and mainstreamed to meet specific MOH and Road Map needs, it is not feasible at this point to designate definitively specific TA needs or topics for consultations for the five years of the project. Please refer to budget line for "Mainstreamed training, TA, and inputs to MOH" in the amended budget. To build local partner

Ekwendeni's capacity for expanding, documenting, packaging, and disseminating results of its agogo approach, Save the Children will technical assistance from its team or outside expert consultants, if necessary.

NBHP 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 health services and practices; IR-1: Increased availability of and access of 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.*

4. Intervention Specific Approach

a. Strategies and activities for newborn health

STRATEGY 1 – DEVELOP EVIDENCE-BASED REPLICABLE SOLUTIONS FOR MATERNAL AND NEWBORN CARE

Through match support for research (e.g., Mai Mwana) and operations research (OR, e.g., community-based newborn care three-district pilot) in newborn health, Save the Children is generating evidence and developing, documenting, and disseminating evidence-based approaches that can be applied elsewhere or taken to greater scale in Malawi. In our work to develop the evidence base for newborn health, both in Malawi and globally; we innovate, ask, and seek answers to important questions about how to meet needs around priority results for newborn care. Evidence generated from the global and Malawi-specific research and OR is shared through peer reviewed publications, technical updates for MOH and partners, policy briefs, and communications materials, as well as in the Save the Children Office of Health PLG meetings held annually. With a global team that include ACCESS and ACQUIRE projects, the International Paediatric Association, the International Federation of Gynecology and Obstetrics, the Population Council, UNICEF, WHO, the World Bank, and many other contributing partners; Save the Children played the role of manager and technical editor for the publication *Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa*²¹ which is a key reference for newborn health on the continent.

Activities associated with Strategy 1:

- Conduct match-funded research and OR (i.e., Mai Mwana and MOH community-based newborn care three-district pilot) with strategic inputs of USAID funds as agreed under the MOU with MOH/RHU.
- Disseminate research and programmatic results, including in peer-reviewed journals.
- Collaborate with UNICEF, WHO, and other stakeholders on decision-making regarding OR for policy dialogue and programmatic strategies (e.g., post-natal visitation schedule).
- Along with UNICEF and other partners, provide leadership and technical support as part of MOH ad hoc task force for design and implementation of community-based newborn care three-district pilot.

- Through sub-grant to Ekwendeni, facilitate definition, refinement, documentation, dissemination, and packaging of innovative *agogo* approach for community mobilization and BCC.

Community PNC three-district pilot

- With matching funds from SNL, collaborate with MOH and UNICEF to conduct operational research on implementation of a community PNC package in three learning districts (Thyola, Dowa, Chitipa).
- In collaboration with MOH, UNICEF and other key partners ensure participation of NBH team members and availability of reference materials during development of community PNC protocols for use in the 3 learning program districts by HSAs (i.e. ANC home visit, PNC home visit, community management of LBW babies, and neonatal sepsis).
- Assist in the development of job aides and supportive supervision at facility and community levels for effective continuum of care.
- Contribute to adaptation of MNH training package for HSAs.
- Facilitate proper documentation and dissemination throughout the life of the pilot.

Mai Mwana Project

- Provide quarterly monitoring of progress.
- Facilitate annual CHAM and MOH visits to study site.
- Facilitate joint dissemination event.

Ekwendeni

- Assist Ekwendeni with census of *agogos* and development of selection criterion for candidates for refresher and new trainings in expansion areas.
- Facilitate annual CHAM and MOH visits to implementation area.
- Facilitate joint dissemination event on lessons learned for national NGOs, religious institutions, and civil society organizations.

STRATEGY 2 – USE OUR EXPERIENCE TO ADVOCATE AND MOBILIZE FOR BETTER PRACTICES, PROGRAMS, AND POLICIES FOR NEWBORNS AND THEIR MOTHERS

Save the Children uses the evidence base and its experience and expertise in newborn health to advocate and mobilize effectively for better practices, policies, and programs. As a Road Map partner, we collaborate with the GOM, MOH/RHU, WRASM-Mw, and other key stakeholders; we leverage resources to build a long-term commitment in Malawi to the maternal and newborn health agenda and to support implementation at scale. We participate pro-actively and make key inputs into the design, implementation, and evaluation of the national Road Map advocacy plan and package. One notable constraint is that the Road Map itself more strongly supports maternal than newborn care and requires strengthening, offering an exciting opportunity to review national standards; integrate and mainstream low cost, effective newborn care interventions; incorporate international best practices, and introduce key neonatal indicators currently lacking.

Activities associated with Strategy 2:

- Collaborate with MOH and Road Map partners on design and implementation of national advocacy plan and package.
- Support civil-society organization WRASM-Mw through MOU and vendor agreement to

enable organizational growth and capacity development for leadership in the Road Map national advocacy plan and package.

- Collaborate with MOH and other partners on conduct of newborn care policy review and dialogue.
- Advocate and provide technical assistance, when necessary, for revised post-natal care visitation schedule and other evidence-based strategies and interventions.
- Advocate in partnership with MOH and other stakeholders for effective HSA recruitment with special attention to community PNC pilot districts.
- Using lessons learned from the three-district pilot, advocate for policy review and dialogue on community management of newborn sepsis by HSAs.

STRATEGY 3 – SUPPORT EFFECTIVE IMPLEMENTATION OF PRACTICES, PROGRAMS, AND POLICIES FOR MATERNAL AND NEWBORN HEALTH

Through technical assistance, capacity-building, and joint planning and evaluation, Save the Children catalyzes and supports MOH/RHU and other implementing partners in adopting and operationalizing policies, evidence-based best practices, and state-of-the-art programs at all levels (i.e., household, community, facility, health system). Much of this effort will be centered around piloting and taking to scale the community-based newborn health package to be piloted in three districts; as well as identification and integration of lessons learned from the Mai Mwana randomized control trial now funded for completion in Mchinji District.

Activities associated with Strategy 3:

- Collaborate with MOH and other partners to operationalize Road Map and FY08 RHU work plan.
- Participate annually in RHU work planning cycle.
- Assist RHU in annual District Implementation Planning cycle.
- Collaborate with MOH, UNICEF, and other partners on taking community-based newborn care package to scale in 28 districts in context of ACSD/IMCI initiative.
- Take lead for review of BCC materials developed under SNL1 and contribute to duplication and dissemination of materials.
- Assist in improving facility-level quality through collaboration with the Health Foundation Quality Improvement project, ACCESS, and by working with MOH/RHU on newborn death audits and social-verbal autopsies.
- Assist in improving community-level strategies for maternal and newborn health in partnership with ACCESS.
- Collaborate with RHU, WHO and other partners in the incorporation of ENC/KMC module into current Safe Motherhood in-service training curriculum.
- Collaborate with MOH and districts to train providers in all 28 districts in ENC/KMC .
- Cooperate with Malawi College of Medicine and other medical faculties to incorporate the ENC pre-service module into the training of medical and clinical officers in partnership with ACCESS.
- Collaborate with partners (e.g., ACCESS and others) and share experiences, expertise, and results of KMC retrospective to move forward the KMC agenda in 28 districts.
- With matching funds conduct retrospective KMC assessment to develop tools and recommendations for low-cost, effective KMC implementation for scale up at district

level. In collaboration with MOH and ACCESS disseminate the results of the retrospective KMC assessment to key stakeholders.

- In collaboration with MOH, ACCESS and other key stakeholders and using lessons learned from the retrospective KMC assessment, provide TA on ENC/KMC (NBH staff knowledgeable in ENC and KMC will be always made available plus appropriate reference materials and experiences from SNL1) during harmonization of RHU training manuals (Safe Motherhood, Life Saving Skills, BEmONC, ENC and KMC) into a one standard competency-based package/curriculum called Essential Obstetric and Newborn Care training manual.
- Facilitate development of supportive supervision tools and proper follow-up process of trainees. First follow-up to be done 6 months post training.
- Participate in a workshop for Health Training Institutions to assess gaps as regards BEmONC and ENC/KMC content and ascertain if competency based training is done. Assess access to appropriate reference materials and models for practical skills training. Facilitate through SNL acquisition of appropriate ENC/KMC reference and training materials.
- Assist RHU to provide support for annual District Implementation Plan (DIP) development by facilitating a joint planning and development of a schedule of DIPs for all districts and ensuring that there is representation at all times for maternal and newborn care. Save the Children will ensure NBH staff is present during DIP development meetings in 6 MOH districts and Mzimba district to facilitate appropriate planning and budgeting on newborn care. Participate in Zonal meetings.
- In collaboration with MOH and key partners conduct stakeholders meetings at identified clinical training sites and participate in site assessments and strengthening of the sites in preparations for trainings.
- Revitalize ENC/KMC TOTs network, first a census will be done to find out how many of the TOTs trained during SNL1 are still available and interested. Facilitate and co-fund 4 national re-fresher courses to all TOTs available (30) that were trained under SNL1 plus others identified by MOH and other key partners using the new integrated Essential Obstetric and newborn care competency based training package (Total 60 to be trained at national level). Supervise the training sessions to ensure quality. The trainings of trainers will be strategized to ensure that a minimum of at least one trainer is trained per district hospital and in 5 CHAM hospitals. A catalogue of contact addresses will be kept at a RHU. The network will be used as a pool where TOTs for district trainings can be sourced.
- Co-fund one training (TOTs) session for 15 tutors from health training institutions for effective pre-service competency based training. Provide follow-up of the trained tutors implementation plans.
- Facilitate in-service trainings of 50 health workers in Essential Obstetric and Newborn Care (EONC) in Mzimba. In collaboration with MOH provide TA during roll-out of EONC training at district level (as stipulated in the DIP) throughout the country by ensuring trainers and appropriate training materials on ENC/KMC are available.
- Using lessons learned from the KMC retrospective assessment provide TA (trainers and reference materials) for the roll-out of KMC to Health Centers in three MOH learning program districts. With lessons learned from the three learning program districts provide TA to scale-up community KMC in other MOH districts.

- Facilitate a joint follow-up of implementation plans and facilitate joint supportive supervision of the TOTs. Conduct frequent supervision of the training sessions during the district scale-up to ensure quality.
- In collaboration with RHU and Health Education Unit, identify existing BCC materials (many developed under SNL1) addressing newborn health issues.
- Support the review and development of revised BCC materials on newborn health
- With lessons learned from the three-district community PNC pilot, provide additional TA during development of community maternal and newborn care BCC materials.

STRATEGY 4 - WORK WITH COMMUNITIES, GOVERNMENT, AND OTHER PARTNERS AND STAKEHOLDERS FOR THE BENEFIT OF MOTHERS AND NEWBORNS

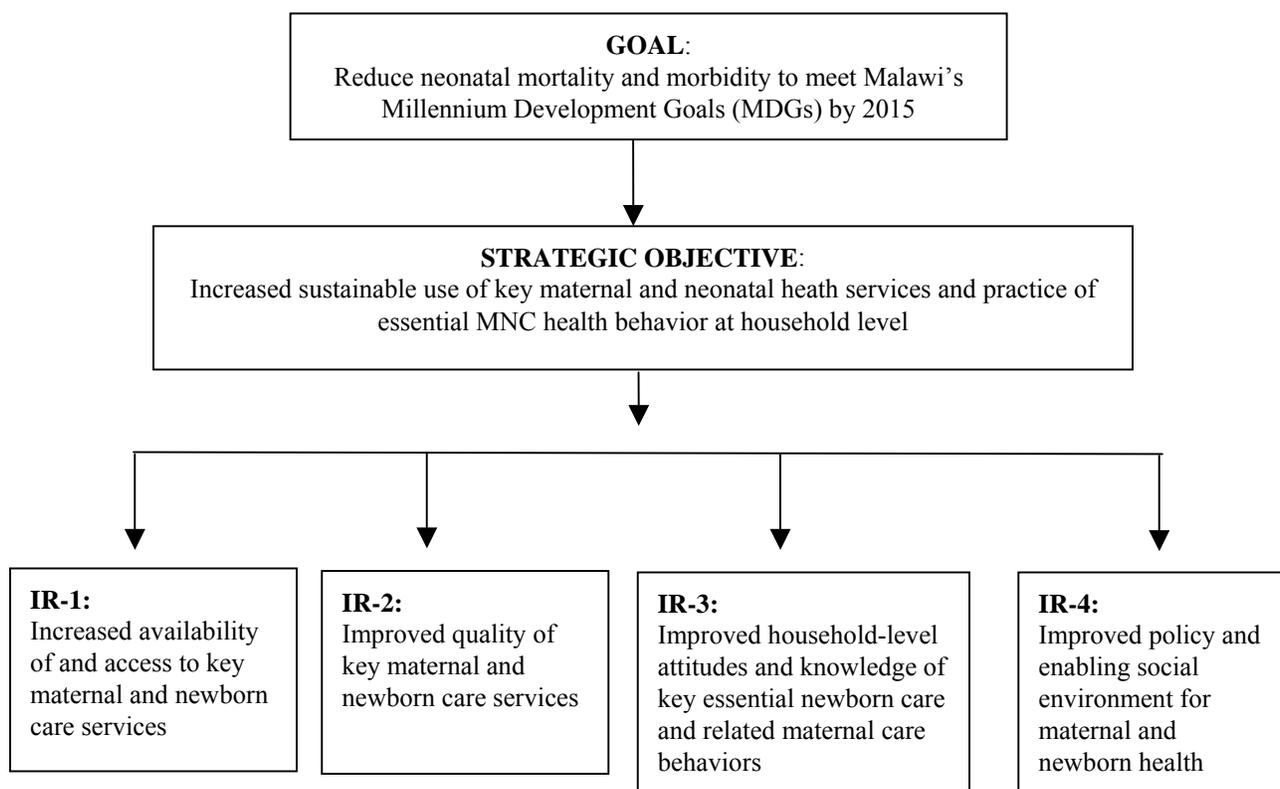
Save the Children works in partnership with the GOM, MOH/RHU, international organizations, donors (including the USAID Mission), and a wide range of Road Map partners to implement the first three strategies and create the will and ensure the actions to address newborn health needs in a sustainable way. Using all four strategies together leverages the impact of each and creates a strong enabling environment. MOH leads the Road Map process.

Activities associated with Strategy 4:

- Participate in subsequent WHO/UNFPA missions, assessments, planning activities, and implementation monitoring for PMNCH initiative in Malawi.
- Link with EU/WHO Safe Motherhood initiative as appropriate within the context of the MOH/RHU planning cycle and coordination with ACCESS.
- Participate in planning and implementation of the ACCESS program in Malawi to start up in October 2007.
- Revitalize ENC/KMC trainers network.
- Support and strengthen WRASM-Mw as a civil society membership organization committed to maternal and newborn health.
- Form a community newborn care learning program task force.
- Recognition by partners of our area of expertise, document number of new partners and policy makers using our messages in public settings.
- Develop a process to document evolution of the SC-MOH partnership.

Documenting the partnership process - As agreed with CSHGP at the Mini-University DIP review in Baltimore, Save the Children will develop a process for documenting the evolution of the partnership in Malawi with MOH and other stakeholders. Based on discussions so far, there is a consensus that this process documentation will look beyond mere numbers (e.g., # meetings, meeting quora, etc.) at issues related to partnership domains such as vision, alignment, communications, distribution of risks and rewards, equality of contribution, mutual accountability, leadership, learning, added value, willingness to change, mutual trust, and management of resources and change. During the first quarter of FY08, La Rue Seims, SNL Senior M&E Advisor and Karen Z. Waltensperger, Africa Regional Health Advisor, will be working with Evelyn Zimba and the Malawi NBH Team to develop tools (both qualitative and quantitative), benchmarks, and a reporting format for this process documentation. More details on development will be reported in the Year I Annual Report.

Figure 5: Results Framework, Malawi Newborn Health Program



b. Behavior change strategy

Behavior change of health worker/community/family/individual: At the level of the health worker, the NBHP invests its behavior change strategy in policy change; pre-service and in-service curricula design and improvement; mainstreamed training; QI; supportive supervision; and performance assessment. Efforts to improve health worker performance are fully coordinated with the Road Map process and ACSD/IMCI Approach Strategy. Under SNL1, the ENC pre-service training module was incorporated into nursing school curricula in both government and CHAM institutions; it has yet to be incorporated into the schools of medicine for training medical and clinical officers. Moreover, the ENC/KMC module needs to be incorporated into the current Safe Motherhood in-service training curriculum for health workers at the district level. If timing is right, Save the Children will be able to work with Mzimba District to test and evaluate the in-service ENC/KMC module and document the training process for 50 district-level health workers in FY08. This will contribute to scale up of ENC/KMC training to all 28 districts.

At the community and household level, the NBHP behavior change strategy is consistent with that of the ACSD/IMCI Approach Strategy and Road Map. Save the Children will contribute its experiences from SNL1 in Malawi and beyond to the design and implementation process. For example, experience in Malawi and evidence from other countries shows the importance of selecting only a few priority action ENC messages, gaining the collaboration of all partners to

deliver the same set of key messages, and using both interpersonal and group methods for delivering these in order to stimulate demand for services. In other SNL countries, Save the Children also found it effective to design and carry out formative research on danger signs and overcoming barriers to inform national BCC efforts. Save the Children will advocate for this type of approach with MOH and Road Map partners, proposing a qualitative inquiry to be conducted (match-funded) in the three pilot districts for the community-based newborn care package. BCC materials (e.g., posters, brochures) developed under SNL1 and endorsed and approved by MOH will be reviewed, revised (if necessary), and re-printed (with USAID branding added) for wider dissemination, including the three pilot districts.

The Ekwendeni *agogo* approach: While typical maternal and child health (MCH) programs focus narrowly on women of reproductive age and the mother-child dyad, Ekwendeni's *agogo* approach is assets-based and engages grandparents as development partners. The *agogo* approach appreciates the power of community norms, works with and not against complex household decision-making dynamics, and leverages social capital of influential elders whose advice and influence cannot be underestimated. Enthusiastic grandparents - informal and formal community leaders and influentials among them – volunteer and are trained in key MNC messages, recognition of danger signs, and evidence-based best practices (EBBP). These *agogos* then commit themselves to spreading the word, within their own families and communities. Under SNL1, Ekwendeni trained nearly 4,000 *agogos*. In order to maintain this complement, Ekwendeni will refresh and train existing and new *agogos*. The approach will be defined, refined, documented, packaged, and disseminated, and evaluated to promote interest and uptake by other NGO, CBO, and district-level service providers. Ekwendeni developed its *agogo* approach messages under SNL1 using the BEHAVE framework (see Annex XIV). As part of Ekwendeni sub-grant program start-up, these messages will be reviewed and updated technically, if necessary, with assistance from the NBHP team. Ekwendeni will document its *agogo* training curriculum and add pre-, post-, and 6-month follow-up tests (sample) to evaluate learning and retention of content. The recruiting and training process will be documented and packaged.

Sustainability is ensured by reinforcing the capacity of a naturally occurring cadre of care provider (grandmothers and grandfathers) whose role is culturally sanctioned. Trained *agogos* become better at being grandparents and step up to provide leadership in their communities, acting as community educators to promote EBBP for newborn care practices. Several features of the *agogo* approach support prospects for sustainability, both of the community education/communication activities and in changes in the promoted behaviors. The community education/communication activities - namely drama, songs, dance and community discussions are all simple, culturally-adapted, participatory and community-lead activities that require very little ongoing outside support. Some follow-up is required to reinforce motivation and be sure that the messages being disseminated are correct. It is already very encouraging that almost all communities where *agogos* have already been trained appear to be continuing these activities on their own. Another advantage of the *agogo* approach is that it contributes to promoting changes in community health norms, by working through grandmother groups and natural leaders. Most health communication/education strategies aim to change the practices of women of reproductive age and often meet with limited support because the proposed changes go against community norms. The *agogo* approach aims to “get to the root of the issue” by promoting change among those, i.e., the grandmothers and grandfathers,

who have the responsibility within the culture for defining and communicating the cultural norms, i.e., “the way things should be done.”

Dissemination plan for BCC materials and approach to scale up of the BCC strategy – Within the contexts of the MNCH Task Force and community newborn health initiative task force, Save the Children will be collaborating closely with MOH/RHU, WHO, UNICEF, UNFPA, ACCESS, PNMCH, and other partners to assemble, review, adapt, and develop a comprehensive set of BCC materials for neonatal health in Malawi. We are not in a position at this time to provide a dissemination plan but will advocate for such during the coming RHU planning cycle.

c. Quality improvement (QI) strategy

The NBHP will work closely with MOH and partners and provide technical assistance where necessary to ensure that quality improvement (QI) for newborn care is built into points of service delivery. QI approaches such as Partner Defined Quality (PDQ)²² will be presented for review by Road Map partners, and Save the Children will offer technical support for QI trials in selected sites (e.g., the three pilot districts for the community-based newborn care package). QI tools (e.g., supervisory checklists, job aids, quality indicators) that facilitate concrete and specific feedback and monitor quality improvement will be offered for consideration and piloting. In its sub-grant activities, Ekwendeni will assure quality through regular supportive supervision, use of QI tools, routine monitoring, and community feedback mechanisms.

In all cases, Save the Children will support MOH QI initiatives within the context of the Road Map, the ACSD/IMCI Approach Strategy, and the RHU work plan. For example, in 2006, Save the Children was part of an RHU working group to add newborn social-verbal autopsies to the existing system of facility-based death audits. The tools developed are currently being translated into local languages for pilot testing. At critical junctures, depending upon need, Save the Children is in a position to offer expert technical assistance for design, development, review, and implementation of quality assurance tools. In addition, Save the Children will maintain communications with The Health Foundation’s QI project being carried out in Kasungu, Salima, and Lilongwe Districts with the aim of integrating best practices and assisting in the dissemination of successful tools and techniques.

d. Access to services

Both the Road Map and the ACSD/IMCI Approach Strategy (Annexes VIII and XII) provide frameworks for improving access and availability of key newborn care services and practices through increasing numbers of trained providers, including HSAs, and moving services closer to the community.

Working at the national level with MOH/RHU, UNICEF, USAID/ACCESS, WHO, and other key partners, Save the Children will play a role with other partners to assist MOH in overcoming access barriers to newborn care services through the following activities:

- Operationalizing the Road Map and RHU work plan on an annual basis
- Increasing the number of health workers trained in all 28 districts in ENC/KMC at the district level
- Increasing ratio of HSAs to residents through greatly expanded recruitment and training

- Reviewing, adapting, and integrating the ENC/KMC module into the current Safe Motherhood in-service training package for district-level providers
- Designing, piloting, evaluating, and taking to scale community-based newborn care package integrated with ACSD/c-IMCI (operations research funded by SNL2/Gates match)

i. Equity issues

Equity is a critical Save the Children value and is pursued in the NBHP through policy dialogue; increasing access and availability; attention to both facility and community contexts; participatory approaches; broad based advocacy; standardization; partnerships; inclusive strategies; disaggregation of data; and data-driven decision-making. While there is no evidence to support gender inequality in the care of neonates in Malawi, the excess NMR for the poorest vs. the least poor has been calculated at 24%²³. It is anticipated that decentralization of budget and prioritization to the level of the district assembly will contribute to more equitable distribution of government resources.

e. Mainstreamed training

In this Expanded Impact, national-level project, training is “mainstreamed”. Save the Children supports MOH training activities relevant to newborn health through joint planning; technical assistance (e.g., for design, adaptation, review, and/or evaluation of training curricula), provision of trainers, and partial funding pooled with other partners, within budgetary constraints. Save the Children feels strongly that this strategy promotes “ownership”, sustainability, and accountability on the part of MOH. Accountability is ensured by application of mutually-agreed upon and strict criteria, documentation, and reporting requirements. Guidelines will be developed jointly with MOH and reflected in the MOU. This strategy is justified in the spirit of partnership, integration, and national program mainstreaming. Illustrative topics of relevance to the newborn include: (1) Comprehensive in-service Essential Obstetric and Neonatal Care module for health workers; (2) Management of Birth Asphyxia; (3) Management of the Sick Newborn; (4) Community-Based Management of LBW Neonates (KMC or “skin to skin”); (5) Perinatal and Maternal Death Audits for First Level Facilities; and (6) HIS and M&E relevant to newborn health. Training sites are selected at the discretion of MOH and may be at the central level or at the regional level; in Lilongwe, Mzuzu, Blantyre, in the bomas (district seats) or at institutions (e.g., district hospitals, central hospitals). MOH has stated a preference for training to be “on-site”, whenever possible.

Please see the revised work plan in Table 6. that includes an expanded training section with timeline. Subsequent annual work plans to be submitted by agreement with CSHGP will include updated training details coordinated with MOH/RHU, ACCESS, PNMCH, and Road Map partners.

f. Sustainability strategy

Because Save the Children is partnering with MOH on the national Road Map initiative integrated with the IMCI Approach Strategy for ACSD with intent for scale-up country-wide, sustainability is likely. At the national-level, sustainability is achieved through joint planning; and adopting and operationalizing policies, norms, and protocols that contribute to the enabling

environment. At the district level, sustainability is achieved through joint planning, improving access to quality services for maternal and newborn care, and integration into existing service delivery packages, including the EHP. At the facility level, sustainability is achieved through expanded training of health workers in ENC/KMC. At the community and household level, sustainability is achieved through improved knowledge and practice as a result of the strengthening the community component of the IMCI Approach Strategy for ACSD.

The Malawi NBH Team is working on a **national scale-up plan for newborn health** begun during the SNL Scale-Up Workshop held in Dubai in June 2007. This plan will be presented as part of the Year I Annual Report to be submitted in October 2007 and will include specific TA activities anticipated.

g. Strategic fit with other Save the Children activities

Save the Children and all of its country offices are this year embarking on a new global 5-year strategic plan (FY 2008-2013). The Malawi Country Office held its strategic planning meeting the week of 26 March in Mangochi; and the Africa Area will hold its regional strategic planning exercise the week of April 23 in Addis Ababa. Strategic planning is guided by the Four Strategies as set out above. Currently, Save the Children in Malawi is active in a range of development interventions in food security, hunger and malnutrition, orphans and vulnerable children, home-based care for those affected by HIV/AIDS, school health and nutrition, and newborn health. In addition, Save the Children's USAID-funded Umoyo Network, a multi-year project to build capacity of local NGOs involved in the fight against HIV/AIDS, is coming to an end in the upcoming quarter. Through the strategic planning process, it is likely that the Malawi Country Office repertoire will be scaled down in order to focus and gain depth in a few key programmatic areas aimed at children 0-8 years, including newborn health, child health and nutrition, and early childhood development. HIV/AIDS is a cross-cutting area in all programs and includes improved links to PMTCT.

h. Roles of major partners

Malawi Road Map partners collaborate with MOH/RHU along the continuum of care. Figure 6 below, from *Opportunities for Africa's Newborns*, details interventions that reduce newborn deaths at clinical, outreach/outpatient, and family/community levels. It is followed by a figure showing how various partners in Malawi – including SC (CS/SNL) - are working along that continuum of care.

Figure 6: Maternal and newborn care interventions across the continuum of care (from *Opportunities for Africa's Newborns*)

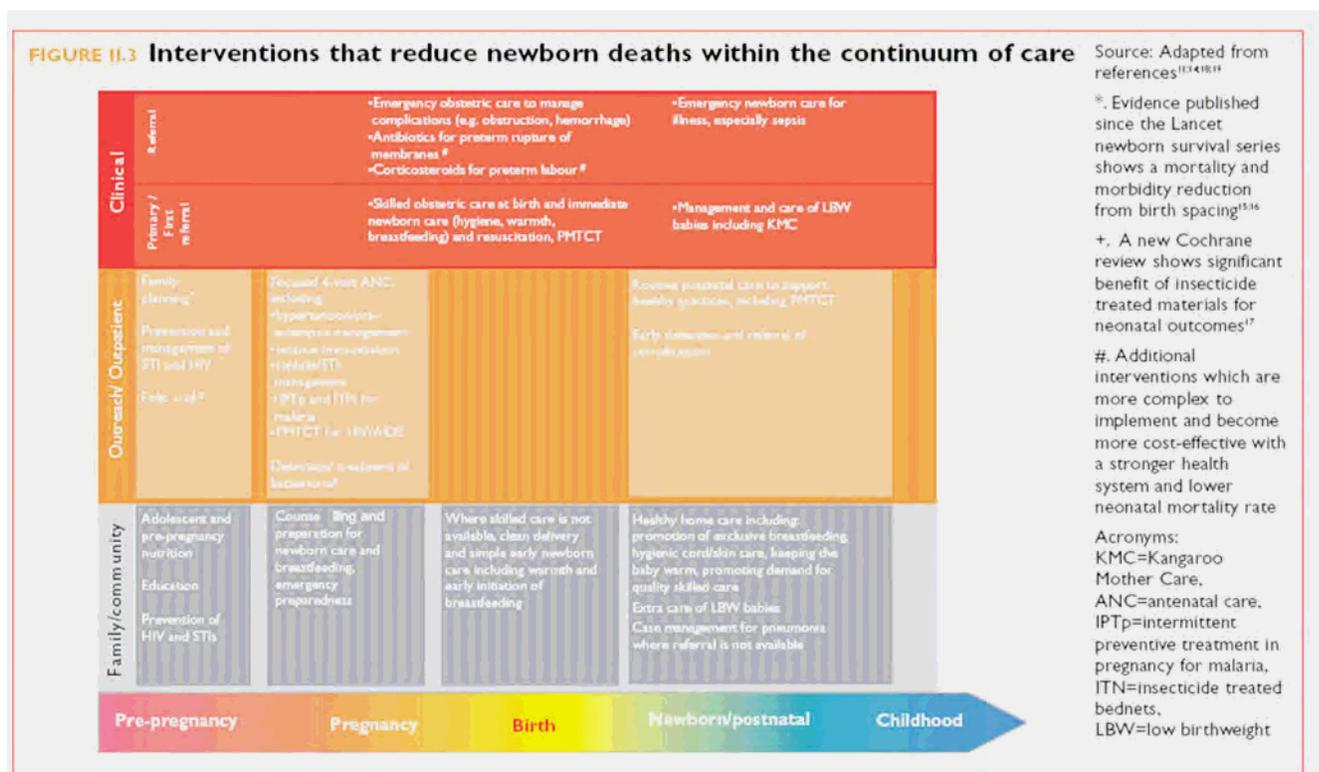


Figure 7: Malawi maternal and newborn health continuum of care by key partners

	Pregnancy	Birth	Post-natal period
Clinical care	WHO, SC (SNL/CS) & ACCESS, UNICEF, PMNCH, Health Foundation, JHPIEGO	WHO, SC (SNL/CS) & ACCESS, UNICEF (BFHI), PMNCH, Health Foundation, JHPIEGO	WHO, SC (SNL/CS) & ACCESS, UNICEF (IMNCI), PMNCH, Health Foundation, JHPIEGO
Outreach / outpatient services	UNFPA, SC (SNL/CS) & ACCESS UNICEF, PMNCH, WHO, Health Foundation, Women and Children First, Mai Mwana, BASICS	UNFPA, WHO, PMNCH, Health Foundation, Women and Children First, BASICS	UNFPA, PNC package SC (SNL/CS) & ACCESS, UNICEF, PMNCH, WHO, Health Foundation, Women and Children First, Mai Mwana, BASICS
Family and community	PMNCH, Women and Children First, SC (SNL/CS) & ACCESS, Mai Mwana, BASICS	PMNCH, Women and Children First, SC (SNL/CS) & ACCESS, Mai Mwana, BASICS	PMNCH, UNICEF, UNFPA, Women and Children First, SC (SNL/CS) & ACCESS, Mai Mwana

Malawi's Road Map states that its "...successful implementation...will depend on sustained political commitment, support and commitment from development partners, civil society and all other stakeholders." The MOH leads the Road Map Process along with all other national strategic, policy, and program initiatives. Save the Children collaborates with the full spectrum of Road Map partners. That list currently includes the World Health Organization (WHO), CHAM, Kamuzu College of Nursing (KCN), UNICEF, UNFPA, and WRASM-Mw). These organizations, along with other committed donors (e.g., Africa Development Bank), combine resources and expertise toward implementing the Road Map with common goals and objectives

As a Road Map partner, **Save the Children** defines its primary role as **reference, catalyst, and technical resource for newborn health** in Malawi. To perform this role requires our working within the system pro-actively, with emphasis on strategic networking and assertive communication. In the context of the Road Map, Save the Children brings to the table global and country-level expertise in neonatal health and community-based approaches. The NBHP, with its two complementary funding sources (USAID and SNL2/Gates), makes it possible for Save the Children to work in collaboration to strengthen the neonatal care component of the Road Map and other policies, norms, and protocols, to address the unfinished newborn agenda in Malawi. This is consistent with Save the Children's role as described in the original application. Award of the CSHGP project influenced Save the Children's decision to commit additional SNL2 funds to Malawi.

The **MOH** leads the Road Map process; plans health services; makes policy; develops service delivery strategies; coordinates donor resources; adopts guidelines and protocols; manages health infrastructure; ensures adequate human resources and conditions conducive to service delivery; plans and executes pre-service/in-service training; endorses and incorporate best practices; and measures its results through monitoring and evaluation. **CHAM** is a key service provider, partner in the Road Map, and critical collaborator in the delivery of newborn health services at the facility and community levels. CHAM delivers 37% of the health services in Malawi, operates ten nursing schools, and trains about three-quarters (77%) of all nurses in Malawi, as well as other cadres of health worker. CHAM's role is to align itself with MOH policy and priorities, upgrade pre-service and in-service curricula and incorporate best practices for ENC, newborn resuscitation, care of the sick newborn, and KMC into its service delivery at all levels. **KCN** develops, tests, evaluates, and validates curricula; takes part in policy dialogue regarding expansion of TBA; and contributes to developing MNC service delivery strategy. **UNICEF** supports the Road Map through re-energizing its Baby Friendly Hospital Initiative; taking a lead role in ACSD/IMCI Approach Strategy; including funding and supporting the community-based newborn care three-district pilot initiative and subsequent scaling up to 28 districts.

As a sub-grantee under the NBHP, **Ekwendeni** is defining, refining, expanding, documenting, packaging, and disseminating its innovative *agogo* approach for community mobilization and BCC. **Mai Mwana** collaborates with Save the Children and MOH to disseminate best practices, key findings, and research results relevant to maternal and newborn care. **WRASM-Mw** plans and conducts national and local advocacy to draw attention to newborn health challenges and solutions. Within the context of the Road Map process, **Save the Children** provides WRASM-Mw with targeted material support for capacity building, demand creation, and advocacy and

policy dialogue with a focus on the neonate. **UNFPA** provides support and assistance to the government in the areas of family planning, adolescent reproductive and sexual health, and is funded by PMNCH to increase access to quality maternal, newborn, and child care services in Malawi.

Finally, Save the Children's global **SNL2** initiative provides technical leadership and support for advocacy, dissemination of the evidence base, and access to state-of-the-art data analysis. The SNL2 research program concerns itself with the effectiveness of interventions and approaches during the first week of life for birth asphyxia, infections, and pre-term births; testing which packages of newborn health interventions work best in different scenarios; and testing the outcomes of specific linkages of newborn health with maternal and child health packages. Finally, SNL2 focuses on documenting scale-up approaches being used by countries.

Save the Children is currently in the process of finalizing the following MOUs and agreements as specified below.

MOU with Ministry of Health/Reproductive Health Unit (MOH/RHA)

Save the Children and the MOH/RHU originally intended to develop an MOU to delineate roles and responsibilities for general partnership in Malawi's Road Map and other national-level work related to maternal and newborn health. However, RHU is not able to enter into agreements. Any agreements between USAID-funded PVOs and MOH are currently on hold pending consensus by Malawi-based based PVOs with the USAID Mission with regard to protocol for signing MOUs with the Government of Malawi. This situation will be updated in the Year I Annual Report.

Agreement with UNICEF for collaboration on three-district pilot

UNICEF/Malawi will not sign an MOU with Save the Children to govern collaboration in the three-district pilot. There is already a global MOU between Save the Children/Saving Newborn Lives and UNICEF headquarters. Roles and responsibilities for collaboration in the community-based newborn care three-district pilot may be put down in an informal agreement that is currently under discussion. This, too, will be reported on in the Year I Annual Report.

Agreement with WRASM-Mw

An agreement for support to WRASM-Mw has been developed and is waiting signature. Given that ACCESS will also be providing resources to build the capacity of WRASM-Mw, it is likely that the agreement will be amended in the first quarter of FY08 in order to maximize resources and ensure synergy.

Sub-Grant Agreement with Ekwendeni Mission Hospital (Synod of Livingstonia)

Ekwendeni's formal project document for the sub-grant is at the advanced draft stage. It is expected to be signed by 30 September 2007. Under the sub-grant agreement, Ekwendeni will define, refine, expand, document, package, and disseminate its *agogo* approach for community mobilization and BCC

Planned Collaboration with USAID Mission: As a Road Map supporter, and major technical partner in the Malawi health sector, the USAID Mission is a key stakeholder in the Newborn Health Program. Child Health Specialist Catherine Chiphazi and Reproductive Health Specialist Lily Banda-Maliro, assigned as Save the Children's point persons at the Mission and representing the Mission's health team, participated in a number of joint MOH planning activities, including the Design Workshop for the community-based newborn care pilot held in February. The current USAID bi-lateral health systems strengthening project (managed by Management Sciences for Health) is not actively involved in newborn care and is closing out shortly. To replace this bi-lateral instrument, the Mission is buying into two USAID global projects, ACCESS and BASICS, through field support.

ACCESS submitted its Malawi proposal to the USAID Global Bureau on 27 July 2007 for an October 2007 start up. As a partner in ACCESS (with JHPIEGO and Constella Futures, Academy for Educational Development, American College of Nurse-Midwives, and Interchurch Medical Assistance), Save the Children has been actively involved in ACCESS Malawi program design, planning, and proposal development and expects to have two to three staff positions on the ACCESS program who will report to the Chief of Party (a JHPIEGO employee). Specifically, Save the Children will provide leadership in the areas of community approaches and scale-up of KMC and the community PNC package. To maximize synergies, close coordination at the country office level will be the responsibility of the NBH Program Manager. Additional details will be provided in the Year I Annual Report to be submitted in October 2007.

5. Program Monitoring and Evaluation Plan

Table 5: M&E Plan for National Newborn Health Program

NOTE: National Road Map targets were set low (sometimes lower than baseline) and were to have been reviewed and revised, along with indicators, at a national MOH/RHU HIS meeting planned for late April 2007. As of the end of July 2007, this important national meeting had not yet happened. An update will be included in the Year I Annual Report.

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	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%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	EOP Target
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%
		# 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%	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%	15%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	EOP Target
		Total # of antenatal visits	Total # of registrants	Malawi: Health Management Information Bulletin: Annual Report, July 2005-June 2006	Service Statistics	Annual	3	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 delivered in a health facility	Total # of women surveyed aged 15-49 years with a birth in 2 years preceding the survey	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	EOP Target
	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%	60%
	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%	30%*

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	EOP Target
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%
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%

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	EOP Target
	Immediate breastfeeding	# of children who started breastfeeding within one hour of birth	# of children born in the five years preceding the survey who ever breastfed	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	69%	80%
	Use of mosquito nets by pregnant women	# women who slept under an ITN the preceding night	# pregnant women	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	15%	40%*
	IPT	# of pregnant women who took at least 2 doses of Sp for IPT of malaria during pregnancy	# of pregnant women who had a live birth in 5 years preceding the survey	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	47%	60%
	Birth Interval	# of births whose interval between the most recent birth and the preceding birth is 36 months or more	total # of births	Malawi: Demographic and Health Survey, 2004	DHS Survey	Combined MICS/DHS scheduled in 2010	50%	50%
IR4 Improved policy and enabling social environment for maternal and neonatal health	Government budget allocation to health sector	Government of Malawi budget allocated to health sector	Total Malawi government budget to all sectors including health					
	Total allocation to health sector: cost per capita	Government and donor total allocation to health sector (in US \$)	Total estimated mid-year population					

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

Objective/Result	Indicators	Numerator	Denominator	Source	Measurement Method	Frequency	Baseline Value	EOP Target
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Malawi, Ministry of Health.

a. Description of the information system

An overview of assessment tools and methods includes:

Baseline assessments:

- Extant data extracted from the DHS, MICS, and HIS
- Health facility assessments (HFAs)
- KPC survey results for Mzimba District (Rapid CATCH)
- Training assessment baseline and immediate post-test
- Qualitative assessment of Ekwendeni *agogo* approach

Mid-term monitoring:

- Annual HIS measures
- Surveillance for tetanus
- Routine program information system tracking input and output level data, e.g., expenditures and persons trained, as well as higher-order qualitative indicators, such as changes in policies, norms, protocols and government strategies
- *Agogo* training assessments conducted 6 months after training (during supervision)
- Participatory mid-term (process) evaluation

Endline assessments:

- Extant data from the DHS, MICS, and HIS
- KPC survey results for Mzimba District (Rapid CATCH)
- A final evaluation of the project

Operations research:

- Design, implementation, and measurement of results of community-based newborn care package to be piloted by MOH in three districts (Thyolo, Dowa, Chitipa) and taken to scale in all 28 districts (SNL2 match activity)
- Completion of randomized controlled trial (Mai Mwana) being carried out in Mchinji District by the Institute for Child Health in London (SNL2 match activity)

b. Objectives, indicators, and targets

Save the Children will monitor the national NBHP using DHS, MICS, and HIS indicators and state-of-the-art measures for newborn health. The indicators are fully-defined, along with sources and frequency of data collection in the attachment, and are organized by intermediate result in the results framework. The data collection methods have also been described in Section 2. Targets are identified, but these will need to be adjusted based upon MOH/RHU decisions to be taken in a Road Map HIS meeting to be held in late April 2007, as well as upon annual reporting from the HIS.

For Mzimba District, a subset of the Rapid CATCH and key indicators will be used to evaluate results. The Rapid CATCH indicators are included as Attachment B along with baseline measures. These measures were described, along with programming implications in Section 2.

The assessment tools will be used to collect both facility and community-based data at both the national level and in selected districts. Data will be compared and contrasted from multiple sources which will provide an additional check on the quality of the data. An overall end-of-project evaluation will include review of the results of all the assessments outlined above.

As the heart of the project's information system for monitoring the national program will be the Government of Malawi's HIS, which has not been described elsewhere in this document; the HIS is described in more detail below.

i. HIS background

The MOH took an inventory of existing information systems in 1999 finding parallel reporting systems along vertical program lines. The government endorsed a strategy of developing an integrated and comprehensive routine HIS from early 2000. By the end of 2003, the government had selected 110 well-defined indicators largely collected from service statistics along with formats, instruments, and guidelines for their use. Maps were developed showing the catchment areas of each public health facility in the entire country for use in planning and monitoring health services by district and facility. HIS policies and strategies have not changed since December 2003.²⁴

ii. HIS indicators

The HIS has 110 national core indicators for monitoring and evaluation of health sector performance and each indicator is carefully defined.²⁵ Data for most indicators is collected through service statistics with denominators estimated. Indicators are classified on six performance dimensions (access, equity, quality, effectiveness, efficiency, and sustainability). Health care financing indicators are also included. In theory, data on the 110 core indicators are compiled and published annually in the Health Management Information Bulletin.²⁶ In practice, although data are collected for all indicators, the Health Management Information Unit is only able to compile data and report on about a quarter of the indicators. In addition to the core indicators, the HIS uses data from population-based surveys, such as the DHS and the MICS, to monitor progress toward national and international goals.

The ***Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi***, developed in October 2005 contains indicators and targets. Unfortunately, the indicators are not consistent with data being collected by population-based surveys or by the HIS. In addition, many of the 2010 targets in the Road Map have already been surpassed, according to the latest DHS and MICS survey results. The MOH is planning a workshop in April 2007 with MOH staff, donors, and other stakeholders to harmonize indicators in the Road Map with existing data collection systems and to revise targets. As mentioned earlier, the Child Survival Monitoring and Evaluation Officer has been invited to attend this workshop. In addition, there is an on-going Technical Working Group for Research and Evaluation within the Government of Malawi. There are two non-governmental organization (NGO) seats on this working group, currently filled by Management Sciences for Health (MSH) and by CARE. The Director and Monitoring, Evaluation and Research Specialist of the national HIS has recommended that we give our inputs to this working group through the two NGO seats.²⁷

iii. Information flow

A health facility compiles data, generates reports on each predefined indicator for use by program staff and other stakeholders, and submits a report either monthly or quarterly to the District Health Officer (DHS), through the HMIS office. On a pilot basis, eight districts are submitting data monthly. The advantages and disadvantages of submitting data more frequently will be weighted and a decision taken by the government to either revert to the former quarterly system or to extend the requirement for monthly reporting to all districts. Each facility compiles data from its entire catchment area and organizes review meetings with stakeholders. In theory, data from community-based workers, traditional birth attendants (TBAs), and private health care facilities are submitted to hospitals and health centers and compiled along with facility statistics, but reporting from private sources is largely incomplete.

The DHO, through the HMIS office, compiles data from all facilities, performs comparative analysis, and sends feedback to each health facility. The MOH headquarters compiles data from all districts and central hospitals, performs some analysis, and provides feedback to those submitting data. The Health Information Management Secretariat (HIMS) sends reports to government program managers and provides general feedback to the DHOs and central hospitals. Program managers respond to the district. Besides the bottom-up reporting and top-down feedback mechanism, as described above, the HIMS compiles data on core indicators from all reliable secondary sources and sends it to districts and central hospitals for their use in planning and management of health services.

Local health staff is tasked with recognizing disease outbreaks, low coverage of health services, and adverse environmental conditions. Main response takes place at the facility level followed by district level. The transmission of information is designed to elicit help from higher levels to respond to urgent outbreaks.

c. Data quality and supervision

Save the Children supervised directly and is responsible for the quality of data in the KPC, which was outsourced to the Millennium Development Group (MDG). The NBHP Manager, M&E Officer, and other Save the Children staff (including a Program Officer on temporary duty assignment from Save the Children's Ethiopia Country Office) participated in the enumerator training and in field supervision to ensure the quality of data collection. Program information at the input and output level is maintained by the NBHP M&E Officer who is supervised by the NBHP Manager.

Save the Children does not have direct control over the quality of data being collected through the DHS, MICS, and the HIS. Data quality procedures and supervision for the DHS and the MICS are well-established and detailed in their country reports of the data. Save the Children is in the process of developing an MOU with the MOH/RHU that will include provision of technical assistance to the HIS, through proper channels, as needed and requested.

d. *Monitoring tools and methods*

The monitoring plan has been described previously. This will include annual review of measures collected in the HIS for Malawi as a whole and for all districts as well as quarterly monitoring of service statistics in those districts in which the program will be working more intensively. In addition, input- and output-level data will be collected and maintained by the M&E Officer. Data collected by the PHC Director at Ekwendeni Hospital will be reported quarterly to the NBHP M&E Officer. Illustrative of the input- and output-level data are:

- Expenditures by budget line item
- Training statistics, including trainings held, number of persons trained, and content of the training
- Training assessments for *agogos*, including pre-test of knowledge, immediate post-test, and post-test of knowledge after six months for retention. Knowledge at these three time periods will be compared
- MOH and other stakeholder activities attended
- Policy dialogue and policy changes at the national and district level
- Surveillance for tetanus
- For selected districts, service statistics relevant to newborn and maternal health that are being collected but not being reported through the HIS.

e. *How data will be collected*

i. Process to determine population denominator

The method of collecting data are described in detail in Sections 2 and 5 of this document. As the program is at the national-level and includes data collection using national population-based surveys and the national HIS, Save the Children has little control over how denominators are determined and how eligible women enter the system. For population-based surveys, the denominator includes those surveyed or a sub-set of those surveyed; and women are interviewed based upon accepted random sampling techniques. For the HIS, denominators are estimated based upon the 1998 national census and 2007 census projections.

ii. How program staff and beneficiaries will contribute to data collection

Save the Children staff will sometimes play an advisory or technical assistance role in data collection and, in other instances, will collect data directly or through contracts of sub-agreements (e.g. the Millennium Development Group and Ekwendeni). As part of the qualitative baseline assessment conducted at Ekwendeni, beneficiaries participated in focus groups and in-depth interviews and were invited to provide input into the review and direction of the *agogo* approach.

f. *How data will be analyzed and used to monitor progress and performance*

The M&E Officer has primary responsibility for compiling, updating, and analyzing program data. Data is reviewed by the NBHP Manager and Deputy Country Office Director, Programs, and shared as appropriate with national level stakeholders and partners. The Ekwendeni PHC

Director will share data from the *agogo* activities carried out under the sub-grant, including with communities.

g. *On-going assessments of essential knowledge, skills*

The plan assesses changes in knowledge through training assessments. Changes in pharmaceuticals, equipment, and services are monitored annual through the HIS.

h. *Describe how M&E skills of local staff and partners will be assessed and strengthened*

Save the Children staff, including technical advisors with SNL2, are available to provide technical assistance to HIS staff at MOH, as needed and requested. Save the Children staff and partners update skills through workshops and other short-term training events in the country or region. Of the enumerators trained for the KPC survey, half were drawn from Mzimba DHO District and the Ekwendeni PHC team, as described in the full report.

i. *Aspects of M&E system to be sustained*

Because Save the Children is not creating any parallel system of routine data-collection and works with MOH to reinforce the national HIS program, sustainability is ensured. DHS and MICS surveys are repeated on a regular interval. The next combined DHS/MICS is scheduled for 2010.

j. *Operations research*

The NBHP has two major foci for operations research:

i. *Mai Mwana Project*

The ***Mai Mwana*** project, originally titled “Improving Essential Maternal and Newborn Care in Poor, Rural Communities in Malawi,” is a multi-year research study that is evaluating the impact of two community-based interventions: (1) participatory women’s groups to improve perinatal care and outcomes in a poor rural community, and (2) the impact of home-based infant feeding counseling to improve breastfeeding, family planning usage, and maternal and newborn care best practices. *Mai Mwana* is conducted by the Institute of Child Health, University College London, in collaboration with Mchinji District DHO, the Department of Paediatrics at Kamuzu Central Hospital (KCH) in Lilongwe, and Save the Children. It is funded by SNL2 (Gates match), DfID, and other donors. The KCH Head of Paediatrics co-directs the project which aims to reduce maternal and neonatal mortality through: (1) improved perinatal care in the home and in health facilities, (2) increased awareness of perinatal health and capacity of the community to act, (3) increased knowledge and skills of health workers in perinatal issues, (4) improved access and availability of ANC, safe delivery kits, and ENC, (5) implementation of PMTCT as a routine component of ANC, (6) increased adherence to optimal infant feeding practices. Additional elements of *Mai Mwana* are health facility strengthening and reinforcement of community-facility linkages. *Mai Mwana* is a cluster randomized controlled trial involving 72 population clusters in the district of Mchinji in the Central Region. The main program intervention is an adaptation of the “community action cycle” linked to women’s groups adapted from Bolivia’s *Warmi*²⁸ model (Save the Children and MotherCare) to increase demand for care and build community capacity to address maternal and newborn care challenges. *Mai Mwana*’s study

design is an adaptation of a study carried out in Makwanpur, Nepal. Warmi reported a reduction in perinatal mortality by more than half; Makwanpur measured the effects of a participatory intervention involving women's groups on birth outcomes and demonstrated a 30% reduction in neonatal mortality before the community action cycle was completed. WCF's current replication of elements of *Mai Mwana*, especially the "community action cycle" in partnership with the DHMTs of Ntcheu and Salima Districts, is described above. *Mai Mwana* has now been refunded for completion, offering the exciting opportunity to collaborate on analyzing and disseminating lessons learned and key results with the aim of promoting uptake and scale.

ii. Community-based newborn care package (three-district pilot)

With matching funds from SNL2/Gates, Save the Children will work with the government to identify operations research in districts designated by the MOH to pilot test new community-based newborn care interventions. Implementation will be supported with catalytic funding by UNICEF and by the SWAp for scale up to 28 districts. Following UNICEF-supported visits of MOH officials to the community-based SEARCH project in India, Save the Children, in cooperation with UNICEF, organized a Design Workshop for MOH to bring stakeholders together to begin planning a three-district pilot. Districts selected are Thyolo, Dowa, and Chitipa Districts, representing three regions of the country, and among the 10 districts in Malawi where ACSD and IMCI/c-IMCI are being accelerated. The pilots will be designed to answer specific operational questions. Main questions which could be addressed include: the use of injectible antibiotics by HSAs; the feasibility, content, net cost, and sustainability of resuscitation at the community level; and the frequency and timing of post-natal visits at home. Please see Annex XI for report of Design Workshop organized by Save the Children in cooperation with UNICEF for MOH and partners.

Newborn care interventions package being promoted in community three-district pilot

Home health care including:

- Demand for skilled care for ANC, delivery, PNC
- First PNC check of neonate within 24 hours of delivery for babies born outside of health facilities
- Series of 3 PNC home visits by trained HSAs
- Immediate and exclusive breastfeeding with no pre lacteal feeds
- Drying and warmth
- Hygienic cord care
- Skin care
- Recognition of neonatal danger signs
- Extra care for LBW neonates
- Early detection and referral for complications
- Referral or case management of neonatal sepsis and pneumonia (to be phased in)
- Coordination with PMTCT

Lessons learned from the three-district pilot will be used to inform scale up of community newborn care to all 28 districts of Malawi. In fact, within the context of ACSD/IMCI, the MNC community package is being taken forward by other organizations, including ACCESS, PNMCH, etc. (See Annex XVIII for a matrix of districts by organization). Lessons learned are and will be disseminated through the community initiative task force for adaptation of the SEARCH model - established in February 2007 - that currently includes MOH, UNICEF, Save the Children – and that will include ACCESS, PMNCH, and others when they become operational. Regular minutes are kept of these task force meetings.

k. Contribution to CSHGP program results

Save the Children will contribute toward CSHGP results as follows:

- **PR1: Improved health status of vulnerable target populations**, including PR1.1 (Increased knowledge and improved practices and coverage related to key health problems in interventions), PR1.2 (Improved quality and accessibility of key health services at health facilities and within communities), and PR1.3 (Increased capacity of communities, local governments and local partners to effectively address local health needs);
- **PR2: Increased scale of health interventions**, especially PR2.1 (Increased population reached through the use of strategic partnerships and networks), PR2.2 (Improved health systems and policies that support effective health programs and services at the national level, and PR2.3 (Improved collaboration with USAID Missions or Bi-lateral programs;
- **PR3: Increased contribution of CSHGP to the global capacity and leadership for child survival and health**, including PR3.1 (Increased technical excellence) and PR3.2 (Improved recognition and visibility of PVO work in health).

l. Contribution to USAID Mission Strategy

The USAID Malawi Mission Strategic Objectives and Intermediate Results: The NBHP is fully aligned with the USAID Mission’s current Strategic Objective (SO) 8: *Adopting behaviors that reduce fertility, the risk of HIV/AIDS and improve child health* and contributes to Intermediate Result (IR) 3: *reduce child mortality* and IR 3.4: *improved prevention and management of childhood illnesses and increased use of malaria prevention practices*. We are assured that Mission commitment to the health of children under five (including newborns) will continue, and will be reflected in the Mission’s new 5-Year Strategy and reduced set of three SOs, including *Improved Health and Education of the Rural Poor*. The new USAID Malawi Strategy, Results Framework, and supporting indicators are soon to be rolled out as the 2007 Operational Plan. When this document is released, the program will review the strategy and realign its program to the extent feasible.

m. Program evaluation plan

Mid-term evaluation - The participatory mid-term (process) evaluation of the NBHP will be held in the early fourth quarter of 2009 over a 3-week period. The evaluation team will be led by an external consultant (to be approved by CSHGP). Other members of the mid-term evaluation team include: Representative of MOH/RHU; Mzimba DHO or designee; Ekwendeni PHC Director or designee; NBHP Manager, Africa Regional Health Advisor, CS Advisor (HQ back-

stop), and representative of non-MOH partner. This evaluation is participatory, focused on process, and will cover both the national level program and activities completed in Mzimba and Ekwendeni between FY07-09.

Final evaluation - The KPC endline survey will be conducted after the rainy season, in the early third quarter of FY2011. The project final evaluation will take place in the early fourth quarter of FY2011 over a 3-week period. The final evaluation team will be led by an external consultant (to be approved by CSHGP) and will include: Representative of MOH/RHU, Representative(s) of SNL2 in Washington, DC, the project's headquarters back-stop, the Africa Regional Health Advisor, Representative of non-MOH partner organization. The evaluation will focus on outcomes and results from the national level program. Evaluation procedures will be consistent with CSHGP guidelines. Methodology will include:

- Review of the results of all assessments, including new DHS, MICS, and HIS measures, as well as Mzimba KPC survey results
- Interviews with key stakeholders
- An assessment of whether the program has reached its quantitative goals at the output, outcome, and impact levels
- An assessment of whether the program has reached its goals at scale throughout Malawi, including influencing supportive policies, norms, and procedures through demonstration and advocacy

6. Program Management

Management Structure The Newborn Health Program of Save the Children in Malawi currently comprises two funding sources: CSHGP and SNL2 (Gates). As the goals and objectives of these two programs are complementary in nature, Save the Children has developed an integrated management structure at the country office level that takes advantage of our global, regional, and country level human resources and capacities, as outlined below.

All NBHP team members are currently in place.

Country Office Management Within the field program, the **Country Office Director**, Paul Mecartney, is responsible for overall strategic leadership and program, financial, and administrative management of the country portfolio. He has over 15 years of international development management experience, primarily with Save the Children, and reports to the Africa Area Director based in Addis Ababa.

The **Deputy Country Office Director, Programs** (20%), Jeanne Russell, manages the development and implementation of the country office portfolio and supervises sector Program Managers in Newborn Health, HIV/AIDS, and Food Security. She has an MPH in international health systems and 15 years of international development experience, also primarily with Save the Children.

The **Deputy Country Office Director, Administration and Finance**, Isaac Chipofya provides administrative and financial oversight to ensure compliance with grant and donor requirements at the field office level, including budget management, fund accounting, and effort reporting. He has over seven years experience managing large USAID-funded capacity building projects, as

well as experience as an auditor. He reports to the Country Office Director and supervises all administrative and financial staff members, including the Office Manager, IT Manager, Senior Accountant, and Accountant. The Internal Auditor and Human Resources (HR) Manager report directly to the Country Office Director to ensure the highest level of attention to the integrity of operations, on the one hand; and to ensure the priority of national staff development, on the other. Country Office Management costs, including salaries and fringes for these management support staff, are budgeted at 4%.

Under the direction of the Country Office Director, the Country Office Senior Management Team (SMT), comprised of the Deputy Directors, Program Managers, and Human Resources Manager, ensures cross-program collaboration, continuity of service, and consistency in development and application of policies and procedures. The SMT meets bi-weekly for program/organizational updates and program and policy reviews, reviewing strategic and operational plans semi-annually. Annually, the SMT and technical officers from across programs meet to review the Country Office Strategic Plan and to design the Program Operating Plan for the next year. Leadership and technical retreats are held periodically, often involving external experts and partner organizations.

Acknowledging the devastating impact of HIV/AIDS in Malawi, the Country Office has established an HIV/AIDS workplace policy and program that is led by HIV/AIDS technical staff and the HR Manager.

Newborn Health Technical Team and Program Management. The NBHP team is led by the **Newborn Health Program Manager** (75% USAID/25% SNL), Evelyn Zimba, who oversees both USAID and SNL2 (match) funding sources under the overall direction of the Deputy Country Office Director, Programs. Ms. Zimba is responsible for overall management of project implementation, technical leadership, coordination with MOH, donors, and international and local partners, and monitoring and evaluation. She is a nurse midwife, holds a Master's degree in Pediatric Nursing from University of the Witwatersrand in South Africa, and has worked in newborn health and capacity building for Save the Children in Malawi since 2003.

Two **Project Officers** (100% LOE each), Reuben Ligowe and Maggie Kambalale, are responsible for liaison and coordination with, and technical assistance to, community-based and national-level partners; as well as capacity-building, mentoring, training, support, and documentation. Mr. Ligowe is a Clinical Officer with experience in paediatrics who is working on his MPH degree. He came to the NBHP from Save the Children's Umoyo Network where he was an HIV/AIDS Officer. Mr. Ligowe brings an excellent grounding in medicine and public health, NGO partner capacity building, PMTCT, and has solid relationships with the MOH. Ms. Kambalale is a nurse midwife who transferred to the NBHP from the position of Adolescent and Reproductive Health Coordinator with Save the Children in Mangochi. She brings strong skills in community level interventions and behavior change communication strategies.

M&E Officer George Chiundu (50% USAID/50% SNL) is responsible for oversight of assessments and surveys, M&E plan implementation, and coordination with the national HIS. He oversees documentation of results and achievements. Mr. Chiundu reports to the MBHP Manager and liaises with MOH/RHU and HIS Unit, providing support to the national HIS and M&E systems to ensure system strengthening and integration of neonatal data. He also provides

essential TA in community-based data systems, building on Save the Children's past experience with newborn health community approaches and village-level monitoring systems. Mr. Chiundu has worked for Save the Children as M&E Officer for SNL1 and subsequently with Umoyo Network. Mr. Chiundu holds a Bachelor of Science degree in Statistics and Computer Science.

The **Finance and Grants Manager** (position currently vacant; 50% USAID/50% SNL) provides overall financial budgeting, monitoring, reporting and regulatory compliance guidance and support to the Newborn Health Program. This position has been posted, and is anticipated to be filled in May.

Project Assistant Loveness Kaunda (50% USAID/50% SNL) provides logistics, communications, and administrative support to the Newborn Health program. She has experience with Save the Children supporting the SNL1 project and subsequently as Administrative Assistant to the HR Manager in the Lilongwe office.

Under SNL2 funding, Save the Children is currently recruiting for a **Research and Evaluation Manager** to provide additional support to the NBHP, especially for operations research (match funded) and M&E. This position will report to the Deputy Country Office Director, Programs.

Headquarters and Regional Management and Backstopping Team. Given its Expanded Impact and national-level focus, the NBHP demands strong backstopping and TA.

Office of Health (OH) Associate Director, Carmen Weder (10% in Yrs 1,3,5; 5% in Yrs 2, 4) is Save the Children's principal contact person with USAID/CSHGP on all issues regarding grant management, budget approvals, financial reporting, and provides backstopping, guidance and communications with the field office on grant management related issues.

Health Advisor Eric Starbuck (5%) is responsible for technical backstopping, monitoring, and guidance and is the principal point person in communications with CSHGP on technical and programmatic issues. The project will benefit from his expertise in M&E and operations research and many years of working closely with CSHGP. He participates in key activities such as project planning, DIP input and review, annual reporting, and midterm and final evaluations. The CS Advisor will make a total of two visits during the life, at midterm and final evaluation, to ensure effective collection, analysis, documentation, and dissemination of program accomplishments and learning.

Africa Regional Health Advisor Karen Z. Waltensperger (20% in Years 1, 3, 5; 15% Yrs 2, 4) supports the project technically and programmatically from her base in South Africa. The project benefits from her 15 years of field experience in sub-Saharan Africa and membership on the SNL2 technical team, helping to ensure integration of the NBHP with the global newborn health initiative. She led the NBHP proposal development process and DIP writing; has been involved in project start-up; and will take part in the midterm and final evaluations, documentation of results, and regular technical assistance visits from her base in Pretoria. She will make 18 regional visits of 18 days average duration during the life of the project to support planning, implementation, and evaluation.

The NBHP accrues synergistic benefits (technical, advocacy) from membership in the SNL2 global learning community, including access to current research results, lessons learned, and

opportunities to support the Road Map through operations research. The NBHP Manager attends the SNL2's annual Program Managers Meeting for newborn health.

Additional technical support is accessed through SNL2 (Gates) match. For example, La Rue Seims, SNL Senior Research and Evaluation Advisor, participated in the in-country DIP process and provided technical assistance for development of the M&E Plan. Senior SNL Senior Advisors Joy Lawn and Steve Wall, and Associate Director for Research and Programs, Shyam Thapa, provided technical assistance during the MOH Design Workshop (February 2007) for the community-based neonatal care pilot to be carried out in three districts. The project benefits from the broad-based support and commitment of the entire Save the Children Office of Health and the agency as whole.

All technical support staff provides guidance by telephone and email in addition to country visits and may be called upon for assistance with internal or external auditing, evaluations, report writing, and dissemination. Internal project reports from the Country Office will be shared with technical staff and feedback sought as needed.

The Save the Children Office of Health organizes the annual Program Learning Group (PLG) for Health meeting in Washington, DC, where the NBHP Manager participates to hone technical and programmatic skills, as well as to share project experience and lessons learned. This meeting coincides closely with the Global Health Conference and Mini-University, in order to reduce international travel expenses.

Please see the Newborn Health Program Organizational Chart in Annex VI.

Responsibilities and Lines of Communication. All Save the Children Malawi Country Office NBHP team members are based at the central office in Lilongwe for maximum access and coordination with MOH, Road Map partners, and national structures. All staff members make frequent trips to the field at critical points in project implementation (e.g., baseline and endline surveys, midterm and final evaluations, dissemination workshops, as well as for routine partner coordination, observations, monitoring, mentoring, joint supervision, training, and TA).

On a quarterly basis, the Newborn Health Program team will review work plans and make any adjustments necessary to ensure successful completion of activities and progress toward meeting objectives. The NBHP Manager will meet with her team and with the Deputy Country Director, Programs, on a weekly basis, with more frequent ad hoc meetings and updates as/when needed.

The MOH, as leader of the Road Map process, is responsible for coordinating partner resources and inputs. The NBHP Manager participates in all meetings of the Safe Motherhood and Newborn Health Sub-Committee of the MOH Sexual and Reproductive Health task force meetings on a quarterly basis, as well as the MOHRHU annual work plan meeting and numerous ad hoc task forces and working groups. As the Road Map progresses, Save the Children will monitor the effectiveness of coordination and collaboration mechanisms and make suggestions to RHU as necessary should mechanisms require further clarity. The same is true of coordination mechanisms established for the community-based newborn care package (still in development though initially through a working group under RHU). At the beginning of Yrs 2 and 5, program review meetings will be held with MOH and key stakeholders to reaffirm commitments and assess progress. Adjustments to work plan will be made based on review results.

Ekwendeni Mission Hospital (Synod of Livingstonia), a CHAM member facility, will receive a sub-grant in the amount of \$176,972 (\$124,972 USAID; \$52,000 match from private funds to expand and document its work with *agogos*. Ekwendeni has successful experience as a sub-grantee with Save the Children in Malawi under both SNL1 and Umoyo Networks. Based on results of the qualitative baseline assessment of the Ekwendeni *agogo* approach conducted by Judi Aubel (The Grandmother Project), Save the Children is in the process of executing a program description and sub-grant agreement with Ekwendeni that will include a detailed program description, M&E plan, and work plan. Oversight of the Ekwendeni sub-grant is performed by the Finance and Grants Manager. The NBHP Manager, Project Officers, and M&E Officer will provide guidance, coordinate technical support and monitor Ekwendeni's project-related activities.

Please see the Newborn Health Program Project Organizational Chart in Annex VI.

7. Organizational Development Not applicable

8. Training Plan

As part of a national program, Save the Children mainstreams its training inputs with those of MOH and other Road Map partners. This means that, rather than conducting its own independent training program, Save the Children supports MOH training activities relevant to newborn health through joint planning; technical assistance (e.g., for design, adaptation, review, and/or evaluation of training curricula), provision of trainers, and partial funding. The NBHP budget contains an annual line item for this partial funding designated "Mainstreamed training, TA, and inputs to MOH". Save the Children feels strongly that this strategy promotes "ownership", sustainability, and accountability on the part of MOH. Accountability will be ensured by application of mutually-agreed upon and strict criteria, documentation, and reporting requirements. Guidelines will be developed jointly with MOH during DIP development and agreed upon by an MOU signed by all parties. This strategy is justified in the spirit of partnership, integration, and national program mainstreaming. Although the 5-year training plan cannot be specified at this point, illustrative topics of relevance to the newborn include: 1) ENC/KMC package for health workers; 2) Management of Birth Asphyxia; 3) Management of the Sick Newborn; 4) Perinatal and Maternal Death Audits and Social-Verbal Autopsies for First Level Facilities; 5) HIS and M&E relevant to newborn health.

Whether at the district or national level, Save the Children's role in training is characterized by: 1) joint planning; 2) joint development/review of training curricula and materials; 3) joint development/review of evaluation tests and tools; 5) facilitation of accessing trainers and training networks; 6) participation in monitoring and evaluation of training packages.

Please see the revised work plan below that includes an expanded training section with timeline. Subsequent annual work plans to be submitted by agreement with CSHGP will include updated training details coordinated with MOH/RHU, ACCESS, PNMCH, and Road Map partners.

9. Work Plan

The revised five-year work plan that follows has been merged with the country office's SNL work plan and represents the integrated Malawi Newborn Health Program as a whole. This work

plan was developed in collaboration with MOH/RHU in July 2007 and contains considerably more detail in the areas of partnerships, training, advocacy, technical assistance, and networking, as requested. The funding source for each activity (SNL or CS) is indicated in the final column. Some activities are supported jointly with funds from both SNL and USAID/CSHGP. We believe this merged work plan is more informative in terms of coordination, synergies, timelines, and benchmarks.

Proposal for submission of annual work plan - With ACCESS initiating its program activities in October 2007 – and with Save the Children’s participation as an ACCESS partner - it is anticipated that coordinated work plan will adapt and develop further. As agreed with CSHGP at the Mini-University DIP review in June 2007, Save the Children will provide detailed annual work plan – to be developed in close collaboration with MOH/RHU, ACCESS, and Road Map partners – and synchronized with the Malawi government planning cycle and July-June fiscal year. According to this cycle, planning commences after the beginning of the new year; a MOH/RHU planning meeting is held in February; and the final MOH/RHU work plan is submitted in April for the fiscal year that begins July 1st. Beginning in early 2008, Save the Children will be in a position to engage earlier and more productively in the MOH/RHU planning cycle for its FY09. This engagement and coordination will be reflected in Save the Children’s detailed FY09 work plan to be submitted to USAID/CSHGP with the FY08 annual report (to be submitted in October 2008). Subsequent FY10 and FY11 work plans will be submitted in October 2009 and October 2010 respectively.

Table 6. Save the Children, Malawi Newborn Health Program Five-Year Work Plan 30 September 2006 – 30 September 2011

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

FY07				FY08				FY09				FY10				FY11			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4

Activity

																				Outputs / Bench Mark	Responsible Person	Funding
Program Management																						
Activity 1: Recruit and hire staff	X																			All positions filled	PM / DCDP / KZW	CS/SNL
Activity 2: Project start-up activities	X																			Start-up activities documented	PM / DCDP / KZW	CS/SNL

Operational Research

Community-based maternal and newborn care

Activity 1: Finalize proposal and budget with MOH, UNICEF and 3 districts for community PNC pilot				X																PNC pilot proposal finalized	PM/MEM	SNL
Activity 2 : Finalize tool and conduct Health Facility Assessment				X	X															HFA report	MEM/MEO	SNL/CS
Activity 3: Collaborate with partners to design, conduct and analyze population-based survey in 3 learning districts				X																KPC report	MEM/MEO	SNL
Activity 4: Design sepsis management protocol				X	X															Sepsis protocol documented	MEM/MEO	SNL
Activity 5: Finalize design of district pilot (sepsis to come later)				X	X															Design developed	MEM/MEO	SNL

- 1 Kang'ombe, CV, Secretary for Health. Letter, Ref. No. Med 4/29. 7 March 2007.
- 2 Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13:978-0-620-37-695-2. ISBN-10: 0-620-37695-3.
- 3 Lawn JE, Cousens S, Zupan J. 4 million neonatal deaths: when? Where? Why? Lancet 2005; 365: 891-900.
- 4 Updated by Kate Kerber from Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13:978-0-620-37-695-2. ISBN-10: 0-620-37695-3.
- 5 The Lancet, Neonatal Survival Series, Elsevier Ltd., London, UK, March 2005. Also available online at www.thelancet.com.
- 6 Darmstadt GL, Bhutta ZA, Cousens S et al. Evidence-based, cost-effective interventions: how many newborn babies can we save? Lancet 2005; 365: 977-88.
- 7 Vulnerability Assessment Committee (VAC), August 2003.
- 8 National AIDS Commission (NAC).
- 9 United Nations Development Program, Human Development Report, 2006.
- 10 This section is excerpted from an SNL report entitled Cultural Beliefs, Societal Attitudes, and Household Practices Related to the Care of Newborns in Malawi by Karen Z. Waltensperger, June 2001.
- 11 Zomba, Queen Elizabeth, Ekwendeni Mission, Bwaila (formerly Bottom), Mulanje Mission and Malosa Mission Hospitals
- 12 The Road Map reports per capita expenditure at about \$12 USD.
- 13 Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13:978-0-620-37-695-2. ISBN-10: 0-620-37695-3.
- 14 Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13:978-0-620-37-695-2. ISBN-10: 0-620-37695-3.
- 15 IMCI Approach Policy for Accelerated Child Survival and Development in Malawi: Scaling up of high impact interventions in the context of the Essential Health Package. Government of Malawi, Ministry of Health. Lilongwe: November 2006.
- 16 State of the World's Newborns: Malawi, Save the Children/Saving Newborn Lives. Lilongwe: January, 2002.
- 17 Personal Communication, Dr. Christopher Moyo, Director HIS and Dr. V.V.R. Seshu Babu, Monitoring, Evaluation, and Research Specialist, HIS March 9th 2007.
- 18 Saving Newborn Lives Formative Study for Newborn Survival: A Study Conducted in Mulanje/Phalombe, Mangochi and Ekwendeni, August-November, 2002.
- 19 Kirkpatrick, Donald. Evaluating Training Programs: The Four Levels. Berrett-Koehler, 1998. ISBN 1576750426.
- 20 Strategic Direction 2008-2012: Getting to Great for Children (Second Draft). Save the Children Federation, Inc. Westport: March 2007.
- 21 Joy Lawn and Kate Kerber, eds. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health (PMNCH). Cape Town, 2006. ISBN-13:978-0-620-37-695-2. ISBN-10: 0-620-37695-3.
- 22 PDQ involves working with health service providers and community members to define what quality MCH services mean from the perspectives of both groups, sharing these perspectives between the two groups, and planning and implementing activities to improve quality from both perspectives and to increase use of essential MCH services. Initially, discussions are conducted with community members, especially mothers, other child caretakers, and decision makers, to understand their perceptions of the quality of services provided by MOH facilities.

Similar interviews are conducted with MOH facility staff. This information is then analyzed and results shared with community leaders and members and with health providers in a joint forum, followed by joint planning sessions and implementation of activities to improve quality. The PDQ process seeks to: (1) Bridge gaps between the health workers and clients to improve communication and appreciation of each other's limitations and strengths; (2) Develop appropriate strategies to strengthen the quality of services from the community perspective, such as achieving consensus on changes in a service to make it more user-friendly or culturally appropriate, or training health workers in communication and counseling skills; (3) Increase use of essential MCH services; (4) Create active community participation in the delivery of essential MCH services, and; (5) Jointly monitor implementation of changes.

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

24 *Health Information System: National Policy and Strategy*, Government of Malawi, Ministry of Health and Population, December 2003.

25 *Measuring Health Sector Performance: A Handbook of Indicators*, Government of Malawi, Ministry of Health and Population, December 2003.

26 *Health Management Information Bulletin: Annual Report*, July 2005-June 2006.

27 Personal Communication, Dr. Christopher Moyo, Director HIS and Dr. V.V. R. Seshu Babu, Monitoring, Evaluation, and Research Specialist, HIS, March 9th 2007.

28 Kathleen O'Rourke, Lisa Howard-Grabman and Guillermo Seoane, Impact of community organization of women on perinatal outcomes in rural Bolivia, *Revista Panamericana de Salud Pública*, Print ISSN 1020-4989, *Rev Panam Salud Publica* vol. 3 no. 1 Washington Jan. 1998, J doi: 10.1590/S1020-49891998000100002.

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ANNEX I
Response to Application De-Briefing

Save the Children Malawi
Newborn Health Program

Note: *Reviewer comments have been re-organized by category to reduce redundancy.*

1. PAST EXPERIENCE The application could be strengthened if the applicant included more information on Child Survival and Health Grants Program (CSHGP) experience and results of activities piloted through those projects. Most of the experiences noted are through the Saving Newborn Lives (SNL) program.

Since 1985, Save the Children has implemented USAID centrally-funded child survival projects, beginning with CS-1 and including CS-2, CS-5, CS-9, and CS-15 in Malawi. Given the 25 page limit for the technical application, and our intention to implement an Expanded Impact project focusing on newborn health at the national level, we chose to highlight the successful national scale newborn health experience carried out under SNL1 as most immediate and most relevant to the proposed project.

2. KANGAROO MOTHER CARE The application would have also benefited if the applicant specified what the project has already achieved at the District level. For example, the applicant could have presented more information on how well the Kangaroo Mother Care (KMC) method has been accepted by the mothers with whom the program has worked.

While community-based KMC is probably a good idea, it is unclear how it will be developed. Is this part of the referral system for KMC? Are babies identified as low birth weight at the health facility? How will at home deliveries be addressed? Is KMC targeted to all newborns? There is no discussion about how many facilities already have a KMC unit or are providing KMC services. Is there a reason why Zomba will not be involved in this aspect of the project, at least in providing TA? The indicators regarding KMC are measuring the number of health facilities providing KMC services. The proposal talks about expanding to the community level, but there are no indicators to measure this. It would be helpful to have some outcome measures of KMC.

There also needs to be more discussion in this section of how the MOH has integrated ENC/KMC training into their 2005 work plan, how many people have been trained, and how many providers remain to be trained. Surprisingly, there is also no discussion about how the Training Network, created by SNL, has been functioning.

Please see Annex IX, Excerpts from SNL Final Evaluation (February 2005) for a summary of Save the Children’s KMC experience in Malawi carried out under SNL1. All six KMC units established under SNL1 continue to function, including Zomba, which had to be “resuscitated” and upgraded to become a training center. It is not currently operational as a training center, however, as Africa Development Bank funding for expansion of KMC is

only now becoming available for the MOH FY08 financial year. With match fund, Save the Children is conducting a current situational assessment of KMC in Malawi to inform the way forward. This is scheduled to take place the last two weeks of July 2007.

Community-based skin-to-skin care for all babies is currently under discussion for inclusion in the community-based newborn health package (match-funded operations research) to be piloted in Thyolo, Dowa, and Chitipa and eventually scaled up country-wide. Save the Children is partnering in this effort, now in the design phase, as described in the DIP document.

KMC appears in the Road Map; and MOH has incorporated KMC objectives and targets into its FY08 work plan (see Annex X). As this DIP was going to press, representatives from the global ACCESS project were arriving to undertake a country visit to assess what role ACCESS might play to fill gaps in maternal and newborn health in Malawi. KMC and community skin-to-skin were both under discussion but no decisions had been made. Information about decisions taken, ACCESS plans for moving forward in Malawi, and links to the NBHP will be provided at the DIP defense at the Mini-University in June.

Revitalization of the KMC/ENC trainers network did/does, in fact, appear in the application Action Plan for Year I as a 3rd quarter activity.

3. COMMUNITY COMPONENT While the proposal provides good information on the situation within the country, it presents very little data specific to Ekwendeni.

The document makes a clear case for why the project is needed in Malawi but it is not clear why Save the Children chose to work in the north. On Pg 5, the proposal states that “rates of chronic childhood malnutrition and HIV rates are highest in Southern and Central Malawi.” More information could be provided as to why the Mzimba District and the partner Ekwendeni were chosen.

The Mzimba District is in the north and has a very small population (note: numbers of beneficiaries are provided in annex D but not in the body of the proposal, also the map provided is for Malawi but no map of the project area is provided).

In addition, the applicant should clarify if the community and capacity building interventions will be implemented only in Mzimba district or in a larger area. The linkage between lessons learned from the community level and application to the national level efforts is not as clear.

Ekwendeni made significant achievements under SNL but this data is not included. The lack of this data leads one to ask what is left to be done in this area and why it was selected as the sole project site. A KMC unit was opened in Ekwendeni hospital under SNL but this information is also not included.

The community component is well articulated but the geographic/project area is unclear and the clinical and training components would greatly benefit from further articulation.

At 44/1,000, Mzimba’s NMR, as measured in the 2006 MICS, is, in fact, the fourth highest of 28 districts in Malawi and over a third (36%) higher than the national NMR of 31.

Notwithstanding, the NBHP is an Expanded Impact project being carried out at the national level in Malawi. The project does not focus on any one district, and there is no “project implementation area” per se. The map of Malawi in the application was appropriate. As the DIP describes, both the project and its community component have co-evolved along with MOH priorities, emerging opportunities, and the government’s growing commitment to neonatal health and community approaches. Accordingly, the project’s community component now comprises selected activities in five districts (Chitipa, Mzimba, Mchinji, Dowa, and Thyolo) in all three regions of the country. Our collaboration with Mzimba has diminished in scope and size, although we will continue to advocate for Mzimba’s inclusion in KMC scale up and other select opportunities. Please see detailed description of the community component in the DIP and updated map in Annex III.

4. IMPORTANCE OF FOCUSING ON NEWBORNS Likewise, the application would have been stronger if more information on the overall health status of children under 5 was presented to demonstrate the importance of focusing on newborns.

Just as our DIP was growing to press, MOH invited Save the Children to participate in a series of working meetings, requested by UNICEF/ESARO, to document Malawi’s success over the past decade in becoming “one of only three countries in sub-Saharan Africa that has demonstrated remarkable reduction of child mortality rate since 1990, such that attaining MDG 4 is very likely¹”. There is no question that Government of Malawi (GOM) commitment to reduction of the U5MR is a key factor of that success, along with growing focus and action on maternal and neonatal care. Indeed, the publication *Opportunities for Africa’s Newborns*² (OAN) lists Malawi 7th among eleven sub-Saharan countries where newborns have the lowest risk of dying.

Notwithstanding, effort to sustain the declining trend in maternal and newborn mortality in Malawi needs to be reinforced. In sub-Saharan Africa (SSA), the NMR as a proportion of U5MR averages 25%, per OAN. As reported in the 2005 Malawi DHS, the NMR (26) was low at 21% of the U5MR (133); among the lowest in Africa. Taking into consideration current coverage indicators, and the impressive decline in U5M, we viewed this as an unusual pattern. In order to facilitate a repeat measure, Save the Children made a financial contribution (\$75,000) from SNL2 funds to UNICEF to increase MICS sample size and add a mortality component in 2006. The MICS Preliminary Report indicates an NMR of 31 and U5MR of 118; with NMR accounting for 26% of the U5MR, closer to the SSA average.

¹ Kang’ombe, CV, Secretary for Health. Letter, Ref. No. Med 4/29. 7 March 2007.

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

5. *SYPHILIS SCREENING* There is no mention of syphilis screening or treatment even though this is a large problem in Malawi and SNL had piloted a rapid test for the MOH.

Syphilis is indeed a significant problem in Malawi, and Save the Children did pilot a rapid test for syphilis in Mangochi District under SNL1. Expansion of this activity through training of ANC providers in WBRT for syphilis screening appears as a line item in the FY08 MOH budget and work plan under PMTCT with links to RHU. Please see Annex IX, Excerpts from the (February 2005) SNL1 Final Evaluation, for a summary and results of the syphilis screening experience in Mangochi.

6. *ENC TRAINING* The proposal does not explain how the 50 health center nurses will be trained or who will do the training (4 district trainers from Ekwendeni and Master Trainers?). Will these trainees be trained on ENC/KMC combined? Will they also be trained on community aspects? Where will they be trained? Ekwendeni may not have an adequate caseload for the training, particularly not if management of the sick newborn is included. How will trainees be supervised?

The MOH/RHU FY08 budget and work plan includes inservice ENC training for health providers in all 28 districts. Districts, including Mzimba, have included this training in their own FY08 District Implementation Plans. As training is mainstreamed, Save the Children's role as a national level partner will be to provide support and technical assistance for this effort, including review and revision of curriculum and training materials, accessing TOT and trainers, and monitoring and evaluation of the training package results. As agreed, the NBHP will assist Mzimba in conducting and documenting its ENC training experience.

7. *MONITORING AND EVALUATION* The use of the GAP analysis tool is commendable and could provide lessons learned for other CSHGP Expanded Impact projects.

While the M&E Officer is well qualified, is 50% of the M&E Officer's time sufficient?

It would have been helpful to have what information is currently available regarding the MOH system of monitoring data and how this program will be a part of the existing system.

IRI on access might need to be reevaluated. Since the home birth rate in the project area is uncertain, it is not possible to assess if 80% of the births can occur in health facilities. More clarification is needed for why the indicator is "80% of births in health facilities" but only "70% delivered by a skilled provider". This suggests that 10% of women who deliver in a health facility will deliver with an unskilled provider, which is unlikely to be the intent.

It is not clear whether the targets are for Mzimba district, a larger area, or national level. The targets seem ambitious for Malawi but may be appropriate for the Mzimba district.

George Chiundu, whose CV was presented in the application, has been hired as M&E Officer for the Malawi Newborn Health Program at 100%, with salary split 50/50 between USAID funding and match.

The entire results framework - including goal, objectives, intermediate results, and indicators - has been thoroughly reviewed and revised as part of the DIP process. As this is an Expanded Impact project operating at the national level, our goals, objectives, intermediate results, and indicators are aligned with those of the MOH; and we focus on national level indicators and data collection. As a national Road Map partner, Save the Children is working with the HIS office at MOH to review and refine targets and indicators. A national-level meeting to review and amend the RHU HIS is scheduled for mid- to late-April 2007, and Save the Children has a place at the table.

As stated earlier, changing MOH priorities and new opportunities have led to updated plans for the community component as originally proposed. Because Mzimba was not selected by MOH as one of the three districts for the community newborn care pilot, we decided not to conduct a GAP analysis there and raise expectations that could not be met. However, the World Bank will be assisting MOH to design and conduct health facility assessments in all districts of Malawi. Although this HFA focuses on malaria, MOH wishes to include maternal and newborn; and Save the Children is working with RHU and HIS to ensure the newborn is well covered.

8. COMMUNICATIONS It is still not clear what the roles of lines of communication are for key partners. MOH will be leading the process but how the organizations will communicate is missing.

Communication happens through regular quarterly meetings of the national Sexual and Reproductive Health Technical Working Group and quarterly meetings of the Safe Motherhood and Neonatal Health Technical Sub-Committee which Newborn Health Program Manager Evelyn Zimba attends on a regular basis. Ms. Zimba also participates in the annual RHU work plan meeting and represents Save the Children on numerous ad hoc working groups, including the one now taking forward plans from the Design Workshop for the 3-district community-based newborn care pilot.

9. BACKSTOPPING The level of effort devoted to headquarters backstopping is budgeted at 15% to 25 %, shared by three people. The applicant is encouraged to consider placing only one person in this position. This would ensure that there is strong commitment³ by whoever is assigned to this position.

Eric Starbuck, Child Survival Advisor, backstops this project technically from Save the Children's home office in Westport and is currently budgeted at 5%. Carmen Weder, Office of Health Associate Director, performs a grant management role and is currently budgeted at 10% in Yrs 1,3,5 and 5% in Yrs 2,4. The project is being supported programmatically and technically in the field by Karen Z. Waltensperger, Africa Regional Health Advisor, at 20%. Karen, who is based in the region (Pretoria) led project design, proposal writing, and DIP development, and has a strong commitment to the Malawi Newborn Health Program. Other technical support comes from SNL2 match. For

example, La Rue Seims, SNL Senior Research and Evaluation Advisor, participated in the DIP process and provided technical assistance for development of the M&E Plan; and SNL Senior Advisors Joy Lawn and Steve Wall, and Associate Director for Research and Programs, Shyam Thapa, assisted with the MOH Design Workshop (February 2007) for the community-based neonatal care pilot to be carried out in three districts. The project benefits from the broad-based support and commitment of the entire Save the Children Office of Health and the agency as whole.

10. MISSION COLLABORATION AND SUPPORT More discussion about Mission involvement in program design, beyond the involvement with the Roadmap, is needed.

The applicant should clarify whether the geographic area for the community component is congruent with Mission priorities.

The applicant has strong support from the Mission. Considering that the Mission has very little funds for child health, its willingness to consider options to support it through global mechanisms is encouraging. USAID has two global mechanisms – BASICS and ACCESS – through which this might be possible.

Representatives of the USAID/Malawi Mission have participated in several of the project's start-up activities. Please refer to the section of the DIP that covers start-up activities for names and details.

As noted above, the project's community component has co-evolved with the government's growing commitment to neonatal health and community approaches over the past 18 months and has been updated to conform to current MOH plans. These changes are described in detail in the DIP. With regard to Ekwendeni specifically, the scope of our collaboration has diminished in size and scope, taking into consideration reviewers' comments and emerging opportunities. In October 2007, representatives of the USAID Mission accompanied Namita Agravat from CSHGP on a community visit to Ekwendeni in late October 2007 where *agogo* activities were observed. The project's focus on expanding, refining, documenting, and packing the *agogo* strategy was discussed at that time.

11. PARTNERING AT THE NATIONAL LEVEL Overall, while the intention might be to build on their previous work, the proposal does not make the case obvious. There is a vision for scale up to the whole country, but a clearer description of how this will be achieved would greatly strengthen this proposal.

There are some uncertainties regarding roll out of the Roadmap which bring up questions about the start up of this project within a national program. The linkage between the national level and the community component and how it will be scaled up is not clear and if this strategy falters, a system is not in place for making adjustments.

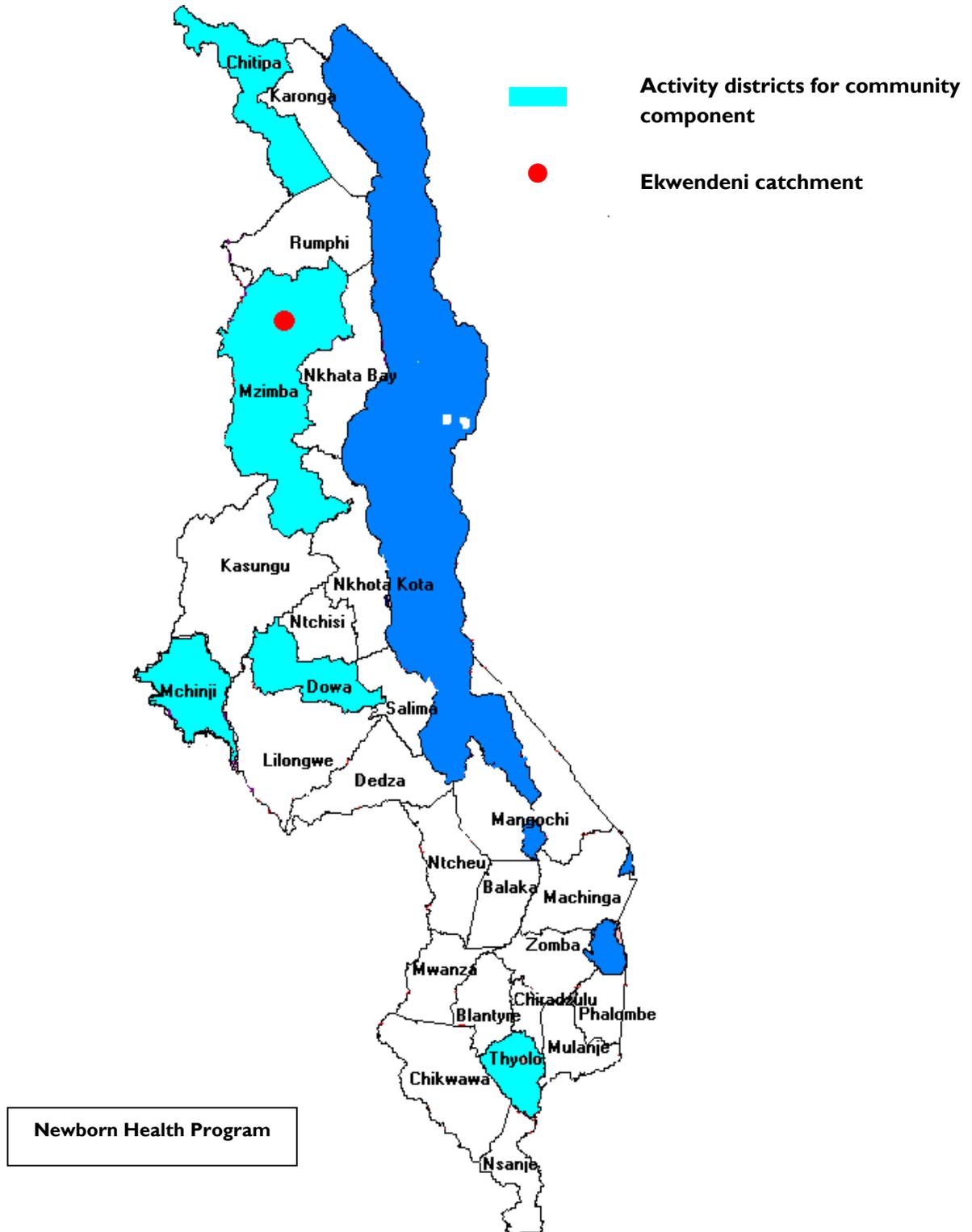
The reviewers allude to the many real challenges involved in partnering at the national-level; and, indeed, Save the Children has already learned a number of interesting lessons

about partnering at the national level. These lessons include the following and are elaborated in the DIP document.

- ✓ **Our timeline is not necessarily their timeline.**
- ✓ **It's not all about us.**
- ✓ **There are times we need to guide; there are times we need to lead; there are times we need to follow.**
- ✓ **When we work in true partnership, we cannot expect to maintain total control.**
- ✓ **We need to position ourselves to leverage every asset and every opportunity.**
- ✓ **It is critical to keep our eye on the long-term goal and understand the path to get there may have many twists and turns!**
- ✓ **Networking and communication are keys to success.**
- ✓ **We need to work within the system PRO-ACTIVELY.**
- ✓ **Our inputs, whether material or technical, must be strategic.**
- ✓ **We need to have something of value to bring to the table.**

ANNEX II
Response to Final Evaluation Recommendations-Not Applicable

ANNEX III Map of Malawi



ANNEX IV
a. “Custodians of Tradition” – Agogo Report



“Custodians of Tradition”
Promote Positive Changes for the Health of Newborns

Rapid Qualitative Assessment of Ekwendeni Agogo Strategy, Malawi



Grandmothers sing and dance to a song about the danger signs of pregnancy and delivery

Judi Aibel, PhD, MPH
The Grandmother Project

With: Kistone Mhango, Rose Gondwe, Maggie Munthali, Agness Hara,
(Ekwendeni Mission Hospital); and Evelyn Zimba (Save the Children/Malawi)

December 2006

Save the Children/Malawi & The Grandmother Project
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Acronyms and Abbreviations

ANC	Antenatal Care
BCC	Behavior Change Communication
BF	Breastfeeding
EBF	Exclusive Breastfeeding
GF	Grandfather
GM	Grandmother
KMC	Kangaroo Mother Care
LEPSA	Learner-Centered Psychosocial Approach for Action
MCH	Maternal and Child Health
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SNL	Saving Newborn Lives
VHC	Village Health Committee

I. Introduction

A. Overview of the *agogo* strategy

For more than one hundred years, Ekwendeni Mission Hospital (Synod of Livingstonia) has been involved in primary health care (PHC) programs in its catchment area in Mzimba District in Northern Malawi. Ekwendeni's PHC program addresses various maternal and child health issues. Past programs have focused almost exclusively on women of reproductive age. In the first phase of Save the Children's Saving Newborn Lives (SNL) initiative (2001-06), Ekwendeni was a partner organization to Save the Children for implementation of community activities for newborn health. Ekwendeni decided to involve grandmothers and grandfathers in its community mobilization and behavior change strategy, given their role and influence in household decision-making related to pregnancy and care of neonates. More than 4,000 grandparents (*agogos* in Tembuka, the local language) from 225 villages were trained and then expected to share their "state-of-the-art" knowledge on maternal and newborn care to promote improved practices within their families and communities.

B. Background to the *agogo* strategy

It is difficult to determine exactly how and when the decision was made to develop the *agogo* strategy. In fact, it seems that there are several elements, and the synergy between them, that contributed to the decision to explicitly involve grandparents in the newborn health promotion activities.

At the outset of the SNL project, in May 2001, a rapid qualitative inquiry on cultural factors related to newborn health was carried out by Karen Waltensperger, now SC/Africa Regional Health Advisor. The results of this rapid assessment clearly revealed the leading role played by grandmothers at the household level during pregnancy and with newborns. It also showed that these senior women serve as advisors to male family members on issues related to pregnancy and newborn care.

Whether a household is patrilineal or matrilineal, 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, p. 8)

In late 2002, Save the Children SNL commissioned a more comprehensive qualitative study entitled, "Saving Newborn Lives Formative Study." It was carried out by Priscilla U. Matina, a local consultant. This investigation focused primarily on the beliefs and practices related to pregnancy and newborn care but gave some attention to household dynamics and decision-making. The report concluded that:

In Mzimba district, paternal grandmothers, or mothers-in-law, play an active role in influencing the care of mothers and newborns, especially for pregnant women and those having children for the first time. (Matina, 2002, p. 50)

According to Kistone Mhango, PHC Coordinator at Ekwendeni Hospital, initial plans for the SNL project did not include activities with *agogos*. He and his team soon realized that “there was a missing” piece in their community strategy. Kistone recounts:

“At the outset of the SNL 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 agogos. We realized that they are the ones who teach the dos and the don’ts to younger women. We realized that our programs with communities would have more impact if the agogos were involved.”

Another important factor related to the decision to develop activities to involve the *agogos* was strong support for this idea from Stella Abwao, the SNL Project Manager at that time. Given Stella’s background (Kenyan) and familiarity with the cultural organization of African families, she was very supportive of the idea of actively involving grandparents in SNL activities.

It is the synergy between these several factors that appears to have led to development of the *agogo* strategy and the initial training of *agogos* in late 2004. According to Ekwendeni PHC staff, at the outset, their idea was to create “*Agogo Clubs*” that would be involved in promoting newborn health in families and communities. Several of the SNL documents later refer to the existence of “*Agogo Clubs*.”

However, discussions with the PHC team revealed that, in fact, their approach to working with the *agogos* has not really involved organizing them into a more formal “club structure” but, rather, it has consisted of progressively integrating them into several existing community activities, namely the village health committees (VHC), the drama groups and other village development activities. For this reason, it was agreed with the PHC team in Ekwendeni that it is more accurate to refer to the activities with the *agogos* as the “*agogo strategy*” rather than “*Agogo Clubs*.”

C. Goal and objectives of the rapid assessment

Since the training of *agogos* in 2004, in a series of workshops held at Ekwendeni Hospital, there has been considerable anecdotal evidence on the positive community response to the *agogo* strategy and of its positive influence on the grandparents’ attitudes and practices. However, prior to this rapid assessment, no previous systematic review or evaluation of the strategy had been carried out. For this reason, and given Save the Children’s interest in documenting and packaging the *agogo* approach as part of its Newborn Health Program with funding from USAID/GH/HIDN/NUT/CSHGP, it was determined that a critical review of the approach should be carried out in close collaboration with Ekwendeni PHC staff.

The purpose of the assessment, as defined in the Scope of Work, was to assist the Ekwendeni PHC team to assess the strengths and weaknesses of the *Agogos strategy* with a view to refinement, expansion, documentation and packaging.

The objectives for the assessment, developed with the PHC team in Ekwendeni, were:

- to assess the relevance of the *agogo* approach for the communities in Ekwendeni's catchment area
- to assess the results of the approach based on qualitative information
- to identify the key factors that have contributed to the positive results
- to identify the strengths and weaknesses of the approach
- to identify the most effective incentives to motivate the *agogos*
- to formulate recommendations for strengthening *Agogo* involvement and learning within the catchment area
- to formulate recommendations for expanding the *Agogo* approach beyond the catchment area
- to formulate recommendations for documenting and “packaging” the approach (in order to be able to share it with others)

II. Methodology

Given the purpose and objectives of this review, a qualitative and participatory approach was used to carry it out. The consultant worked closely with Ekwendeni and Save the Children staff in order to develop the methodology, collect and analyze the information and formulate conclusions and recommendations.

A. Data collection: instruments and sample of interviewees

Data was collected through group and individual interviews and also through review of existing documentation (secondary data.)

Focus group discussions using semi-structured interview guides (specific to each category of interviewees) were conducted with a total of 451 community members consisting of: grandmothers (148); grandfathers (79); young women with children under 1 year of age (88); VHC members (92); and drama group members (44); and 14 Ekwendeni staff members who have been involved in *agogo* activities in one way or another. (See Table I. below.) Interviewees were selected using convenience sampling.

Individual interviews using a structured questionnaire consisting of 8 questions were carried out with 76 grandmothers and 38 grandfathers in order to test their knowledge of priority messages related to the care of pregnant women and of newborns. Interviewees were selected using convenience sampling. [The fact that the sample has twice as many grandmothers (GMs) and grandfathers (GFs) reflects the fact that about twice as many GMs attended the community meetings called by Ekwendeni staff in the context of this review.]

Review of available documentation on the *agogo* strategy was also carried out though this was of limited scope given that the available documentation on development and implementation of the strategy is very limited.

Table I. Focus group interviewees by category

Village	Persons interviewed					Ekwen- deni staff
	Agogo		Drama groups	Village Health Committees (VHC)	Women w/ children < 1 year	
	Grand- fathers	Grand- mothers				
Vyalema Kumwenda	3	6	10	9	146	14
Mopho Jere	6	17	6	7	16	
Lazaro Jere	15	18	-	10	12	
Madang'ombe Mumba	6	12	10	10	12	
Sunduzwayo Tembo	17	28	-	13	13	
Mugulumu Kamanga	6	11	9	10	11	
John Kaunda	9	20	9	10	12	
Yotamu Nkhambule	17	36	-	23	6	
Total by category	79	148	44	92	88	
Total number persons interviewed = 465						

B. Data collection team

The data collection and analysis was coordinated by Judi Aubel, consultant for the assessment and Founder of The Grandmother Project, a US-registered NGO. The interviews of both groups and individuals were carried in the local language by: Kistone Mhango, Rose Gondwe, Maggie Munthali, Evelyn Zimba and Agness Hara. Community visits and interviews took place between December 8 and 12, 2006.

C. Data analysis

During the data collection phase, on a daily basis, following the community visits, the assessment team sat together, reviewed the notes taken and discussed the main themes and trends that emerged from the data. All focus group interview notes were typed and additional analysis of the data was also done by the consultant.

III. Findings

A. Results of the *agogo* strategy

The initial rationale for involving *agogos* in community newborn health activities was to promote improvements in their knowledge and changes in their attitudes and advice regarding the care of pregnant women and of newborns. However, anticipated results of *agogo* involvement were not defined in terms of *behavioral outcomes*. The Behavior Change Communication (BCC) strategy (planning chart), developed in mid-2003 for SNL, does not

include any anticipated results related to *agogo* knowledge, advice or practices. All relate to women's knowledge and practices.

Since the *agogo* training sessions took place in the fall of 2004, there has been very limited formal monitoring and follow-up to assess the effect of the training and other community-based newborn health activities on the knowledge, advice and practices of the *agogos* and their families. Monitoring visits were not included in the original plan and neither was there time nor resources to do systematic follow-up in the more than two hundred villages in the Ekwendeni catchment area. On the other hand, in the course of other community activities and contact with community members at the hospital, considerable anecdotal information was collected by Ekwendeni staff that has consistently shown both the enthusiasm of communities toward *agogo* involvement and the positive changes in *agogo* attitudes and practices. Unfortunately, no system was developed for collecting feedback from communities and the anecdotal information and observational data was not recorded in any way.

The information collected during this assessment, though essentially qualitative in nature, clearly suggests that there have been positive changes in *agogo* knowledge, attitudes and advice. (Those findings are discussed below.) In addition to the results related to newborn care practices, the *agogo* strategy has had some very positive and unanticipated results related to improvements in intergenerational communication and collaboration between younger and older community members.

1. *Increased knowledge, improved advice and practices related to maternal and neonatal health*

- *Learning by agogos*

The information collected both from community members and Ekwendeni staff clearly suggests that there has been considerable learning on the part of both GMs and GFs and that in many cases their new knowledge on care of pregnant women and newborns has been put into practice.

Individual interviews were carried out with 114 *agogos* (38 grandfathers and 76 grandmothers) to assess their knowledge of key messages communicated during training and in other community activities related to: antenatal care (ANC); danger signs of pregnancy and with newborns; timing of the first bath; modes of mother-to-child transmission of HIV; and Kangaroo Mother Care (KMC).

Results of the interviews showed: on five of the ten parameters (messages) assessed, fifty percent or more of the *agogos* have mastered the priority information; the *agogos* have particularly high levels of knowledge regarding *early ANC* (85%) and *KMC* (76%) while their knowledge of HIV mother-to-child transmission remains inadequate (11%) as does their knowledge of newborn danger signs (35%); and levels of knowledge of grandmothers and grandfathers are similar on all topics except for those related to delaying the first bath where grandmothers' knowledge is significantly better than that of grandfathers.

The information collected through **focus group interviews** supported these findings regarding knowledge acquisition on the part of the *agogos*. During the group interviews, both grandmothers and grandfathers who spoke up tended to be those who had higher levels of knowledge. This is frequently the case in group interviews that those who speak up tend to be those who have more confidence in their own experience and learning.

During the group interviews, both with *agogos* and women with young babies, there were numerous testimonies regarding how the new knowledge of the *agogos* has been put into practice related to: early and frequent ANC; transport of premature babies to the hospital using KMC; rapid referral to the hospital of women and newborns with danger signs; use of exclusive breastfeeding (EBF); and delaying the first bath of newborns.

Testimonies from Ekwendeni hospital staff also support the conclusion that *agogos* have learned and are putting into practice priority messages. Hospital nurses reported: a considerable increase in early ANC visits (i.e. at three months of pregnancy); decreased use of traditional medicine to accelerate labor; babies transported to the hospital especially by men or grandfathers using KMC; improved newborn care; and increased EBF.

2. *Improved communication and collaboration between elders and youth*

In all communities where interviews were carried out, community members reported that the *agogo* strategy has also contributed to an unanticipated, but very positive, result related to improving intergenerational communication and collaboration between younger and older community members.

Past community health and development programs in Malawi, implemented both by Ekwendeni and by other organizations, have involved and trained young people and have not systematically involved the *agogos*. Both youth and grandparents reported that in the past they always felt uncomfortable with the *youth-focused approach* first, because of the expectation that young people should teach their elders and secondly, because it excluded grandparents who are the designated “teachers” in the local culture.

One of the young members of a village health committee explained how difficult it was for them to try to teach their elders:

“It was always very uncomfortable for us trying to communicate new health concepts to our elders. When we were trained, we were told to do so, but we knew that culturally it was not appropriate for younger people to be teaching older ones.”

And one of the very old grandmothers explained how the elders reacted to the youth-focused approach:

“All of the programs choose young people to be trained. When they return, they come to us to tell us what they have learned. When they do this, I scream at them and tell

them that we will not listen because it is not appropriate in our culture for youth to teach elders.”

A grandfather, who has recently become a member of the VHC in his community as a result of the *agogo* strategy, described the “cultural conflict” that exists when programs target youth and exclude elders:

“When youth try to teach their elders, they are showing a lack of respect for our cultural values regarding the role of elders in the society.”

On the other hand, now that the *agogos* have also been “officially trained,” both they and younger community members feel that grandparents’ culturally-designated place, as *teachers of the younger generations*, has been restored. The *agogos* reported that now they feel more respected in the community and more comfortable being involved in community activities and collaborating with younger people in the VHCs, drama groups and other community activities.

Conclusion: The information collected during this assessment clearly shows that the *agogo* strategy has had two very positive results: first, there have been positive changes in *agogos* knowledge, attitudes and advice related to the care of pregnant women and of newborns; and second, the *agogo* strategy has contributed to some very positive, but unanticipated results related to improvements in intergenerational communication and collaboration between younger and older community members.

B. Factors that have contributed to the results of the *agogo* strategy

One of the objectives of the assessment was to identify key factors that have contributed to the positive results of the *agogo* strategy. This is important both in order to know what existing activities should be strengthened and/or expanded and in order to be able to systematically orient others who are interested in understanding and possibly using the strategy. Through both community level interviews and discussions with Ekwendeni staff the following factors were identified as having contributed to the positive results.

1. *The basis for the strategy is culturally-defined roles and relationships*

The strong support for the involvement of *agogos* in maternal and neonatal health activities from both community members and Ekwendeni staff stems from the fact that the *agogo* strategy builds on cultural roles and responsibilities. At both the household and community levels, *agogos* influence decision-making and practices related to maternal and neonatal health. By explicitly acknowledging the role of the *agogos* as family advisors and teachers the strategy has been a strong source of motivation for them to be more involved in community programs than in the past. In the *agogo* strategy, the roles that the *agogos* are expected to play mirror their culturally-defined advisory roles. Community interviewees, young and old, stated that past development programs that have given youth a central role have been at odds with the culturally-designated roles where elders are the advisors and teachers of youth, and not the reverse.

- ***Builds on the respective roles of grandmothers and grandfathers at the household level***

At the household level, both earlier studies and the information collected during this assessment clearly show that grandmothers and grandfathers play complementary, but different, gender-specific roles related to maternal and neonatal health.

Grandmothers (e.g., mothers-in-law in this part of Malawi which is patrilineal) are the direct advisors of young women and direct care-givers of young children. Grandmothers are responsible for ensuring close follow-up both of pregnant women and newborns on a day-to-day basis. Given both their experience, related to pregnancy and infant care, and their intimate involvement with women and new babies, if a problem arises, they are aware of it before any male family members get involved and they are the *first-line decision-makers* about what should be done. Given their role and intimate involvement with both pregnant women and newborns, it is extremely relevant for them to be involved in community activities in order to strengthen their knowledge and the advice they give not only to younger women but also to their husbands and sons.

Grandfathers are usually not directly involved with pregnant women and newborns, on a day-to-day basis, and play a secondary and supportive role in a rather detached way. For example, culturally it is not acceptable for grandfathers, the fathers-in-law, to communicate directly with their daughters-in-law. According to both community members and Ekwendeni staff, when GFs are advised by their wives, or other senior women in the family, that special resources or logistical support are required for either pregnant women or newborns, then they take on a more active role. In these instances, based on grandmothers' advice in most cases, they often make "official decisions" regarding transport and other aspects.

Grandfathers and men are officially regarded as household "decision-makers," but, in fact, as regards issues related to women and children's health and well-being, in most cases they are *second line decision-makers* who provide support to grandmothers when required. Given the role of grandfathers in organizing emergency transport, it is particularly important that they be aware of the urgency of such evacuations when grandmothers observe danger signs with either a woman or newborn.

While the roles of GMs and GFs are complementary, clearly GMs are more directly involved than GFs in maternal and neonatal health activities at the household level on a day-to-day basis. In the past it seems that activities were developed for "grandparents" without any attention to the difference in their roles. For the purposes of developing future *agogo* activities, the distinction between the roles of GMs and GFs should be kept in mind in terms of role descriptions, training content and activities developed with the two sub-groups. The greater involvement of GMs in maternal and neonatal health may warrant investing more resources in reinforcing grandmothers' knowledge, for example, by providing more in-depth and longer training for them than for GFs.

- ***Contributes to changing community norms***

As Kistone frequently says, "grandparents are the custodians of tradition." Specifically regarding the care of pregnant women and of newborns, grandmothers and grandmother peer groups, or *social networks*, play a key role in communicating and enforcing community norms of

behavior. Involving *agogos* in health education activities can increase their knowledge of priority (modern) practices that can, in turn contribute to changing community norms that are communicated to younger women. This is another factor that supports the need to continue to involve the *agogos* in health education and communication activities.

Most communication strategies dealing with maternal and child health topics aim to change individual behavior, and in order to do so they focus on women of reproductive age. Often these strategies lead to increases in women's knowledge but do not result in changes in their behavior because it is difficult for them to adopt practices that go against community norms and advice of senior women, or GMs, in the family. The *agogo* strategy contributes to changing community norms by working through *agogo* groups, those who are involved in setting such norms.

2. *Inherent motivation of agogos to learn*

Another factor that has significantly contributed to the results of the *agogo* strategy is their inherent motivation to learn, which was clearly and repeatedly revealed in the community interviews. In all communities visited both grandmothers and grandfathers expressed a strong interest to learn more about maternal and child health. Ekwendeni staff who facilitated the *agogo* workshops also stated that during training virtually all of the *agogos* demonstrated an eagerness to learn. GMs and GFs alike stated that the opportunity to learn more about the “modern concepts” related to the health of women and children equips them to be able to better teach their children/ grandchildren and to save lives.

There is an often-heard saying in the Tembuka language that “an old potato cannot be bent.” However, in all communities the *agogos* said that they reject this widespread and negative belief regarding the capacity of older people to learn and change. The group interviews with them regarding priority practices promoted in the SNL project clearly showed that they are capable of learning. And in all communities they insisted that they want to learn more, not only about newborn care, but also about other aspects of maternal and child health.

3. *Training of agogos at Ekwendeni*

Another determining factor related to the results observed from the *agogo* strategy was the training they received at Ekwendeni. The mere fact that the *agogos* were “invited to Ekwendeni to be trained” was a landmark event for them. It alone appears to have contributed greatly to increasing their own confidence in their role and importance in the family and community. For Ekwendeni staff who facilitated the training sessions, the experience was significant insofar as it helped them to modify their attitudes toward the *agogos*. It helped them to begin to see grandparents more as “partners” than as “obstacles,” the attitude that many of them held prior to the training.

The second important aspect of the training was the approach, or methodology, used to train the *agogos*. No training manuals or detailed reports on the training events were prepared that describe in detail the methodology used. According to the PHC team members, “for each of the topics addressed, the *agogos* were asked to share what they know and then the Ekwendeni facilitators told what they know.” From the information provided to the assessment team, it

appears that the approach used was: very participatory; built on participants' past experience and knowledge; and based on a dialogue between community members and health providers. During the assessment it was not possible to find out exactly how the training was done due to the absence of documentation on the training. In future training events an explicit attempt should be made to document both the activities used and the reaction and feedback on them received from participants.

[Note: After my departure from Malawi the PHC team informed me that they had used the Learned-Centered Psychosocial Approach (LEPSA) in the training. Additional information on LEPSA approach was not available before the completion of this report. This information might help to understand exactly how the training was carried out.]

Several weaknesses were identified with the training, specifically related to documentation of the event. All future training events could be strengthened by ensuring that the following elements are defined and used: training goals and objectives for the workshop sessions; post-tests carried out (orally) with participants to assess their learning; and a detailed training plan for each training event to include detailed feedback from community members, observations from facilitators and lessons learned for the future.

In conclusion, the training of the *agogos* at Ekwendeni produced very positive results, not only in terms of learning but also in terms of increasing the status of the *agogos* in their communities and their motivation to contribute to community health improvements and change.

4. *Community organization and leadership in the Ekwendeni catchment area*

For any community intervention, in addition to the characteristics of the intervention itself, another critical factor that influences the effects of the strategy is the community context into which it is introduced. Since 1980, Ekwendeni PHC programs have been active in the catchment area, where the *agogo* strategy was introduced. These programs have included extensive training of community leaders and groups both on various health topics and on leadership, VHC development etc. These efforts, over the years, have contributed greatly to strengthening the *social* infrastructure, or community organization and capacity in the Ekwendeni area. Compared to many other parts of Malawi, it appears that the level of community organization and responsiveness to development initiatives is quite high in this part of Mzimba District. During the assessment an attempt was made to collect information on the key principles and elements of the community capacity building activities that Ekwendeni carries out but it was not possible to get any specific information in this regard. [Note: Perhaps with more time one could interview the facilitators who conducted such training, as well as participants in past workshops in order to discover its content, methods used etc.]

The *agogo* strategy was “planted” in a very fertile place where community leadership is quite strong, as are community groups such as VHCs. The impressive results of the strategy are undoubtedly due to the combination of the innovative and culturally-adapted strategy that builds on community resources, i.e., the *agogos*, and the strong community leadership and organizations that existed prior to the introduction of this strategy. If this innovative approach is

introduced in a place where the social infrastructure is very weak, most likely the results would be considerably less.

- ***Support for agogo activities by village headmen***

During the rapid assessment it was observed that in communities where the village headman strongly encourage the *agogos*, they do appear to be more involved in community activities and, in turn, more committed to modifying some of their practices related to pregnancy and newborns. Encouragement of the *agogos* by the village headman is clearly an important factor in motivating them to participate in community activities and to share their knowledge within their families and with others in the community.

5. VHC collaboration with and support for agogos

Generally, the president of the VHC is the village headman and, in most cases, he is an *agogo*. Prior to the training of the *agogos*, VHC members did not include any other *agogos*. This is largely explained by the fact that one of the initial criteria for the choice of VHC members was that they be literate, which automatically eliminated most *agogos*. According to younger VHC members, before the *agogos* were integrated into the committees, it was difficult for the VHC, composed almost entirely of younger people, to make it heard in the village.

Since the *agogo* training, the grandparents have progressively been integrated into the VHCs and now virtually all of the committees have several *agogo* members. According to elder and younger community members alike, incorporation of the *agogos* into the committees has, on the one hand, increased the credibility and influence of these structures in the community while, on the other hand, it has strengthened communication and collaboration between younger and elder VHC members.

Prior to the *agogo* training the VHCs were trained on the basic essential newborn care messages/information related to the care of pregnant women and newborns. This was an important starting point for preparing them to work more closely with the *agogos* to promote those priority practices. Under the leadership of the village headmen, it appears that most of the VHCs are promoting maternal and neonatal health activities in collaboration with the *agogos*. In most cases, too, the VHCs are also collaborating with the drama groups, particularly to help mobilize community members and organize community drama performances.

6. Drama performances on essential newborn care themes

Another activity initiated under SNL-1 that has definitely contributed to increasing the involvement and reinforcing the learning of the *agogos* is the drama group performance. The performances of the drama groups are very effective insofar as they allow community members to “have fun while learning,” as many community interviewees reported.

The drama groups were trained by a specialist in popular theatre and most of the plays that are being used were designed during the training workshop. This approach to developing the plays seems to be an excellent one as it helps ensure that the technical content being disseminated is

accurate. The original six plays that were written and distributed during training have been repeatedly used, the high quality of the presentations is excellent, and communities appear to enjoy seeing them multiple times. At some point in the future, however, it would be good to have additional plays developed to ensure variety and also to incorporate other topics, namely, Prevention of Mother to Child Transmission (PMTCT) and other HIV/AIDS topics, EBF and the importance of warming and drying (including delay of first bath for the newborn). Monitoring data on levels of knowledge of both *agogos* and young women, such as that collected in the individual interviews during the rapid assessment, can be used to identify topics/messages that need to be further reinforced and for which additional scripts could be developed for the drama groups.

At the beginning of SNL-1, all of the drama group members/actors were young people. They presented the plays on the various topics related to pregnancy and newborn health. In a number of communities there were negative reactions to this and protests from village headmen who felt that: 1) it was not appropriate for taboo topics, such as pregnancy, to be presented on the stage in front of everyone; and 2)) in was not appropriate for young people to be teaching the elders about these topics. This feedback from communities was useful and after the *agogo* training it was decided to incorporate *agogos* into all of the drama groups. The inclusion of *agogos* has had several positive consequences: 1) now elders and younger people are working together presenting the dramas; 2)) the fact that both youth and elders are involved has greatly increased the interest of the *agogos* in the performances; and c) *agogo* involvement has made it more acceptable to discuss previously-taboo topics on stage.

The drama groups seem to be highly motivated and community interest in their performances appears to be a key in encouraging them to continue the presentations, a factor contributing to their motivation. It seems that in most cases the village headmen and VHCs encourage them to perform and take charge of mobilizing communities for the performances. It is fantastic that these drama activities have been sustained by the communities themselves over the past three years, as most were initially trained in 2003.

7. *Dancing to songs on priority topics*

Another activity/tool that contributes to reinforcing *agogo* interest and learning regarding maternal and newborn care are the songs that have been developed on various priority life-saving topics. It appears that the songs, all in the local language, are almost always accompanied by dancing which increases the “enjoy while learning effect.” According to community informants, the songs are used at various times in the community, when meetings of various types are held, during mobile clinics and at other types of gatherings.

As an educational tool, songs are very effective insofar as they are culturally-adapted, participatory and inexpensive and they can be used by communities themselves. It appears that the songs primarily deal with “priority technical messages” regarding practices that are promoted by Ekwendeni, i.e., proposed changes in harmful cultural practices. It seems that the songs give limited attention to the positive cultural roles, values and practices. It was not possible, during the short period of the assessment, to determine if there are songs to address all of the topics.

8. Posters and brochures

Three posters and very simple and attractive brochures were developed under SNL-1 on: priority practices during pregnancy and danger signs; newborn care; and KMC for premature babies. It is difficult to assess how much these materials have contributed to learning on the part of the *agogos*, who are mostly illiterate. During all of the interviews with *agogos*, VHCs, drama groups and young mothers, practically no mention was made of the brochures or posters. As compared with other communication activities and influences discussed above, it does not appear that these print materials have had a significant impact on the *agogos*.

Conclusion: As discussed earlier, the assessment team concluded that the encouraging results of the *agogo* strategy can be attributed to the synergy between the various factors discussed above, some related to the context in which the *agogo* strategy was implemented and others associated with the characteristics and components of the strategy itself.

D. Weaknesses and constraints related to implementation of the *agogo* strategy

1. Very limited monitoring and supervision

Follow-up visits for monitoring and supervision of *agogo* activities were not included in the SNL-1 work plan, resources were not allocated for such visits and, consequently, they did not take place. Occasional informal follow-up was done. In all of the communities visited during the assessment, the *agogos* themselves said that they wished that there had been supervision visits to “encourage us” and to “make sure we are on the right path.”

2. Very limited documentation

As with many organizations involved in community programs, the efforts of the PHC team at Ekwendeni in the context of the newborn health program were focused on “implementing activities at the community level.” According to Kistone, his team members all had very heavy workloads under SNL-1 and “documentation” was not viewed as a priority relative to “implementation.” It also seems that for the PHC team members the rationale for documenting ongoing community activities was not entirely clear. Now that the value of the innovative *agogo* strategy has been recognized, it is becoming clearer to Ekwendeni staff that in order to be able to share the approach with others within Ekwendeni district and beyond, there is a real need to systematically document it.

One of the assessment objectives was to collect all available documentation on the *agogo* approach including: periodic monitoring reports that include lessons learned; training modules and reports; and educational/ communication materials developed. But unfortunately, very little written material was found. At present, no filing system has been established for organizing documentation on *agogo*-related activities and the PHC team does not have a clear idea of “what should be documented” and “how it should be documented.” Key pieces of the “documentation process” should include: 1) descriptions of major activities carried out (objectives, steps, strengths and weaknesses of activity implementation); 2) feedback from both community members and development workers on activities carried out; and c) periodic development of

“lessons learned” with community and development actors based on strengths and weaknesses in the implementation of activities.

3. Limited focus on positive cultural roles and practices

In the interviews with community groups, a predominant theme that emerged was that they have learned that there are various “harmful cultural practices” related to the care of pregnant women and newborns that they should abandon. For example, in the otherwise wonderful dramas and songs that are being used, the focus is primarily on encouraging community members to “stop certain harmful practices” and to “adopt recommended ones.” In these education/communication activities, there is relatively little discussion or focus on “positive roles and practices” that are part of the culture and that people should be encouraged to feel proud of and that they should be actively trying to preserve. For example, songs could be developed that praise the role of grandparents as advisors of the younger generation.

In fact, in behavior change communication (BCC), as the term suggests, the focus is on getting people to change certain (harmful) behaviors. This focus and orientation was adopted by the Ekwendeni PHC team that was followed to develop the BCC strategy in SNL-1 using the BEHAVE framework. The BEHAVE methodology is being widely promoted in child survival and other health programs.

In these times when rural Malawian communities are suffering both from severe poverty but also from much illness and death associated with HIV/AIDS, and where cultural traditions and values are at risk of being lost, it seems particularly important that development programs explicitly aim to acknowledge and value the positive features of local cultures. Another example would be that, in the songs and dramas developed, the role and commitment of elders related to maternal and neonatal care in the family could be featured as a positive resource.

IV. Conclusions

Innovative MCH strategy in Malawi

The *agogo* strategy developed at Ekwendeni Mission Hospital is an innovative and promising approach to community health promotion that is grounded in cultural values and roles. It appears to be the first time that grandparents have been viewed as key actors and explicitly involved in community maternal and child health promotion in Malawi. Past maternal and child health programs have focused almost exclusively on women of reproductive age, and occasionally on women and their husbands. The reaction to the *agogo* strategy, on the part of both community members and health workers, has been very positive and both believe that the approach is both culturally-relevant and an effective way to promote change in family attitudes and practice related to maternal and newborn care.

Limitations of past “youth-focused” community programs

Past community health and development programs in Malawi, implemented both by Ekwendeni and other organizations, have primarily involved and trained young people and have not systematically involved the *agogos*. Both youth and grandparent interviewees reported that in the past they always felt uncomfortable with the *youth-focused approach* first, because of the

expectation that young people should teach their elders and secondly, because it excluded grandparents who are the designated “teachers” in the local culture.

Cultural-relevance of the *agogo* strategy

At both the household and community levels, *agogos* influence decision-making and practices related to maternal and neonatal health. The *agogo* strategy builds on their culturally-designated roles and responsibilities. There is a broad consensus among community members and health/development staff that it is very relevant to involve the *agogos* in programs aiming to promote newborn care and well-being for two major reasons. First, grandmothers are directly involved in the care of pregnant women and of newborns and grandfathers play a supportive role related to these activities. Second, *agogo* involvement can contribute to changing community norms that can, in turn, promote sustained behavior change.

Anticipated results of the *agogo* involvement

The information collected during this assessment, though essentially qualitative in nature, clearly suggests that there have been positive changes in *agogos*' knowledge, advice and practices, especially related to: ANC ; danger signs of pregnancy and in newborns; newborn care; breastfeeding; and KMC for small babies requiring extra attention.

Unanticipated results of *agogo* involvement

The *agogo* strategy has also contributed to an unanticipated, but very positive result, related to improvements in intergenerational communication and collaboration between younger and older community members. All communities stated that in the past, grandparents felt excluded from and frustrated by the prevalent *youth-focused development programs*. They stated that, by acknowledging the culturally-designated role of the *agogos* as teachers of younger community members, and by strengthening the knowledge of the *agogos*, they have been encouraged to work together with young people, in a spirit of mutual respect, to promote community health and development.

Factors related to encouraging results of *agogo* intervention

The assessment team concluded that the very encouraging results of the innovative *agogo* strategy cannot be attributed only to the formal *agogo* training at Ekwendeni, but rather to a combination of factors that include that training. On the one hand, there are two important pre-existing contextual factors that appear to have contributed to the positive results of the approach, namely, the strong leadership and high level of community organization that exists in most communities in the Ekwendeni catchment area, and the skills of Ekwendeni field staff in community facilitation, participation and capacity-building. On the other hand, various components of the intervention, or approach, itself have clearly contributed to the positive results, namely: 1) the participatory and culturally-sensitive training methodology used with the *agogos*; 2) the fact that the *agogos* were for the first time officially invited to a training session at Ekwendeni; 3) the frequent drama performances over the past three years that convey information on priority maternal and newborn practices; 4) the frequent use of songs, accompanied by dancing, that reinforce key messages on priority practices; 5) the training of VHCs on essential newborn care topics and their role in disseminating them to other community members; and 6) the inclusion of *agogos* into both the VHCs and drama groups, of which they

were not previously a part. In conclusion, the positive results of the *agogo* strategy can be attributed to the synergy between the several factors listed above.

Prospects for sustainability

There are several features of the *agogo* approach that support the prospects for sustainability, both of the community education/communication activities and of the changes in health-related practices that they promote. The community education/communication activities - namely drama, songs, dance and community discussions - are all simple, culturally-adapted, participatory and community-lead activities that require very little ongoing outside support. Some follow-up is required to be sure that the messages being disseminated are correct. It is very encouraging that almost all communities appear to be continuing these activities on their own. Another advantage of the *agogo* approach is that it contributes to promoting changes in community health norms, by working through grandmother groups and leaders. Most health communication/education strategies aim to change the practices of women of reproductive age and often meet with limited support because the proposed changes go against community norms. The *agogo* approach aims to “get to the root of the issue” by promoting change among those, i.e., the grandmothers, who have the responsibility within the culture for defining and communicating the cultural norms, i.e., “the way things should be done.” Changing cultural norms is like changing the operating system on the hard disk of a computer.

Weaknesses in implementation of the *agogo* strategy

While overall implementation of the strategy has been very effective, a few weaknesses were identified related to: 1) limited monitoring and supervision of the strategy; 2) very limited documentation of the approach used including accomplishments, feedback received from different stakeholders, lessons learned in the course of implementation; and 3) insufficient recognition and encouragement of the positive cultural roles and practices in the community activities and communication materials. Regarding this last point, the communication/ education strategy to promote improved maternal and newborn care focuses primarily, as behavior change strategies (BCC) invariably do, on discouraging harmful traditional practices. Limited attention is given to reinforcing the positive cultural roles and traditions. Community interviewees often stated in a rather apologetic way, “We have learned that many of our traditional cultural practices are harmful and that we should abandon them.” In this regard, the content of the songs and dramas focuses primarily on the “harmful” practices to be forgotten and “good” practices to be adopted while limited attention is given to positive features of the cultural heritage.

Untapped community resource: informal grandmother leaders

In all communities there are informal grandmother leaders who have status in the community and who influence the attitudes and practices both of younger women and of other senior women, i.e., their peers. The grandmother leaders stand out in any community because they are confident, articulate and open to new ideas and they are often looked to for their opinions and advice. For any effort that seeks to promote changes in community health-related norms and practices, these senior women can play a leading role in motivating others to change. Based on cultural tradition, grandfather leaders are officially recognized, as the village headmen and his advisors, but the grandmother leaders are not. Acknowledging the importance of the grandmother leaders and giving them a specific role in the organization of community activities could strengthen efforts to promote change among other women, both young and old.

Roles of grandmothers and grandfathers are different but complementary

Grandmothers and grandfathers play complementary but gender-specific roles related to maternal and neonatal health at the household level. Grandmothers are the direct advisors of young women and direct care-givers of young children. If problems arise they are the *first-line decision-makers* about what should be done and advise not only younger women but also their husbands and sons. Grandfathers usually play a distant and supportive role as regards issues related to pregnancy and the care of newborns and take on a more active role when extra resources are required. When there are special needs or problems, they are called upon to mobilize resources, transport, etc. The *agogo* strategy has strengthened the knowledge of both grandmothers and grandfathers and, in so doing, it has reinforced their complementary support for pregnant women and newborns.

Incentives to motivate the *agogos*

The interviews and observations at the community level suggest that the *agogos* have an inherent and strong motivation to participate and to learn about maternal and newborn health. Unlike younger people who may be motivated by material gadgets such as t-shirts, it would appear that for the *agogos*, public recognition of their role and experience, and the opportunity to learn more about maternal and child health may be their strongest incentives for them to be actively engaged in community activities and to share their new knowledge with others in the family and community.

V. Recommendations:

Documentation of all future activities

In the future, the Ekwendeni PHC team needs to document all *agogo* activities to include: objectives; steps; lessons learned/advice for implementing each step in the process; feedback (including quotes) from both community and health outreach workers on activities carried out; and results in both quantitative and qualitative terms. A definite constraint to documenting *agogo* activities in the past was the lack of time to do so. In the future, documentation activities need to be included in the work plan to increase the chances that they will be carried out.

Guidelines for documentation of community activities

It was clear from discussions with the Ekwendeni PHC team that, while they are convinced of the value of documenting the *agogo* activity, it is not clear to them how to do so. It would be beneficial to provide them with simple guidelines on what should be documented and how.

Training of *agogos*

It would be beneficial to provide refresher training to the *agogos* and also to train additional *agogos* who have not already been trained. Factors that should be considered in organizing such training include: 1) deciding whether the number of *agogos* trained from each village should be the same or whether more should be trained from bigger villages and vice-versa; 2) whether the same number of grandmothers (GM) and grandfathers (GF) should be trained or if the proportion of GMs should be greater given their greater direct role in household maternal and newborn care; 3) whether the training for GMs and GFs should be the same length of time or whether GM training should be longer; and d) the need to review and adjust the training content to put more

emphasis on topics given less attention in the initial training (such as PMTCT) or on gaps in current knowledge of GMs or GFs (based on results of individual interviews conducted during this assessment or conducted in the future).

Development of a training curriculum

In order to be able to share, or disseminate, the participatory and culturally-sensitive approach used in the *agogo* training with people outside of the Ekwendeni area, it is of critical importance that a comprehensive training curriculum be developed that includes: 1) training goals and objectives; 2) a detailed plan including learning activities and materials and instructions to facilitators for each learning activity; 3) a tool for pre- and post-assessment of participants' knowledge; and 4) a tool for collecting both participant and facilitator feedback on the training. The curriculum should include discussion of facilitator attitudes required for learning from and teaching grandparents. Most health sector staff is not used to working with grandparents and their attitudes toward them are a critical factor in motivating them to learn and to change.

Giving more explicit attention to positive cultural roles and practices

Certainly a major focus of community health programs should be on discouraging harmful practices and promoting acceptance of technically optimal ones. However, at the same time programs should be concerned that they are not only encouraging communities to change their "bad" practices but are also acknowledging and reinforcing positive cultural roles, values and traditions. This is particularly important in the current context of rural Malawi where communities are torn apart by AIDS, where there is widespread poverty, and where traditional values and practices are at risk of being lost. It is critical that programs not only work to improve the physical health of communities but also support their psychological health and their need to feel proud of their cultural heritage and identify. Recognition and praise of their cultural past, roles and traditions can easily be incorporated into the drama presentations and songs. For example, in several places in West Africa, songs of praise of the grandparents and their contribution to families and the younger generation have been developed and have had a very positive effect on elders and young people alike.

Acknowledging and encouraging GM leaders

The *agogo* approach acknowledges and involves grandparents as a group and the traditional community male leaders, who are invariably *agogos*, serve as spokespersons for the grandparent group with Ekwendeni staff. While the approach gives official recognition to the male *agogo* leaders, it does not explicitly acknowledge the less formal, but nevertheless influential, grandmother leaders. Efforts should be made to identify and acknowledge the grandmother leaders in each community and to encourage them to play a more formal role as collaborators of the male community leaders and as intermediaries with Ekwendeni staff. This more "public" recognition will contribute to increasing the importance not only of the grandmother leaders in the community, but of the grandmother groups in general. This should in turn increase their motivation to be involved in community activities to promote priority maternal and newborn care practices.

Role of grandmothers and grandfathers in household and community health promotion

In the *agogo* strategy community activities were developed for "grandparents" without any attention to the specificity of their roles. In the future, the distinction between the roles of GMs

and GFs should be kept in mind in terms of role descriptions, training content and activities developed with the two sub-groups. The greater involvement of GMs in maternal and neonatal health may warrant investing more resources in reinforcing grandmothers' knowledge, for example, by providing more in-depth and longer training for them than for GFs.

Follow up support to drama groups

Available information suggests that the quality of the drama performances is very good and that the drama groups are very motivated. Refresher training of the groups should be anticipated at some point in order to present them with new plays on priority topics not systematically dealt with in the existing ones (on PMTCT, EBF and other topics, to be determined) and to provide additional motivation. It appears that one of the strengths of the approach used to develop the activities of the drama groups is the fact that "standardized" play scripts were developed and taught to them. This approach helps avoid the problem of multiple groups developing performances with inaccurate technical health content.

Guidelines on training of drama groups and techniques for developing plays

As suggested in the report done on the training of the drama groups, it would be useful to develop a "Drama Group User Manual" to enable people in other organizations and places to establish drama groups and to develop education plays. The consultant who coordinated the training of the drama groups could be a resource person for accomplishing this task.

Follow up to ensure technical accuracy of messages being disseminated

It is important that there be a system to ensure that the messages in the songs, dramas etc. are accurate. In one village we observed a drama presentation in which the Kangaroo Mother Care technique was demonstrated, however, a clothed baby was shown being wrapped onto a man's chest, i.e., the importance of skin-to-skin contact was not shown.

Expand song topics

At the same time that the content of the songs is verified to make sure of their technical accuracy, key topics/information that are not yet included in any of the songs should be identified. In addition, it would be very beneficial to develop some "songs of praise" of the grandmothers and grandfathers to acknowledge their important roles and experience and to provide some balance to the other songs asking people to stop certain traditional practices. All of the songs should also be translated into English so that they can be shared with other areas of Malawi (where languages other than Tembuka are spoken).

Additional participatory learning activity: stories to reinforce key practices

The current complementary use of drama, song with dance and the plans for refresher/additional training of *agogos* will all contribute to reinforcing *agogo* learning and adoption of new health practices and norms. An additional culturally-grounded activity that could be developed to further reinforce their learning would be open-ended, or problem-posing, stories used as a catalyst for discussion. Short stories-without-an-ending could be developed by Ekwendeni staff and community representatives, for example, drama group members, along with open-ended discussion questions. These could be used with and by groups of grandmothers, grandfathers, younger women and younger men. Stories and group discussion have proved to be very effective education/communication tools with both grandparents and younger people in other

countries. Perhaps the local consultant who trained the drama groups could help organize a workshop in which such stories and questions would be developed.

Health worker training to change attitudes about *agogos*

In many cases, health and development workers who are involved in community programs that promote changes in community practices and norms view grandparents as an obstacle in such programs, assuming that they are opposed to change. Prior to adoption of the *agogo* strategy, Ekwendeni PHC staff report that they too tended to view grandparents as a constraint rather than as a resource. Anticipating expansion of the *agogo* strategy beyond the Ekwendeni catchment area, a critical prerequisite for effectively working with the *agogos* is that the health/development workers respect their role in the community and their experience, and believe in their capacity to learn and contribute to promoting positive health practices. Changing health workers' attitudes is a challenging task and a training strategy should be developed that is based on experiential learning and adult education methods to help these workers to reassess their attitudes and approach to *agogos* in the community.

Documenting lessons learned: guidelines for doing so

An important part of documenting community programs is periodically analyzing program strategies, accomplishments and constraints and formulating lessons learned for ongoing/future program implementation. Such "lessons learned" exercises should be carried out periodically to capture the important details of the program implementation experience. The PHC team should be provided with simple guidelines on how to organize/carry out lessons learning exercises with program stakeholders.

The Agogo Approach: written and visual guidelines

To help others to understand and to use the *agogo* approach, it would be useful to develop both a written manual that provides guidelines on all principles, steps, constraints and "lessons learned" related to all key elements of the approach. If resources permit, it would also be useful to produce a DVD that presents the principles, components, steps and outcomes of this innovative and promising approach.

Appendix I: Individual Interview Guide for Agogos

Individual Interview: Agogo

GM [] GF []

Name of Community ----- Date: -----

Name of Village-----

1. When should a pregnant woman have her first antenatal visit? [] []

2. During pregnancy mention at least two danger signs? [] []

[1]

[2]

3. What are the two most important things to do with a newborn? [] []

[1]

[2]

4. Mention at least two danger signs of a newborn? [] []

[1]

[2]

5. When should the baby be given the first bath? [] []

6. Why at that time? [] []

7. How can HIV be transmitted from the infected mother to her baby? [] []

8. How should you carry a premature baby to the hospital? [] []

Appendix II:

Table II: Results of *Agogo* Interviews on their Knowledge and Advice for the Care of Pregnant Women and of Newborns

Question Number	Total No. of Grandfathers interviewed	Total % for GFs who answered correctly	Total No. of Grandmothers interviewed	Total % of GMs who answered correctly	Total number of GMs and GFs who answered correctly
(1) Early ANC	38	34/38 89%	76	70/76 92%	97/114 85%
(2) 2 danger signs of pregnancy	38	20/38 53%	76	40/76 53%	60/114 53%
(3) 2 danger signs of newborns	38	13/38 34%	76	27/76 36%	40/114 35%
(4) 2 priority practices w/ newborns	38	21/38 55%	76	35/76 46%	56/114 49%
(5) First bath delayed	38	18/38 47%	76	53/76 70%	71/114 62%
(6) Reason for delayed bath	38	8/38 21%	76	31/76 41%	38/114 33%
(7) 3 Modes of mother-to-child HIV transmission	38	5/38 13%	76	8/76 9%	12/114 11%
(8) KMC for premature baby	38	28/38 74%	76	59/76 78%	87/114 76%

Appendix III.
Key Conclusions of the Rapid Assessment and Lessons Learned & Recommendations
Developed by the Ekwendeni PHC team

Conclusions (That describe strengths/weaknesses/challenges)	Lessons Learned & Recommendations (What should be done in the future)
Choice of <i>agogos</i> in each village	
- Same number were selected in each village even though the number of <i>agogos</i> differs from village to village	-Selection of <i>agogo</i> is done at village level based on age (50 years +) however some villages have more <i>agogos</i> than the others.
- In some villages many <i>agogos</i> were not trained	-Conduct initial training for the untrained <i>agogos</i> and refresher courses for the trained <i>agogos</i> .
Agogo Training: content	
- No goals and objectives for training have been found	-To include the goals and objectives for the training on the training manual which were omitted last time.
- The content focused primarily on: danger signs of pregnancy and of newborns, ANC, bad cultural practices related to pregnancy and newborns, early initiation of BF and KMC. Topics discussed to lesser extent were: EBF and PMTCT.	-To give more information on EBF and PMTCTT including positive cultural practices.
Agogo Training methods used	
- Participatory approach where participants discussed traditional practices related to each topic and facilitators presented new/modern information. Community members appreciated very much this approach where both they and facilitators were sharing and learning.	-To continue the participatory approach used was LEPSA (Learner Centered Psychosocial Approach and Action Orientated) when training the <i>agogos</i> .
- There is no document that describes exactly how the participatory approach was used that others could follow to use the same approach	-Participatory approach included discussions, demonstrations, story telling, case studies, role-plays and others though no documented.
Agogo training duration	
- Community members all said that the duration (two days) was too short	-Maximum 10 days.
Agogo training curriculum	
- Facilitators were given a list of topics to cover but a detailed training curriculum was not developed	-Curriculum to be in place when funding is available.
Report/documentation of training	
- No report of the training activity (including lessons learned for future training sessions) was prepared.	-Training report was included in Quarterly reports but separate training reports can be written in future if necessary.
Sharing information learned during training	
- The grandmothers (GM) share their information with other GMs and with young women in the family and neighborhood. The grandfathers (GF) share their information with young men. GFs do not directly advise young women/daughters-in-law.	-Culturally grand fathers do not talk directly to their daughter-In-laws, instead they can talk directly to their sons. Other means of communication will still be available in the community to pass on information to respective groups.

Collaboration between <i>agogos</i> and VHC	
-Before <i>agogo</i> training, few VHCs had <i>agogo</i> members except for village headmen (VHC chairmen). Now almost all VHCs have <i>agogo</i> members. “Now the <i>agogos</i> and youth are working together.”	-To continue strengthening their collaboration through supervision and training.
Collaboration between <i>agogos</i> and drama groups	
- Before the <i>agogo</i> training all drama group members were young people. This caused many problems because: a) they were talking about taboo topics in front of everyone; b) it was not appropriate for youth to be teaching elders in this way.	-The Drama groups should continue working with <i>agogo</i> frequently refreshed together.
- Now all drama groups have some members who are <i>agogos</i> . Youth and <i>agogos</i> are working together.	-To continue working together.
- Encouragement/support for <i>agogos</i> from village headmen	
- Encouragement of the <i>agogos</i> by the village headmen is an important factor in motivating them to share their knowledge and participate in community activities. Where the village headman strongly supports <i>agogos</i> and other community activities they appear to be more involved and have more knowledge of appropriate practices.	-Encourage all the village headman to be supporting the <i>agogos</i> activities in their community.
Motivation & capacity of <i>agogos</i> to learn	
- In all villages the <i>agogos</i> seem to be very motivated to learn. In all villages they said that they want to learn more about maternal and newborn health and about other health topics.	-To include other healthy topics for example family planning in their training.
- In all villages there were testimonials even from very old <i>agogos</i> /GMs talking about the practices they have changed.	-To encourage them to continue striking the balance between the harmless and harmful cultural practices.
Supervision/follow-up of <i>agogos</i>	
- No supervision of the <i>agogos</i> was done. In all communities they said they wished that there had been supervision to encourage them and to “make sure that we are on the right path.”	-Make sure all <i>agogos</i> are supervised by developing the supervision plan and follow it.
Responsibility for teaching about pregnancy and newborn care	
- In the past almost all people sent for training were young people. The young people were expected to teach the elders. Both <i>agogos</i> and younger people interviewed said that the <i>agogos</i> did not want to listen to/learn from youth. According to cultural values, if young people try to teach old people they are showing disrespect.	-To continue training both the <i>agogos</i> and the youth together for good communication and participation in their villages.
- Now that the <i>agogos</i> have been trained they now have the knowledge required for them to play their culturally-defined role as teachers of the younger generation.	-Frequent refresher courses for additional knowledge and skills which should be easily be transferred to younger generation.
Drama groups and performances	
- During the training the outlines for 6 plays were prepared and given to participants. They practiced acting them out. This approach helped ensure that the priority messages on each topic were included in the plays.	-Drama performances harmonized messages said by the <i>agogos</i> and fill the communication gaps where <i>agogos</i> cannot reach with their messages as they can move up and down with their bicycles.
- Many performances are conducted during outreach clinics. Often the groups of women who attend the dramas are 100 persons or more. In groups this large it is difficult for many of the participants to listen and to learn.	-Drama performances will be encouraged to both outreach clinics and villages levels for effective dissemination of information.
- In the report on the training of the drama groups it was recommended that a “Drama group	-The drama group manual should be revised to incorporate the needs

user manual” be developed that could be followed by these groups to help them develop dramas that are both educational and entertaining. This has not been done yet.	of the participants.
- The play on PMTCT was very cursory.	-Need for additional training of drama groups in PMTCT.
Use of (thematic) songs	
- Songs on each of the priority topics/themes related to maternal and newborn health were developed during the training of the drama groups and then learned by all of the participants.	-Songs are powerful tools for passing out information to the public.
- Songs are frequently used in communities during drama performances, when meetings are held and at under-5 clinics.	-Songs are powerful tools for passing out information to the public.
- Songs are almost always accompanied by dancing. These methods are very motivating as people love to dance and sing. Also while enjoying themselves the songs facilitate learning.	-Keep it up.
- All of the songs talk about harmful cultural attitudes/practices that need to be changed. No songs have been composed about the positive roles, values and practices in the culture that are valuable and should be preserved.	-Songs reflect both positive and harmful practices but the main emphasis is on harmful cultural practices.
Documentation/reports etc. on agogo strategy and results	
- The available written information on different aspects of the <i>agogo</i> strategy and results is very, very limited. The key principles and steps followed, and the feedback on <i>agogo</i> activities received from both community and Ekwendeni staff have not been systematically recorded either.	-This is the first of its kind initiative in the country of Malawi and it has been a learning process for Ekwendeni to involve the <i>agogos</i> in the maternal newborn care survival. As a result there has been much on practical than documentary because of limited resources/ literature review.
- Where follow-up visits were conducted, with the drama groups, and data was collected on their performance, this data was not systematically analyzed.	-Following the phasing out of first phase of SNL follow up was irregular done because of limited financial and technical support for monitoring and evaluation.
PMTCT	
- When drama groups were trained and songs developed there was less emphasis on PMTCT. The drama performance on PMTCT & VCT is very short/limited. There are no songs on these topics.	- Under SNL1, PMTCT and VCT were not part of the proposal as a result they were limited messages on these topics.
Role of women <i>agogos</i>/GMs in promoting health in the community	
- In all communities there are informal GM leaders who stand out because they are confident, articulate and open to new ideas. While GF leaders are officially recognized (village headman and his advisors) the GMs are not. It would be good to find some ways to acknowledge and strengthen the role of the GM leaders within the GM groups.	-It is the responsibility of each community to designate their leader as so the wish and this can be done informally in their villages.

Appendix IV:
Individuals Interviewed at Ekwendeni Hospital

1. Grace Chunda – Enrolled Nurse/ Midwife
2. Edward Kasonkanji – Clinical Officer
3. Lennah Thole – Traditional Birth Attendant Coordinator
4. Deliwe Msiska – Registered Nurse
5. Elina Mwalwanda – Community Nurse
6. Jane Mwenitete – VCT Supervisor
7. Lean Mhango – Enrolled Nurse/ Midwife
8. Agness Hara – Child Survival Coordinator
9. Dr. Sekeleghe Kayuni – Hospital Director
10. Mr EH Msowoya – Hospital Accountant
11. Mr MJBA Msowoya – Principal Administrator
12. Kistone Mhango – Primary Health Care Director
13. Rose Gondwe – Newborn Health Coordinator
14. Maggie Munthali – Assistant Newborn Health Coordinator
15. Lucy Ngulube – Health Surveillance Assistant (HSA).

Appendix V.

Consultant Scope of Work CS-22 Malawi

Agogo Club Rapid Qualitative Assessment **Ekwendeni Mission Hospital, Mzimba District**

Consultant: Judi Aubel, PhD, MPH

Location: Malawi (Lilongwe and Mzimba District)

Duration: 21 days (includes 14 days in country, 2 travel days and 5 report writing days)

Dates: 4-18 December 2006 (in-country)

Deliverable: Report of *Agogo Club Rapid Qualitative Assessment*, including recommendations for expansion, packaging, and dissemination strategy - in final draft form with all appendices, references, etc. - (due 18 January 2007)

Background information: Under SNL-1 (the first phase of Saving Newborn Lives in Malawi), Save the Children partner Ekwendeni Mission Hospital in Mzimba District developed the *Agogo Club* approach as part of its community-level behavior change strategy. This innovative approach

- is assets-based
- engages grandmothers and grandfathers as key development partners
- appreciates the power of community norms
- works with and not against complex household decision-making dynamics
- leverages the considerable social capital of influential elders

Under SNL-1, as part of community mobilization, enthusiastic grandparents – informal and formal community leaders and influentials among them – volunteered and were trained in key maternal and newborn care messages, recognition of danger signs, and evidence-based best practices. These *agogos* then committed themselves to spreading the word, within their own families and communities. Under SNL-1, Ekwendeni trained more than 4,000 *agogos*. Under CS-22, Ekwendeni aims to increase the reach of this approach by doubling the pool of trained *agogos*. We hope to improve, expand, document, and package the approach to promote interest and uptake by PVOs, NGOs, CBOs, and others working in health and other sectors.

Purpose of Consultancy: The purpose of this consultancy is to assist the Ekwendeni to assess strengths and weaknesses of its innovative *Agogo Club* approach with a view to refinement, expansion, documentation, and packaging. The final report (deliverable) is to include recommendations that are simple, cost-effective, efficient, and appropriate to the context.

Day 1 (M) – Arrival in Lilongwe

Day 2 (Tu) – Briefing SC/Mw country office & travel to Mzuzu
 Day 3 (W) – Introduction to Ekwendeni team/Development of questions to be answered
 Day 4 (Th) – Development of data collection tools
 Day 5 (F) – Tool development, cont'd.
 Day 6 (Sa) – Tool development, cont'd./Exercises to test tools
 Day 7 (Su) -
 Day 8 (M) – Data collection
 Day 9 (Tu) – Data collection, cont'd.
 Day 10 (W) – Data collection, cont'd.
 Day 11 (Th) – Data analysis
 Day 12 (F) – Data analysis
 Day 13 (Sa) – Wrap-up and departure/Return to Lilongwe
 Day 14 (Su) – Write up preliminary findings (bullets)
 Day 15 (M) – De-briefing with SC/Mw and departure

Illustrative questions to be answered:

1. *Agogos* are currently mobilized for multiple activities, e.g., VCT, PMTCTT, newborn health, child survival, etc. How best to integrate and ensure that messages are consistent?
2. What kinds of communication mechanisms could we develop to assist in two-way information sharing?
3. Can *agogos* become less messenger, more decision-maker?
4. What would be the most effective incentive(s) to motivate *agogos* (e.g., ID tags, t-shirts, etc.)?
5. Is the current 2-day training in maternal and newborn health adequate for *agogos*? How could training be structured and improved?

SNL-1 ended some 18 months ago. How well have the messages been retained and the *Agogo* Clubs sustained? What is the future sustainability potential?

Appendix VI: References

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ANNEX IV
b. Mzimba KPC Final Report and Annexes

FINAL REPORT

Malawi



Newborn Health Program
Knowledge, Practice and Coverage Survey
for Mothers of Children 0-23 Months in Mzimba District, Malawi

Dr Tobias Chirwa (PhD)
George Bello
Paul Nkhoma
James Kaphuka

March 2007



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Paul Nkhoma
Millennium Consulting Group
March 2007

List of Abbreviations and Acronyms

AMSTL	Active Management of Third Stage of Labour
ARI	Acute Respiratory Infections
CATCH	Core Assessment Tool on Child Health
CHAM	Christian Health Association of Malawi
CI	Confidence Interval
DA	District Assembly
DEFF	Design Effect
DHO	District Health Office
DHS	Demographic Health Survey
DMO	District Medical Officer
EA	Enumeration Area
HSA	Health Surveillance Assistant
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Net
KPC	Knowledge, Practices and Coverage
KPCCT	KPC Coordination Team
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
ORS	Oral Rehydration Solution
RA	Research Assistant
TA	Traditional Authority
TBA	Traditional Birth Attendants
TTV	Tetanus Toxoid Vaccination
USAID	United States Agency for International Development
VA	Vitamin A
WHO	World Health Organization

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Executive Summary

Background

The Demographic and Health Survey (DHS, 2004) shows that Malawi has made significant progress in a number of health indicators during the last 15 years preceding the survey, including some with direct bearing on maternal and child health. Yet women and children are still an at-risk and largely-neglected population in the country. Maternal and child mortality rates remain high. Infant mortality is 76/1000 live births while child mortality is 62/1000 giving an overall under-five mortality rate of 133 per 1,000. The risk of neonatal deaths (27/1000 live births) is almost twice (1.8 times) higher than the risk of post-neonatal deaths (49/1000 live births). These estimates, are however, between 27-36 percent lower than in the 15 year period prior to DHS 2004.

Objectives of the KPC

Specifically, the objectives of this KPC were to:

- Estimate Knowledge, Practice and Coverage for selected priority child health indicators for potential project indicators
- Assisting the project to identify and prioritize problems that exist within the project area and assist the project team to write and finalize their project proposal
- Developing local capacity to collect, analyze, and use information for decision-making
- Helping build consensus between the project and relevant local partners – Mzimba District Health Office (DHO) and Ekwendeni Mission Hospital.

Methods

Survey tools were adapted by Save the Children in consultation with the Africa Regional Health Advisor and a Health Project Coordinator from Save the Children Ethiopia who was on temporary duty assignment to the Malawi country office. The law in Malawi requires that any interviews with more than five people on an issue be approved by the National Statistical Office (NSO). Prior to the survey, this consent was obtained in addition to that from the District Commissioner.

The household survey primarily used indicators and questions drawn from the KPC 2000 + modules, Revised Rapid CATCH, and Minimum Activities for Mothers and Newborns (MAMAN). The instrument was translated in Tumbuka and pre-tested before taking it to the field. Six local men and women with a health background were hired as enumerators in addition to seven others with experience in surveys. To begin with, training was organized for the enumerators and survey supervisors on survey methodology and tools. They were oriented on the purpose, method and tools of the KPC survey. Training was conducted from 29 January to 1st February 2007. Even with the rainy season being at its peak, data collection was completed successfully during 2-7 February 2007, with few difficulties.

Thirty cluster sampling methodology was used. Probability proportionate to size (PPS) of census enumeration areas was used to select the clusters. In each cluster, 10 households were selected by using a spinning bottle method to collect information from women having children

less than 24 months of age. In cases where there was more than one child under the age of two in the household the youngest child was used as the index child.

After completion of fieldwork, questionnaires were collected and double-entered and verified in the database created in EPI Info (Version 6) and analyzed by using STATA statistical software. Key indicators were crosschecked for consistency and reliability.

Findings

A set of forty-one (41) indicators were selected from the Rapid CATCH to be relevant for the Mzimba KPC. Below are the results for the specific indicators by potential area of intervention.

Maternal and Newborn Health

The following are results for key indicators under maternal and newborn health activities:

Antenatal Care

Percentage of mothers with children age 0-23 months who got ante-natal care by a skilled health worker prior to the birth of her youngest child **(96%)**

Percentage of children age 0-23 months who were seen by a skilled health attendant at least 4 times or more during the pregnancy of her youngest child **(68%)**

Antenatal Counseling

Percentage of mothers who received ante-natal care who were counseled on delivery preparations **(97%)**

Percentage of mothers who received ante-natal care who were counseled on breast feeding **(94%)**

Percentage of mothers who received ante-natal care who were counseled on child spacing **(94%)**

Percentage of mothers who received ante-natal care who were counseled on immunization **(96%)**

Percentage of mothers who received ante-natal care who were counseled on danger signs during pregnancy **(89%)**

Tetanus Toxoid

Percentage of mothers with children age 0-23 months who received at least two doses of tetanus toxoid before the birth of the youngest child **(100%)**

Percentage of mothers with children age 0-23 months who received at least two doses of tetanus toxoid WHILE pregnant with their youngest child **(75%)**

Percentage of mothers with children age 0-23 months who received at least two doses of tetanus toxoid before the pregnancy of their youngest child **(87%)**

Maternal health card possession

Percentage of mothers with children age 0-23 months with a maternal card (interviewer checked) **(63%)**

Accessibility to health facility

Percentage of mothers with children age 0-23 months who reside within 5 kilometers from a health facility OR are able to get to a health facility within 1 hour **(86%)**

Knowledge of maternal danger signs during pregnancy

Percentage of mothers with children age 0-23 months who know at least two danger signs during pregnancy **(36%)**

Percentage of mothers with children age 0-23 months who first seek care from a health facility when they have danger signs during pregnancy **(97%)**

Iron Supplementation

Percentage of mothers with children age 0-23 months who received or bought iron supplements while pregnant with their youngest child **(96%)**

Place of Delivery

Percentage of mothers with children age 0-23 months who gave birth to their youngest child at a health facility **(79%)**

Percentage of mothers with children age 0-23 months who gave birth to their youngest child outside a health care facility **(21%)**

Skilled delivery assistance

Percentage of children age 0-23 months whose births were attended by skilled health personnel **(79%)**

Clean Cord Care

Percentage of children age 0-23 months whose delivery involved use of clean birth kit or whose cord were cut by a new razor blade **(93%)**

Active Management of Third Stage of Labor (AMSTL)

Percentage of children age 0-23 months whose births involved AMSTL by skilled birth attendant **(58%)**

Drying and Wrapping

Percentage of newborns who were dried and wrapped with warm cloth or blanket immediately after birth (before placenta was delivered) **(57%)**

Placement at birth

Percentage of children age 0-23 months that were placed with the mother immediately after birth **(40%)**

First bath

Percentage of children age 0-23 months whose first bath was delayed at least 24 hours after birth **(48%)**

Post-partum visit

Percentage of mothers of children age 0-23 months who received a post-partum visit from an appropriately trained health worker within three days after the birth of the youngest child – health facility delivery **(41%)**

Percentage of mothers of children age 0-23 months who received a post-partum visit from an appropriately trained health worker within three days after the birth of the youngest child – home delivery **(13%)**

Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth **(44%)**

Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth – home delivery **(8%)**

Knowledge of neonatal danger signs

Percentage of mothers of children age 0-23 months who are able to report at least two known neonatal danger signs **(29%)**

Child Spacing

Percentage of children age 0-23 months that were born at least 24 months after the previous surviving child **(91%)**

Breastfeeding

Percentage of newborns that were put to the breast within one hour of delivery and did not receive pre-lacteal feeds **(48%)**

Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours **(37%)**

Vitamin A Supplementation

Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months **(76%)**

Child Immunization

Percentage of children age 12-23 months who received a measles vaccination **(85%)**

Percentage of children age 12-23 months who received a DPT 1 vaccination before they reached 12 months **(82%)**

Percentage of children age 12-23 months who received a DPT 3 vaccination before they reached 12 months **(79%)**

Malaria

Percentage of mothers of children age 0-23 months who took an effective anti-malarial drug during pregnancy of their youngest child **(88%)**

Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began **(2%)**

Percentage of children age 0-23 months who slept under an insecticide-treated bed net the previous night (Q68=12) Malawi protocol **(64%)**

Control of Diarrhea

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 (**12%**)

Percentage of children age 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements (**0%**)

Acute Respiratory Infections

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 (**52%**)

Water and Sanitation

Percentage of households of children age 0-23 months that treat water effectively (**21%**)

Percentage of mothers of children age 0-23 months who live in a household with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the last 24 hours (**2%**)

Anthropometrics

Percentage of children age 0-23 months who are underweight ($-2SD$ for the median weight for age, according to WHO/HCHS reference population) (**28%**)

Background

Child Survival Project

The Save the Children is implementing a national-level Expanded Impact project entitled “Expanded Impact Child Survival Project Advancing Malawi’s Road Map to Reduce Newborn Mortality” funded by USAID Child Survival and Health Grants Program. The project is known as Save the Children’s Malawi Newborn Health Program. According to the Terms of Reference, the project is part of a country-wide effort to achieve the Millennium Development Goals (MDG) 4 and 5 of reducing child and maternal mortality, integrated into a national MOH program. The project incorporates community elements that demonstrate affordable evidence-based approaches and interventions to improve newborn health.

Save the Children sent out invitations to selected individuals and/or firms to submit proposals to undertake a newborn health **Knowledge, Practices and Coverage (KPC) Survey** targeting mothers with children aged 0-23 months in Mzimba district. A KPC implies that Save the Children had wished to understand the attitude, knowledge and practices of its intended clients (mothers) in order to make their project interventions more responsive to the needs of the target group. The KPC required that the consultant employ appropriate participatory methodologies in the conduct of the study and in line with the *KPC 2000+ tool*. Indeed, it is widely accepted that participatory processes build local ownership of projects as well as improve the effectiveness of interventions and policies.

Purpose of the Mzimba KPC Survey

The primary purpose of the proposed study is to *obtain baseline data on selected indicators in order to inform project activities* of the Newborn Health Project. The aim of the Mzimba district KPC is to generate a set of 30-40 indicators to monitor and estimate the results of newborn health activities in the district.

Specifically, the objectives of this KPC were to:

- Estimate Knowledge, Practice and Coverage for selected priority child health indicators for potential project indicators
- Assisting the project to identify and prioritize problems that exist within the project area and assist the project team to write and finalize their project proposal
- Developing local capacity to collect, analyze, and use information for decision-making
- Helping build consensus between the project and relevant local partners – Mzimba District Health Office (DHO) and Ekwendeni Mission Hospital.

Process and Partnership Building

During the design of assignment, five members were identified as a focal team for the purposes of implementing the study. These members included the Regional Health Advisor (Africa), the Newborn Health Program Manager, the Monitoring and Evaluation Officer (Save the Children (Malawi), and Health Project Coordinator (Save the Children Ethiopia). External members included a Healthcare Advisor from a Christian Health Association of Malawi (CHAM) facility within the district and a District Medical Officer from the main government district hospital. It had also been intended to have the Monitoring and Evaluation Officer from the District Assembly in the team, but due to other commitments and the short time nature of the exercise, it was not possible for the assembly to participate. This group was known as the KPC Coordination Team (KPCCT).

Collectively, the team had the following roles and key responsibilities:

- Assisted in the selection of enumerators to participate in data collection
- Developed draft survey instruments (questionnaire, interviewer instructions and Indicators and Tabulation Plan)
- Reviewing the outputs of the consultant throughout the process of the assignment
- Participated in the effective translation of the questionnaire
- Monitoring and supervision of the KPC during fieldwork
- Providing frequent feedback to the team on any desired data needs as preliminary results are fed to the management team
- In the long run, follow up on actions recommended in the KPC

In addition to this team, six (6) of thirteen (13) enumerators were provided from the district's health facilities of Ekwendeni Mission Hospital and Mzimba District Hospital. The enumerators were responsible for participating in the training, including translation of the questionnaire and pre-testing it. Furthermore, they were charged with selecting respondents and conducting

interviews with mothers of children age 0-23. More importantly, each field team was led by a district health person.

Characteristics of the potential beneficiary population

A total 300 mothers in Mzimba District whose children were aged 0-23 months old were interviewed. Sixty-three percent (184) of the mothers were aged 20-29 years. Of the 300 women interviewed, 208 (69%) and 75 (25%) had attended primary and secondary school education respectively. A similar pattern is also reflected in number of years spent in school where 213 (71%) spent at most 8 years in school. The majority of women speaks Tumbuka [284 (95%)] and is most comfortable communicating in Tumbuka [262 (87%)] than in Chichewa and Ngoni. Seventy-eight percent (233) of the households were headed by husbands/partners of the mothers interviewed and followed by 14% (43) of households that were headed by the mothers themselves. Expectedly, 78% (233) of the mothers reported living in the same household with the biological father of their youngest child – showing that as long as the husband/partner is present in the household, he culturally assumes the role of head of household. Sixty-four percent (193) of the mothers reported that they do not work outside their home to earn money. Relative to other income earners, harvesting was frequently mentioned among those women who reported working outside the home. In the event that the woman is away from home, 42% (121) of the women reported that they take the baby with them and 31% (88) reported that the child's grandmother takes care of the child.

Table 1: Background Characteristics of Mothers of Children aged 0-23 months

Characteristic	N=300	%
Age of Mother (in years)*		
< 20 years	31	10.7
20-29	184	63.2
>=30 years	76	26.1
Missing age	9	
Level of Education		
None	17	5.7
Primary	208	69.3
Secondary	75	25.0
University	-	-
Tertiary	-	-
Years in School		
0	13	4.3
<= 8 years	213	71.0
>8 years	74	24.7
Languages		
Chichewa	103	34.3
Tumbuka	284	95.0
Ngoni	11	3.7
Head of Household		
Mother (Respondent)	43	14.3

	Husband/Partner	233	77.7
	Female Relative	10	3.3
	Male Relative	10	3.3
	Other relations	4	1.3
Biological father resident in household			
	Yes	233	77.7
Means of earning money			
	No outside work	193	64.3
	Handicrafts	4	1.3
	Harvesting	49	16.3
	Business	28	9.3
	Servant/Household work	3	1.0
	Salaried work	11	3.7
	Piece Work	12	4.0

*There were 9 women who could not provide their age.

Information on the youngest child, aged between 0-23 months, of the 300 mothers interviewed was collected. Table 2 below shows the age and sex distribution. Of the 300 children, 149 (48.7%) were boys and 151 (50.3%) were girls. Thirty-seven percent (112) of the children were less than 6 months old and cumulatively, sixty-three percent of the children (188) were less than 12 months of age.

Table 2: Age and Sex Distribution of Children aged 0-23 months

Characteristic		N=300	%
Sex of Child	Boy	149	49.67
	Girl	151	50.33
Age of child (in months)	< 6	112	37.33
	6-12	76	25.33
	12-23	112	37.33

Table 3 shows sex ratios distribution by age of children and age of mother. As observed, the overall sex ratio of 0.99 is typical of a Malawi population. The table shows a normal sex ratio distribution between boys and girls except for those born to mothers aged less than 20 years but can be attributed to the small numbers in that age group.

Table 3: Sex Ratio Distribution by Age of Children and Age of Mothers

Age of child (months)	Boy N	Row %	Girl N	Row %	Total	Sex Ratio (M/F)
< 6	56	50	56	50	112	1.00
6-12	35	46.05	41	53.95	76	0.85
12-23	58	51.79	54	48.21	112	1.07
Total	149	49.67	151	50.33	300	0.99

Age of Mother (years)						
< 20 years	19	61.29	12	38.71	31	1.58
20-29	87	47.28	97	52.72	184	0.90
>=30 years	40	52.63	36	47.37	76	1.11
Total	146	50.17	145	49.83	291	1.01

Methods

Authorizations

The Malawi law requires that studies of the type of the Mzimba KPC be approved by the National Statistical Office (NSO). The approval process involves the examination of the survey questionnaire, the sampling design and overall methodology of the study. Save the Children submitted all the required documentation and consent was obtained from the NSO. In addition to the NSO consent, the District Commissioner for Mzimba also provided written authorization for the study.

Questionnaire development and administration

The survey questionnaire which targeted both the mother and the youngest child was adapted by Save the Children from questions in the KPC 2000+ modules, the Revised Rapid CATCH, and the Minimum Activities for Mothers and Newborns (MAMAN). Along with the questionnaire, an indicators and tabulation plan as well as interviewer instructions were also prepared. The instruments were then reviewed by both Save the Children and the consultant for appropriateness in meeting the stated objectives and indicators. The questionnaire was divided into 11 topical areas as follows: (i) Respondent background information, (ii) child spacing, (iii) maternal and newborn care, (iv) breast feeding and infant and young child feeding., (v) vitamin A Supplementation, (vi) child immunizations, (vii) malaria- treatment of fever of mother and child, (viii) control of diarrhea, (ix) acute respiratory infections/pneumonia, (x) water and sanitation, and; (xi) anthropometrics.

One type of questionnaire covering all topic areas was administered to all households with eligible children. The questionnaire covered issues related to the mother of the youngest child in the household as well as issues related to the child itself. To standardise the questionnaire administration, it was translated into Tumbuka, the main language in Mzimba district. All respondents were interviewed in private in order to ensure confidentiality and frank discussions. The content of the questionnaire was acceptable as there were no refusals encountered and all questions were effectively answered.

Selection, Recruitment and Training of Research Field Data Collectors

Personnel trained in quantitative and qualitative data collection methods were recruited to conduct the KPC survey. Half of the enumerators were recruited from a pool of experienced enumerators maintained at MCG while the other half, were selected from among health workers

from the survey district. The KPC team was recruited with special consideration to gender balance and mix of disciplines and qualifications. Selection of some of the interviewers from the survey district was aimed at building capacity within the district for future small scale surveys. Secondly, these individuals were better placed to know the district and its cultural issues. In total, there were 13 research assistants, including three (3) team leaders. Of the team leaders, two were women with a nursing background while the male was a clinical officer. In all, there were five (5) females of whom three (3) were practicing nurses/midwives. Of the eight (8) males, three (3) were practicing health workers. The rest of team was picked for their experience in research work.

The research assistants and supervisors involved in the survey were trained for a period of one week (including pre-testing of the questionnaires). The training covered survey objectives, sampling methodology, data collection and interviewing techniques to maintain quality data, research ethics, a review of study instrument and measurement techniques. Survey pre-testing was conducted in EAs (within Mzimba) which were not selected into the baseline survey. In addition to the survey team, stakeholders from the district and Save the Children participated in the training workshop. This mix of expertise enabled issues related survey questions to be decided upon.

Sampling design and sample size calculation

Sample size determination for the baseline survey was based on the recommended sample size used in Knowledge, Practices, and Coverage survey which is normally set at 300 (refer to KPC 2000+ manual). This is obtained in 30 clusters of 10 respondents each. This sample size is adequate for estimation of most coverage indicators in KPC survey. This survey used the same recommended sample size of 300 obtained in 30 clusters of 10 respondents each. Therefore, households with eligible children (children aged between 0 and 23 months) were targeted for the survey.

Selection of Respondents

In the Cluster Sampling Methodology, a two-stage random cluster sampling technique was used. The first level of sampling was random selection of 30 clusters (enumeration areas) using probability proportional to sample size (PPS) of the EAs. This technique involved listing all EAs with their population sizes then identifying sampling interval by dividing cumulated population by the required number of EAs (30). First EA was randomly selected within this interval and subsequent EAs were selected after adding this sampling interval to the cumulative population size of the previous selected EA until all EAs were selected. The names, codes, and other identifying factors of the clusters of the survey were obtained from the National Statistics Office, which compiled them during the 1998 population census. As an EA consists of a number of villages, the village located at the centre of the EA was selected. This village was normally a community made up with several smaller groups of households. The enumerators covered first the centre village and then moved outwards as long as they were in the same EA. Maps from NSO aided in identification of the enumeration areas and villages.

The second level of sampling was the selection of 10 households (sampling units) from each cluster. The first household for the interviews was selected by first going to the centre of the village. A bottle was then spun to determine a direction. Households in the selected direction were counted and one household randomly selected as the first household for the survey. Subsequent households were selected by going to the third nearest household on the right hand side of the main entrance of the previous household until the required sample size in that cluster was reached. In case no eligible child was found in the selected household the next nearest household with eligible child was selected. The selection of third household in this survey was meant to reduce the effect homogeneity thereby design effect (DEFF) within selected clusters. This normally helps to increase the precision of the estimates.

Each team of enumerators had a team leader who was responsible for sampling households. In each selected household with an eligible child, the mother of the youngest child in that household meeting the entry criteria was interviewed and the child was weighed. The household was eligible for inclusion if the youngest child was aged between 0 to 23 months. Depending on the age of the child, hanging scale or baby scale was used to weigh the child. All children were weighed without their clothes on. A household in the survey was defined as people living together and sharing the same cooking pot.

Measurement of Children

In order to assess the prevalence of underweight in surveyed children, the age of the youngest child was collected in months; the exact date of birth was recorded as indicated in the health passport. Where the health passport was missing, the mother was asked to recall with the help of a local calendar of events. In addition to child's age, the children were weighed and recorded in kg. Children were weighed using a 25kg hanging scale or baby scale to the nearest 100g. The accuracy of the scale was checked each day and was adjusted to zero ("0") before taking new measurements.

Data Collection and Quality Control

Three teams of four research assistants and one supervisor were formulated for data collection. Each team covered 2 clusters per day and therefore each enumerator covered a minimum of four questionnaires in a day. Time taken for completing a questionnaire ranged from 30 to 50 minutes and improved with time. The data collection took 5 days. Cluster allocation to teams was done in advance. However, some changes to cluster allocations were made due to logistical constraints. To ensure adherence to survey methodology and collection of quality data, each team was led by a supervisor who supervised the performance of the team and completion of assigned tasks.

All members of the team were responsible for ensuring that the data collected at each household was as accurate and comprehensive as possible. Interviewers checked the completed questionnaires to see if they were clearly filled out before going to the next household, ensuring that all answers were clear and reasonable, and that their handwriting is legible. At the end of the day all interviewers checked all filled questionnaires to ensure that all items are completed and skip patterns were followed before handing them over to the team supervisor. The team supervisor cross checked the filled questionnaires and any discrepancies were referred to the

enumerator for correction. Each day all team members met to review the problems encountered and areas requiring improvement.

In addition, the Health Project Coordinator and the M&E officer were part of the field team and participated in the supervision of data collection.

Data Entry, Cleaning and Analysis

Filled questionnaires were submitted to MCG data processing section. All questionnaires were checked for accuracy and consistency before being entered into computers. Before data entry, clerks were trained for two days on questionnaire content, skip patterns, and how to enter the data using the pre-designed templates. The data was doubled entered in Epi Info version 3.2 and took about 10 days to complete all questionnaires. For purposes of verification of the data accuracy, a program to check for consistency and range checks for errors during data entry and analysis was created. Data analysis was done using statistical software known as STATA to generate the required indicators.

Results and Discussion

Child Spacing

Indicator: Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child: 91%

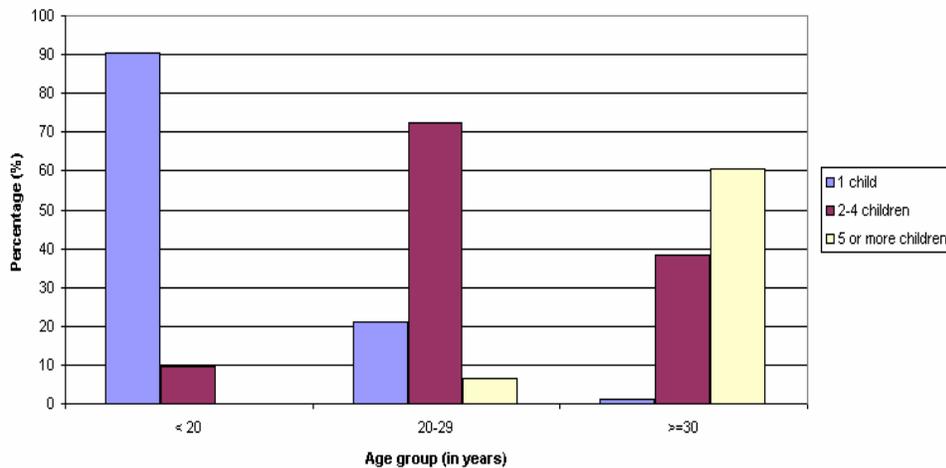
The survey sought to assess child spacing practices within Mzimba district. To obtain this information, the mothers were asked how many children had ever been born to them and the dates of birth between the youngest child and the previous surviving child. The KPC shows very high levels of practicing child spacing with 91% of children aged 0-23 being born at least 24 months apart between the previous surviving child and the youngest child.

Figure 1 below shows the distribution of number of children ever born by age of mother. The mean number of children ever born to mothers interviewed is 3.05 (SD: 1.77). As expected, the total number of children a woman has ever given birth to increases with age, with none of mothers aged less than 20 years, about 7% of those aged between 20-29 years and about 60% of those aged 30 and above having 5 or more children.

Similarly, the mean number of children ever born decreases with increasing number of years spent in school or equivalently level of education. Respectively, the mean number was 4.7, 3.2 and 2.2 for mothers who never attended school, attended primary and secondary school

The percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child has been estimated at 91% (148/163). The percentage increases by age from 87% to 95% in mothers aged 20-29 and over 30 years. However, we note a decrease in the percentage with increase in years spent in school from 100% (12/12), 91% and 83% in those who have never been to school, those who have spent 8 years in school and those who spent more than 8 years respectively.

Figure 1: Distribution of number of children ever born by age of mother



Maternal and Newborn Care

As the project will promote the concept that the mother and child are a dyad and that a healthy mother is necessary for a healthy baby, interventions include the maternal continuum including antenatal care, delivery, and postnatal care. At least one antenatal care visit was universal in Mzimba District. Nearly all mothers had had at least one antenatal care visit by a skilled attendant (96%) prior to the birth of her youngest child. Only two-thirds (68%), however had received the government-recommended four visits. A program emphasis will be to increase the proportion of women who complete the recommended four visits.

The quality of the antenatal care visits appears high with the large majority of those counseled receiving counseling messages. Most received counseling on delivery preparations (97%), immunization (96%), breast feeding (94%), and child spacing (94%) and the large majority (89%) received counseling on danger signs during pregnancy. Surprisingly, although counseling on danger signs was relatively high, only 36% could recall two or more danger signs during pregnancy. Similarly, only 29% could report at least two neonatal danger signs. The quality of counseling may need to be improved. Most received or bought iron supplements while pregnant (96%). All had received at least two tetanus toxoid (TT) shots at some point in their lives, and 75% had received TT2 or more while pregnant with their youngest child. Most (87%) took antimalarials.

Essential newborn care, to be emphasized in this program, clearly has room for improvement. More than half of the mothers (52%) bathed their baby within 24 hours. Only 57% dried and wrapped their baby immediately after birth. Most newborns (60%) were not placed with their mother immediately after birth. Most importantly, very few mothers delivering at home and their babies received a checkup within 3 days after delivery. Of the 39 mothers who delivered at home, only five (13%) received a checkup within three days and only three of their newborns received a checkup during the crucial three-day period when most newborn deaths occur. Only

half (48%) breastfed their babies within one hour, and only 36% were exclusively breastfeeding in the 24 hours preceding the survey.

The following sections present the results of each of the 26 priority indicators for Mzimba KPC under maternal and newborn care intervention area.

Antenatal Care During Pregnancy

Antenatal care visits of at least 4 times to health facilities with skilled personnel are recommended to all pregnant mothers. Although most of the mothers reported that they got antenatal care by a skilled health worker, most of them had less optimal number of visits to the health facilities as shown in Table 1 below.

Table 1: Antenatal Care Indicators

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who got antenatal care by a skilled health attendant prior to the birth of her youngest child	300	289	96%
percentage of mothers with children age 0-23 months who were seen by a skilled health attendant at least 4 or more times during the pregnancy of her youngest child	300	203	68%

Antenatal Counseling Indicators

Health education and counseling are normally given during antenatal visits, counseling might cover areas on delivery preparations, breastfeeding, child spacing, immunizations, and danger signs that occur during pregnancy. In the district, most of respondents reported having counseled in these areas as shown in Table 2 below.

Table 2: Areas Mothers are Counseled on during Antenatal Visits

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on delivery preparations	289	281	97%
percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on breast feeding	289	272	94%
percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on child spacing	289	273	94%
percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on immunization	289	276	96%
percentage of mothers with children age 0-23 months receiving antenatal care who were counseled on danger signs during pregnancy	289	258	89%

Tetanus Toxoid Indicator

Tetanus toxoid vaccination (TTV) is recommended to all childbearing or pregnant mothers. All the surveyed mothers had received at least two TTV before the birth of the youngest child. 75% of them received the TTV during the pregnancy of the child and 87% received before the pregnancy of their youngest child as shown in Table 3.

Table 3: Tetanus Toxoid Vaccination to Mothers of Youngest Child

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child	300	300	100%
percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations WHILE pregnant with their youngest child	300	225	75%
percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations BEFORE the pregnancy of their youngest child	300	260	87%

Maternal Health Card Possession Indicator

Possession of maternal cards in the surveyed community was reported at 63% as shown below. The cards are necessary for documenting all maternal care rendered to the mother including vaccinations. Hence mothers without documented vaccinations for instance TT vaccine would be given again despite being given before. This increases wastage and work load.

Table 4: Maternal Possession of Health Cards

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months with a maternal card (interviewer confirmed)	300	190	63%

Accessibility of the Health Facility

Good access to health facilities has shown to be positively correlated to disease notifications at the health facilities (Bello et al 2005). Mothers are more likely to go to health facilities if they require medical treatment. Access to a health care facility was high, with 86% residing within 5 km. or one hour of a facility. Most (93%) had a clean cord cut, not surprising with such a high facility birthrate.

Table 5: Accessibility to Health Facilities by Mothers of Children Below 24 Months

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who reside within 5 kms from a health facility OR are able to get to a health facility within 1 hour	300	257	86%

Maternal Knowledge of Maternal Danger Signs during Pregnancy

Maternal knowledge of possible dangers during pregnancy and seeking care from a health facility prevents further complications during pregnancy. In this survey, only 36% of the mothers knew at least two danger signs during pregnancy. However, most the mothers reported that would first seek care from a health facility if they had the danger signs as shown in Table 6 below.

Table 6: Maternal Knowledge of Maternal Danger Signs during Pregnancy

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who know at least two danger signs during pregnancy	300	108	36%
percentage of mothers with children age 0-23 months who first seek care from a health facility when they have danger signs during pregnancy	300	292	97%

Iron Supplementation

Iron supplementation during pregnancy is recommended for all pregnant mothers for prevention of maternal anemia. In the present survey, 96% of the mothers reported having received iron tablets during their pregnancy.

Table 7: Iron Supplementation of Mothers

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who received or bought iron supplements while pregnant with the youngest child	300	287	96%

Indicator for Place of Delivery

In the survey, number of the children delivered at the health facility (hospital, private clinic or health centre) and those delivered at home (mother's home, other home, traditional birth attendant or on the way to the hospital) were assessed. Home deliveries are prone to maternal death due to delivery complications that might not promptly be attended to by a skilled provider. The majority (79%) (238) gave birth at a health facility with a skilled attendant, much higher than the Malawi average of 57% (DHS, 2004).

Table 8: Place of Delivery

Indicator	Denominator	Numerator	%age
percentage of mothers with children age 0-23 months who gave birth in a health facility	300	238	80%
percentage of mothers with children age 0-23 months who gave birth outside a health care facility	300	62	21%

Indicator for Skilled Delivery Assistance and Clean Cord Cutting

Of the children born at a health facility all of them were attended by a skilled health worker (medical doctor, nurse/midwife or clinical officer/medical assistant). Use of clean birth cut in the district was high as shown in

Table 9 below probably due to good awareness of infection prevention messages or just a reflection of maternal knowledge of infection prevention and not necessarily what was actually done.

Table 9: Skilled Birth Attendant and Clean Cord Cutting in Newborns

Indicator	Denominator	Numerator	%age
percentage of children age 0-23 months whose births were attended by skilled personnel	300	238	79%
percentage of children age 0-23 months whose delivery involved use of a clean birth kit or whose cord was cut with a new razor blade	300	280	93%

Active Management of Third Stage of Labor (AMSTL)

Active management of third stage of labor (AMSTL), which involves the mother being given an injection that prevents heavy bleeding, skilled birth attendant using controlled traction on the placenta and massaging the uterus after placenta delivery to prevent heavy bleeding, was only reported in 58% of mothers who delivered at health facility. Use of this technique in health facilities during deliveries helps to reduce maternal death due to severe blood loss (haemorrhage) which is one of the contributing factors of maternal mortality in mothers giving birth especially at home.

Table 10: Active Management of Third Stage of Labor

Indicator	Denominator	Numerator	%age
percentage of children age 0-23 months whose birth involved AMSTL by skilled birth attendant	238	138	58%

Wrapping, Placement and First Birthing of Newborns

Of the children surveyed 57% were wiped and wrapped with warm cloth immediately after birth and that 40% of the surveyed children were placed with the mother. First bath of them was delayed for at least 24 hours after delivery in 48% of the children as recalled by the mother (Table 11). It is recommended that all newborns need to be placed with their mothers and first bathing of the newborn be done at least after 24 hours.

Table 11: Newborn Drying, Placement and First Bathing

Indicator	Denominator	Numerator	%age
percentage of newborns who were dried and wrapped with warm cloth or blanket immediately after birth (before placenta was delivered)	300	171	57%
percentage of children age 0-23 months who were placed with the mother immediately after birth	300	121	40%
percentage of children age 0-23 months whose first birth was delayed at least 24 hours after birth	300	145	48%

Indicator for Post-Partum; Natal Visit

Regardless place of delivery, mothers and their newborn are supposed to be checked up by skilled health worker within three days for better care in case of any complications. In the present survey, overall only 41% for mothers and 44% children received a postnatal check up within three days of delivery by a trained health worker. When the two were disaggregated by either the children born delivered at health facility or at home, the proportions were as shown in Table 12: Postpartum Check-Ups for Mothers and Newborns below.

Table 12: Postpartum Check-Ups for Mothers and Newborns

Indicator	Denominator	Numerator	%age
percentage of mothers of children age 0-23 months who received a post-partum check up by an appropriate trained health worker within three days after the birth of the youngest child	300	123	41%
percentage of mothers of children age 0-23 months who received a post-partum check up by an appropriate trained health worker within three days after the birth of the youngest child – HOME DELIVERY	39	5	13%
percentage of children age 0-23 months who received a post-natal check up by an appropriate trained health worker within three days after birth	300	131	44%
percentage of children age 0-23 months who received a post-natal check up by an appropriate trained health worker within three days after birth - HOME DELIVERY	39	3	8%

Knowledge of Neonatal Danger Signs

Knowledge of danger signs for newborn by mothers or caretakers is essential for prompt health seeking thereby averting early childhood death. In the survey district (Table 16 below), only 29% of the mothers of surveyed children were able to report at least two danger signs that would indicate the child was ill. There is need to increase education awareness of this knowledge through programmatic interventions in the district.

Table 13: Indicator for Knowledge of Neonatal Danger Signs

Indicator	Denominator	Numerator	%age
percentage of mothers of children age 0-23 months who are able to report at least two known neonatal danger signs	300	88	29%

Breastfeeding/Infant and Child Feeding

While breastfeeding is almost universally practiced in the district where 298 children out of the 300 (99.3%) children surveyed were ever breastfed, necessary breast feeding practices are poor in the district. As shown in

Table 14 below, only 48% of the children age 0 – 23 months were breast fed within the first one hour of life and that they were not given prelacteal feeds. Exclusive breastfeeding in children below 6 months was only practiced in 37% of the surveyed children aged below 6 months.

Table 14: Breastfeeding/Infant and Child Feeding

Indicator	Denominator	Numerator	%age
percentage of children age 0-23 months who were put to the breast within one hour of delivery and did not receive prelacteal feeds	300	145	48%
percentage of infants age 0-5 months who were exclusively breast fed in the last 24 hours	112	41	37%

Vitamin A Supplementation

Indicator: Percentage of children age 6-23 months who received a Vitamin A dose within the last 6 months: 76%

The data show that overall, almost 4 children in 5 of age 6-23 months have received a dose of vitamin A supplementation. Table 15 shows vitamin A Supplementation among 6-23 months children within the last 6 months by sex. The results show that 76% of children had received a dose of vitamin A, the percentage for male children was 78% while for females children were 74%.

Table 15: Vitamin A Supplementation among children 6-23 months within the last 6 months by sex

Sex	% Children who received Vitamin A supplementation dose	Total Number of Children who received Vitamin A supplementation	Total Number of Children
Male	74	69	93
Female	78	74	95
Total	76	143	188

Child Immunization

This section presents data on vaccinations coverage for measles, DPT1 and DPT3 among children 12-23 months, the age range by which children should be fully vaccinated. The information on vaccination coverage was collected from vaccination cards shown to interviewers by the mothers/caregivers of the children and from the verbal reports of the mothers/caregivers. The results of the surveys indicate that 90% of the child vaccination cards or child health booklets were seen by the interviewers.

Indicator: percentage of children age 12-23 months who received a measles vaccination: 95%
Table 16 below presents information on percentage of children age 12-23 who received a measles vaccination according to the source of information by sex. Based on the information from the vaccination health cards, it is estimated that 40 % of these children had received the measles vaccination while based on information from mothers 44 % had received the measles vaccination. Variation by sex.

Table 16: Measles Vaccinations by Sex of Child

Sex	Information based on vaccination cards/ health booklet	Information based on mother's report
Male	39.6 % (59/149)	56% (57/102)
Female	40.4% (61/151)	56% (55/98)
Total	40.0 (120/300)	56% (112/200)

Indicator: percentage of children age 12-23 months who received DPT1 vaccination before they reached 12 months: 82%

Indicator: percentage of children age 12-23 months who received DPT3 vaccination before they reached 12 months: 79%

Table 17 below shows numbers and percentage of children 12-23 months who had received DPT1 and DPT3 vaccines at any time before the survey and percentage vaccinated by 12 months of age. Overall, 79% of all children 12-23 months had received DPT1 at any time before the interviews while slightly over two-thirds had received DPT3 based on the information from health booklets/ vaccination cards. Out of the children age 12-23 months who had received DPT1 and DPT3 at any time before the interviews, 82% and 79% had received DPT1 and DPT3 respectively before their first birthday (that is before 12 months of age).

Table 17: Number and Percentage of Children 12-23 Months who Received DPT 1 and DPT3 before their First Birthday

Indicator	Vaccine		
	DPT1	DPT3	
Percentage Vaccinated by 12 months of age	79%	65%	
Number Vaccinated by 12 months of age	92	88	

Malaria – Treatment of a Child with Fever

Indicator: Percentage of mothers with children age 0-23 months who took an effective anti-malarial drug during the pregnancy with the youngest child: 88%

In the survey, mothers who received antenatal care in the last 2 years before the surveys were asked whether they took any effective anti-malarial drug while pregnant with the youngest child. The survey results show that over 8 women in every 10 did take an effective anti-malarial drug during the pregnancy with the youngest child. The results further indicate that there is slight variation among the percentage of mothers who took the anti-malarial drug during the pregnancy with the youngest child by their level of education as shown in Table 18.

Table 18: Mothers Taking Effective Anti-Malarial Drugs during Pregnancy by Level of Education

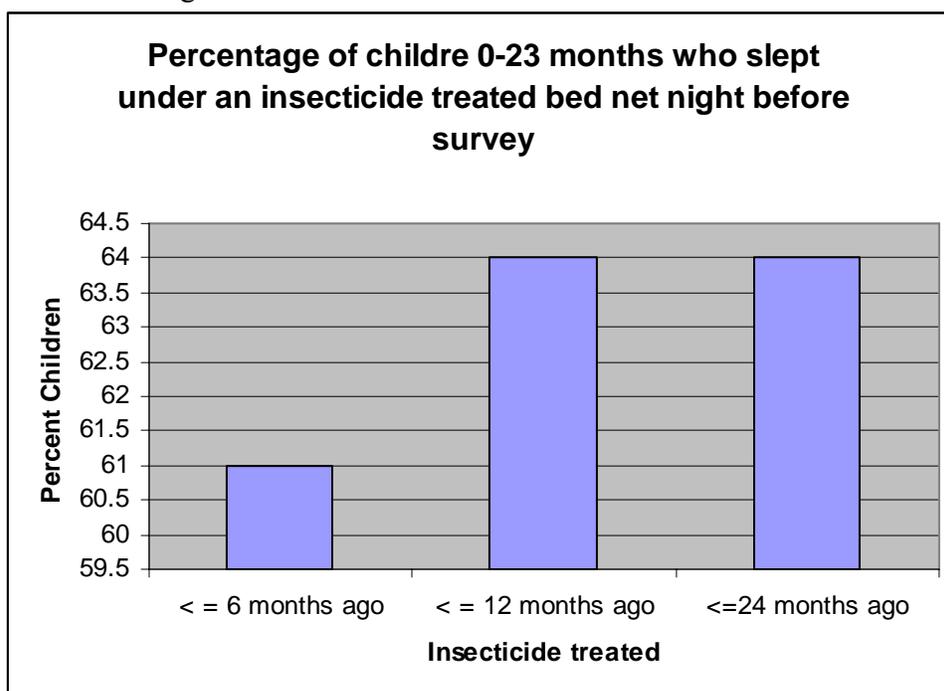
Level of Mothers' Education	Percentage who took effective anti-malarial drug
Education level of mother	
None	
Primary	94%
Secondary	92%
	93%
Total	88%

Indicator: Percentage of children age 0-23 with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after fever began: 2%

In the survey the mothers were asked whether their children had been ill with fever at any time in the last 2 weeks preceding the survey. The data show that less than half (44%) of the children age 0-23 months were reported to have had a fever in the two weeks preceding the survey. Among the children with symptoms of fever, 84% sought treatment for the fever and almost all of them (99%) took some drug for the fever but it was only 2% of these children who were treated with an effective anti-malarial drug with 24 hours.

Indicator: Percentage of children age 0-23 who slept under an insecticide treated bed net on night before the survey. The survey also gathered information on the ownership of mosquito nets that could be used while sleeping in the households. For those households that reported that they have a mosquito net the respondents were also asked whether anyone slept under the mosquito on the night before the survey. The data show that almost 79 percent of the households interviewed have at least a mosquito net while 21 percent do not have. About 97 percent of the children age 0-23 slept under a mosquito net the night before the survey, among them 89 percent were reported by their mothers as having slept under an ever soaked or dipped in a liquid treated to repel mosquitoes or bugs. About two-thirds of the mosquito nets were last soaked 12 months and 24 months ago as seen in Figure 2 below.

Figure 2: Percentage of children sleeping under treated bed net the previous night by period of soaking



Water and Sanitation

The study sought to find out assess whether the household uses an improved supply point for drinking water. A protected water source means that measures are in place to prevent water from becoming contaminated, especially through runoff. Protected wells, boreholes and piped water are considered improved water sources. On the other hand, unprotected water sources include rivers, unprotected wells, dams and ponds. On sanitation, this survey only targeted hygiene practices of the mothers of children age 0-23 as it relates to occasions when they have to wash their hands and whether they use soap at all. The indicators of key interest in this survey are shown in the table below.

Table 19: Child Health Indicators for Water and Sanitation

Description of Indicator	Denominator	Numerator	(%)
Percentage of households of children age 0-23 months that treat drinking water effectively	33	7	21
Percentage of mothers of children age 0-23 months who live in a household with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the last 24 hours	300	5	2

Safe Drinking Water

Water plays an important role in determining the health status of newborn children. Use of unprotected sources of water, such as rivers and unprotected wells increases the risk of spread of

water-borne diseases such as Diarrhoea and intestinal parasites. These infections may in turn affect the nutritional status of the child and household. The results also show that a small proportion of households obtained water from unprotected sources in Mzimba (11.0%) while approximately 33% and 56% had access to clean water from taps and boreholes, respectively. Thus, nearly 90% of households have access to clean and improved water sources as compared to a national average of 64% (DHS, 2004). Households that use unprotected sources of water should be taught ways of treating the water to make it safe for drinking. Only about 3.3% compared to a national average of 8.0% depend on rivers for their major source of drinking water.

Table 20 : Household Sources of Drinking Water shows the breakdown for access to drinking water.

Table 20 : Household Sources of Drinking Water

Water source	Total	Percent (District)	DHS (National)
Tap	98	33	20
Borehole	169	56	44
Unprotected well	23	8	25
River	10	3	8

Source: KPC and DHS (2004)

Drinking Water Treatment Methods

Beside using an improved water supply and storing drinking water safely, treating this water through physical or chemical means can further reduce the risk of contamination. Households may use one type of treatment or a combination depending on the method. All methods used were recorded without attempting to know how regularly and effectively they treat their drinking water. Table 3 shows that only 11.56% of the households treat their drinking water and that for these, boiling is the most commonly used method (54.84%) followed by adding chemicals (46.67%) and straining water through cloth (10.34%). Methods which are not used include sedimentation, water filter (whether ceramic, sand or composite) and solar disinfection

Hand washing Places and Maternal Practices

Hand washing is one behavior that can substantially reduce the risk of disease transmission. Mothers were asked whether their households had a special place for hand washing. However, the existence of a hand-washing facility will not reduce the risk of disease if individuals do not practice appropriate hand-washing behavior. The table below shows that households rarely have dedicated places for hand washing. More than half of the households (52%) do not have a specific place where they usually wash their hands. Of those that had specific places, in about one-third (31%) the place is within their yard, 10% have them outside the yard, 6.3% are near a cooking place and only one percent are inside or near a toilet.

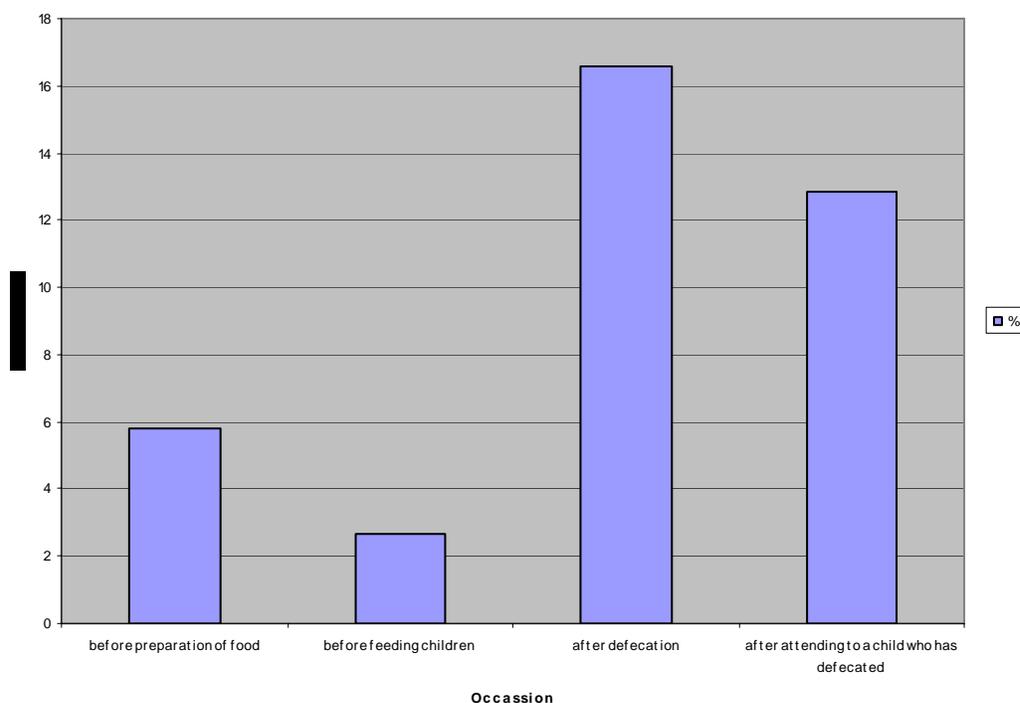
Table 21: Position of Hand washing Places

Position of Hand washing place	Total	Percentage (%)
No specific place	155	52%
Elsewhere in yard	93	31%
Outside yard	30	10%
Inside/near kitchen/cooking place	19	6%
Inside/near toilet facility	3	1%
Total	300	100%

The mothers were asked for their permission for the interviewer to see and observe the hand washing place. The purpose of the observation was to establish whether there was in place soap or any other locally used cleansing agent when washing hands. The possible responses were soap, detergent, mud/sand, ash and none. In the absence of the cleansing agent, the mothers were asked to bring it within one minute; otherwise it was considered that the household do not usually use the item at the hand washing place. The essence of this is that if they cannot bring it within the shortest possible time, the likelihood that they use it for hand washing is low. In total, 148 households allowed the inspection of their usual hand washing places. In the majority of the cases {(90) (approximately 61%)}, households did not have in place any hand cleansing agent. Substantially, however, about 38% had soap in place.

Hand washing with soap is one behavior that can substantially reduce the risk of disease transmission. In order to assess whether the mother had used soap to wash her or her child's hands during the last 24 hours, they were asked under what occasions. Approximately 88% (190) of the respondents had used soap in the last 24 hours before the interview. Only when the mother mentions that they used soap for washing their hands or that of their children did the survey proceed to assess the occasion among the following four cases (i) before food preparation, (ii) before feeding children, (iii) after defecation and; (iv) after attending to a child who had defecated. Figure 3: Occasions for mothers wash hands with soap shows that in the majority of cases when mothers used soap, they or their child had defecated (29%). It further shows that it is rare to wash hands with soap when one wants to prepare food (6%) or to feed children (3%).

Figure 3: Occasions for mothers wash hands with soap



Control of Diarrhoea

Diarrhoea is one of the leading causes of death among children of age 0-23 months in Malawi. In addition to improving the mother's knowledge in appropriate breastfeeding practices, measles immunization, improved water and sanitation utilization, diarrhoea is commonly managed through use of oral rehydration therapy. The common supplies are commercially available oral rehydration solution (ORS) or home made fluids. In addition to this, diarrhoea may be treated with zinc supplements, but this has not been accepted by the MOH in Malawi. Other medications used (most often inappropriately) for diarrhea include antimotility, injection, intravenous fluid and home-made remedy/herbal medicines; as well as antibiotics such as flagyl, bactrim, amoxycilin or tetracycline.

Use of ORS, Home Fluids and Syrups

Indicator: Percentage of children age 0-23 months with diarrhoea in the last two weeks who received Oral Rehydration solution and/or home made fluids: 12%

The survey shows that about 37% (110) of the children age 0-23 had had diarrhoea in the last two weeks. In 48% of cases of diarrhoea, an ORS liquid and/or home-made fluid was given to the child. Nevertheless, this shows a very poor level of knowledge and practice by mothers on what nutrition action to take when their child is sick. The table shows that out of a total of 110 mothers of ill children in the survey, 97 (88%) mothers used a fluid to treat their children of whom 51 mothers (53%) at least used ORS to treat the illness, while 46 (47%) never used it. Similarly, of 85 mothers who responded to whether they had used a home-made fluid, 35 (41%) had used it while 50 (59%) had never. Furthermore, 28 mothers also treated their children with

an antibiotic. The use of antibiotics appears to move with age as the practice becomes more prevalent the older the age group as can be seen for less than 20 years (0%), 20-29 years (64%) and 71% for those 30 years and older.

Zinc Supplementation

Indicator: Percentage of children age 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements (0.00%)

Zinc is an essential micronutrient in human growth, maintenance of the immune system and child development. Zinc supplements are said to be very effective in treating acute cases of diarrhoea. There was virtually no one who used zinc supplementation for control of diarrhoea. The MOH of Malawi has not authorized treatment of diarrhoea with zinc supplements.

Use of Other Medication

Antibiotics such as flagyl, bactrim and amoxycilin were also a popular, though inappropriate, remedy in treating diarrhoea. Twenty-seven mothers, (25%) who treated their babies with ORS or homemade fluids, also provided them with an antibiotic, 4 (3.6%) also treated their babies with traditional herbal medicine while another combined 3.6% used injection, intravenous fluid (drip) and antimotility medication.

ARI/Pneumonia

Indicator: 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 (52%)

Acute respiratory infections (ARI)/pneumonia is one of the killer diseases of under two years of age children. The survey assessed the knowledge of mothers whether they know the danger signs that seek immediate treatment. The danger signs included trouble in breathing, breathing faster than usual with short fast breaths. Mothers were also asked for their treatment seeking behaviour during the illness of their child.

Prevalence of Coughs and Seeking Medical Care

Prevalence of cough in the last two weeks prior to the interview was at 55% (164/300) of children age 0-23. Of these, 81 (49%) had trouble in breathing or would breath faster than usual with short, fast breaths. When a child had a cough, 38% (62/164) sought advice for the cough or fast breathing with the majority seeking advice from a nurse (31%), a doctor (24%), clinical officer/medical assistant (18%). Virtually none of the mothers ever sought advice or treatment from a Health Surveillance Assistant (HSA).

Anthropometrics

Indicator: Percentage of children age 0-23 months who are underweight (-2SD for the median weight for age, according to WHO/HCHS reference population) (28%). At the end of the interview, the mother was asked for permission to weigh their child. All 300 mothers gave permission and their children were weighed. Prevalence of underweight was calculated in 271 of CS-22, Malawi, Detailed Implementation Plan, April 2007 (Revised August 2007)

the 300 children. The 29 children were excluded because they were flagged. Underweight was estimated at 27.7 (95% CI; 22.5 – 33.5%) in the district among children 0 – 23 months.

Table 22: Percentage of Children 0-23 Months Old Who are Underweight

Indicator	Denominator	Numerator	%age
percentage of children age 0-23 months who are under weight (-2 standard deviations for median weight for age according to WHO/HCHS reference population)	271	71	28% (95% CI; 22.5 – 33.5%)

ANNEX V

Agreements

Save the Children is in the process of developing written Memoranda of Understanding and agreements as specified below. Completed agreements will be provided at the Mini-University for the DIP review.

MOU with Ministry of Health/Reproductive Health Unit (MOH/RHA)

- Roles and responsibilities for general partnership in Malawi's Road Map and other national-level work related to maternal and newborn health

MOU with MOH/RHU and UNICEF

- Roles and responsibilities for community-based newborn care 3-district pilot

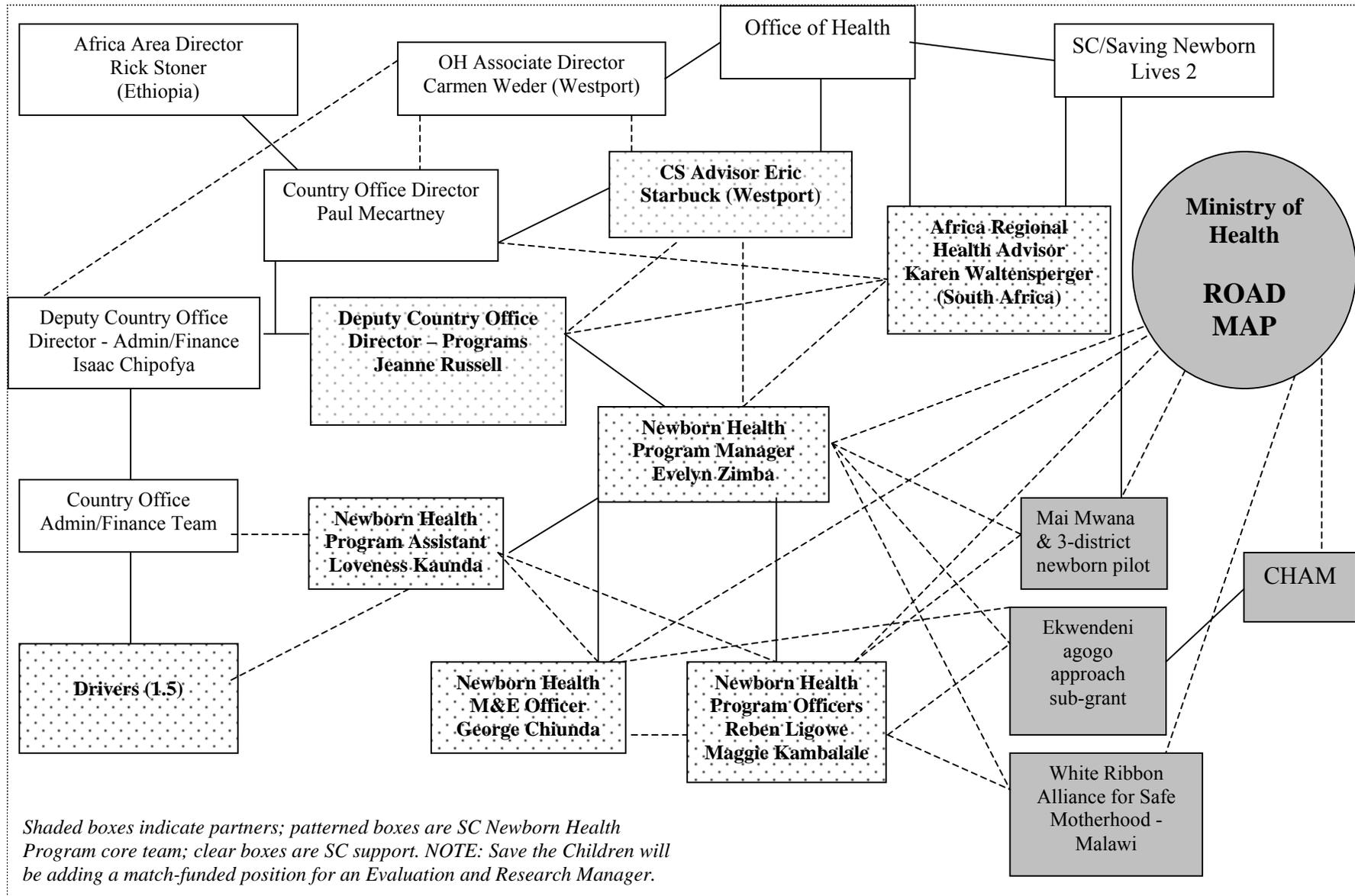
MOU with WRASM-Mw

- Roles and responsibilities for collaboration and support

Sub-Grant Agreement with Ekwendeni Mission Hospital (Synod of Livingstonia)

- Formal agreement, work plan, and budget for 18-month project to define, refine, expand, and document the *agogo* strategy for use by other NGOs and CBOs

ANNEX VI Organization Chart



ANNEX VII
Resumes/CVs/JDs
a. Manager, Newborn Health Program Job Description

1.0 JOB DESCRIPTION				
Position Manager, Newborn Health Program	Department MWFO	Reports to Deputy Country Director, Programs	Reportees / Supervision Project Officers (2), M&E Officer, Project Assistant	Grade 13
2.0 POSITION PURPOSE				
<p>The Newborn Health Program Manager effectively leads and manages the unified newborn health program in the Malawi Country Office, including Saving Newborn Lives (SNL2) and USAID (CS-22) funding sources. She is responsible for providing technical leadership and oversight, day-to-day management and operational guidance, and representing the Country Office newborn health programs with governmental and non-governmental stakeholders. She provides technical assistance in newborn health issues to partners, including Mai Mwana, MOH, and Save the Children staff members and programs.</p>				
3.0 JOB RESPONSIBILITIES, DUTIES AND TASKS				
3.1 Core Responsibilities & Duties				
Plan and oversee the implementation and monitoring of the Country Office Newborn Health Program and provide technical and operational leadership.				
Build, lead, and supervise the newborn health team.				
Provide leadership and TA in newborn health to MOH and other in-country development partners and serve as key spokesperson for the newborn in-country.				
Liaise and maintain excellent relationships with the Ministry of Health, non-governmental organizations, donor agencies and other in-country stakeholders as appropriate. Assure program strategies are developed in close coordination with in-country counterparts at the Ministry of Health, other stakeholders and organizations. Coordinate and/or represent the Country Office's newborn health priorities and programs in professional circles and through meetings, conferences and presentations.				
Advocate on behalf of newborn programs and Save the Children and report on potential new funding, leveraging opportunities, and partners as appropriate. Provide support and input for development of proposals on maternal and newborn health interventions.				
Organize and manage technical and programmatic inputs for programs, and liaise effectively with country, regional, and headquarters technical and management staff.				
Coordinate planning and implementation/oversight of operational research with SNL, USAID, MOH, CHAM, UNICEF, and other development partners. Oversee research sub-grant performance against plans.				
Organize and facilitate regular program review and planning meetings, co-leads detailed implementation planning process, defend DIP, and represent the Country Office at Mini-University.				
Document and disseminate program achievements, success stories and lessons learned. Prepare periodic and annual project reports.				
Monitor budgets against expenditures and maintain financial stewardship.				

3.2 Occasional Significant Duties

Make presentations at relevant forums.

Perform other relevant duties as requested by the Country Director and Deputy Country Director.

Participates in Office of Health Program Learning Group and other ad hoc technical working group meetings and committees, as invited

4.0 JOB SPECIFICATION (MINIMUM JOB REQUIREMENTS)

Education	Relevant Experience (In Yrs)	Skills
Clinician (masters level nurse-midwife) with postgraduate training and education in neonatal health, pediatrics, obstetrics, midwifery, or related area of practice.	Minimum five years experience in maternal and newborn health programming and practice; firm grounding in primary health care and public health desirable. In-depth knowledge of Malawi's formal and informal health system essential.	<ul style="list-style-type: none">• Ability to work in a complex environment with multiple tasks, short deadlines and intense pressure to perform• Proficiency in writing technical and programmatic reports that document program direction or results• Ability to interact skillfully and diplomatically with numerous counterparts, both domestically and internationally.• Experience working in cooperation with colleagues who represent a wide range of interests and needs.• Ability to build, lead, and effectively mentor and supervise a team.

5.0 DECISION-MAKING & AUTHORITY

This position has a high degree of decision making and authority, under the guidance of the Deputy Country Director, Programs.

6.0 PERFORMANCE INDICATORS

1. Timely submission of quality project documents, including budgets, activity plans, and reports.	2. Demonstrated staff development through organization, mentorship, and supervision.
3. Program planning and review activities are timely, productive (action and decision-oriented), and commensurate to the needs of projects, the country office, regional and HQ counterparts, and donors.	4. Financial resources are well managed and expenditures against budget are monitored with finance staff.

7.0 APPROVALS

Prepared By: Jeanne Russell Signature _____

Approved By: _____ Signature _____

Location:

Preparation Date: 8/7/06

ANNEX VII
Resumes/CVs/JDs
b. Evelyn Zimba's CV

- Address:** P.O. Box 30374, Lilongwe 3, Malawi
Tel: 265-1-753888 (O), 265-1762187 (H) 265-8-277091 (Cell)
E-mail: ezimba@llmw.savechildren.org ezimba_2001@yahoo.co.uk
- Nationality:** Malawian
- Languages Spoken:** English, Chichewa & Tumbuka
- Education:** **University of Witwatersrand, Johannesburg, RSA**
2000: Masters Degree in Nursing (Paediatrics & Child Health)
- University of Malawi**
1992: BSc. Nursing (Education, Community & Management)
1985: University Certificate in Midwifery
1983: Diploma in Nursing
- Marymount Secondary School**
1980: Malawi School Certificate of Education
1978: Malawi Junior Certificate
- Employment:** **2003 December to date** – Save the Children (US) -Malawi Field Office
1994 November to 2003 November – University of Malawi, Kamuzu College of Nursing
1985 August to 1994 October – Ministry of Health and Population, Malawi
- Related Training:**
- 2005: Community-based Programming for PMTCT and HIV Counselling and Testing,**
CORE / USAID / Save the Children Federation USA, Malawi
- 2005: Gender Analysis and Mainstreaming in Reproductive Health,**
White Ribbon Alliance, Malawi
- 2003: The Practices and Principles of Pre-Hospital Trauma Management,**
Lilongwe Central Hospital and Tees, East and North Yorkshire Ambulance Service
NHS Trust: BTLS International
- 2002: National Trainer: Integrated Management of Childhood Illnesses, Malawi**
Ministry of Health and Population (MOHP)
- 2002: National Trainer: Integrated Disease Surveillance and Response, MOHP**

2002: National Trainer: Cholera Control and Management, MOHP

2002: HIV/AIDS HBC Volunteer Roman Catholic: Lilongwe Diocese

**1997: Management of Diarrhoea & Acute Respiratory Infections in Children,
MOHP**

1993: Lactation Management, MOHP& IBFAN Africa

1987: Family Planning Service Provider, MOHP

WORK EXPERIENCE

2006 August to date – Newborn Health Program Manager, Save the Children

- Provision of technical and operational leadership for the planning, implementation and monitoring of the Country Office Newborn Health projects
- Provision of leadership and TA in newborn health to MOH and partners, and ensuring excellent relationships with the MOH, non-governmental organizations, donor agencies and other in-country stakeholders as appropriate
- Ensuring that program strategies are developed in close coordination with in-country counterparts at the MOH, other stakeholders and organizations.
- Representing the Country Office's newborn health priorities and programs in professional circles and through meetings, conferences and presentations.
- Provision of support and input for development of proposals on maternal and newborn health interventions
- Organizing and facilitating detailed implementation planning process for CS22
- Monitoring budgets against expenditure and maintaining financial stewardship

2005 May to July 2006 – Capacity Building Coordinator, Umoyo Network, Save the Children

- Principal focal liaison between the Umoyo Network Capacity Building for Quality HIV/AIDS Services Project and 8 supported NGO's
- Coordination of all capacity building activities for the 8 supported NGO's
- Provision of technical support during identification of capacity building needs of the NGO, planning, training and mentoring in areas of organizational development, such as strategic planning, governance, management, human resource development, office systems and HIV/AIDS mainstreaming
- Ensuring that technical specialists and external consultants provide technical assistance in a timely manner
- Ensuring timely submission of NGO quarterly reports and review by technical specialists
- Responsible for production of quarterly reports, quarterly and monthly work plans and monitoring of progress of capacity building plan through regular visits to NGO's and by keeping a database of all the activities done

2003 December to April 2005 - Program Officer, Saving Newborn Lives (SNL) Save the Children

- Coordination of the planning and implementation of SNL Malawi initiative through partnership strategy.

- Provision of technical support in the development of SNL training manuals, behaviour change and communication materials and ward protocols, as well as in the procurement of equipment for the implementation of SNL activities
- Development of Whole Blood Rapid Syphilis Testing (WBRST) training manual and supervision of trainings, service implementation and monitoring
- Provision of supportive supervision and capacity building to Save the Children staff and partners (government and non-governmental) in the implementation of SNL activities. Provision of support to local and international consultants.
- Responsible for project documentation, production of progress reports and monitoring and evaluation

1994 November to 2003 November - Lecturer Medical / Surgical Nursing, University of Malawi, Kamuzu College of Nursing (KCN)

- Provision of technical support to the college and staff on issues pertaining to Paediatric nursing and coordination of Medical/Surgical Nursing departmental activities
- Curriculum planning and development, formulation of evaluation tools and assessment of students for both classroom work and clinical practice
- Classroom and clinical teaching to the generic and mature entry degree students and supervision of student's research projects from proposal writing through to dissemination of findings
- Coordination of the establishment of Livingston Memorial Private Clinic at KCN that offers under-five, family planning, outpatient and youth friendly services.
- Provision of technical support to District Health Management Teams (DHMT) on disease surveillance and response system
- Provision of technical support in both pre-service and in-service trainings of health providers on Integrated Management of Childhood illnesses (IMCI)

1993 September to 1994 October - Professional Officer (PO) In-service Educator, Kamuzu Central Hospital (KCH) - Ministry of Health and Population

- Managed the development of Job Descriptions, training manuals of support staff as well as the design, planning and implementation of in-service education program to all cadres of health personnel at KCH
- Provision of technical support and supportive supervision to staff in the Paediatric and Postnatal Wards of KCH and Bottom Maternity

1992 September to 1993 September - Tutor and Deputy Principal for the Enrolled Nursing and Midwifery program (PO) St. Johns School of Nursing (MOH on secondment to CHAM)

- Management of the school activities, budgeting and overseer of the purchasing of food items for the School
- Coordinating the selection of students, provision of classroom and clinical teaching and conducting students' assessments at the school
- Facilitated curriculum planning and development and the formulation of evaluation tools

1986 July to 1990 August - State Registered nurse/Midwife (SRNM), In-charge of Chitedze Health Centre, MOH

- General administration, service provision and coordination of all services that were offered at the clinic *i.e.* child spacing, midwifery care, medical-surgical nursing, community nursing and psychiatry nursing

1985 August to 1986 June – SRNM, Ward In-charge Kamuzu Central Hospital: Bottom Maternity Hospital, MOH

- Management of the implementation of services at Postnatal Ward
- Provision of care to mothers during labour and postnatal period
- Facilitated supervision of students from Kamuzu College of Nursing and School of Health Sciences.

1999: SRNM - Johannesburg Hospital & Institute for Child Health and Development, Transvaal Memorial Hospital, RSA

- Provision of paediatric medical/surgical nursing care as well as care to children with physical and mental disabilities and those with signs or history of physical and sexual abuse.

2000: SRNM: Parklane Private Clinic (NetCare), Baragwanath Hospital in Soweto, and Alexandra Primary Health Care (PHC) Clinic, RSA

- Provision of intensive care nursing to neonates and assisting mothers on infant feeding option of their choice in the context of HIV accordingly
- Provision of care to children with burns and cancer conditions, provision of screening services and immunizations to the under five children and provision of outpatient and community care of children through home visits.

Computer Skills

Word processing, Spreadsheets, MS Excel and Internet Explorer

Research

- 2000: A study on the knowledge and practices of primary care givers as regards to home care of HIV/AIDS children in Blantyre, Malawi 2000. Published in August Curatoris Journal of South Africa 2001. A paper presented at the College of Medicine Research Dissemination Conference: November 2001. In Dar ES Salaam United Republic of Tanzania at the 2nd African Honour Society for Nurses Conference: August 2003.
- 1992: A study on Factors that affect the acceptance of intrauterine contraceptive device as a method of Family Planning. A paper presented at the Scientific Association of Malawi, Bunda: December 1997.
- 1997: Nursing process a reality at ward level: literature search. A paper presented at the University of Malawi Research and Publication Workshop

Consultancy & Technical Assistance

- 2003: Perceived AIDS Stigma: A Client and Nurse Perspective – A Multinational Study in Five African Countries, Republic of South Africa, Botswana, Swaziland, Tanzania & Malawi

- 2003: Study on Peoples Access to Treatment and Alternative Therapy for People Living with HIV/AIDS and Chronically Ill People (PLWA'S): Funded by Action Aid: Malawi Strategies for Action
- 2003: Development of Trainers Guide and Pre-testing Guidelines for the Document "Key Family and Community Childcare Practices - MOHP and Ministry of Gender, Youth & Community Services
- 1998: A study on Home Based Care of People Living with AIDS in Malawi -Funded by National Aids Commission of Malawi.
- 1995: A study on the Evaluation of Traditional Birth Attendants practices in Malawi 1995: Funded by UNICEF.

Professional Conferences and Workshops Attended

- 2007: Design, Monitoring and Evaluation Workshop – Lilongwe, Malawi
- 2006: Africa Newborn Health Research Workshop – Addis Ababa, Ethiopia
- 2005: International Confederation for Midwives and Pre-conference Workshop – Brisbane, Australia
- 2004: Society for Education, Action and Research in Community Health (SEARCH) - Community Neonatal Care Project – Gadchiroli, India
- 2004: Saving Newborn Lives (SNL) Program Managers meeting - Bamako, Mali
- 2004: Champions for Change: Increasing Maternal & Newborn Survival -Maternal & Neonatal Health Programs – Accra, Ghana
- 2003: African Honour Society for Nurses Conference – Dar es Salaam, Tanzania
- 2002: Evaluation of the National Strategy for Community Participation in Primary School Management, MOH
- 2002: Evaluation and development of the Curriculum for management of Malawi Contraceptive Distribution and Logistics Management Information System, MOH
- 2001: Pain management in HIV/AIDS patients on Home Based Care: Adopting Uganda Strategies. Queen Elizabeth Central Hospital (QECH)
- 1999: Taking the Lead in Health Care, University of Witwatersrand: Johannesburg, RSA.
- 1987: Expanded Program on Immunizations, MOH

Membership

Home Based Care National Task force, Malawi National Association of Nurses, Eastern Southern and Central African College of Nurses (ESCACON), Scientific Association of Malawi, African Honour Society for Nurses, White Ribbon Alliance and registered with the Nurses and Midwives Council of Malawi.

ANNEX VIII
Summaries and Excerpts from Training and Technical Guidelines-Malawi Road Map



Republic of Malawi

Ministry of Health



**Road Map for
Accelerating the Reduction of
Maternal and Neonatal
Mortality and Morbidity
in Malawi**

October 2005

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LIST OF ACRONYMS

AIP	Annual Implementation Plan
ANC	Antenatal care
ART	Antiretroviral Therapy
BCI	Behaviour Change Intervention
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CHAM	Christian Health Association of Malawi
CMS	Central Medical Stores
COM	College of Medicine
CPR	Contraceptive Prevalence Rate
DDCS	Deputy Director Clinical Services
DFID	Department for International Development
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DIP	District Implementation Plan
DNO	District Nursing Officer
EHP	Essential Health Package
EmOC	Emergency Obstetric Care
FP	Family Planning
FWCW	Fourth World Conference on Women, held In Beijing, China, 1995
GNP	Gross National Product
GTZ	German Technical Assistance Agency
HA	Health Assistant
HEU	Health Education Unit
HMIS	Health Management Information System
HMIU	Health Management Information Unit
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSA	Health Surveillance Assistant
ICPD	International Conference on Population and Development

IMR	Infant Mortality Rate
IPC	Internal Procurement Committee
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Bed net
KMC	Kangaroo Mother Care
MBTS	Malawi Blood Transfusion Services
MDG	Millennium Development Goal
MDHS	Malawi Demographic and Health Survey
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOU	Memorandum of Understanding
NMCM	Nurses and Midwives Council of Malawi
NSO	National Statistics Office
PAM	Physical Assets Management
PMTCT	Prevention of Mother to Child Transmission
POA	Programme of Action
POW	Programme of Work
QECH	Queen Elizabeth Central Hospital
RHU	Reproductive Health Unit
SMI	Safe Motherhood Initiative
SMP	Safe Motherhood Project
SWAp	Sector Wide Approach
TA	Traditional Authority
TBA	Traditional Birth Attendant
TOR	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VHC	Village Health Committee
WHO	World Health Organization

FOREWORD

The Government of Malawi has over the years provided sexual and reproductive health services including maternal and newborn health care to its people. The Government with the support from various development partners has implemented several safe motherhood programmes in various districts of the country. Despite all these efforts the maternal mortality has continued to rise.

A number of studies have assisted to shed more light on the maternal mortality situation in the country. These studies have suggested an urgent need to further strengthen the Ministry of Health for the provision of quality health care services in order to reduce the high maternal and newborn mortality.

Consequently the Reproductive Health Unit of the Ministry of Health conducted a national EmOC assessment to identify the capacity of the health care delivery system to reduce maternal and neonatal mortality and to propose an action orientated plan: hence the development of this Road Map. The Road Map stipulates various strategies which will guide policy makers, development partners, training institutions and service providers in supporting Government efforts towards the attainment of MDGs related to maternal and neonatal health.

This Road Map was developed with financial as well as technical support, from WHO, UNFPA and UNICEF. In this regard I wish to extend my heartfelt gratitude for this assistance. My sincere gratitude also goes to all other stakeholders and officials who have contributed toward the development of this document.

I wish to urge you all to use this document to the maximum and for the benefit of the Malawi Nation.

Dr. Hetherwick Ntaba

Hon. Minister of Health

ACKNOWLEDGEMENTS

This Road Map is a culmination of efforts involving several individuals and stakeholders. I therefore wish, on behalf of the Ministry of Health, to extend my sincere gratitude and appreciation to all individuals and organizations that contributed to the development and finalization of the Road Map.

Firstly, many thanks go to Dr Mothebesoane-Anoh, Dr. Helga Fogstad and their team from the World Health Organization (WHO) for providing the necessary technical direction during the initial stage of developing this Road Map.

Secondly, the following individuals worked tirelessly during this initial phase of the road map development:

Lilly Banda-Maliro	USAID
Rosyln Kalawa	CHAM
Violet Kamfose	DNO-Dowa
Edgar Kuchingale	KCH-OBGYN
Dorothy Lazaro	UNFPA
Bailah Leigh	RHU-MOH
Valentino Lema	OBGYN/UNFPA
Juliana Lunguzi	UNICEF
Ken Maleta	COM
Theresa Mwale	WHO
Jane Namasasu	DDCS(RH) RHU-MOH
Jonathan Ng'oma	DHO-Ntheu
Jean Nyondo	UNICEF
Esther Ratsma	GTZ
Francis Sungani	QECH-OBGYN
Ellen Thom	UNFPA

The small technical working group comprising of Jane Namasasu, Dr Bailah Leigh, Professor Valentino Lema and Juliana Lunguzi finalized the document.

The final editing and costing of this Road Map was undertaken by the following:

Dr. Paul Dielemans, Dr. Helga Fogstad, Dr. Julia Kemp, Dr Bailah Leigh, Dorothy Lazaro, Joyce Mphaya, Theresa Mwale, Jane Namasasu, Andy O'Connell, and Peter Salilika.

Last but not least, WHO, UNFPA and UNICEF for the technical and financial support.

This Road Map was developed under the leadership of Mrs. Jane Namasasu, Deputy Director for Clinical Services responsible for Reproductive Health.

Dr. W.O.O. Sangala

Secretary For Health

EXECUTIVE SUMMARY

The Ministry of Health undertook a national assessment of availability, quality and utilisation of EmOC services to determine the capacity of the health delivery system to reduce maternal and neonatal mortality. This is in conformity with the now universally accepted fact that availability of EmOC and skilled attendance at birth are key to reducing maternal mortality. This assessment built on previous studies conducted in this country. All these have underlined the following as some of the main contributing factors to the high maternal mortality ratio in the country:

- Shortage of staff and weak human resource management
- Limited availability and utilisation of maternal health care services
- Weak referral systems
- Weak community participation and involvement

This national Road Map is consequently being developed in response to the current maternal mortality crisis in Malawi, and indeed to the Global and the African Union call for each country to develop a country- specific Road Map. It draws and builds on the Programme of Work (SWAp) and the Emergency Human Resources Programme of Malawi. This is therefore in conformity with government commitment to accelerate the attainment of the MDGs related to maternal and neonatal health in Malawi.

The Road Map has a vision, rationale, a goal and the following objectives:

- To increase the availability, accessibility, utilisation and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system.
- To strengthen the capacity of individuals, families, communities, Civil Society Organisations and Government to improve maternal and neonatal health.

These are followed by nine strategies, which will guide policy makers, programme managers, development partners, training institutions and service providers in government efforts towards the attainment of MDGs related to maternal and neonatal health. Each strategy has interventions, which are presented in detail from page 12-24. The interventions are costed.

The Road Map will be implemented within the context of the SWAp. Ninety four percent of the total funds for implementing the first phase of the Road Map, including Human Resources, is already costed in the Programme of Work of the SWAp. There is thus a need for an additional six percent to make up for the funding gap.

1.0 BACKGROUND

Malawi is a land-locked country in Central Africa. The United Republic of Tanzania borders it to the North and Northeast; the Republic of Mozambique to the East, South and Southwest; and the Republic of Zambia to the West and Northwest. It has a total surface area of 118,484 square kilometres, of which approximately 80% is land. The remaining area is mostly composed of Lake Malawi, which is about 475 kilometres long and runs down Malawi's eastern boundary with Mozambique. Administratively, the country is divided into three regions, The North, Central and South. The Southern Region is the largest in terms of size and population. There are 27 districts, out of which 12 are in the Southern Region, 9 in the Central Region and 6 in the Northern Region. Each District is made up of several Traditional Authorities (TAs), which are in turn composed of villages, the smallest administrative unit in Malawi (1).

The total population of Malawi is 11,937,934. Females comprise 51% of the total population, of whom 42.2% is in the reproductive bracket, i.e. 15-49 years. Eighty five percent of the population live in the rural areas. The urban population has grown significantly over the past 10 years (1, 2).

Malawi is one of the poorest countries in the world with an estimated GNP per capita of US \$ 170.00 in 2000 (3). Its economy is predominantly agriculture-based, depending on tobacco (providing the bulk), tea, sugar and coffee (1,3,). Sixty five percent of the population is defined as poor and unable to meet their daily consumption needs, and over 50% of the population is defined as food-insecure (2).

The country is reported to have one of the highest maternal mortality ratios globally, currently estimated at 1120 per 100,000 live births up from 620 per 100,000 live births in 1992 (1). Adolescent pregnancies comprise about 25% of all births and 20% of maternal deaths. The lifetime risk of maternal death in Malawi is estimated at 1:7, one of the highest globally. Some of the underlying causes of the high maternal death include early childbearing and the high fertility rate. According to the MDHS (2000), the mean age at first childbearing was 19 years, and the total fertility rate was 6.3. The neonatal mortality rate is equally high, estimated at 42/1000 live births (1).

Nearly all health care services in Malawi are provided by three main agencies. The Ministry of Health (MOH) provides about 60%; the Christian Health Association of Malawi (CHAM) provides 37% and the Ministry of Local Government (MoLG) provides 1%. There is a small private-for-profit health sector limited to the urban areas as well as health services provided by private companies, private practitioners, commercial companies, the Army and the Police.

There are three levels in the health system i.e. primary level comprising of health centres, health posts, dispensaries, and rural hospitals; second level made up of district and CHAM hospitals; the tertiary level consisting of the central hospitals and one private hospital with specialist services.

Malawi's health system is grossly under-resourced. Per capita expenditure is about US \$ 12, which is inadequate for delivery of basic primary health care. In 2002, an extensive exercise to determine the cost of delivering an "Essential Health Package" (EHP) of well proven and cost effective health services that would deal with the main burden of disease, calculated a figure of US \$ 17.53 per capita per year (1).

2.0 INTRODUCTION

The last three decades have witnessed significant renewed concern over women's health, particularly because of increasing poor reproductive outcomes such as maternal mortality, among other issues. The Global Safe motherhood Initiative (SMI), launched in Nairobi (1987), brought to the world's attention the widespread problem of pregnancy-related deaths and disability. The Conference called for reduction of global, regional and national maternal mortality ratios (MMR) by 50% between 1990 and 2000. In response to that, Malawi, like many countries in the developing world, established their national safe motherhood programme (5).

The International Conference on Population and Development (ICPD) held in Cairo, 1994, established the reproductive health concept. This was reaffirmed by the Fourth World Conference on Women (FWCW, Beijing, 1995) (6,7). The ICPD programme of action called for reduction of MMR by 50% between 1990 and 2000, and a further 50% between 2000 and 2015. The issue of women's rights in matters relating to their sexuality and reproductive processes were considered critical for the attainment of reproductive health and well-being and socio-economic development (6). It was hoped that with the broad based life-span approach advocated in the concept of reproductive health with safe motherhood at its heart, pregnancy and childbirth would no longer carry with them the risk of death and disability as had been the case hitherto.

Concerned by the worsening poverty situation and its relationship with health, especially for the most vulnerable groups, the United Nations (2000) adopted the Millennium Declaration, which led to the establishment of Millennium Development Goals (MDGs). The Millennium Summit identified maternal health as an urgent priority in the fight against poverty. Four of the eight MDGs (MDG 3, 4, 5, and 6) have direct bearing on maternal and neonatal health. MDG 3 calls for promotion of gender equality and empowerment of women; MDG 4 calls for reduction in child mortality, MDG 5 calls for reduction of maternal deaths, and MDG 6 urges nations to halt the spread of HIV/AIDS, control and prevent malaria and other infectious conditions. The MDGs set targets and indicators for monitoring progress (8).

The enabling environment for making progress and eventually achieving the MDGs include among others, peace and stability, a genuine democratic evolution, good governance, economic growth and increasingly equitable distribution of the benefits of growth, social inclusion and delivering on promises made by both national governments and international partners. Notwithstanding this, there is now consensus that the MDGs cannot be achieved without effectively addressing population dynamics and Reproductive Health issues (9)

Recent global evidence indicates that availability of Emergency Obstetric Care (EmOC) and skilled attendance at birth are key to the reduction of maternal mortality. Cognisant of that Malawi undertook a national assessment of availability, quality and utilisation of EmOC services in 2005. The results of this assessment clearly show poor access and utilisation of EmOC services, poor quality of health care services as evidenced by high case fatality rates. Some of the barriers to the utilisation of maternal health care services include social and cultural/traditional beliefs and practices (10).

Concerned by the high maternal mortality ratios in various countries in Africa, the African Union (2004) urged each Member State to develop a country-specific Road Map to accelerate attainment of MDGs related to maternal and neonatal health. The Regional Reproductive

Health Task Force together with other stakeholders developed a generic Road Map to accelerate the attainment of MDGs related to maternal and neonatal health (11), to guide Member States in developing theirs. Consequently, the government of Malawi has renewed its commitment to address maternal health issues in a more comprehensive manner.

This national Road Map draws and builds on the Programme of Work (SWAp) and the Emergency Human Resources Programme of Malawi. It is being developed in response to the current maternal mortality crisis in Malawi, and indeed to the Global and Regional call for each country to develop a country-specific Road Map. This is therefore in conformity with government commitment to accelerate the attainment of the MDGs related to maternal and neonatal health in Malawi.

3.0 THE ROAD MAP

3.1 Rationale

Recent evidence indicates that availability of EmOC and skilled attendance at birth are key to reducing maternal mortality. Cognisant of that, Malawi undertook a national assessment of availability, quality and utilisation of EmOC services, which built on previous studies. All these have underlined the following factors as contributing to the high maternal mortality ratio in the country:

- Shortage of staff and weak human resource management
- Limited availability and utilisation of maternal health care services
- Low quality maternal health care services
- Weak procurement and logistics system for drugs, supplies and equipment
- Problems of infrastructure
- Weak referral systems
- Weak monitoring, supervision and evaluation
- Inadequate coordination mechanisms among partners and stakeholders
- Weak community participation and involvement
- Harmful social and cultural beliefs and practices.

As a result of the foregoing, the Malawi government has made a renewed commitment to address the issue of maternal mortality and morbidity. Cognisant of the mother- neonatal dyad, the government has also included issues of neonatal mortality and morbidity in its renewed efforts, in line with the call by the African Union to each Member State to develop a country-specific Road Map for the reduction of maternal and neonatal mortality and morbidity. Consequently, a multisectoral group consisting of government and its development partners came together and developed this National Road Map for accelerating the attainment of the Millennium Development Goals related to Maternal and Neonatal Health.

3.2 Vision

All women in Malawi go through pregnancy, childbirth and the postpartum period safely and their babies are born alive and healthy through the implementation of effective maternal and neonatal health interventions.

3.3 Goal

To accelerate the reduction of maternal and neonatal morbidity and mortality towards the achievements of the Millennium Development Goals (MDGs).

3.4 Objectives

1. To increase the availability, accessibility, utilization and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system.
2. To strengthen the capacity of individuals, Families, Communities, Civil Society Organisations and Government to improve Maternal and Neonatal Health.

3.5 Strategies and Interventions

Strategy 1: Improving the availability of, access to, and utilisation of quality Maternal and Neonatal Health Care including family planning and PMTCT services.

Interventions:

1. Provide essential health care package for Maternal and Neonatal Health, with priority on health centre level, particularly in rural and remote areas
2. Upgrade health facilities to be able to provide minimum package for Maternal and Neonatal Health, with first priority to BEmOC facilities
3. Reinforce blood transfusion services at each hospital
4. Review, define and adopt minimum standards and protocols of care for Maternal and Neonatal Health
5. Conduct maternal death reviews and clinical audit
6. Provide supportive supervision to enhance quality of care
7. Strengthen Family planning services

Strategy 2: Strengthening human resources to provide quality skilled care

Interventions:

1. Ensure adequate staffing at the health facility to provide the Maternal and Neonatal Health essential health care package
2. Increase and improve training of Maternal and Neonatal Health staff
3. Build the capacity of training institutions to provide competency based training
4. Develop, review and update policies that enable health professionals use their skills

Strategy 3: Strengthening the referral system

Interventions:

1. Establish /strengthen communication system between health centre and referral hospital
2. Establish/strengthen referral system including transport

Strategy 4: Strengthening national and district health planning and management of Maternal and Neonatal Health care including FP services

Interventions:

1. Strengthening capacity of DHMT for better management of Maternal and Neonatal Health services including FP services
2. Review the HMIS so that it captures all essential information on Maternal and Neonatal Health for planning purposes

Strategy 5: Advocating for increased commitment and resources for maternal and neonatal health care including FP services

Interventions:

1. Develop advocacy package on Maternal and Neonatal Health with priority on BEmOC services
2. Conduct National Health Accounts exercise
3. Maternal and Neonatal Health accorded priority in DIPs and AIP

Strategy 6: Fostering of partnerships

Interventions:

1. Improving partnership collaboration and coordination between and among all stakeholders
2. Promoting effective public/private partnership

Strategy 7: Empowering communities to ensure continuum of care between the household and health care facility

Interventions:

1. Build capacity of HSAs to empower communities to utilise Maternal and Neonatal Health services
2. Establish/strengthen community initiatives for RH including Maternal and Neonatal Health
3. Raise awareness of the community on Maternal and Neonatal Health issues including birth preparedness and danger signs
4. Empower communities, especially men, to contribute towards timely referrals
5. Review and define role of TBAs in Maternal and Neonatal Health

Strategy 8: Strengthening services that address adolescents' sexual and reproductive health services.

Interventions:

1. Establish/strengthen youth friendly health services

Strategy 9: Strengthening monitoring and evaluation mechanisms for better decision-making and service delivery of Maternal and Neonatal Health services

Interventions:

1. Strengthen MOH capacity for monitoring and evaluation
2. Operations Research
3. Evaluation of Road Map for impact

3.6 Monitoring and Evaluation

Indicators have been developed to monitor and evaluate the Road Map. Most of these indicators are included in the national HMIS.

Priority EmOC Indicators

Greater emphasis will be placed on the routine collection and processing of data on the following process indicators for monitoring progress towards maternal and neonatal mortality reduction

1. Percentage of health centres offering Basic EmOC services.
2. Percentage of hospitals offering Comprehensive EmOC services.
3. Geographic distribution of Basic and Comprehensive EmOC services
4. Proportion of births assisted by a skilled attendant
5. Proportion of all births in EmOC facilities
6. Proportion of expected direct obstetric complications treated in EmOC facilities (Met Need)
7. Proportion of all expected births by Caesarean Section
8. Case fatality rate of direct obstetric complications
9. Proportion of expected maternal deaths reported in each district.
10. Proportion of Low Birth Weight babies
11. Number of Neonatal deaths
12. Percentage of mothers and newborns receiving two postnatal care visits

The following indicators will also be used to monitor the implementation of various interventions of the Road Map.

I. Management indicators

1. Percentage of health facilities conducting maternal death review and submitting to national level
2. Proportion of Health facilities with protocols and guidelines in performance and quality improvement including infection prevention

3. Percentage of hospitals with functional blood transfusion facilities
4. Percentage of facilities with functioning neonatal resuscitation facilities
5. Number of districts that prioritise provision of basic EmOC services in their DIPs
6. Proportion of health facilities with functioning communication system
7. Coverage of ambulances per population
8. Proportion of health facilities receiving regular supportive supervision
9. Proportion of health facilities with 24 hours coverage of skilled attendants to provide emergency obstetric care

II. Antenatal Care Indicators

1. Percentage of pregnant women receiving 4 focused ANC visits
2. Proportion of mothers counselled on infant feeding
3. Proportion of pregnant women screened for syphilis
4. Proportion of pregnant women receiving VCT
5. Proportion of HIV positive pregnant women receiving ART e.g. Nevirapine
6. Proportion of newborns of HIV positive mothers receiving ART e.g. Nevirapine
7. IV. Community Indicators
8. Percentage of HSAs trained in providing Maternal and Neonatal Health care
9. Proportion of VHCs addressing Maternal and Neonatal Health issues

III. Impact Indicators

These indicators will be measured at the end of each phase of implementation and as part of the regular MDHS.

1. *Maternal mortality ratio.*
2. *Neonatal mortality rates*

4.0 DETAILS OF INTERVENTION

Strategy 1: Improving the availability of, access to, and utilisation of quality Maternal and Neonatal Health Care						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
1.1 Provide essential health care package for MNH, with priority on health centre level, particularly in rural and remote areas	Provide Focused ANC	DHO	% of health facilities providing focused ANC	20	60	100
			% pregnant women receiving 4 focused ANC visits	10	40	60
			% of pregnant women screened for syphilis	20	50	90
			% of pregnant women received VCT	10	40	60
			% of pregnant women found to be HIV positive	25	20	15
			% of pregnant women received iron/folate supplementation	10	40	60
			% of pregnant women received IPT	20	40	60
			% of pregnant women using ITNs	10	40	70
	Provide Intra Partum Care, with priority given to implementing BEmOC services	DHO	% of pregnant women receiving skilled care at delivery	19	40	60
			% of deliveries in EmOC health facility	19	40	60
			% of HIV positive mothers received ART (e.g. Nevirapine)	25	50	75
			% of direct obstetric complications treated in EmOC facilities	18.5	40	60
			% of births by caesarean section	2.8	5	8
			% of mothers initiating breastfeeding within half an hour after delivery	20	50	70
			% of Low Birth Weight babies	20	15	10
	Provide Essential neonatal care	DHO	Case Fatality Rate (CFR)	3.4	2.5	2
			% of health facilities with neonatal resuscitation services	40	80	90
			% of neonatal receiving essential neonatal care including resuscitation	30	50	70
			% of neonatal exclusively breast fed for 6 months	20	40	60
	Provide Kangaroo Mother Care (KMC)	DHO	% of neonatal of HIV positive mothers received ART	25	50	75
% of health facility providing KMC			5	20	40	

Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
	Provide Postnatal care	DHO	% of mothers receiving postnatal care within 2 weeks	10	30	60
			% of mothers receiving postnatal care at 6 weeks	20	30	40
			% of postnatal mothers received Vitamin A supplementation	20	40	60
			% of postnatal mothers receiving modern contraceptives	21.5	40	60
1.2 Upgrade health facilities to be able to provide minimum package for MNH, with first priority to BEmOC facilities	Ensure that under the SWAp POW infrastructure development plan, upgrading health facilities to provide BEmOC services is given the highest priority	PAM	% of health facilities offering BEmOC services	2%	50%	100%
	Rehabilitate existing hospitals to provide Comprehensive EmOC services	PAM	% of hospitals offering Comprehensive EmOC services	58%	80%	100%
	Ensure that the MOH consolidated procurement plan has prioritised equipment and drugs to provide BEmOC services	RHU PAM CMS	% of health centres having the necessary equipment and drugs to provide BEmOC services	2%	50%	100%
	Ensure with PAM that the standard equipment list is regularly reviewed and updated to provide MNH services, with priority on BEmOC services	RHU	Standard equipment lists updated in line with national standards to provide MNH services	2003	updated	updated
1.3 Reinforce Blood transfusion services at each hospital	Ensure with MBTS that each hospital is equipped to provide Blood transfusion services	RHU MBTS	% of hospitals with functional blood transfusion services for maternity cases	20	100	100
1.4 Review, define and adopt minimum standards and protocols of care for MNH	Ensure that the MNH clinical protocols developed through SMP are in place and kept updated	RHU	Standards and protocols revised every 5 years	2004	Updated	Update d
			% of health facilities with updated standards and protocols in place	50	75	100

Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
1.5 Conduct maternal death reviews and clinical audit	Institutionalise maternal death reviews	RHU	% of health facilities conducting maternal death review and submitting to national/zonal level	20	100	100
	Analyse maternal death and audit reports and compile for the entire country	DHO RHU	Reduction in CFR	3.4	2.5	2
1.6 Provide supportive supervision to enhance quality of care	Ensure supportive supervision for essential maternal and neonatal care is included in the MOH integrated supervisory checklist with priority on BEmOC	RHU	MNH included in MOH integrated supervisory Checklist	-	Checklist available	Checklist available
	Review/update supervisory check lists	RHU	Check lists reviewed/updated every 5 years	2002	Updated	Updated
	Conduct quarterly supervisory visits at all levels	DHO	% of health facilities receiving regular supervisory visits	20	50	70
			% DHO reporting on supervisory visits	60	80	100

Strategy 2: Strengthen human resources to provide quality skilled care							
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets			
				Baseline	2010	2015	
2.1 Ensure adequate staffing at the health facility to provide the MNH essential health care package	Implement 6-year Emergency Human Resource programme	HR	% of established posts filled:				
			Nurse/midwife technicians	36%			
			Registered Nurse/midwives				
			Clinical Officers (with midwifery and obstetric skills)	73%			
			Medical Assistants (with midwifery skills)	47%			
				Medical Officers with obstetric and neonatal skills	36%		
	Ensure that the deployment and incentive programme in the Emergency Human Resource Programme prioritises the deployment of staff with BEmOC skills to rural health facilities	HR	% of established posts in rural areas filled				
			Rural incentive scheme to support the deployment of staff in rural areas in place		Incentive scheme in place	Incentive scheme in place	
	Ensure EMOC is the highest priority in the Emergency Human Resource Programme for re-engagement of staff, re-deployment of staff and placement of volunteer specialist doctors and nurse tutors	HR RHU	No. of health workers in place:				
			Nurse/midwife technicians	4717	7035		
			Registered Nurse/midwives				
			Clinical Officers (with midwifery and obstetric skills)	942			
			Medical Assistants (with midwifery skills)	718			
Medical Officers with obstetric and neonatal skills			139				
Volunteer specialist doctors							
Nurse/Midwife tutors							
Average norm of number of births to practising skilled attendants	350	250	175				
% of births attended by skilled health personnel	19	40	60				
2.2 Increase and improve training of MNH staff	Revise curricula in line with latest evidence and ensure that BEmOC training (6 signal functions) is compulsory in the pre-service training for nurse/midwives, clinical officers and medical assistants	HR RHU	Curricula revised and implemented	-	Revised and implemented	Revised and implemented	

Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
	Increase intake of enrolment to ensure adequate numbers of staff for deployment	HR	Intake of enrolment of:			
			Nurse/midwife technicians	300		
			Registered Nurse/midwives	90	600	
			Clinical Officers	110		
			Medical Assistants	150		
			Medical Officers	60		
			Lab technicians	25		
	Anaesthetic Officers	30				
	Implement an in-service programme on essential obstetric and neonatal care with focus on BEmOC for all registered nurse/midwives, nurse/midwife technicians and medical assistants, with priority given to health centre based staff	HR RHU Training Institutions	# of nurse/midwife technicians trained	-		
			# of registered nurse/midwives trained	-		
# of medical assistants trained			-			
# of HC staff trained in BEmOC			-			
2.3 Build the capacity of training institutions to provide competency based training	Train tutors and lecturers to provide competency based training	HR RHU Training Institutions	# of tutors/lecturers that have received competency-based training	0	60	120
	Provide institutions with teaching and learning materials to provide competency based training, with priority focus on BEmOC	HR RHU	% of training institutions fully equipped	0	50%	100%
2.4 Develop, review and update policies that enable health professionals use their skills	Revise the midwifery practice policy to ensure that midwives are able to provide BEmOC services	NMCM RHU	Updated policy	-	Policy updated	
			Increased BEmOC services	2%	50%	100%

Strategy 3: Strengthen the referral system						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
3.1 Establish / strengthen communication system between health centre and referral hospital	Install/repair radio communication, ground /mobile phone at all health facilities, with priority to facilities providing BEmOC services in rural areas	PAM RHU	% of facilities with functioning communication system	30	100	100
			% of health facilities in rural areas with communication system			
3.2 Establish/strengthen referral system including transport	Review/develop relevant guidelines on referral system and implement transport policy that prioritises and ensures that health facilities in rural areas are able to provide BEmOC services	Admin RHU	% of health facilities with referral system guidelines in place	-	50	100
			% of expected obstetric and neonatal complications actually being referred	5	50	90
	Provide motorised ambulances between health facilities	PAM	# of motorised ambulances per 10.000 population	0.2	0.5	1

Strategy 4: Strengthening national and district planning and management of Maternal and Neonatal Health Care						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
4.1 Strengthen capacity of DHMT for better management of MNH services	Provide guidance and support to DHMT on planning, implementation and monitoring of MNH interventions and ensure that MNH issues are prioritised in the DIPs, with special focus on health centres in rural areas	RHU Planning Unit	Reports of meetings available	-	Meetings conducted	Meetings conducted
		<i>DHO</i>	# of DIPs that prioritise provision of BEmOC services in all health centres	0	15	27
	Conduct meetings with DHMT for information sharing, updating of standards and policies, discussing key issues	RHU	% of health facilities implementing the full MNH EHP	20	40	60
	Review Terms of Reference and membership of DHMT to reflect prioritising MNH	Planning DHO RHU	# of DHMTs with revised TOR	-	15	27
4.2. Review the HMIS so that it captures all essential information on MNH for planning purpose	Review and update HMIS in line with the Road Map, including international agreed process indicators	HMIS RHU	<i>Updated HMIS</i>	2002	Updated HMIS	Updated HMIS
	Train HMIS personnel, service providers and managers to improve on data and information management of MNH	RHU DHO	% of health facilities reporting on MNH indicators	50	100	100

Strategy 5: Advocating for increased commitment and resources for Maternal and Neonatal Health						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
5.1. Develop advocacy package on MNH with priority on BEmOC services	Develop advocacy materials	RHU HEU	Advocacy materials developed	-	Materials developed	Materials developed
	Use advocacy materials to mobilise resources	RHU HEU	Advocacy materials developed and used	-	Materials used	Materials used
	Hold annual meetings with the parliamentary health committee on MNH issues	RHU	Increased budgetary allocation for MNH care available	11%	13%	15%
	Ensure that parliamentary health committee briefs all MPs on MNH	RHU	Increased budgetary allocation for MNH care available	11%	13%	15%
5.2 Conduct National Health Accounts exercise	Analyse health sector budget commitment and expenditure on MNH	RHU				
	Ensure that MNH is prioritised within the existing commitments to the health sector	RHU Planning Unit	% of total funds for MNH increased	100	150	250
	Advocate that available additional MOH and donor resources are committed to fill any gap	RHU	Hold stakeholders meeting to advocacy for additional resources	-	Sufficient resources	Sufficient resources
5.3 MNH accorded priority in DIPS and AIP	Advocate during the development of DIPS and AIP the importance of MNH, with priority on BEmOC	RHU Planning	% of increased budgetary allocation within DIP and AIP		25%	30%

Strategy 6: Fostering Partnerships						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
6.1 Improving partnership collaboration and coordination	Transform the current Emergency Safe Motherhood Taskforce into a Technical Working Group to oversee MNH policy development and review progress on implementation of the Road Map	RHU	TORs developed for TWG and quarterly meetings conducted	-	TWG in place and functional	TWG in place and functional
	Highlight MNH and progress against the Road Map in the Annual Health Sector Report	RHU Planning	Annual Health Report reports on progress on Road Map	-	Progress included in annual report	Progress included in annual report
	Ensure that MNH programme review is included in annual SWAp review	RHU Planning	Report of annual SWAp review includes MNH programme review	-	Included in annual SWAp review	Included in annual SWAp review
6.2 Promoting effective public/private partnership	Ensure that basic and comprehensive EmOC services are a priority within the currently developed and implemented Service Agreements with CHAM	Planning RHU	# of districts with service agreements in place that emphasises on EmOC	3	15	27
	Explore more active involvement of the private sector in MNH issues	Planning RHU	# of service agreements / MOU	-	3	10

Strategy 7: Empowering communities to ensure continuum of care between the household and health care facility						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
7.1 Build capacity of HSAs to empower communities to utilise MNH services	Train HSAs to orient communities on MNH issues including birth preparedness and danger signs to increase utilisation of services	HR DHO RHU	# of HSAs trained	2500	6000	12000
			# of districts with EHP coverage of HSAs (1:1000 population)			
			Utilization of services increased (skilled attendants)	19	40	60
7.2 Establish / strengthen community initiatives for RH including MNH	Liaise with relevant authorities to revitalise Village Health Committees (VHCs)	DHO	% Functional VHCs	30	50	70
	Train VHCs in MNH issues including birth preparedness, danger signs and collection of maternal death data	DHO	% of functional VHCs addressing MNH issues	30	60	90
	Establish emergency preparedness committees	DHO	# of communities with functional emergency preparedness committees	-	500	1500
			% of pregnant women with birth preparedness plans	10	40	80
	Establish mechanisms for monitoring VHC activities with respect to MNH issues	DHO	DHO reports on VHC activities available	5	25	50
			# of districts implementing community initiatives for RH issues at village level	4	20	27
			# of villages implementing community initiatives for RH in the districts	240	1600	3500
			% of TAs addressing MNH needs	10	30	60
	Develop and support implementation of verbal autopsy at community level	DHO RHU	# of communities implementing verbal autopsy	-	500	1500

Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
7.3. Raise awareness of the community on MNH issues including birth preparedness and danger sign	Ensure that health promotion materials on birth preparedness and danger signs are finalised and printed	RHU HEU	% VHC with health promotion materials available	10	30	50
	Use community based organizations to disseminate health promotion information on MNH care	DHO	Reports on dissemination through community based organisations	-	Reflected in annual health report	Reflected in annual health report
	Disseminate BCI materials through appropriate media	HEU	Reports on dissemination through different media (radio, TV, print, drama)	-	Reflected in health report	Reflected in health report
7.4. Empower communities, especially men, to contribute towards timely referrals	Mobilise Village Health Communities to establish transport plans	DHO	# VHC's with transport funds		500	1500
			# of communities with transport plans for referral	-	500	1500
	Procure and maintain bicycle ambulances	DHO PAM	# of bicycle ambulances	120	500	1500
7.5. Review and define role of TBAs in MNH	Conduct meetings to define role of TBAs in MNH	RHU	Role of TBAs defined and disseminated	-	Defined role	
	Support TBAs in their new role	DHO	% of pregnant women delivered by TBA	20%	15%	10%

Strategy 8: Strengthening services that address adolescents' sexual reproductive health issues						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
8.1. Establish/strengthen youth friendly health services	Develop/Review training manual to address adolescent sexual and reproductive health	RHU HR	Revised Training manual available	-	Manual reviewed	Manual reviewed
	Provide youth friendly services in all health facilities	DHO	% of health facilities providing youth friendly services	5%	25%	60%
			Teen age pregnancies as % of total pregnancies	25	20	15
	Uptake of FP among adolescents		15	25	40	
Incorporate adolescent health services into the pre-service curricula	HR RHU	Updated curricula	-	updated	updated	
Strategy 9: Strengthening monitoring and evaluation mechanisms for better decision-making and service delivery of MNH services						
Intervention	Activity	Leading agent(s)	Indicator	Baseline and Targets		
				Baseline	2010	2015
9.1. Strengthen MOH capacity for monitoring and evaluation	Establish office for maternal and neonatal health at national level to coordinate collation and analysis of data on maternal and neonatal health and disseminate the reports	HR RHU	Officer responsible for MNH in place at national level	1	2	2
			MNH reports available		Reports available	
	Review existing maternal mortality review forms to include a section on neonatal deaths	RHU	Revised forms available		Forms available	
9.2. Operations research	Conduct research on identified issues	RHU Research	Research reports disseminated		Reports available	
9.3. Evaluation of Road Map Impact	Conduct formative evaluation after 5 years	RHU Planning	Evaluation report available		Report available	
	Conduct End term Evaluation in 2015	RHU Planning	Final evaluation report			Report available

5.0 COSTING OF ROAD MAP 2005 - 2010

The Road Map will be implemented within the context of the SWAp. Ninety four percent of the total funds for implementing the first phase of this Road Map, including human Resources, is already costed in the Programme of Work of the SWAp. There is thus a need for an additional six percent to make up for the funding gap. Costing is in US Dollars

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
1.1 Provide essential health care package for Maternal and Neonatal Health	<ul style="list-style-type: none"> • Provide Focused ANC • Provide Intra Partum Care • Provide Essential Neonatal Care • Provide Kangaroo Mother Care (KMC) • Provide Postnatal Care 	Total \$33,961,232	Activity 2.1.2/2.1.3/2.1.4/2.1.5/2.1.6/2.1.7 Total \$27,400,000	\$6,561,232	POW: Procure EHP pharmaceuticals, medical and lab supplies (25%) Estimated cost: EHP costing model (costs for PMTCT and ITNs not included)
1.2 Upgrade health facilities to be able to provide minimum package for MNH	<ul style="list-style-type: none"> • Ensure that under the SWAp POW infrastructure development plan, upgrading health facilities to provide Basic EmOC services is given the highest priority • Rehabilitate existing hospitals to provide comprehensive EmOC services • Ensure that the MOH consolidated procurement plan has prioritised equipment and drugs to provide BEmOC services • Ensure with PAM that the standard equipment list is regularly reviewed and 	Total \$26,437,500	Activity 4.2 \$15,100,000 Activity 4.1.3/4.1.4/4.1.5 \$7,900,000 Activity 3.1.1/3.1.2/3.1.3 \$3,437,500 Total \$26,437,500	0	POW: - upgrade existing maternities / dispensaries to HC level to support the full range of EHP services (100%) - rehabilitate existing health facilities to support the delivery of the full range of EHP services (100%) - Procure and distribute essential basic equipment (25%) Estimated cost: Assumed that POW costing is sufficient

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
	updated to provide MNH services, with priority on BEmOC services				
1.3 Reinforce Blood transfusion services at each hospital	<ul style="list-style-type: none"> Ensure that functional blood banks are established at all hospitals in line with the National Blood Transfusion Services and that priority is given within this programme to minimum requirements for Comprehensive EmOC services 	Part of intervention 1.1 and 1.2	Part of intervention 1.1 and 1.2	0	Comment: Lab supplies and basic equipment are included in the costing under intervention 1.1 and 1.2
1.4 Review, define and adopt minimum standards and protocols of care for MNH	<ul style="list-style-type: none"> Ensure that the MNH clinical protocols developed through SMP are in place and kept updated 	Total \$50,000	Activity 6.2.5.5.4 \$500 Total \$500	\$49,500	POW: Redevelopment and update of various health services / interventions, standards, protocols and guidelines (25%) Estimated cost: Consultative meetings, printing and distribution
1.5 Conduct maternal death reviews and clinical audit	<ul style="list-style-type: none"> Institutionalise maternal death reviews Analyse maternal death and audit reports and compile for the entire country 	0	0	0	No cost
1.6 Provide supportive supervision to enhance quality of care	<ul style="list-style-type: none"> Ensure supportive supervision for essential obstetric and neonatal care is included in Zonal Office checklist with priority on 		Activity 5.2.3		POW: - Routine supervision at sub-district level (25%) Estimated cost: Assumed that POW costing

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
	BEmOC <ul style="list-style-type: none"> Review/update supervisory check lists Conduct quarterly supervisory visits at all levels 	Total \$1,175,000	Total \$1,175,000	0	is sufficient (but doesn't include supervision costs made by zonal and central level)
2.1 Ensure adequate staffing at the health facility to provide the MNH essential health care package	<ul style="list-style-type: none"> Implement 6-year Emergency HR Programme Ensure that the deployment and incentive programme in the Emergency Human Resource Programme prioritises the deployment of staff with BEmOC skills to rural health facilities Ensure EMOC is the highest priority in the Emergency Human Resource Programme for re-engagement of staff, re-deployment of staff and placement of volunteer specialist doctors and nurse tutors 	Total \$171,600,000	Total \$171,600,000	0	6-year emergency HR programme: Target is 5776 nurse/midwives in 2010 Estimated cost: Assumed that HR costing is sufficient to reach 40% skilled attendants (250 deliveries per midwife), while 16% of nurse/midwives actually work in maternity
2.2 Increase and improve training of MNH staff	<ul style="list-style-type: none"> Revise curricula in line with latest evidence and ensure that BEmOC training (6 signal functions) is compulsory in the pre-service training for nurse/midwives, clinical officers and medical assistants Increase intake of enrolment 		Activity 6.2.1.1 \$135,000		POW: Develop and coordinate pre-and in-service training programmes for MOH (25%) Estimated cost: Training of 2500 health workers (MA, CO and nurses) in BEmOC

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
	<p>to ensure adequate numbers of staff for deployment</p> <ul style="list-style-type: none"> • Implement an in-service programme on essential obstetric and neonatal care with focus on BEmOC for all registered nurse/midwives, nurse/midwife technicians and medical assistants, with priority given to health centre based staff 	Total \$5,000,000	Total \$135,000	\$4,865,000	
2.3 Build the capacity of training institutions to provide competency bases training	<ul style="list-style-type: none"> • Train tutors and lecturers to provide competency based training • Provide institutions with teaching and learning materials to provide competency based training, with priority focus on BEmOC 	Total \$250,000	0	Total \$250,000	POW: No cost centre Estimated cost: Training of 100 tutors
2.4 Develop, review and update policies that enable health professionals use their skills	<ul style="list-style-type: none"> • Revise the midwifery practice policy to ensure that midwives are able to provide BEmOC services 	0	0	0	No cost
3.1. Establish/strengthen communication system between	<ul style="list-style-type: none"> • Install/repair radio communication, ground /mobile phone at all health facilities 		Activity 4.1.1/4.1.2 \$1,900,000		POW: Equip facilities with basic utility systems (water, electricity and telecommunications) –

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
health centre and referral hospital		Total \$1,900,000	Total \$1,900,000	0	GOM/CHAM (50%) Estimated cost: Assumed that POW costing is sufficient
3.2 Establish/strengthen referral system including transport	<ul style="list-style-type: none"> • Provide motorised ambulances between health facilities • Review/develop relevant guidelines on referral system and implement transport policy 	\$25,400,000 \$50,000 Total \$25,450,000	Activity 5.1.1/5.1.2 \$25,400,000 Total \$25,400,000	\$50,000	POW: Equip district with vehicles and equipment adequate for transport needs/finance routine transport costs & maintenance (100%) Estimated cost: Assumed that POW costing for ambulances is sufficient Consultative meetings, printing and distribution of guidelines is not costed in POW
4.1 Strengthen capacity of DHMT for better management of MNH services	<ul style="list-style-type: none"> • Provide guidance and support to DHMT on planning, implementation and monitoring of MNH interventions • Conduct meetings with DHMT for information sharing, updating of standards and policies, discussing key issues • Review Terms of Reference and membership of DHMT 	Total \$500,000	- Activity 6.2.5.2.3 \$112,800 - Activity 6.2.7.2.2 \$37,850 Total \$150,650	\$349,350	POW: - Provision of support to the district (institutional and capacity development) for implementation tracking of DIPS (25%) - Complete and implement the District Management Manual (25%) Estimated cost: POW costing is insufficient for organising 6-monthly meetings

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
4.2 Review the HMIS so that it captures all essential information on MNH for planning purpose	<ul style="list-style-type: none"> • Review and update HMIS in line with the Road Map • Train HMIS personnel, service providers and managers to improve on data and information management of MNH 	Total \$387,375	- Activity 6.2.5.2.7 \$37,375 - Activity 6.2.1.2/6.2.1.3 \$350,000 Total \$387,375	0	POW: - Conduct POW M&E (25%) - Develop/update and disseminate tools and guidelines for HIM and use (25%) - Provide tools and equipment required for data collecting and processing (25%) Estimated cost: Assumed that POW costing is sufficient
5.1 Develop advocacy package on MNH	<ul style="list-style-type: none"> • Develop advocacy materials • Use advocacy materials to mobilise resources • Hold annual meetings with parliamentary health committee on MNH issues • Ensure that parliamentary health committee briefs all MPs on MNH 	Total \$100,000	0	\$100,000	POW: No cost centre Estimated cost: Development and printing of advocacy materials
5.2 Conduct National Health Accounts exercise	<ul style="list-style-type: none"> • Analyse health sector budget commitment and expenditure on MNH • Ensure that MNH is prioritised within the existing commitments to the health sector • Advocate that available 	0	0	0	No cost

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
	additional MOH and donor resources are committed to fill any gap				
5.3 MNH accorded priority in DIPS and AIP	<ul style="list-style-type: none"> Advocate during the development of DIPs and AIP the importance of MNH, with priority on BEmOC 	0	0	0	No cost
Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of Funds (Apportion)
6.1 Improving partnership collaboration and coordination	<ul style="list-style-type: none"> Transform the current Emergency Safe Motherhood Task Force into a TWG to oversee MNH policy development and review progress on implementation of Road Map Highlight MNH and progress against the Road Map in the Annual Health Sector Report Ensure that MNH programme review is included in annual SWAp review 	Total \$5,000	Activity 6.2.5.3.1 \$5,000 Total \$5,000	0	POW: Coordinate inputs from development partners to ensure adequate resourcing of the joined POW (100%) Estimated cost: Assumed POW costing is sufficient
6.2 Promoting effective public/private partnership	<ul style="list-style-type: none"> Ensure that EmOC services are a priority within the currently developed and implemented service agreements with CHAM Explore more active involvement of the private sector in MNH issues 		Activity 6.2.7.2.4 \$242,000		POW: Enhance inter-agency collaboration through the implementation and monitoring of service agreements, MOUs and Code of Conducts with NGO and private sector partners

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
		Total \$242,000	Total \$242,000	0	(100%) Estimated cost: Assumed that POW costing is sufficient for ensuring and exploring but does not include the actual implementation of service agreements
7.1 Build capacity of HSAs to empower communities to utilise MNH services	<ul style="list-style-type: none"> • Train HSAs to orient communities on MNH issues including birth preparedness and danger signs to increase utilisation of services 	Total \$672,500	Activity 1.3.1 \$672,500 Total \$672,500	0	POW: Integrated in-service training of health workers (10%) Estimated cost: Assumed POW costing is sufficient
7.2 Establish / strengthen community initiatives for RH including MNH	<ul style="list-style-type: none"> • Liaise with relevant authorities to revitalise Village Health Committees (VHCs) • Train VHCs in MNH issues including birth preparedness, danger signs and collection of maternal death data • Establish emergency preparedness committees • Establish mechanisms for monitoring VHC activities with respect to MNH issues • Develop and Support implementation of verbal autopsy at community level 	Total \$60,000	0	\$60,000	POW: No cost centre for training of VHCs Estimated cost: Training of 60 VHCs

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
7.3. Raise awareness of the community on MNH issues including birth preparedness and danger sign	<ul style="list-style-type: none"> • Ensure that the health promotion materials on birth preparedness and danger signs by HEU are finalised and printed • Use community based organizations to disseminate health information on MNH care • Disseminate BCI materials through appropriate media 	Total \$5,350,000	Activity 5.2.4 \$5,350,000 Total \$5,350,000	0	POW: IEC and health education activities undertaken (25%) Estimated cost: Assumed POW costing is sufficient
7.4. Empower communities, especially men, to contribute towards timely referrals	<ul style="list-style-type: none"> • Mobilise Village Health Communities to establish transport plans • Procure and maintain bicycle ambulances 	Total \$2,000,000	0	\$2,000,000 0	POW: No cost centre for procurement of bicycle ambulances Estimated cost: Procurement of 4000 bicycle ambulances
7.5. Review and define role of TBAs in MNH	<ul style="list-style-type: none"> • Conduct meetings to define role of TBAs in MNH • Orient TBA's on their new role 	0	0	0	No cost, assumed that this activity will be taken care of by HSAs
8.1. Establish/strengthen youth friendly health services	<ul style="list-style-type: none"> • Develop/review training manual to address adolescent sexual and reproductive health • Provide youth friendly services in all health facilities • Incorporate adolescent health services into the pre-service curricula 	Total \$75,000	Activity 6.2.5.5.5 \$15,500 Total \$15,500	\$59,500	POW: Develop a programme to train health workers on customer care – attitudes, waiting times, confidentiality and privacy (100%) Estimated cost: Assumed that POW costing is insufficient for developing,

Intervention	Activity	Estimated Cost (5 yrs)	Costed in POW	Funding gap	Comments / Source of funds (Apportion)
	curricula				printing and distributing a manual
9.1. Strengthen MOH capacity for monitoring and evaluation	<ul style="list-style-type: none"> Establish office for maternal and neonatal health at national level to coordinate collation and analysis of data on maternal and neonatal health and disseminate the reports Review existing maternal mortality review forms to include a section on neonatal deaths 	Total \$200,000	Activity 6.2.6.1.4 \$200,000 Total \$200,000	0	POW: Host health information databank and health resource centre and disseminate information to specific and general users (25%) Estimated cost: Assumed POW costing is sufficient
9.2. Operations research	<ul style="list-style-type: none"> Conduct research on identified issues 	Total \$250,000	0	\$250,000	POW: No cost centre Estimated cost: 50,000 per annum
9.3. Evaluation of Road Map Impact	<ul style="list-style-type: none"> Conduct formative evaluation after 5 years Conduct End term Evaluation in 2015 	Total \$100,000	Activity 6.2.5.2.6 \$10,000 Total \$10,000	\$90,000	POW: Design and implement an appropriate joint annual POW review progress (100%) Estimated cost: Assumed that POW costing of 10,000 USD for 5 years is insufficient
	OVERALL TOTAL	\$275,765,607	\$261,081,025	\$14,684,582	<i>Additional 6% of funds required to implement the Road Map till 20</i>
	TOTAL (without HR)	\$104,165,607	\$89,481,025	\$14,684,582	

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ANNEX IX

Excerpts from February 2005 Saving Newborn Lives Final Evaluation in Malawi (Kangaroo Mother Care and Rapid Syphilis Testing)

II. Kangaroo Mother Care

Zomba Central Hospital was selected to conduct KMC training since a KMC unit was already established and had been utilizing this approach since 1999. The role of the KMC Unit was to assist the SNL implementing sites to establish KMC units and train their staff. SNL/M envisioned that the Zomba KMC Unit, because of their experience with KMC, could function as a Learning Center for KMC, with relatively little assistance. Similar to ENC, KMC was implemented as a separate component. Zomba KMC Unit had one KMC Trainer responsible for all trainings, who had worked in the KMC unit for many years. There was also a KMC Coordinator who coordinated and supervised KMC implementation activities and was also responsible for data analysis. A Pediatrician was responsible for the clinical management of low birthweight babies. She played a vital function in linking this to KMC training aspects, so worked in liaison with the KMC Trainer and KMC Coordinator. SNL/M and Zomba team learned from the experiences of Zimbabwe and South Africa in initiating the Zomba KMC Learning Center.

As needs emerged, a training manual and systemic training approach were developed including guidelines on how to establish a KMC unit (e.g. space requirements, furniture and supplies needed). The Zomba KMC master trainer conducted five-day trainings and a total of 12 KMC district trainers from the different hospitals were trained. KMC units have been established and became operational at St. Luke's Hospital (September 2003), Queen Elizabeth Central Hospital (September 2003), Ekwendeni Mission Hospital (December 2003), Bottom Maternity of Lilongwe Central Hospital (February 2004), Mangochi District Hospital (July 2004), and Mulanje Mission Hospital has recently received SNL support to start a KMC Unit. It was noted that KMC admission and discharge criteria at different facilities were not standardized. A total of 253 health providers were trained in KMC. Table 2 shows the number and cadres of health workers trained on KMC in the various health facilities.

Table 2: Number and Cadres of Health Workers Trained on KMC

Cadre of Health Worker Trained	Ekwendeni Mission Hospital	Mangochi District Hospital	Queen Elizabeth Central Hospital	Zomba Central Hospital	KCN	Bottom Maternity - LCH	Total
Enrolled Nurse Midwife	17	14	9	58	6	30	128
Nurse Midwife Tech	14	18	1	6	0	14	53
State RNM	5	2	3	4	0	21	41
Clinical Officer/MO	3	2	0	1	0	9	15

Medical Assistance	0	0	0	2	0	1	3
Other	0	2	2	9	0	0	13
Total	39	38	15	80	6	75	253

A rudimentary follow-up system that required mothers to bring their babies back to the Zomba KMC unit existed to track low birthweight babies after discharge from the KMC unit. This system did not include the follow-up of babies right up to the community level, and many mothers did not bring their babies back to be seen. A dropout study revealed that 50% of babies lost to follow-up, had died. As a result of this study, a more comprehensive monitoring system was developed. This system involves active participation of the health centers and the HSAs in the follow-up of babies to the community level, but it is yet to become fully functional at all KMC sites.

a. Accomplishments

1. Developed a systematic training approach and a KMC training manual
2. Trained 12 District KMC Trainers from 6 health facilities
3. Trained a total of 253 health workers in KMC
4. Established KMC units at 5 sites (St. Luke's Hospital, Ekwendeni Mission Hospital, Mangochi District Hospital, Bottom Maternity – Lilongwe Central Hospital, Queen Elizabeth Central Hospital in Blantyre) and provided recent support to Mulanje Mission Hospital for KMC implementation
5. Developed low birthweight register and data collection tools
6. Developed specific BCC materials for KMC.
7. Inclusion of KMC (with ENC) in CHAM pre-service nurse training curriculum.
8. Established National KMC Taskforce.
9. Developed National KMC Guidelines through the task force that are currently under final review
10. KMC incorporated into the MOH workplan 2005/2006

b. Challenges and Constraints

1. Conceptualizing ENC and KMC as separate components created gaps that the project had to later address (e.g. providers at Bottom Hospital initially only trained in KMC had to be later trained in ENC).
2. More time was needed than anticipated to build the technical capacity of Zomba as a KMC training center, including development of a systematic training approach and appropriate training materials.
3. The lack of a comprehensive follow-up system to track the outcomes of the babies after discharge from the KMC unit, has limited the information available to inform providers and the program about the outcome of babies managed with KMC, for possible improvements.
4. Awareness of KMC among antenatal women and the community in general was limited.
5. BCC materials for KMC were produced and distributed late within the program's cycle.
6. Limited attention to building the capacity of the providers in interpersonal and behavior change communication, led to women with low birthweight babies

misunderstanding the rationale for KMC and the importance of follow-up after the baby is discharged

7. KMC data collection and use was poorly understood at several KMC units.
8. The role of Zomba staff in terms of supervision of DTs and trainees was not clearly articulated
9. A lack of vehicles, inadequate staff and time, hampered effective and timely support and supervision, particularly to health providers at health centers and other districts beyond Zomba.

c. Recommendations

1. A clearly articulated follow-up/referral system to track the progress of babies discharged from the KMC Unit should be developed to improve on the system already set up, and currently not fully functional. This should include a workable communication system, enhanced referral sheets, collaboration and involvement of health centers and HSAs at community level.
2. KMC admission and discharge criteria among facilities should be standardized.
3. A KMC supervisory system should be strengthened for trainers and health providers. The DTs should continue to conduct supervision for at least a year.
4. Key data required to monitor KMC (e.g. type of data necessary, frequency of reporting, use of case fatality and appropriate cross- tabulations) should be identified and clarified with KMC providers and ensure clear linkages between data collection and use.
5. Data collection tools need to be re-designed to facilitate clinical management of LBW babies and inform the refocusing of program interventions.
6. The role and function of the Training Network should be explored further as outlined within the ENC component.

III. Rapid Syphilis Testing

In January 2004, the Malawi MOH mandated district hospitals to use whole blood rapid syphilis tests (WBRST), to screen women attending antenatal clinics and subsequently treat those found syphilis positive. Considering the negative impact syphilis has on the newborn, SNL/M's approach was to train non-laboratory technicians (e.g. nurses) at the health center level to perform WBRST and provide treatment. This approach is being piloted in Mangochi at the district hospital and 12 selected health centers. SNL/M in collaboration with the MOH initially developed a training manual for whole blood rapid syphilis testing. This manual will subsequently be used by MOH in other districts to train health providers.

From April to December 2004, a total of 8,090 out of 10,462 women attending antenatal clinic, have been screened for syphilis using WBRST. Table 3 highlights the outcomes of WBRST in Mangochi.

**Table 3: Outcomes of Whole Blood Rapid Syphilis Screening in Mangochi
April to December 2004**

Activity	Number (n)	Percentage (%)
1. Pregnant women attending antenatal clinic	10,462	100
2. Pregnant women screened for syphilis using WBRST	80,90	77.3
3. Pregnant women screened and found with positive syphilis test	519	6.4
4. Pregnant women with positive syphilis test who received no treatment	278	53.5
5. Pregnant women with positive syphilis test who received first dose treatment with Benzathine Penicillin 2.4.mega	241	46.4
6. Pregnant women with positive syphilis test who started and completed treatment	135 (n = 241)	56.0
7. Pregnant women with positive syphilis test who received first dose treatment and whose partner also received first dose treatment	103 (n = 241)	42.7
8. Pregnant women with positive syphilis test who completed treatment and whose partners also completed treatment	61 (n = 135)	45.1
9. Partners who started and completed treatment	61 (n = 103)	59.2

Of women screened 6.4% had a positive test and 46.4% received first dose treatment with Benzathine Penicillin 2.4 mega units. For women who started treatment, about half (56.0%), completed the full treatment. For women who started treatment (received first dose), 42.7% of partners also started treatment. Of the fewer partners (103) who started treatment, 59.2% completed the treatment regimen.

SNL/M will further document the findings related to the implementation of rapid syphilis testing in Mangochi. These findings and lessons learned will inform the MOH on further implementation of antenatal rapid syphilis screening and treatment at district and health center level.

a. Accomplishments

1. Newly developed whole blood rapid syphilis testing (WBRST) training manual by SNL/M in collaboration with the MOH and this will be used by the MOH to train health providers in other districts.
2. Trained 27 health providers, mainly nurses, in WBRST.
3. Piloted WBRST in 12 health centers in Mangochi district, where nurses conduct the screening.
4. Screened a total of 8,090 (77.3%) of women attending antenatal clinics for syphilis using WBRST, and 6.4% women found positive.
5. Of 519 women found syphilis positive, 46.4% (241) received first dose treatment and 56% of these (135/241) completed the full treatment regimen.

6. Of 241 women who started treatment, 42.7% (103) partners also started treatment and of 135 women who completed treatment, 45.1% (61/103) of partners also completed treatment.

b. Challenges and Constraints

1. About half (53.5%) of the antenatal women screened and found to have a syphilis positive test did not receive any treatment.
2. Most women testing positive are asymptomatic so it is difficult for providers to convince them and their partners to get treatment.
3. Treatment by painful injections deters many women from coming for subsequent treatment doses.
4. Women failing to go for subsequent syphilis treatment doses in turn end up not going for further antenatal services, to avoid nurses knowing they had failed to complete the syphilis treatment regimen.
5. As with other STI programs, convincing male partners to come to the health facility for counseling, screening and treatment proves difficult.
6. High ratios of antenatal mothers to health worker, limits time available to perform all the necessary tasks (adequate counseling, examination of clients, performing the screening test and providing treatment).

c. Recommendations

1. More nurses and other suitable health staff should be trained at district hospitals and health centers to provide rapid syphilis screening and treatment. This will reduce the burden for the few trained nurses and move the performance of WBRST beyond the lab technicians, to nurses and other suitable cadres.
2. BCC and counseling materials should be developed for clients (women/partners) and for health workers to enhance the understanding of the importance of syphilis screening and need to complete the treatment regimen.
3. SNL/M should document and share findings of the WBRST pilot interventions at health center level (where nurses perform the screening), to inform future replication by MOH in other district sites (health centers and hospitals).

ANNEX X
MOH/RHU JY08 Workplan

ANNEX XI
Newborn Health Design Workshop Final Report

Malawi Newborn Health Design Workshop
Capital Hotel, Lilongwe
February 15-16, 2007

Draft Summary Proceedings
Prepared by Save the Children
on behalf of the
Ministry of Health
Reproductive Health Unit

Draft
March 6, 2007



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EXECUTIVE SUMMARY

The purpose of the workshop was to design a community-based newborn care package for Malawi that is scaleable, affordable and evidence-based, with the overall aim of improving newborn health and survival.

The workshop was hosted by the Ministry of Health in partnership with Save the Children and in close coordination and collaboration with UNICEF. It represents one of several initiatives being undertaken by the Ministry of Health to realize improvements in maternal, newborn, and child health necessary to achieve the Millennium Development Goals (MDG) for maternal and child health.

The workshop was attended by about 40 individuals, with representing a broad range of stakeholders, including the MOH, UNICEF, WHO, UNFPA, USAID, the visiting delegates of UN agencies funded through PMNCH, Save the Children, other NGOs, and other professional organizations. The agenda is in Appendix 1 and a list of participants in Appendix 2.

The objectives of the workshop were to:

1. Scan the existing situation, coverage of care and trends to identify opportunities and gaps for saving the 16,000 newborns who die in Malawi each year
2. Identify key building blocks for delivery of a package to promote healthy behaviors and to deliver an effective, sustainable postnatal care package (what, who, how, supervision)
3. Agree on next steps to detail the package, develop and test it in practice and maximize effective scale up

The workshop was officially opened by the Principal Secretary of Ministry of Health, Mr. Chris Kang'ombe, who noted the objectives of the workshop, the current situation with regard to newborn health and survival in Malawi, Ministry plans and structures to reduce maternal, neonatal, and child mortality, and the availability of low-cost interventions to reduce neonatal mortality, and the reductions that can be achieved through these efforts. Mr. Kang'ombe's remarks were echoed by representatives from WHO, UNICEF, and Save the Children, all of whom committed to working in partnership with the MOH in efforts to reduce newborn mortality in Malawi.

The first day of the workshop consisted of several presentations to review and summarize the policy environment and current initiatives in reducing maternal, newborn, and child mortality.

In the afternoon of the first day, three working groups were formed to review and provide feedback on the possible package design in terms of the following aspects: what, linkages with other programs, who, where, when and how. Each group's presentation is summarized in tabular form in Appendix 3. Several areas for further dialogue and consultation were identified, as follows:

- It was agreed that the HSA is the logical worker of choice for a community-based newborn care package. This is because creation of a new cadre of workers is unrealistic in light of

policy and structural implications and longer-term plans for deployment of community nurses and nurse midwives, and in the context of ACS/D/c-IMCI. Questions remain with respect to supervision, roles and responsibilities (focused on newborn care or newborn care in addition to other responsibilities?), gender (most are male), and training (the current package of training is only eight weeks).

- HSAs need new job descriptions to include newborn care and need to be provided with special skills in maternal and newborn health. An HSA workload analysis is needed, including workload processes, supervision, and implications.
- It was proposed that HSAs be supervised by Community Health Nurses (CHNs) in the area of newborn health as many are now being supervised by Environmental Health Officers.
- The HSA would undertake home visits for ANC and PNC. Numbers will need to be determined based on formative research but provisionally some participants recommended 3 ANC and 4 to 6 PNC plus extra for low birth weight babies.
- HSAs are not currently trained to conduct deliveries nor allowed to do so according to policy, and most deliveries at community are conducted by TBAs, who are not trained in resuscitation and are not encouraged to deliver. Many felt that neonatal resuscitation at home would not be included in the first stage of a package of care for the newborn, and the focus for the intrapartum period would be on using TBAs to facilitate skilled attendance and on improving EmOC and resuscitation at facilities.
- In terms of increasing access to management of neonatal infections, HSAs are to be trained in the new IMCI algorithm for young infant care but would refer babies with infections. There may be an option of training HSAs in the “Where there is no referral module” but this would need piloting and process data and policy change.
- How and who provides effective PMTCT and what guidance to give to pregnant women that are HIV+ to avoid stigma and discrimination is a continuing issue. In PMTCT, TBAs refer promptly HIV+ women for hospital delivery. However, most of them do so as because of fear of infection.
- The role and definition of TBAs, including trained TBAs, remains unresolved and requires further dialogue and consultation. Referral of women for delivery in Dowa health facilities is working very well by TBAs because the TBA gets a fee of K200 per referral made which is equivalent to the amount she demands for conducting a delivery. A question is whether this can be feasible and sustainable at scale.
- The presence of a skilled caregiver at birth remains a gap for home deliveries and will remain so until long-term plans for community nurses and midwives are realized. In addition, who provides essential newborn care at birth remains a question.
- There was a suggestion to make use of community initiation counselors (*nankungwi*) who are senior women with decision making power regarding sexual reproductive health (SRH) issues, just as the *agogos* in Ekwendeni are used.
- Some felt there is need to include obstetricians to the next meetings because they are also crucial in this area of maternal and neonatal care

Following presentations, the second day of the meeting focused on the question: in order to guide and accelerate the scaling up of the package, what do we need to do and what do we need to know? The sub-questions discussed were: what policy and programmatic questions needed to be answered; what level of evidence is warranted; what is the duration of the evidence-generation

(pilot) project; in which districts should the project be undertaken; who are the potential partners; and who will do what?

Dr. Joy Lawn from Save the Children gave an overview of integrated newborn care package design and evaluation in other African countries including Ghana, South Africa, Tanzania, Uganda, Ethiopia and the Mai Mwana project in Mchinji District, Malawi. It was introduced by looking at whom the data is for, for what purpose, and at what level of evidence. In order to determine how much evaluation is needed, we need to ask “whom are we trying to influence and what is the change we expect?”

To inform *programmatic* design and action and make the package work (or know why it is not working) requires:

- formative research to design the package and content (for example, what are current home practices for care of the umbilical cord, why, and how could this be optimised)
- process assessment (e.g., number of HSAs trained, retention of HSAs, availability of drugs, percentage of newborns with infection treated)

To influence major *policy* change for a Government and donors to invest in scaling up a package nationwide may require data on neonatal deaths, cost per life saved, cost per visit, cost per capita of the package. Neonatal mortality is measured through pregnancy surveillance, which is complex and difficult to do well, and population-based surveys with large samples.

To influence the *wider scientific community* requires an evaluation design, e.g., randomisation which minimises the possibility that a result could be due to chance

The following points were introduced as basis for discussion:

- Context: NMR for the country is now at 27 (32 in MICS), and 53% of births take place in facilities
- Intervention: Using the existing HSA and other linked cadres with supervision by CHNs to provide home visits and link to health system, increasing access to management of neonatal sepsis
- Evaluation design: before and after? Also cost data? Other?
- Data collection: surveys and surveillance? Formative research before?

Outcomes of the discussion/next steps are summarized as follows:

Package design. To be finalized by a technical working group and presented for agreement/consensus, preferably prior to the mid-term review of the SWAp.

Sites. The districts of Thyolo, Dowa, and Chitipa, representing Northern, Central, and Southern regions of the country, should be selected as the evidence-generating districts for the newborn health intervention package. These are among the 10 districts where ACSD/c-IMCI program is being implemented. Thus, the three will be the “study” districts where close monitoring and evaluation activities will be undertaken. It was also suggested that interventions should be district wide, but need to have criteria for health facility catchment area eligibility in terms of staff and resources.

Linkages to health system and scaling up. Given the focus on sustainable impact at scale, it was agreed that the initiative would need to be implemented within the larger health delivery system with the cadre of providers that have been formally approved. This means that the project should try to mobilize, and test the effectiveness of, HSAs and community nurse-midwives, among others.

Remit. The initiative should be designed to answer specific operational questions and should represent the whole district, collaborating closely with the DHO in each district. The main policy questions to be addressed should include the use of antibiotics by community health workers (HSAs and midwives), feasibility, content, net cost and sustainability of resuscitation at the community level, and the frequency and timing of postnatal visits at home.

When to start. Everyone agreed that preparations should begin as soon as possible. To the extent possible, priority should be given to posting the new cohort of graduating nurses to the selected sites. In addition, preparation should be synchronized with the financial year to the extent possible. Both components of research and programmatic interventions can start at the same time in the three pilot districts.

Measurement. Specific indicators or design issues were not discussed at length, but it was felt that the Working Group should: (a) produce recommendations for review and vetting by the stakeholders; (b) address the question of duration for the “study” which would largely depend on “what” is being measured (e.g., proximate behavior-change communication indicators or neonatal mortality); and (c) identify specific roles and responsibilities for the key partners, with specific timelines of activities.

NEXT STEPS

The following were discussed and agreed to be the next steps for the pilot component:

1. Formation of a working group, led by the MOH RHU. The RHU will call the first meeting of the working group. The first task will be to develop a Terms of Reference for the Working Group and respective roles and responsibilities.
2. Capture proceedings of the design workshop and circulate them to all stakeholders and regulatory bodies for their comments by end of February 2007.
3. Resolve outstanding issues and develop a protocol with the design and parameters for the pilots, including minimum resource requirements in terms of health facility staff and supervisors, HSAs, and supplies and equipment.
4. Determine costs and prepare and initiate resource mobilization plans.
5. Conduct formative research and baseline surveys in the selected districts, with the DHO/MOH working with communities as part of site preparation and an inventory of what exists/is available in the districts.
6. Secure approval for the deployment of new graduating nurses and new locally based female HSAs to the three districts

It was proposed that the Working Group (WG) should be composed of representatives from:

- RHU/MOH, with the Desk Officer for Safe Motherhood as Coordinator of the Working Group
- DHOs from Dowa, Thyolo and Chitipa
- UNICEF
- UNFPA
- WHO
- Save the Children
- CHAM

Apart from organizational members in the Working Group, key stakeholders in the process need to be identified, and at a minimum will include Zonal Health Support Officers, the Nurses and Midwife Council, and the National Health Sciences Research Committee.

INTRODUCTION AND OBJECTIVES

The purpose of the workshop was to design a community-based newborn care package for Malawi that is scaleable, affordable and evidence-based, with the overall aim of improving newborn health and survival.

The workshop was hosted by the Ministry of Health in partnership with Save the Children and in close coordination and collaboration with UNICEF. It represents one of several initiatives being undertaken by the Ministry of Health to realize improvements in maternal, newborn, and child health necessary to achieving the Millennium Development Goals (MDG) for maternal and child health. Save the Children provided financial support for the workshop through the Bill and Melinda Gates Foundation.

The workshop was attended by about 40 individuals, with the representation of a broad range of stakeholders, including the MOH, UNICEF, WHO, UNFPA, USAID, the visiting delegates of UN agencies funded through PMNCH, Save the Children, other NGOs, and other professional organizations. The agenda for the workshop is in Appendix 1 and the list of participants in Appendix 2.

The objectives of the workshop were to:

1. Scan the existing situation, coverage of care and trends to identify opportunities and gaps for saving the 16,000 newborns who die in Malawi each year
2. Identify key building blocks for delivery of a package to promote healthy behaviors and to deliver an effective, sustainable postnatal care package (what, who, how, supervision)
3. Agree on next steps to detail the package, develop and test it in practice and maximize effective scale up

OFFICIAL OPENING

The workshop was officially opened by the Principal Secretary of Ministry of Health Mr. Chris Kang'ombe. Mr. Kang'ombe highlighted the objective of the workshop, which is to develop a

community-based maternal and newborn postnatal care package for Malawi that is scaleable, affordable and evidence-based, with the overall aim of improving newborn health and survival.

Mr. Kang'ombe highlighted the progress that the Government of Malawi has made over the years with support from various development partners improving maternal and newborn health in all the districts of the country. Yet maternal deaths still claim 5,400 lives/year, 14,900 neonates die each year, and there are 22,200 stillbirths annually.

Mr. Kang'ombe stated that evidence demonstrates that 2/3 of newborn deaths could be prevented through essential maternal, newborn, and child health packages already in policy, through high coverage and improved newborn care, and through a continuum linking maternal, newborn and child health care through the life cycle and between homes and health facilities.

Mr. Kang'ombe emphasized that the Malawi government through the Ministry of Health Reproductive Health Unit (RHU) developed the Road Map for Reducing Maternal and Neonatal Morbidity and Mortality in an effort to redress the situation and define various strategies to guide policy makers, development partners, training institutions and service providers in supporting Government efforts towards the attainment of MDGs related to maternal and neonatal health.

This workshop is therefore one of the initiatives taken by MOH in partnership with UNICEF and Save the Children in an effort to achieve the Millennium Development Goals (MDG) of reducing child and maternal mortality.

Other speakers at the opening included UNICEF Country Representative Aida Girma, WHO Representative Dr. Matshidiso Moetie, and Save the Children Country Director Paul Mecartney. Together, they echoed the sentiments of Mr. Kang'ombe, outlining the magnitude of newborn deaths in sub-Saharan Africa and Malawi, the availability of cost-effective solutions to preventing newborn deaths, and the collective commitment of their organizations and others in working in partnership with the Ministry of Health to facilitate the development of scaleable and nationally owned strategies to close gaps in maternal, newborn, and child health coverage, including postnatal and community based care.

WORKSHOP PRESENTATIONS AND DISCUSSIONS

DAY 1 PROCEEDINGS

Objective 1: To scan the existing situation, coverage of care and trends to identify opportunities and gaps for saving the 16,000 newborns that die in Malawi each year, linking to the SWAp and existing health system

Presentation: An Overview of Newborn Health in Malawi

Dr. Joy Lawn, Senior Research and Policy Advisor, Newborn Health, Save the Children

Presentation highlights:

- In Malawi each year, 5,400 women die of pregnancy-related causes; approximately 22,000 babies are stillborn, and at least 16,000 babies die in the first month of life. Nearly 200,000

babies with low birth weight may live but not reach their full potential, and an unknown number of babies are infected with HIV through MTCT.

- Under-five deaths are being reduced, but progress is slower in reducing neonatal mortality, which represents 26% of under-five deaths
- Most babies die at home within the first week and especially the first day. Undercounting may be by as much as 10-30%. Infections and diarrhea account for 32% of deaths, and asphyxia 22%. The majority of newborn deaths are in low birth weight babies, the majority of these preterm.
- Delays in recognition and decision making, care seeking, financial limitations, delays in transportation, and delays in receiving appropriate care once in the facility all contribute to newborn mortality.
- There are high inequities in neonatal death rates and services coverage between urban and rural populations. Along the continuum of care, antenatal care and immunization rates are relatively high, but skilled care at delivery, postnatal care, and exclusive breastfeeding rates are low.
- Malawi is making strides in newborn health. In *Opportunities for Africa's Newborns*, the report highlighted that Malawi is achieving elimination of maternal and neonatal tetanus, has a strong health sector planning process, and has witnessed increased investments in maternal, newborn, and child health.
- While integrated packages at family/community, outreach/outpatient, and clinical levels are all necessary in the long-run, approximately one-third of neonatal deaths could be averted with outreach and family or community-based interventions now: Routine postnatal care, promoting healthy behaviours including increased use of skilled intrapartum care, extra care of small babies in the community, linking to facilities, and treating neonatal infections especially where referral is not possible.
- Postnatal care and systematic scaling up of community health promotion and care with strong links to the health system represents a major opportunity in Malawi. ACSD/IMCI, the Road Map, and vertical programs with large funding bases all provide opportunities to improve coverage.
- The fact that Malawi is above the regional average for coverage of some key packages such as antenatal care, skilled attendance and IMCI, also provide key opportunities to add or strengthen newborn care interventions.

Presentation: Neonatal mortality in Malawi and Policy Options

Dr. Girmay Haile, Head of Section, Social Policy, Advocacy & Communication, UNICEF

Presentation highlights:

- The presentation also highlighted that as under-5 and Infant Mortality Rates (IMR) are being reduced, neonatal mortality is becoming an important proportion of these deaths, reflecting low coverage of interventions to prevent them.
- Most of these deaths occur at home regardless of whether delivery was at home or at a health facility.
- The presentation highlighted challenges to the health system which includes inadequate human resource, inadequate infrastructure, poorly equipped facilities and distance to health facilities. Mothers are usually discharged 24 hours after delivery and only 21% come for

early postnatal care. Following delivery the first health facility visit is usually at 6 weeks for immunizations.

- There has been less emphasis on postnatal care and support for mothers in the community and the role of the TBA is still unclear. The debate on “Who is the newborn caregiver?” among health professional is still unresolved.
- Policy and program actions need to provide early, integrated postnatal care to strengthen the linkages between maternal health and child health programs.
- This can be achieved if postnatal care is provided through community providers that make routine home visits. The challenges are human resource and efficiency of the system.
- However, if Community Health Nurses (CHN) and Health Surveillance Assistants (HSAs) are given training this seems to be a feasible option.

Discussion

- Participants stressed that culture is a very important factor and challenge. Communities often don't see the newborn baby as a human being, e.g., if a newborn dies it is considered a women's issue and men are not involved. There is thus the need to develop strong BCC interventions to address harmful cultural practices and help improve the social enabling environment.
- Participants noted that in many instances, different programs are working separately even though they are addressing the same issue in the same geographic area. Implementing agencies should thus work in partnership and the MOH and partners should strive to integrate services to avoid duplication and maximize impacts.
- Participants agreed it is important to involve influential figures in the community and family to promote healthy practices and care seeking. Ekwendeni Mission Hospital gave an example of working with the agogos (grandparents), who are very influential in decision making at family or community level. Similarly, men are central decision makers and need to be involved and engaged in newborn health.
- TBAs are still popular and perform about 11% deliveries. While there are concerns around their capacities and practices, most people in rural areas have confidence in them. As the role of TBAs continues to be assessed, there are good examples of working with them to facilitate skilled delivery in facilities in some of the districts, such as Dowa.

Presentation: Sector Wide Approach (SWAp)

Dr. Ann Phoya, Director, SWAp

Presentation highlights

- The health sector SWAP is an overarching policy adopted to improve delivery of health service to the nation especially the rural poor
- Its overall aim is to improve the health status of the people by: defining health priorities and a package of health interventions that addresses major causes of morbidity & mortality as well as levels of service delivery; systems that would support delivery of health interventions; mobilizing necessary financial resources & agreeing on modalities of funding
- The SWAp became operational in 2004 with the signing of an MOU between Government and development partners. A six pillar Program of Work outlining key activities to be implemented was finalized in March 2005.

- Principles include: Strong leadership by Government in defining its agenda and letting partners know; partnership based on trust between government and its partners or donors in the sector; commitment by all partners; transparency & accountability; and involvement of all stakeholders in the sector, including communities
- Memoranda of Understanding (MOU) spell out undertakings or commitment of each partner; funding modalities, planning cycles, and targets and mechanisms for monitoring & evaluation
- Governance Structures include Committees that ensure transparency and accountability in the implementation of the MOU and provide technical input in the implementation of the Program of Work (POW). They include the Health Sector Review Group; Senior Management Committee; and various Technical Working Groups (Financial management & procurement, HR, Pharmaceuticals & medical Supplies, Infrastructure, M&E&R, TB, HIV/AIDS, SRH, Malaria etc.)
- The POW is the National health Plan for 2004-2009. It spells out six major areas of focus: HRH supply of drugs & medical supplies; Supply of equipment; Infrastructure Development; District operation (delivery of health interventions); and Policy development, standards setting, and monitoring & evaluation. The POW also spells out financial resources to implement proposed activities for each major area
- Implementation Modalities. The POW is annualized each year to guide implementation of by Central level, districts and partners. Partners participate in implementation at either central or district level by integrating their activities in the MOH/CH/Dist Implementation Plans. Financing of Implementation Plans is either through pooling of funds or discrete mechanisms.
- Monitoring and Evaluation. A SWAP M & E Framework has been designed and approved by the Health Sector Review Group. Targets in the M&E Framework have incorporated the Health related MDGs, MGDS indicators; other health related impact and process or indicators. Different approaches have been agreed upon to collect data on performance e.g. DHS, annual special surveys, and HMIS from service delivery points.
- Progress is monitored through Joint Midyear and Annual reviews. 2007 marks the third year of implementation; the POW is therefore due for Mid-term evaluation.
- To date, necessary fiduciary systems are in place, and have resulted in increased donor confidence to the sector. More partners have signed up the SWAP MOU, and there are now seven. Four Joint Reviews have been conducted successfully, and zonal support offices are in place to support implementation of DIPs. There is steady increase in resource mobilisation, and Governance structures are functioning and providing necessary policy & technical inputs.
- Challenges include: Setting sustainable mechanisms for implementing the EHP at community level; some partners developing stand alone work-plans along side the District implementation plan (DIP) or the Annual Implementation Plan (AIP); inadequate financing; access to the EHP still problematic as not all areas of the essential health package are included in services agreements; the SWAP is viewed by some people as a project; and a lengthy training period is needed to produce the necessary numbers of health workers to implement the EHP at all levels of service delivery

Presentation: Road Map for Reducing Maternal and Neonatal Morbidity and Mortality
Fannie Kachale, Acting Deputy Director, Clinical Services – RHU, MOH

Presentation Highlights:

- The presentation provided a background of the problem and previous approaches in addressing maternal and neonatal care with the conclusion that most obstetric complications are neither predictable nor avoidable but can be effectively managed. The focus should therefore be on emergency obstetric care and skilled delivery that is available, accessible, and on time.
- With the African Union call for all Member States to develop and implement strategies to accelerate the reduction of maternal mortality, WHO developed a generic Road Map for adoption and adaptation by all countries.
- Malawi developed its Road Map in 2005 with a vision that “*all women in Malawi go through pregnancy, childbirth and the postpartum period safely and their newborns are born alive and healthy through the implementation of effective maternal and newborn health interventions*”. The goal is to accelerate the reduction of maternal and newborn morbidity and mortality towards the achievements of the Millennium Development Goals (MDGs).
- The objectives include: To increase the availability, accessibility, utilization and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system; and to strengthen the capacity of individuals, families, communities, civil society, organisations and government to improve Maternal and Neonatal Health.
- The Road Map has 9 strategies: 1) Improving the availability of, access to and utilisation of quality Maternal and Neonatal Health (MNH) care including family planning and PMTCT services; 2) Strengthening human resources to provide quality skilled care; 3) Strengthening the referral system; 4) Strengthening national and district health planning and management of MNH care; 5) Advocating for increased commitment and resources for MNH care; 6) Fostering partnerships; 7) Empowering communities to ensure continuum of care between household and health facility; 8) Strengthening services that address adolescents’ sexual and reproductive health issues; and 9) Strengthening monitoring and evaluation mechanisms for better decision-making and service delivery of MNH care.
- Each strategy includes several interventions that have several activities. The implementers at district level will use the Road Map as a guiding document to ensure that all priorities are included in their District Implementation Plans.
- Implementation will be done in two phases with phase 1 from 2005 to 2009 and phase 2 from 2010 to 2014, with evaluations at the end of each phase and a final one in 2015. The key indicators being addressed relates to management and coordination issues, availability and accessibility of services, utilization and quality of services, community initiatives and impact of interventions.

Presentation: Accelerated Child Survival and Development (ACSD) in Malawi

Kelvin Nindi, IMCI secretariat, MOH

Presentation Highlights

- ACSD is a set of interventions specifically packaged to reduce childhood morbidity and mortality and in Malawi is attained through IMCI approach, which addresses the major causes of under-five mortality.

- ACSD is designed to attain MDG4 of reducing childhood mortality by 2/3 by the year 2015 in Malawi. It covers effective case management, pre-service training, health systems support, promotion of family and community key child care practices and addresses cross cutting issues, e.g., management, financing and human resources
- Delivery settings include home-based delivery of high impact interventions by parents, guardians, etc.; community based delivery by HSAs and other extension workers; health facility based delivery of high impact interventions; and mass campaigns delivery of high impact interventions such as child health days, malaria SADC week.
- Progress to date includes: Development of the ACSD Policy in collaboration with several ministries; Launch of the IMCI Policy by Minister of Health with 7 ministries participating in November 2006; 5 Year Strategic Plan drafted; Eight districts to kick start the process, with district and village plans developed and costed, orientation of DEC members on the concept and principles of IMCI strategy, training of DTWG in all districts, training of 500 H/W in IMCI case mgt training, training of about 100 facilitators, training of 5,000 HSA to commence shortly (1/1000 people), and strengthening NGO partnerships to support ACSD.

Presentation: Mai Mwana Research Project Infant Feeding Intervention

Hilda Chapota, Mai Mwana Project

Presentation Highlights

- Mai Mwana is a cluster-randomised controlled trial implemented by the Institute for Child Health in London and funded by Save the Children (Saving Newborn Lives). It aims at assessing the effectiveness of two community based interventions to reduce maternal and neonatal morbidity and mortality.
- In total there are 24 zones for Infant Feeding intervention with 72 Volunteer Mai Mwana Counselors (VMCs) and 24 government HSAs whose role is supervision. There are 2 - 4 VMCs per zone and they make a total of 5 visits to the mother/woman. The 1st visit is done during the third trimester of pregnancy, 2nd visit within the first week after delivery, 3rd at one month after delivery, 4th at 3 months after delivery and the 5th is done after 5 months of delivery.
- The infant feeding trial outcomes of interest include: Infant morbidity and mortality rates, exclusive breastfeeding rates, early cessation of breast feeding in HIV+, growth between 1 and 6 months, MTCT, changes in safe sex behaviour and traditional beliefs associated with breastfeeding.
- While results (outcomes) are not yet available, coverage and acceptability of the volunteer breastfeeding intervention is quite high and may provide learning for the use of volunteers in other programs.
- The program has also collected a wealth of formative and process evaluation information and learning that can be consulted by other working in maternal and newborn health.

Presentation: Policymakers Visit to India & Pakistan

Dr. Dorothy Namate, Director of Health and Technical Services, MOH

Presentation Highlights

- The objectives of the policymakers' trip to India and Pakistan were to:

- Orient participants to the rationale, basic principles, methods, effects and limitations of the home based newborn care at SEARCH, the IMNCI programme in India and the Lady Health Visitor in Pakistan.
 - Have the participants study the process and outcome of various programmes and based on this understanding
 - Identify appropriate approaches of newborn care at home and communities, that can be applied as part of the continuum of care for maternal, newborn and child health in Malawi.
- Dr. Abhay Bang’s SEARCH model was presented, as well as the applicability and implications of the program to Malawi. The following recommendations were made from the tour:
 - Determination of choice – chances of success against the tripod causes of sepsis, asphyxia and pre-term births. The proposed choice is the SEARCH Model with provision of injectable antibiotics for sepsis in the home; keeping pre-term babies warm using special bags; and use of ambu bags to stimulate normal breathing among asphyxiated babies
 - Adapt the SEARCH Gadchiroli Model and include it in the management of common childhood illnesses using HSAs as the community health worker.
 - Mount an advocacy campaign to ensure that relevant UN bodies, bilateral partners, regulatory bodies, pediatricians and district health management teams include newborn health as one of their priorities.
 - Initiate management of common childhood illnesses using the village clinic setting.
 - Communicate to all about the institutionalization of the SEARCH Model in Malawi on an incremental basis

Presentation: Home Based Newborn Care Proposal for Thyolo District

Dr. Noor Alide, Thyolo DHO

Presentation Highlights

- This presentation looked at the possible package design based on SEARCH model, and outlined health indicators, problem statement and assumptions specific for Thyolo district.
- Objectives, key activities, process and interventions to be addressed were described:
 - Health education and behavioural change communication
 - Attending delivery and immediate care of newborn including asphyxia.
 - Early detection and treatment of neonatal sepsis at community level
 - Detection and home management of LBW and preterm
 - Breast feeding, promotion and problem solving
 - Thermal care
 - Management of HIV positive women
 - Malaria

- Vitamin A supplementation
- De-worming
- Management of diarrhea with ORS
- Early referral
- The district personnel for the community-based newborn care package and selection criteria and training for the Village Health Workers (VHW) were outlined as well. VHWs should be able to read and write, be a permanent resident of the village, have education level standard 5 to 8, be a married female with children, have support of the family to take up the role of VHW, willingness to attend deliveries, and willingness of the community to accept her as a VHW.
- TBAs were identified as access points to mothers and neonates. Consideration was given to deliveries that are not attended by TBAs or health facility through notifications to the CHW.
- Unresolved issues identified in the presentation included:
 - What will the remuneration package for the CHW be like?
 - SEARCH allowed CHWs to provide treatment using injections, is Malawi ready for this approach?

Discussion

Questions and comments included:

- How would the SEARCH model be adapted and applied in Malawi, where the NMR baseline is at 27-31/1,000 compared to the SEARCH site at 60-65/1,000. Given the high level of mortality at the India site, as well as cultural and health system differences (SEARCH did not work with the formal health system), some participants stressed that careful adaptation of the SEARCH package is required for the Malawi context.
- The issue of TBAs as providers of care in cases where delivery is inevitable was discussed. Many are already trained and respected in the community. Replacing them requires time and sensitivity.
- It was noted that the revised c-IMCI manual in Malawi has already added most of the essential newborn care interventions in the HSAs training manuals. However, a challenge that will require further consultation is gentamycin injection by the HSAs for infection.
- It was pointed out that there was need to consider sustainability of the community volunteer and the criteria for selection. This was later raised as a policy constraint (establishing a new cadre of worker would take time) and one that should also be reviewed against long term plans for other cadres of staff at community level (discussed further later in this document).

Presentation: Evidence and experiences from South Asia

Dr. Steve Wall, Senior Newborn Health Research Advisor, Save the Children

Presentation highlights

The presentation reviewed the status of various community based models for neonatal care and results and learning to date:

- SEARCH model of home-based neonatal care (India)
- Community management of newborn infection (Nepal)
- Home-based newborn care package (Bangladesh)
- Clinic-based newborn care package (Bangladesh)
- Integrated newborn health package in existing system (Pakistan)
- Participatory women's groups to improve newborn health (Nepal)
- Community mobilization and behaviour change to improve newborn health (India)

Key model components and contextual issues were presented and a handout, *Tested Models of Community-Based Newborn Health Care: Evidence and Experience from South Asia*. The handout was also used in group work where issues to be considered in designing newborn care for Malawi were discussed.

Key lessons learned from these studies:

- A large impact on neonatal mortality is achievable through community-based intervention packages.
 - Content and delivery strategies can vary substantially from 'supply' to 'demand' – especially according to setting – and still have large impact.
 - Community-based newborn health care can be delivered through *existing health systems*, achieving high coverage and impact.
 - Questions remain about how to deliver newborn health intervention packages through MCH programs and existing systems.
 - Package should address gaps in newborn care and be seen as feasible to be delivered through existing programs/health systems at scale.
 - Challenge is to take lessons from settings in Asia and develop similar evidence base in Africa.

Objective 2: To identify key building blocks for delivery of a package to promote healthy home behaviors and to deliver an effective, sustainable postnatal care package (what, who, how, supervision)

Working Group Discussions

In the afternoon of the first day, three working groups were formed to review and provide feedback on the possible package design in terms of the following aspects: what, linkages with other programs, who, where, when and how. Each group's presentation is summarized in tabular form in Annex 2. Several areas for further dialogue and consultation were identified, as follows:

- It was agreed that the HSA is the logical worker of choice for a community-based newborn care package. This is because creation of a new cadre of workers is unrealistic in light of policy and structural implications and longer-term plans for deployment of community nurses and nurse midwives, and in the context of ACS/D/c-IMCI. Questions remain with respect to supervision, roles and responsibilities (focused on newborn care or newborn care in addition to other responsibilities?), gender (most are male), and training (the current package of training is only eight weeks).

- HSAs need new job descriptions to include newborn care and need to be provided with special skills in maternal and newborn health. An HSA workload analysis is needed, including workload processes, supervision, and implications.
- It was proposed that HSAs need supervised by Community Health Nurses (CHNs) in the area of newborn health as many are now being supervised by Environmental Health Officers.
- The HSA would undertake home visits for ANC and PNC. Numbers will need to be determined based on formative research but provisionally some participants recommended 3 ANC and 4 to 6 PNC plus extra for low birth weight babies.
- HSAs are not trained to conduct deliveries or allowed to do so according to policy and most deliveries at community are conducted by TBAs, who are not trained in resuscitation and are not encouraged to deliver. Many felt that neonatal resuscitation at home would not be included in the first stage of a package of care for the newborn, and the focus for the intrapartum period would be on using TBAs to facilitate skilled attendance and on improving EmOC and resuscitation at facilities.
- In terms of increasing access to management of neonatal infections, HSAs are to be trained in the new IMCI algorithm for young infant care but would refer babies with infections. There may be an option of training HSAs in the “Where there is no referral module” but this would need piloting and process data and policy change.
- How and who provides effective PMTCT and what guidance to give to pregnant women that are HIV+ to avoid stigma and discrimination is a continuing issue. In PMTCT, TBAs refer promptly HIV+ women for hospital delivery. However, most of them do so as because of fear of infection.
- The role and definition of TBAs, including trained TBAs, remains unresolved and requires further dialogue and consultation. Referral of women for delivery in Dowa health facilities is working very well by TBAs because the TBA gets a fee of K200 per referral made which is equivalent to the amount she demands for conducting a delivery. A question is whether this can be feasible and sustainable at scale.
- The presence of a skilled caregiver at birth remains a gap for home deliveries and will remain so until long-term plans for community nurses and midwives are realized. In addition, who cares for the newborn at birth remains a question.
- There is need to make use of community initiation counselors (*nankungwi*) who have decision making powers regarding sexual reproductive health (SRH) issues, just as the *agogos* in Ekwendeni are used.
- Some felt there is need to invite obstetricians in the next meetings because they are also crucial in this area of maternal and neonatal care

DAY 2 PROCEEDINGS

Objective 3: Maximizing and accelerating effective scale up

Following presentations, the second day of the meeting focused on the question: in order to guide and accelerate the scaling up of the package, what do we need to do and what do we need to know? The sub-questions discussed were: what policy and programmatic questions needed to be answered; what level of evidence is warranted; what is the duration of the evidence-generation (pilot) project; in which districts should the project be undertaken; who are the potential partners; and who will do what?

Presentation: Integrated newborn care packages under consideration in various African countries: what to evaluate? Dr. Joy Lawn

- The presentation gave an overview of integrated newborn care package design and evaluation in other African countries including Ghana, South Africa, Tanzania, Uganda, Ethiopia and the Mai Mwana project in Mchinji District, Malawi. It was introduced by looking at who the data is for, for what purpose, and at what level of evidence.
- The well-documented experiences so far are from *Asia*. Only 2 out of 7 presented yesterday are in the public sector and several have no links to *health system*. These are studies, none are at *scale*. Therefore:
 - Need adaptation and assessment in *Africa*
 - In African contexts with stronger health systems need to operationalise links with the *health system*
 - Important to consider the issue of getting to *scale* while designing
- A key question: Is it better to reach the whole nation with a simpler package with 15% reduction of neonatal deaths than reach one corner with 50% reduction
- How much evaluation is needed? Evaluation measures need to be determined based on the following:
 - Who to influence and what is the expected change
 - To inform *programmatic* design and action and make the package work (or know why it is not working) requires:
 - formative research to design the package and content (for example, what are current home practices for care of the umbilical cord, why, and how could this be optimised)
 - process assessment (e.g., number of HSAs trained, retention of HSAs, availability of drugs, percentage of newborns with infection treated)
- To influence major *policy* change for a Government and donors to invest in scaling up a package nationwide may require data on neonatal deaths, cost per life saved, cost per visit, cost per capita of the package. Neonatal mortality is measured through pregnancy surveillance, which is complex and difficult to do well, and population-based large sample surveys.
- To influence the *wider scientific community* requires an evaluation design, e.g., randomisation, which minimises the possibility that a result could be due to chance

The following points and questions were introduced for discussion:

- Context: NMR for the country is now at 26 (32 in MICS), and skilled attendance during birth is at 56%
- Intervention: Using the existing HSA and other linked cadres with supervision by CHNs to provide home visits and link to health system, increasing access to management of neonatal sepsis
- Evaluation design: before and after? Also cost data? Other?
- Data collection: surveys and surveillance? Formative research before?

Discussion

Outcomes of the discussion and next steps are summarized as follows:

Package design. To be finalized by a technical working group and presented for agreement/consensus, preferably prior to the mid-term review of the SWAp.

Sites. Thyolo, Dowa, and Chitipa districts, representing three regions of the country, should be selected as the evidence-base districts for the newborn health intervention package. These are among the 10 districts where ACSD/c-IMCI program is being implemented. Thus, the three will be the “study” districts where close monitoring and evaluation activities will be undertaken. It was also suggested that interventions should be district wide, but need to have criteria for health facility catchment area eligibility in terms of staff and resources.

Linkages to health system and scaling up. Given the focus on sustainable impact at scale, it was agreed that the initiative would need to be implemented within the larger health delivery system with the cadre of providers that have been formally approved. This means that the project should try to mobilize, and test the effectiveness of, HSAs and community nurse-midwives, among others.

Remit. The initiative should be designed to answer specific operational questions and should represent the whole district, collaborating closely with the DHO in each district. The main policy questions to be addressed should include the use of antibiotics by community health workers (HSAs and midwives), feasibility, content, net cost and sustainability of resuscitation at the community level, and the frequency and timing of postnatal visits at home.

When to start. Everyone agreed that preparations should begin as soon as possible. To the extent possible, priority should be given to posting the new cohort of graduating nurses to the selected sites. In addition, preparation should be synchronized with the financial year to the extent possible. Both components of research and programmatic interventions can start at the same time in the three pilot districts.

Measurement. Specific indicators or design issues were not discussed at length, but it was felt that the Working Group should: (a) produce recommendations for review and vetting by the stakeholders; (b) address the question of duration for the “study” which would largely depend on “what” is being measured (e.g., proximate behavior-change communication indicators or neonatal mortality); and (c) identify specific roles and responsibilities for the key partners, with specific timelines of activities.

NEXT STEPS

The following were discussed and agreed to be the next steps for the pilot component:

1. Formation of a working group, led by the MOH RHU. The RHU will call the first meeting of the working group. The first task will be to develop a Terms of Reference for the Working Group and respective roles and responsibilities.

2. Capture proceedings of the design workshop and circulate them to all stakeholders and regulatory bodies for their comments by end of February 2007.
3. Resolve outstanding issues and develop a protocol with the design and parameters for the pilots, including minimum resource requirements in terms of health facility staff and supervisors, HSAs, and supplies and equipment.
4. Determine costs and prepare and initiate resource mobilization plans.
5. Conduct formative research and baseline surveys in the selected districts, with the DHO/MOH working with communities as part of site preparation and an inventory of what exists/is available in the districts.
6. Secure approval for the deployment of new graduating nurses and new locally based female HSAs to the three districts

It was proposed that the Working Group (WG) should be composed of:

- RHU/MOH, with the Desk Officer for Safe Motherhood as Coordinator of the Working Group
- DHOs from Dowa, Thyolo and Chitipa
- UNICEF
- UNFPA
- WHO
- Save the Children
- CHAM

Apart from organizational members in the Working Group, key stakeholders in the process need to be identified, and at a minimum will include Zonal Health Support Officers, the Nurses and Midwife Council, and the National Health Sciences Research Committee.

Appendixes:

Appendix 1: Agenda

Appendix 2: List of participants

Appendix 3: Summary of Group Work on Newborn Package of Care

Appendix 4: Summary of Evidence from Asia

Appendix 1: Agenda

DAY 1 - Thursday, 15 February 2007		
08h00	Coffee and tea	
08h30	Welcome <i>(Official opening postponed until 2pm)</i>	Chair Dr. D. Namate (Director of Health and Technical Services – MOH) <ul style="list-style-type: none"> Fannie Kachale (Acting Deputy Director, Clinical Services – RHU MOH)
08h45	Group introductions and announcements	<ul style="list-style-type: none"> Evelyn Zimba (Programme manager for Newborn health, Save the Children)
09h00	Goals and objectives of Design Workshop	<ul style="list-style-type: none"> Dr. Fannie Kachale
09h10	Objective 1: Scanning the situation for Malawi's newborns, current coverage, trends and gaps An overview of newborn health in Malawi Q&A Presentation on Neonatal Mortality in Malawi and Policy Options (10 min) Q&A	Chair Dr. D. Namate <ul style="list-style-type: none"> Dr. Joy Lawn, (Senior Research and Policy Advisor, Newborn health, Save the Children) Girmay Haile (Head of Section Social Policy, Advocacy & Communication)
10h00	TEA BREAK	
10h15	Objective 1: Scanning Malawi's policy and program environment for opportunities to scale up newborn care linked to the SWAp <ul style="list-style-type: none"> The SWAp – opportunities for newborn care scale up (10 min) The Road Map (10 min) IMCI and ACSD/c-IMCI (10 min) Volunteer Counselor/home visitor Model-Mai Mwana (10 min) 	Co-chair Dr. D. Namate and Dr Juan Ortiz (Deputy Country Representative, UNICEF) <i>(after each talk pause for clarifications but hold major discussion for end of this session)</i> <ul style="list-style-type: none"> Dr. Ann Phoya, Director SWAp Fannie Kachale Kelvin Nindi, IMCI Secretariat, MOH Sipho Jale / Dr. Charles Mwansambo
11h00	Plenary discussion of key opportunities and remaining gaps	Facilitated by Fannie Kachale and Jeanne Russell (Deputy Country Director, Save the Children)
11:30	Learning and adaptation from newborn care packages MOH reports of visits to SEARCH <ul style="list-style-type: none"> Policymakers visit to India & Pakistan (10 mins) Possible package design based on SEARCH visit proposal (20 mins) Evidence and experiences from India, Bangladesh, Pakistan and Nepal (30 mins) Plenary discussion regarding adaptation to the Malawian context	Chair: Dr. Some, UNICEF <ul style="list-style-type: none"> Dr Namate, / Dr. M. Joshua Zonal Health Officer Central East Dr. Noor Alide – District Health Officer, Thyolo Dr Steve Wall (Senior Newborn Health Research Advisor, Save the Children) Facilitated by Dr Some and Mr Nindi

13h00	LUNCH	
14h00	Official Opening	Facilitated by Dr. D. Namate <ul style="list-style-type: none"> ▪ Aida Girma, UNICEF Country Representative ▪ Dr Matshidiso Moeti, WHO Country Representative ▪ Paul Mecartney, Save the Children Country Office Director ▪ Mr. Kang'ombe – Principal Secretary for Health
14h30	<p>Objective 2: Defining the building blocks of the package: Group work to review and provide feedback on the possible package design in terms of:</p> <ul style="list-style-type: none"> ▪ <i>What</i> (package content) ▪ <i>Linkages with other programmes, e.g.,</i> maternal health programs, ACSD/c-IMCI, PMTCT and paediatric HIV/AIDS (how to operationalise a continuum of care with linkages between key packages and between home and facility) ▪ <i>Who</i> (delivery of the package) ▪ <i>Where?</i> ▪ <i>When?</i> ▪ <i>How</i> (Training, supervision, logistics management, etc.) <p>(see group work sheet for details)</p>	Facilitated by Dr Lawn and Dr Phoya Group 1- Dr Namate and Dr Susan Kambale Group 2 – Dr Noor Alide and Dr. Juan Ortiz Group 3 - Fannie Kachale and Evelyn Zimba
1600	Break	
1615	Group work continues	
17h00	End of day	
DAY 2 – Friday, February 16		
08h00	Tea and coffee	
08h30	Group feedback 10 mins per group 10 mins discussion after each group Plenary discussion 30 mins	Facilitated by Dr Some and Jeanne Russell
10h00	BREAK	
10h15	<p>Objective 3: Maximizing effective scale up: To be able to scale up this package what do we need to do and what do we need to know to guide and accelerate effective scale up?</p> <ul style="list-style-type: none"> ▪ Context and some examples from other African countries testing similar packages. <p>Small group work</p> <ul style="list-style-type: none"> ▪ Questions to be answered by testing in the pilot area (e.g. package design, process, effects on behaviours and care seeking, impact, cost?) ▪ Level of evidence required and possible evaluation designs ▪ When? (When does the pilot begin and end?) 	Facilitated by Dr Some and Jeanne Russell Joy Lawn Group 1 - Dr. Noor Alide and Dr Susan Kambale Group 2 – Dr Joshua and Dr Juan Ortiz Group 3 - Fannie Kachale and Evelyn Zimba

	<ul style="list-style-type: none"> ▪ Where? ▪ Who are the partners? Who will do what? 	
13h00	LUNCH	
14h00	Feedback from small groups Group feedback 10 mins per group 10 mins discussion after each group Plenary discussion 30 mins	<input type="checkbox"/> Facilitated by Dr Some and Shyam Thapa
15h30	BREAK	
15h30	What are the next steps?	<input type="checkbox"/> Facilitated by Fannie Kachale
16h00	Closing remarks	<input type="checkbox"/> Dr M. Joshua/Fannie Kachale MOH <input type="checkbox"/> UNICEF - TBD <input type="checkbox"/> Paul Mecartney
16h15	End of workshop	

Appendix 2: List of Participants

NO	NAME & TITLE	ORGANIZATION & ADDRESS	CELL, TEL FAX, E-MAIL
1.	Kistone Mhango PHC Director	Ekwendeni Mission Hospital P.O.Box 19 Ekwendeni	Cell: 08 333499 Tel: 01 339235/246 Fax: 01333 059 ekwephc@sdp.org.mw
2.	Dr. Dorothy Namate Director of Health & Technical Services	Ministry of Health Box 30377 Lilongwe	Cell: Tel: 01 789 400 Fax: 01 789 365 E-Mail: namated@sdp.org.mw
4.	Mr. Kelvin Nindi National Program Officer - IMCI	Ministry of Health Box 30377 Lilongwe	Cell: Tel: 01 789 400 Fax: 01 789 365 E-Mail:
6.	Dr. Ann Phoya Director – SWAp	Ministry of Health Box 30377 Lilongwe	Cell: Tel: 01 789 400 Fax: 01 789 365 E-Mail:
7.	Dr. Charles Mwansambo Pediatrician	Kamuzu Central Hospital P.O.Box 149 Lilongwe	Cell: 08 826946 Tel: 01 762025 - Home Fax: 01 756380 cmwansambo@malawi.net
8.	Ms. Aida Girma Country Representative	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mail: agirma@unicef.org
9.	Dr. Juan Ortiz Deputy Country Representative	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mailjortiz@unicef.org
10.	Dr. Eliab Some Head of Health & Nutrition Section	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mail: essome@unicef.org
11.	Lucy Kachapila Project Officer	UNICEF Box 30375 Lilongwe	Cell:n09 939 981 Tel: 01 770 788 Fax: 01 773 162 E-Mail: lkachapila@unicef.org
12.	Joyce Mphaya Project Officer	UNICEF Box 30375 Lilongwe	Cell: 08 891 561 Tel: 01 770 788 Fax: 01 773 162 E-Mail: jmphaya@unicef.org
13.	Francesca Munthali Assistant Project Officer	UNICEF Box 30375 Lilongwe	Cell: 08 306 165 Tel: 01 770 788 Fax: 01 773 162 E-Mail: fmunthali@unicef.org
14.	Stanley Chitekwe Project Officer	UNICEF Box 30375 Lilongwe	Cell: 09 964 548 Tel: 01 770 788 Fax: 01 773 162 E-Mail: schitekwe@unicef.org

NO	NAME & TITLE	ORGANIZATION & ADDRESS	CELL, TEL FAX, E-MAIL
15.	Girmay Haile Head of SPAC	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mail: ghaile@unicef.org
16.	Dr. Miriam Chipimo RH/ HIV Unit Head	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mail: mchipimo@unicef.org
17.	Luwei Pearson Maternal & Newborn Health Program Coordinator for Regional Office of East & Southern Africa	UNICEF Box 30375 Lilongwe	Cell: Tel: 01 770 788 Fax: 01 773 162 E-Mail: lpearson@unicef.org
19.	Fannie Kachale Acting Deputy Director	MOH- RHU Lilongwe	Cell: 08 586 485 Tel: 01 751 552 Fax: 01 751 539 E-Mail: fankachale@yahoo.co.uk
20.	Diana Khonje Principal Reproductive Health Officer	MOH-RHU Lilongwe	Cell: 09 411 400 Tel: 01 751 552 Fax: 01 751 539 E-Mail: Dianakhonje90@yahoo.co.uk
21.	Lilly Banda Maliro Reproductive Health Specialist	USAID Box 30455 Lilongwe 3	Cell: Tel: 01 772 455 Fax: E-Mail
23.	Catherine Chiphazi Child Health Advisor	USAID Box 30455 Lilongwe 3	Cell: 09 960 017 Tel: 01 772 455 Fax: 01 773 181 E-Mail: cchiphazi@usaid.gov
27.	Dr. Matshidiso Moetie Country Representative	W.H.O. Box 30390 Lilongwe 3	Cell: Tel: 01 772 215 /755 Fax: 01 772 350 E-Mail: moetim@afro.who.int
28.	Puline Simwaka		Cell: Tel: Fax: E-Mail
29.	Dr. Susan Kambale Project Officer	W.H.O. Box 30390 Lilongwe 3	Cell: Tel: 01 772 215 /755 Fax: 01 772 350 E-Mail: kambales@afro.who.int
30.	Desiree Mhango Director of Health Programs	CHAM Box 30378 Lilongwe	Cell: Tel: 01 775 404 Fax: 01 775 406 E-Mail
31.	Mrs. Jacintha Mtengezo	Nurses & Midwives Council Box 30361 Lilongwe	Cell: 08 863 080 Tel: 01 772 044 Fax: 01 773 932 / 01931 E-Mail: jmtengezo@yahoo.co.uk

NO	NAME & TITLE	ORGANIZATION & ADDRESS	CELL, TEL FAX, E-MAIL
32.	Mrs. Asernia J. S Banda	Women & Children First (Perinatal Care) C/O Ntcheu DHO Ntcheu	Cell: 09 292 504 Tel: Fax: 01 235 459 E-Mail
33.	Stewart Mwalabu	The Health Foundation Manobec Complex P/Bag 418 Lilongwe 3	Cell: 08 206 892 Tel: Fax: 01 754 103 E-Mail:
34.	George Chiundu NBH M & E Officer	Save the Children P.O.Box 30374 Lilongwe	Cell: 09 234662 Tel: 01 753888 Fax: 01 756257 gchiundu2001@yahoo.com
35.	Dr. Martius Joshua Zonal Officer	Dowa District Hospital Dowa	Cell: 09 912 683 Tel: 01 282 222 Fax: 01 282 200 E-Mail
36.	Dr. Noor Alide DHO Thyolo	Thyolo Hospital Box 21 Thyolo	Cell: 08 366 786 Tel: 01 473 411 Fax: E-Mail
37.	Dr. Alexandra Pipek Zonal T/A	P/Bag 1 Mzuzu	Cell: 08 554 208 – Dr. Gonani Cell: Dr. Alexander Pipek : 09 158 676 Tel: Fax: 01 331 883 E-Mail: agonano@yahoo.com E-Mail: pipeka@yahoo.co.uk
38.	Leonard Banda Acting Zonal Officer South West	Blantyre	Cell: 08 339 050 / 09 683 693 Tel: 01 872 130 Fax: 01 872 551 E-Mail: banda_leonard@yahoo.com
39.	Dr. Ellen Mbweza	Kamuzu College of Nursing Box 415 Blantyre	Cell: 08 940 513 Tel: Fax: 01 756 424 E-Mail: embweza@kcn.unima.mw
40.	Dr. Pat Walker	College of Medicine Blantyre	Cell: 09 796 772 Tel: Fax: E-Mail: pat.awalker@yahoo.co.uk
41.	Mrs. Madalo Malemba	Malawi College of Health Sciences Box 30368 Lilongwe 3	Cell: 09 945 244 Tel: 01 756 777 Fax: E-Mail: madalomalemba@yahoo.com
42.	Loveness Kaunda NBH Project Assistant	Save the Children Box 30374 Lilongwe	Cell: 09 957 054 Tel: 01 753 888 Fax: 01 756 257 E-Mail: lkaunda@llmw.savechildren.org
43.	Steve Wall Snr Newborn Health Advisor	Save the Children Box 30374 Lilongwe	Cell: Tel: Fax: E-Mail: swall@dc.savechildren.org

NO	NAME & TITLE	ORGANIZATION & ADDRESS	CELL, TEL FAX, E-MAIL
44.	Shyam Thapa Associate Director of Policy & Program Research	Save the Children Box 30374 Lilongwe	Cell: Tel: Fax: E-Mail: SThapa@dc.savechildren.org
45.	Joy Lawn Snr research & Policy Advisor	Save the Children Box 30374 Lilongwe	Cell: Tel: Fax: E-Mail: joylawn@yahoo.co.uk
46.	Jeanne Russell Deputy Director - Programs	Save the Children Box 30374 Lilongwe	Cell: 08 206 848 Tel: 01 753 888 Fax: 01 756 257 E-Mail: jrussell@llmw.savechildren.org
47.	Paul Mecartney Country Director	Save the Children Box 30374 Lilongwe	Cell: 08 206 828 Tel: 01 753 888 Fax: 01 756 257 E-Mail: pmcartney@llmw.savechildren.org
48.	Rueben Ligowe NBH Program Officer	Save the Children Box 30374 Lilongwe	Cell: 08 508 538 Tel: 01 753 888 Fax: 01 756 257 E-Mail: rligowe@llmw.savechildren.org
49.	Evelyn Zimba NBH Program Manager	Save the Children Box 30374 Lilongwe	Cell: 08 277 091 Tel: 01 753 888 Fax: 01 756 257 E-Mail: ezimba@llmw.savechildren.org
50.	Maggie Kambalame NBH Project Officer	Save the Children Box 30374 Lilongwe	Cell: 08 308 064 Tel: 01 753 888 Fax: 01 756 257 E-Mail: mkambalame@llmw.savechildren.org
51	Kumbukani Kuntiya WRA	Save the Children Box 30374 Lilongwe	Cell: 08 866 033 Tel: 01 753 888 Fax: 01 756 257 E-Mail
52	Ellious Chasukwa HAC	Christian Health Association of Malawi Box 30378 Lilongwe 3	Cell: 09 948 583 Tel: 01 775 180 Fax: 01 775 406 E-Mail: echasukwa@cham.org.mw
53	Hilda Chapota HSSO	Maimwana Project Box 2 Mchinji	Cell: 08 393 486 Tel: 01 242 476 Fax: E-Mail: maimwana@malawi.net
54	Martha Mondywa Acting Registrar	Nurses & Midwives Council Box 30361 Lilongwe	Cell: 09 407 207 Tel: 01 772 044 Fax: 01 773 932 E-Mail: nmcm@malawi.net

NO	NAME & TITLE	ORGANIZATION & ADDRESS	CELL, TEL FAX, E-MAIL
57	Sipho Jale Acting Project Manager	Maimwana Project Box 2 Mchinji	Cell: 08 879 285 / 09 705 995 Tel: 01 242 476 Fax: E-Mail: tsjale@yahoo.com
58	Michele Usuelli Cesta Med. Coordinator	Cestas Cestas Box 20479 Lilongwe 2	Cell: 08 591 895 Tel: cestas@malawi.net Fax: E-Mail
59	Felitus Siyamada Enrolled Nurse Midwife	Kamuzu central Hospital Box 149 Old Wing Lilongwe	Cell: Tel: 01 791 094 Fax: E-Mail
60	Dr. Sinyiza DHO	Mzimba district Hospital Mzimba	Cell: Tel: Fax: E-Mail
61	Mr. Enock Bonongwe	Ministry of Women Lilongwe	Cell: 08 851 746 Tel: Fax: E-Mail: ebonongwe@yahoo.co.uk
62	Dr. Bejoy Nambiar	THFC, Area 4 Manobec Complex Lilongwe	Cell: 08 748 486 Tel: Fax: E-Mail: b.nambiar@ich.uch.ac.uk
63	Elsie Chitedze Project Assistant	UNICEF Box 30375 Lilongwe	Cell: 08 868 905 Tel: 01 770 788 Fax: 01 773 162 E-Mail: echitedze@unicef.org
64	Dr. Bernadette Dealman	W.H. O Geneva	Cell: Tel: Fax: E-Mail
65	Dr. Mamadou Diallo	W.H.O Geneva	Cell: Tel: Fax: E-Mail
66.	Dr. Andrew Mbewe	W.H.O. Regional Office for Africa Congo Brazavill	Cell: Tel: Fax: E-Mail

Appendix 3: Summary of Group Work on Newborn Package of Care

Group 1 Work

What	Who	When	Where	How
<i>ANC</i>	Female HSAs	ANC	Health post	Using check list
<ul style="list-style-type: none"> Map of all women of child bearing age Listing all pregnant women Visit each pregnant women, one for each trimester (first trimester visit may not always be possible) Involving men Community support mechanisms (chiefs, monthly women group meetings, birth preparedness, clean delivery, emergency referral, promotion of skilled birth) 	(ANC, PNC) 1: 1,000 population	Child birth	Home	Female HSAs from the same location
<i>child birth</i>	TBAs (inevitable home birth)	PNC		Community nurse and nurse midwife are supervisors of HSAs
<ul style="list-style-type: none"> Reorient roles of TBAs - TBAs to accompany mothers delivering in health facilities with incentives (200 MK) Awareness of obstetric danger signs and timely referral to a skilled care provider by TBAs and HSAs Inevitable home births (clean delivery and simple immediate newborn care) – link to birth preparedness Timely recognition and referral of obstetric complications – link up with upgrading health facilities 	Community mobilizers – try to use the existing ones			Upgrade health facilities for EmONC, IMNCI, BFHI, PMTCT
<i>postpartum</i>	Chiefs			
<ul style="list-style-type: none"> Linkages between facility and HSAs in order to get information of ‘mother/baby coming home’ Support good care practices at home – breastfeeding, hygiene, warm (skin to skin), cord and eye care, birth spacing) Reinforce the practice of routine PNC and pre-discharge check up for mother/baby Recognizing maternal and newborn danger signs through home visit using a checklist <ul style="list-style-type: none"> Home birth (day 0, 1, 3, 7, 14, 28) – formative research to find out most 	Women groups			
	Other community workers			

What	Who	When	Where	How
<ul style="list-style-type: none"> feasible timing and frequency of visit <ul style="list-style-type: none"> ○ Facility birth (first visit within 24 hours after discharge, 1, 3, 7, 14, 28) ○ High risk baby needs more visits • Identification and treatment of infection at home or refer to HSAs (Oral and Injectable), supervised by the health center team (HSAs are giving EPI so have the skills), HSAs are trained in and have been delegated to handle all ESP package) - WHO IMCI algorithm? 				

Group 2 Work

What	Who	Where	How
<ul style="list-style-type: none"> • Health education [ANC; HIV (PMTCT); Nutrition; Danger signs; Birth preparation; male involvement; Breastfeeding; Hygiene] • Clean delivery • Resuscitation • Thermal care (dry immediately; delay bathing) • Recognition and detection of danger signs and referral • Exclusive Breastfeeding; • Cord management; • Infection prevention; • Prompt treatment of infection 	<p><u>Criteria for mother-newborn care giver:</u></p> <ul style="list-style-type: none"> • Lives within the community • Can care for the mother and newborn individually or part of a team • Should be [paid or] given incentives to motivate and ensure retention and continuation of services • Select in consultation with the community members to ensure acceptability and respect • Be part of the team that ensure continuum of care home-community-facility <p><u>At community level:</u></p> <ul style="list-style-type: none"> • HSA, preferably female • CHDs volunteers • Mother-Baby Care Workers (Mai-Mwana Care Giver) • TBAs • VHC – members • Women groups 	<p><u>EHP/ACSD delivery strategies:</u></p> <ul style="list-style-type: none"> • Family/Household care practice: • Home visit by workers • Village Clinic Days • Outreach/mobile services • Facility-based (EPI+; ANC+; Maternity; PNC; MCH) • Child Health Days • HTC week <p><u>Family/Household care practice:</u></p> <ul style="list-style-type: none"> • Birth attendant to know what to do with a none breathing baby; • Provide performance-based incentives for every newborn successfully cared for. • Team may vary from community to community but consists of HAS, TBA, <i>Mai-Mwana</i> worker; VHC members and women groups. 	<ul style="list-style-type: none"> • Home visits by CHW • Strengthen capacity and community level • Referral should be for both emergency obstetric care and newborn care • Refer for injections at the nearest health facility • Revise the VHR to include parameters important for the new born care.

Group 3 Work

What	Who	Where	When	How
1. PMTCT	HSAs, TBA	Sensitization- Community VCT/other components- Health facility	Pre natal Post natal - day 1, 3	Policy and guidelines to be put in place
2. IM Antibiotics	HSAs	Community – identification Referral to Health facility	Post-natal	
3. Ambu Bag	HC, focus to DH, RH, HC	Health facility	Post delivery	
4. Prevention of Hypothermia	TBA, HSAs	Home/community referral	Post natal	
5. Breastfeeding	TBA, HSAs	Home/community referral	Post natal	
6. Skin to skin care (KMC)	TBA, HSAs	Home/community referral	Post natal	
7. Clean delivery	TBA	Home/community referral	Delivery	
8. Clean cord care	TBA, HSAs	Home/community referral	All the time from delivery to postnatal period	
9. Birth preparedness	TBA, HSAs	Home/community referral	Pre-natal	
10. Immunisation	HSAs	Community Health Centre	Soon after birth	
11. Post natal check ups	HSAs,TBA, Health worker	Home/community Encourage health facility visit	Day 1, 3, 7, 6 weeks	
12. Special care for pre term/low birth weight	Home, HSAs, TBA, HC	Home/community referral	Day 1, 3, 7, weekly follow up until 2.kgs	
13. Assist care of the newborn at delivery	HSAs, HC	TBA	Immediately after delivery	

What is needed?

1. Checklist for administering of antibiotics (how many to consider, for how long treatment, need for policy change)
2. Low birth weight baby – need for checklist for pre term and low birth weight babies
3. HSAs – need to recruit more female HSAs
4. Need for community mobilization

Tested Models of Community-Based Newborn Health Care: Evidence and Experience from South Asia						
Package	Baseline/Context	Design	Content	Delivery Strategy	Results	Lessons
Home-based neonatal care (HBNC)^{1,2} SEARCH (India)	- NMR > 60 - Facility delivery 5% - Established relationship between SEARCH and Gadchiroli villages	- Before and after mortality - Non-intervention areas as comparison	- Pregnancy surveillance - Antenatal counseling - Newborn care at delivery - Birth asphyxia management - Special care for preterm & LBW - Sepsis identification & management (Cotrim + Gent)	- CHW routine home visits (8); additional visits for high risk - Trained TBAs for deliveries - Group session for pregnant women - Medical supervision every 2 weeks - Performance-based incentives	- Neonatal mortality: NMR ↓ 62% in 3rd yr - Sepsis case fatality: CFR ↓ 58% - Asphyxia specific NMR declined - Cost: \$5.30 USD per newborn	- Mortality surveillance helped to sensitize and mobilize communities - Helpful to integrate with community management of ARI man - Links with TBAs enabled high CHW attendance at deliveries
Home-based neonatal care (HBNC)³ Ankur NGO (India)	- NGO area baseline NMR 32 – 69 - Facility deliveries range from <10% (tribal) to around 50% (urban)	- Before and after mortality - No controls	- Same as SEARCH (changed from tube-mask to bag-mask)	- Same as SEARCH except two fewer routine CHW postnatal visits	- Neonatal mortality: NMR ↓ 51% in 3 yrs - Coverage: 90% received at least 4 CHW post-natal visits	- High coverage possible in various NGO settings - Importance of NGO management & leadership
Community management of newborn infection⁴ MINI (Nepal)	- NMR 39 - Facility delivery 9% - High coverage of c-IMCI & community management of ARI	- Before-after study of feasibility & coverage for newborn sepsis with appropriate antibiotics - Comparison non-intervention area - Cohort study of sepsis cases	- Volunteer: 1 st day counseling on danger signs - Volunteer: identifies sepsis + cotrim + referral for injection Gent - CHW: injects gent x 7d	- Existing health system: female community health volunteers + government peripheral health workers (CHW)	- Coverage: among possible severe bacterial infections, 90% received Gent injections, 80% received 7 doses Gent	- Acceptable to families, volunteers, and health providers - Volunteers weighing newborns facilitated demand for early (Day 0) visit
Home Newborn care package⁵ Sylhet (Bangladesh)	- NMR 49 - Facility delivery 8%	- Cluster randomized controlled trial	- CHW pregnancy surveillance - 2 antenatal visits - Postnatal visits days 1, 3, 7 - Newborn sepsis mgmt (PCN + Gent)	- Paid CHWs provide pregnancy surveillance, counseling, newborn visits - Community group education sessions - Strengthened health facilities	- Neonatal mortality: NMR ↓ 43% in 3rd yr - Practices: rapid and large improvement in household practices ⁶	- CHW attendance at delivery big challenge - Sick infants identified by home visits much more than via care-seeking by families
Clinic-based newborn care Package⁵ Sylhet (Bangladesh)	- NMR 49 - Facility delivery 8%	- Cluster randomized controlled trial	- Community mobilization + education sessions - (No CHW home visits) - Health facility strengthening	- Paid male & female community mobilizers - Strengthened health facilities	- Neonatal mortality: NMR ↓ 9% (NS) in 3rd yr - Practices: modest & slow improvements in household practices & care-seeking	- Intervention without home visits, relying only on improved care-seeking, is slow to achieve impact

Tested Models of Community-Based Newborn Health Care: Evidence and Experience from South Asia						
Package	Baseline/Context	Design	Content	Delivery Strategy	Results	Lessons
Integrated newborn health package in existing system ⁷ Hala (Pakistan)	- NMR 42 - Facility delivery 26% - Lady Health Workers (LHW) cover 60-70% of population - Home deliveries attended by TBA	- Cluster randomized controlled trial (pilot)	- Pregnancy surveillance - 2 LHW antenatal visits - 5 LHW postnatal visits - ENC messages and basic care by LHWs - Newborn sepsis management in facilities	- Existing system of LHWs + additional CHWs where LHW coverage is low - Community health committees (CHC) to address emergency transport	- Neonatal mortality: NMR ↓ 16% in one year - Practices: increased deliveries with skilled attendant	- Delivery attendance by LHW is challenge - Community emergency transport fund possible (but difficult) - Both 'supply' and 'demand' should be addressed
Participatory women's groups to improve newborn health ⁸ Makwanpur (Nepal)	- NMR 39 - Facility delivery 4%	- Cluster randomized controlled trial	- Women's group action cycle: problem identification, prioritization, planning to address causes of maternal/newborn mortality	- Paid facilitators for women's groups - Health system strengthening	- Neonatal mortality: NMR ↓ 30% after 2 yrs - Significant reduction in maternal mortality - Improved ANC, hygienic care, trained birth attendant - Cost: \$0.90 per person per year ⁹	- 'Direct' coverage of only 31% of pregnant women attending any group suggests intervention may have changed norms for household practices
Community mobilization and BCC to improve newborn health ¹⁰ Shivgarh (India)	- NMR 62 - Facility delivery 12%	- Cluster randomized controlled trial	- Pregnancy surveillance - Community mobilization and BCC around key messages: birth preparedness, clean delivery, immediate breastfeeding, skin-to-skin care, clean cord & skin care	- Paid CHWs + volunteer community activists - Community meetings (targeting community gatekeepers) - Home visits: 2 antenatal, 2 postnatal (Days 0/1 + 2/3)	- Neonatal mortality: NMR ↓ 50% after 18 mos - Near universal acceptability and practice of skin-to-skin care ¹¹	- Community mobilization facilitated rapid acceptance, use, and 'demand' for improved care practices

1. Bang et al. Lancet 1999.

2. Bang et al. J Perinatol suppl 2005.

3. Bang, A. Unpublished. PLEASE DO NOT CITE.

4. Dawson et al. Poster. Pediatric Academic Societies, San Francisco, 2006.

5. Baqui et al. Unpublished. PLEASE DO NOT CITE.

6. Baqui et al. Poster. Countdown to Child Survival, London, 2005.

7. Mennon et al. Poster. Countdown to Child Survival, London, 2005.

8. Manandhar et al. Lancet 2004.

9. Borghi et al. Lancet 2005.

10. Darmstadt et al. Poster. Countdown to Child Survival, London, 2005.

11. Darmstadt et al. J Perinatol. 2006.

Annex XII
Executive Summary of IMCI Five-Year Strategic Plan



IMCI five-year strategic plan for accelerated child survival and development in Malawi:

Scaling up high impact interventions in the context of Essential health package, 2006 – 2011

EXECUTIVE SUMMARY

INTRODUCTION

Children under five years of age bear a disproportionately higher burden of disease and death than adults in the world. Globally, nearly 11 million child deaths occur every year, most of them (98%) in the world's poorest countries in sub-Saharan Africa and Asia. Seven in ten deaths (70%) in children under-five can be attributed to one or a combination of the following: diarrhea, acute respiratory infections (especially pneumonia), measles, malaria and other fevers, and malnutrition. Malnutrition is associated with 54% of all child deaths. Recent studies have shown that approximately 63% of child deaths could be prevented by achieving universal coverage with high impact interventions. Malaria accounts for 40% (4.2 million episodes of illness) of all outpatient visits. Anaemia, most of which is considered to be attributed to malaria, is estimated to be responsible for about 40% of all under five hospitalisation and 40% of all hospital deaths in under five children (World Bank report 2000). Upper respiratory tract infections contributes 12% (1.26 million episodes), and diarrhea diseases, 7% (730,000 episodes). Malnutrition is endemic with 60% of the children chronically malnourished. In addition the HIV and AIDs epidemic has exacerbated these conditions, it is estimated that 80,000 children < 0-14 years are infected with HIV and less than 5% (6,000) are on Anti-retroviral therapy. A follow up survey on family care practices that promote child health and development (2004) revealed that 60% (163,000) of under-five deaths are occurring at home. The main contributing factors include distance to the health facilities, poor health care seeking behavior, poor hygiene practices and non compliance to health worker advice.

This Five-Year Strategic Plan spells out how the Government of Malawi will scale up the high impact interventions to more children and mothers in all villages in Malawi more quickly, more equitably, and more lastingly. Scaling up will ensure universal coverage to all villages and to reach the MDGs of reducing child mortality and child malnutrition. The formulation of the IMCI policy and the five-year strategic plan for ACSO has been guided by (a) the MDGs and the human rights based approach to programming, (b) implementation within the context of the EHP and SWAP, (c) decentralization of operational decisions to local assembly and the community levels, (d) consideration of the multiplicity of partners essential for the comprehensive child survival, growth and development, (e) recognition of existing policies and programmes addressing child survival and development issues.

VISION

To keep all children in Malawi healthy and free from all common childhood illnesses so as to survive, grow and develop to their full potential.

MISSION

To provide holistic and integrated services for the survival, growth and development of children under-five years of age

GOAL

The goal of the IMCI policy is to contribute to the reduction of childhood morbidity and mortality by two thirds between 2000 and 2015 in Malawi.

OBJECTIVES

- (1) All children suffering from common illnesses managed holistically at out-patient and in-patient of health facilities and at home.
- (2) All health facilities have at least two IMCI trained health service providers; supplied with all essential drugs and supplies; and have adequate transportation and communication systems for effective management of common childhood illnesses.
- (3) Eighty percent of households practice all the key care practices of IMCI.
- (4) All IMCI partners support efforts to scaling up and maintain universal coverage of a standardized minimum package of maternal, newborn and child high impact interventions using the IMCI approach through a managed partnership.

KEY RESULTS

By 2011

- (1) 95% of infants will receive full range of routine EPI antigens by their first birthday from the 2005 baseline of 63%
- (2) 90% of pregnant women will receive two doses of tetanus toxoid vaccine from the 2005 baseline of 66%
- (3) 80% of pregnant women will receive two doses of SP for prevention of malaria from the 2004 baseline of 66%
- (4) 70% children under 5 children and PW will sleep under ITNs from the 2005 baseline of 60%
- (5) 80% of health facilities will be able to manage common childhood illnesses according to national guidelines from the 2005 baseline of 50%
- (6) 75% of households will use/demonstrate key child care practices (Use of ORS, Prompt treatment of fever, Use of ITN & Vit A). "A" supplementation) from the 2004 baseline of 50%
- (7) 75% of infants will be exclusively breastfed for ≥ 6 months from the 2004 baseline of 53%

- (8) 98% of children aged 6-59 months receive one dose of Vitamin “A” every six months from the 2005 baseline of 95%
- (9) 95% of children aged 6-59 months will receive one dose of anti-helminths drug every 6 months from the 2005 baseline of 10%
- (10) 80% and 70% of the population will have sustained access to safe drinking water and sanitation respectively from the 2004 baseline of 67% for water and 46% for sanitation)

KEY OUTPUTS

Outputs	Baseline	2006/07	2007/08	2008/09	2009/10	2010/11
1. Number of districts oriented to new the IMCI policy and strategic plan	0	28	28	28	28	28
2. Number of districts covered with all components	13	28	28	28	28	28
3. Number of districts covered with component 1 and 2	17	28	28	28	28	28
4. Number of Traditional Authorities/ADCs covered with IMCI	39	100	161	161	161	161
5. Number of community leaders oriented in IMCI	1,170	3,000	4,830	4,830	4,830	4,830
6. Number of villages with component 3	2,400	15,000	20,000	30,000	35,000	40,000
7. Number of health workers trained in IMCI	2,179	3,691	5,202	5,202	5,202	5,202

ACCELERATION

This term is used to refer to **three dimensions of programming**. The first dimension is the deliberate decision taken to strategically and realistically select those strategies and activities which will be funded and implemented within three years for processes (training, formation of committees, support groups and other structures) and within five years for reaching every village with implementation (availability of goods and access to services at village/community level). The second dimension is the selection of strategies to be employed to reach all children and women in all villages. These delivery strategies have been derived and amplified from those developed for EHP: **(a)** home visits, **(b)** village clinic days, **(c)** village feedback meetings, **(d)** community facility inspections, **(e)** mobile/outreach programme/services and **(f)** facility-based services. The third dimension is the packaging of the high impact interventions into packages to be delivered in an integrated manner according to the delivery strategies/outlets. The IMCI Strategic plan contains these packages in the delivery strategies.

DELIVERY STRATEGIES

Delivery strategies ¹ for high impact maternal, child and newborn interventions in Malawi	
A.	Home/Family and Community-based interventions
A1.	Disease prevention <ol style="list-style-type: none"> 1. ITNs for children under-five and pregnant mothers 2. Exclusive Breastfeeding and awareness of infant feeding options for HIV positive mothers 3. Complementary feeding 4. Water, sanitation and hygiene practices (Disposal of all faeces safely, and washing your hands with soap after defecation, and before preparing meals and feeding children) 5. Family planning and HIV testing promotion
A2.	Treatment <ol style="list-style-type: none"> 6. Home care for sick child 7. Prompt care seeking (with 24 hours) 8. Adherence to treatment prescribed
A3.	Social and mental development <ol style="list-style-type: none"> 9. Recognition of the four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc), 10. Prevention of child abuse/neglect and taking appropriate action whenever it occurs 11. Stimulation of the child through talking, playing, and other appropriate physical and emotional interactions appropriate for the age
B.	Home Visit by Health Surveillance Assistants (HSAs) and other extension workers
B1.	To a household with a baby delivered/delivering at home <ol style="list-style-type: none"> 1. Be present at to ensure clean delivery or immediately after to assess. 2. Emergency newborn care (i.e. resuscitation) and refer 3. Dry, wrap and skin to skin 4. Immediately breastfeed and encourage exclusive breastfeeding 5. Cord care and temperature management 6. Assess weight, temperature and refer for vaccination 7. Register in the Village Health Register 8. If low birth weight: give extra care – Kangaroo care; keep warm; assist with feeding and hygiene; inform to look for danger signs 9. If known HIV positive status of mother, ARVS for prevention of mother to child transmission within 72 hours of birth
B2.	To a household with a mother delivering/delivered at home <ol style="list-style-type: none"> 1. Clean delivery 2. Assess bleeding, temperature and breast problems, if necessary for emergency obstetric care 3. Refer for post-partum check up within 72 hours 4. Discuss danger signs, 5. Nutrition counseling and family planning 6. Postpartum Vitamin A 7. Known HIV status of mother/father
B3.	Children birth to 2 months <ol style="list-style-type: none"> 1. Essential newborn care (weight, temperature, feeding, cord care) 2. Assessment of young infants for infection and diarrhoea 3. Treatment and referral when required (antibiotics - oral for pneumonia, oral plus injectable for very severe disease; and ORT) 4. Extra care (Kangaroo mother care) for LBW infants 5. Support for initiation of early and exclusive breastfeeding and correction of problems 6. Home care practices and danger sign awareness for the sick newborn 7. If known HIV positive status of mother, ARVS for prevention of mother to child transmission within 72 hours of birth 8. Referral to CTC for severely malnourished

¹ Delivery strategies refer to approaches to reach most children and mothers.

Delivery strategies¹ for high impact maternal, child and newborn interventions in Malawi	
B4. Children 2 month to 5 years	<ol style="list-style-type: none"> 1. Integrated case management of the five most important causes of childhood deaths (Acute respiratory infections (ARI); Diarrhea; Measles; Malaria; Malnutrition ; and Other serious infections) 2. Vitamin A 3. Anti-helminthic treatment 4. Breastfeeding and complementary feeding counseling 5. Family/community education 6. Promote home care practices 7. Promotion for immunization 8. Co-trimoxazole prophylaxis and testing for HIV at 18 months for HIV exposed 9. Referral to CTC severely malnourished and SFP for moderately malnourished.
C. Village Clinic Day by HAS	<ol style="list-style-type: none"> 1. Treatment of minor ailments 2. Antenatal care 3. De-worming 4. Growth monitoring and nutrition promotion 5. Breastfeeding and complementary feeding counseling 6. Referral for HIV interventions
D. Health Facility-based interventions – Outreach/Mobile Services	<ol style="list-style-type: none"> 1. Holistic case management 2. Vaccination (EPI) 3. ITN 4. IPT 5. De-worming 6. Post-partum vitamin A 7. Counseling on breastfeeding, complementary feeding, family planning and vaccinations 8. Referral for HIV interventions
E. Health facility-based interventions – Health Centres and Hospitals	
E1. EPI plus	<ol style="list-style-type: none"> 1. Vaccination 2. Vitamin A 3. Counseling on BF, CF 4. ITNs
E2. ANC plus	<ol style="list-style-type: none"> 1. Focus ANC (TT, Iron and folic acid, BP, Urine for proteins, Foetal lie, Syphilis and other STI detection and treatment, PMTCT (HIV counseling, testing and provision of ARVs), IPT, management and/or referral for obstetric complications. 2. ITNs 3. Breastfeeding and complementary feeding counseling
E3. Maternity (adjust to health centre and hospital)	<ol style="list-style-type: none"> 1. Six signal functions (Antibiotics (parenteral); Oxytocic drugs (parenteral); Anticonvulsants (parenteral); Manual removal of the placenta; Removal of retained products; Assisted vaginal delivery (vacuum extraction or forceps); 2. Cesarean section and blood transfusion, if necessary 3. Neonatal resuscitation with bag and mask 4. Assisted ventilation (hospital only) 5. Hypothermia Management (re-warming) 6. Antibiotics for neonatal sepsis (injectable) 7. Essential newborn care 8. Immediate and exclusive breastfeeding 9. Post-partum Vitamin A 10. PMTCT (HIV counseling, testing and provision of ARVs)
E4. In-patient facilities (Paediatric Wards, etc)	<ol style="list-style-type: none"> 1. Integrated case management of the five most important causes of childhood deaths (Acute

Delivery strategies¹ for high impact maternal, child and newborn interventions in Malawi	
	<ul style="list-style-type: none"> respiratory infections (ARI); Diarrhea; Measles; Malaria; Malnutrition ; and Other serious infections) 2. Neonatal resuscitation with bag and mask 3. Assisted ventilation (hospital only) 4. Paediatric HIV care and support 5. Co-trimoxazole prophylaxis and testing for HIV at 18 months for HIV exposed 6. Stimulation of the child through talking, playing, and other appropriate physical and emotional interactions appropriate for the age 7. Recognition of the four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc), 8. Vitamin A supplementation 9. De-worming
E5	<p>Nutrition Rehabilitation Units (NRUs)</p> <ul style="list-style-type: none"> 1. Integrated case management of the five most important causes of childhood deaths (Acute respiratory infections (ARI); Diarrhea; Measles; Malaria; Malnutrition ; and Other serious infections) 2. Management of severely malnourished and referral to and from CTC programmes 3. De-worming 4. Post-partum vitamin A 5. Counseling on breastfeeding, complementary feeding, family planning and vaccinations 6. Referral for HIV interventions
F.	Mass campaigns
F1.	<p>Child Health Days</p> <ul style="list-style-type: none"> 1. Vaccination 2. Vitamin A and other micronutrients 3. De-worming 4. Health education and promotion of family and community key care practices, including PMTCT and paediatric HIV/AIDS care and treatment
F2.	<p>SADC Malaria Week</p> <ul style="list-style-type: none"> 1. ITNs for children under-five and pregnant mothers 2. Re-treatment of ITNs 3. De-worming 4. Health education and promotion of family and community key care practices, including PMTCT and paediatric HIV/AIDS care and treatment 5. Vitamin A and other micronutrients
F3.	<p>Mass media (TV, Radio, Newspapers, etc)</p> <ul style="list-style-type: none"> 1. Food diversification 2. Children protection against neglect and abuse 3. Vital registration 4. PMTCT and Paediatric HIV/AIDS care and treatment
F4	Any other events selected by the District IMCI TWG
G.	Community Based Child Care Centres
	<ul style="list-style-type: none"> 1. Stimulation of the child through talking, playing, and other appropriate physical and emotional interactions appropriate for the age 2. Recognition of the four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc), 3. Prevention of child abuse/neglect and taking appropriate action whenever it occurs 4. Identification and enrolment of OVCs to CBCCCs 5. Growth monitoring and supplementary feeding 6. Vitamin A supplementation 7. De-worming 8. Co-trimoxazole prophylaxis and testing for HIV at 18 months for HIV exposed 9. Water, Sanitation and Hygiene
H.	Other delivery strategies (as articulated by various sectors)
H1.	Child Protection Committees

Delivery strategies¹ for high impact maternal, child and newborn interventions in Malawi

1. Recognition of the four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc),
2. Prevention of child abuse/neglect and taking appropriate action whenever it occurs
3. Psycho-social care for OVC
4. Paediatric HIV care and support

H2. School Health Programme

1. Water, Sanitation and Hygiene
2. De-worming
3. Recognition of the four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc),
4. Prevention of child abuse/neglect and taking appropriate action whenever it occurs
5. Paediatric HIV care and support

H3. Others delivery strategies identified by sectors

ANNEX XIII

Beneficiary Calculation Worksheet-2007 Projections

Beneficiary Population Groups	Malawi National Program	Selected MOH Demonstration Districts			Mchinji (Mai Mwana)	Mzimba		
		Chitipa	Thyolo	Dowa		Total Mzimba	Ekwendeni	Non-Ekwendeni
Total Population	13,187,632	168,880	592,630	511,448	440,162	614,453	70,000	544,453
Women 15-49	3,165,032	40,531	142,231	122,748	105,639	147,469	16,800	130,669
Pregnant Women	456,460	7,363	25,839	22,299	19,191	26,790	3,052	23,738
Children 24-59 mos.	1,516,578	19,421	68,152	58,817	50,619	70,662	8,050	62,612
Children 0-23 mos.	1,120,949	14,355	50,374	43,473	37,414	52,229	5,950	46,279
Children 12-23 mos.	527,505	6,755	23,705	20,458	17,606	24,578	2,800	21,778
Children 0-11 mos.	593,443	7,600	26,668	23,015	19,807	27,650	3,150	24,500
Newborns	44,274	567	1,990	1,717	1,478	2,063	235	1,828

Source: *Statistical Yearbook 2006* Population Projections based on 1998 census, National Statistics Office, <www.nso.malawi.net>.

Breakdowns for women 15-49 based upon the national proportion of this population segment in the 1998 census.

Pregnant women estimate by taking 77% of annual live births (40/52) + 77% of annual neonatal deaths, approximately equal to stillbirths.

Newborns (0-28 days) estimated by taking 7.7% of annual live births, or 28/365.

NMR=31/1,000/CBR=43/1,000 from *Malawi Multiple Indicator Cluster Survey 2006 Preliminary Report*, Nat'l Statistical Office, 2007.

Children 24-59 months calculated as 11.5% of total population; children 12-23 months as 4% and children 0-11 months as 4.5%.

Note: Figures are "point in time" at the beginning of the project rather than 2007 annual figures; e.g. at the beginning of the project, the project will be addressing 44,274 newborns.

ANNEX XIV
SAVING NEWBORN LIVES
BEHAVIOURS RELATED TO INTRAPARTUM PERIOD

AUDIENCE	BEHAVIOR	KEY FACTORS	ACTIVITIES
In order to help	To:	We will focus on:	Through (Still under revision)
All pregnant women	Report to health facility/ TBA at onset of labour for delivery.	<ul style="list-style-type: none"> ▪ Increasing awareness on the importance of family members/community to have pre-arranged transport before labour starts. ▪ Encouraging decision makers to authorize pregnant mother(s) to report to a delivery place in their absence to ensure peace of mind and gain recognition. ▪ Increasing perception that a good mother seeks care for delivery early to have a live and healthy baby whether one perceives pain or not. ▪ Increasing awareness that reporting at onset of labour will ensure carefully monitored labour that will lead to a healthier baby despite long stay in hospital. 	<ul style="list-style-type: none"> ▪ Health talks (utilizing IEC materials). ▪ Mass Health Education campaign ▪ Ono-to-one counseling ▪ Establishment of transport committee ▪ Conduct Village Health Meetings ▪ Orient influential leaders ▪ Assessment of already existing transport systems in the communities
All health workers/trained TBAs and untrained TBAs	Practice proper infection prevention during labour and delivery. (Note: Dependant on availability of adequate supplies-SMP contribution/MOHP/SNL input)	<ul style="list-style-type: none"> ▪ Motivating the DHMT to solicit strategic materials for infection prevention. ▪ Encouraging health workers to use infection prevention practices learned. 	<ul style="list-style-type: none"> ▪ Holding ward meetings ▪ Establishing cleaning squads e.g. labour ward ▪ Displaying & communicating IP protocols ▪ Conducting in-service/on job

AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
		<ul style="list-style-type: none"> ▪ Maintaining clean delivery practice. Note: Infection prevention to be done also in postpartum period. 	<ul style="list-style-type: none"> training for health workers and TBAs ▪ Purchasing strategic materials for infection prevention (buckets, drums and soap, etc.) ▪ Supervision using a checklist.
Health workers, TBA	Assist the health worker/TBA to initiate breastfeeding immediately.	<ul style="list-style-type: none"> ▪ Creating awareness on physiological and psychological benefits of initiating breastfeeding immediately. ▪ Creating awareness of putting baby to breast to promote love. ▪ Address cultural issues surrounding initiating breastfeeding immediately. 	Creating BFHI activities: <ul style="list-style-type: none"> ▪ Trainings on breastfeeding ▪ Development of Health Facility specific guidelines. ▪ Formation of breastfeeding support groups ▪ Formation of breastfeeding task forces.
Mothers	Assist the mother to initiate breastfeeding immediately.	<ul style="list-style-type: none"> ▪ Creating awareness on physiological and psychological benefits of initiating breastfeeding immediately. ▪ Creating awareness of putting baby to breast to promote love. ▪ Address cultural issues surrounding initiating breastfeeding immediately. 	<ul style="list-style-type: none"> ▪ As above.
Health worker	Have positive attitudes towards pregnant women and their guardians/accompanying relatives.	<ul style="list-style-type: none"> ▪ Improving the health workers' interpersonal communication skills. ▪ Motivating DHMT to solicit funds to buy curtains to increase privacy during delivery. 	<ul style="list-style-type: none"> ▪ Refresher courses on communication skills.

AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
Pregnant women who prefer to deliver at home by untrained person.	Deliver at a health facility or by a trained person.	<ul style="list-style-type: none"> ▪ Encouraging utilization of life saving skills learned in management of first stage of labour. ▪ Increasing privacy during labour. ▪ Increasing trained personnel accessibility. ▪ Addressing cultural issues that have effects on delivery at H/F or TBA. ▪ Promoting positive health worker attitudes. 	<ul style="list-style-type: none"> ▪ Conducting focus group discussions (FGDs) ▪ Conducting performance assessment of different delivery positions. ▪ Conducting in-service training (On the job training-OJT). ▪ Incorporating various delivery positions in curriculum. ▪ Conducting refresher training. ▪ Criterion based maternal audits. ▪ Regular supervision.

**SAVING NEWBORN LIVES
BEHAVIOURS RELATED TO POSTPARTUM PERIOD**

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
1.	Postnatal mothers delivered either at home or health centre.	Seek postpartum care within the first week after delivery	<ul style="list-style-type: none"> ▪ Integrating postnatal care in already existing services. ▪ Increasing knowledge of mothers on benefits of postnatal care in 1st and 6th week. ▪ Increasing counseling by health workers related to importance of attending 1st and 6th week postnatal care. 	<ul style="list-style-type: none"> ▪ Conducting health talks during ANC. ▪ Counseling women after delivery and before discharge, with one week appointment date recorded on card. ▪ Using radio messages, jingles, etc. on benefits of postnatal care. ▪ Orienting staff on integrated services. ▪ Mobilizing community for integrated services. ▪ Monitoring process and provision of integrated services. ▪ Gathering information available on postpartum care. ▪ Community dialogue. ▪ Training health workers in related counseling.
2.	Postnatal mothers	Exclusively breastfeed babies for up to 6 months.	<ul style="list-style-type: none"> ▪ Convincing mothers that breast milk is adequate for the baby. ▪ Improving skills of mothers to manage breastfeeding (EBM, positioning, etc.) ▪ Improving health worker skills to counsel and demonstrate appropriate breastfeeding practice. 	<ul style="list-style-type: none"> ▪ Counseling services for breastfeeding mothers. ▪ Formation of breastfeeding support groups. ▪ Mass media campaigns. ▪ Appropriate management of breast conditions/problems.

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
3.	Postnatal mothers	Practice proper cord care	<ul style="list-style-type: none"> ▪ Increasing awareness that the cord stump is not an infected wound and that it heals naturally. ▪ Understanding more about why women “cannot come out” until the cord falls off. ▪ Encouraging the “coming out” even before the cord falls off. 	<ul style="list-style-type: none"> ▪ Counseling mothers before discharge. ▪ Community dialogue sessions. ▪ Conducting related research.
4.	Health workers	Practice prophylactic treatment of eyes of all newborns	<ul style="list-style-type: none"> ▪ Working with MOHP to establish magnitude of <i>ophthalmia neonatorum</i> (eye infection), related policy and supply of antibiotic eye drops 	<ul style="list-style-type: none"> ▪ Health education talks for mothers. ▪ Counseling mothers before discharge. ▪ Advocate for prophylaxis through MOHP.
5.	Postnatal mothers	Recognize postpartum danger signs for babies and seek care in a timely manner.	<ul style="list-style-type: none"> ▪ Increasing knowledge of mothers on postpartum danger signs of babies and importance of seeking timely and appropriate care. ▪ Increasing health worker and TBA knowledge on postpartum danger signs. ▪ Addressing cultural beliefs and interpretation of danger signs encouraging health workers to counsel all pregnant women on danger signs related to newborn. 	<ul style="list-style-type: none"> ▪ Awareness campaigns through drama and other appropriate media. ▪ Use of mass media (radio) ▪ Health education talks. ▪ Focus group discussions (FGDs).
6.	Postnatal mothers	Mothers with low birth weight babies (LBWs) to maintain “skin to skin” contact (KMC) while seeking health care.	<ul style="list-style-type: none"> ▪ Increasing mothers’ and caretakers’ knowledge and skills in Kangaroo Mother Care (KMC). ▪ Increasing awareness on the benefits of KMC. ▪ Creating awareness in community and amongst health workers about 	<ul style="list-style-type: none"> ▪ Teach mothers and caretakers about KMC. ▪ Monitor uptake of KMC practice and outcomes.

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
			viability of LBWs.	
7.	Health workers	Manage LBWs using KMC	<ul style="list-style-type: none"> ▪ Increasing health worker and TBA knowledge and skills on KMC, and awareness on benefits. 	<ul style="list-style-type: none"> ▪ Training on KMC. ▪ Supervision of KMC activities. ▪ Monitoring KMC practices, progress and outcomes.
8.	Health workers and TBAs	Recognize danger signs of the newborn and refer in timely manner	<ul style="list-style-type: none"> ▪ Increasing health worker and TBA knowledge on postpartum danger signs. ▪ Encouraging health workers to counsel all pregnant women on danger signs related to newborn. 	<ul style="list-style-type: none"> ▪ Training on essential newborn care (ENC), danger signs and their management. ▪ Regular supervision of TBAs and health workers. ▪ Life saving skills training-community/health facility.
9.	Health workers	Resuscitate asphyxiated (unable to breathe) newborns adequately.	<ul style="list-style-type: none"> ▪ Increasing health worker and TBA knowledge on danger signs related to Apgar scoring. ▪ Encouraging communities to develop and support referral systems. ▪ Encouraging health workers to prioritize referral of sick newborns/babies with danger signs. 	<ul style="list-style-type: none"> ▪ Procurement and distribution of necessary basic equipment. ▪ Training health workers in resuscitation. ▪ Related supervision of health workers.
10.	Traditional Birth Attendants (TBAs)	Refer LBWs in KMC position	<ul style="list-style-type: none"> ▪ Increasing TBA knowledge and skills on how to refer LBWs in KMC position. 	<ul style="list-style-type: none"> ▪ In-service training of TBAs. ▪ Monitoring of TBA practice related to newborns. ▪ Regular supervision.
11.	Health workers and TBAs, Mothers, Relatives and Caretakers.	Dry and wrap babies to keep them warm immediately after delivery.	<ul style="list-style-type: none"> ▪ Increasing knowledge on the importance of keeping newborn babies dry and warm immediately after delivery. 	<ul style="list-style-type: none"> ▪ Refresher training. ▪ Regular supervision. ▪ Monitoring of practice of draying and wrapping for warmth.
12.	Mothers	Room in with their babies immediately after	<ul style="list-style-type: none"> ▪ Encouraging grandmothers to support rooming in. 	<ul style="list-style-type: none"> ▪ Education of mothers, grandmothers on rooming in.

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
		delivery.	<ul style="list-style-type: none"> ▪ Assessing feasibility of practicing rooming in within current maternity/postnatal environment (e.g. size of beds, etc.) 	<ul style="list-style-type: none"> ▪ Observing and monitoring implementation of the practice.
13.	Health workers, TBAs, mothers, relatives	Not to wash newborn babies within first 24 hours after delivery.	<ul style="list-style-type: none"> ▪ Understanding and addressing cultural issues surrounding the washing of babies within 24 hours. 	<ul style="list-style-type: none"> ▪ Refresher training. ▪ Health education talks. ▪ Regular supervision. ▪ Education of mothers and caretakers. ▪ Research on related cultural factors/beliefs.
14.	Health workers	Practice infection prevention measures during care of postnatal mothers and their babies.	<ul style="list-style-type: none"> ▪ Increasing availability of equipment, materials, supplies for infection prevention. ▪ Strengthen skills of health workers related to infection prevention (SNL vs. SM inputs) 	<ul style="list-style-type: none"> ▪ Related facility assessments. ▪ Procurement and distribution of equipment, materials and supplies. ▪ Refresher training and use of IP protocols. ▪ Regular supervision (SNL vs. SM inputs)

**SAVING NEWBORN LIVES
BEHAVIOURS RELATED TO ANTENATAL CARE**

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
1.	Women of childbearing age 15-49 years	Attend ANC at least 4 times during pregnancy	<ul style="list-style-type: none"> ▪ Facilitate daily ANC services at all Health Facilities. ▪ Promote benefits of attending ANC at least 4 times. ▪ Utilize existing information on pregnant women perspective to ANC services. ▪ Improve health worker attitudes towards ANC clients. 	<ul style="list-style-type: none"> ▪ Facilitative supervision and discussions with health workers. ▪ Conducting research on client perspectives of ANC. ▪ Community IEC campaigns on benefits of 4 ANC visits (drama, songs, etc.). ▪ Using positive deviance case scenarios. ▪ Training health workers on IPCC skills. ▪ Increasing outreach services. ▪ Client exit interviews.
2.	Health workers, TBAs	Counsel antenatal mothers on breastfeeding (BF)	<ul style="list-style-type: none"> ▪ Strengthened B/F counseling component of ANC services into existing systems/services. ▪ Update knowledge and counseling skills on B/F for relevant health workers. ▪ Improve the attitudes of relevant health workers toward breastfeeding counseling at during antenatal period. 	<ul style="list-style-type: none"> ▪ Training staff on integrated counseling. ▪ Updating health staff knowledge and practices (refreshers). ▪ Developing and provide IEC materials (vernacular-as appropriate).
3.	Health workers, TBAs, spouse/family members	Refer pregnant women with antenatal danger signs early.	<ul style="list-style-type: none"> ▪ Sensitizing community members on implications of late referral. ▪ Assisting communities develop referral action plans. ▪ Advocating for the empowerment 	<ul style="list-style-type: none"> ▪ Conducting FGDs with families, women, men (spouses). ▪ Hold discussions with key community stakeholders (VHCs, chiefs, etc.).

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
			<p>of women to seek care in timely manner.</p> <ul style="list-style-type: none"> ▪ Improving health workers' attitudes towards ANC clients. ▪ Collecting and understanding local terminology related to danger signs. 	<ul style="list-style-type: none"> ▪ Community awareness raising campaign. ▪ Health education of women. ▪ Developing community referral action plans (participatory). ▪ Briefing health workers and TBAs on related role. ▪ Training health workers in IPCC. ▪ One-to-one counseling of pregnant women.
4.	Pregnant women	Take 2 doses of SP at 4 and 7 months respectively	<ul style="list-style-type: none"> ▪ Increasing knowledge on importance of taking 2 doses of SP at stated intervals (improved health status and productivity). ▪ Encouraging mothers to attend ANC early and regularly (see specific item on ANC). ▪ Working with MOHP to enable TBA/HAS to provide SP. ▪ Improving counseling related to adverse and positive effects of presumptive treatment. 	<ul style="list-style-type: none"> ▪ Health education. ▪ Counseling women. ▪ In-service training for health workers. ▪ Regular record checks of women's cards/booklets. ▪ Gather information from CHSU regarding non-compliance for 2nd dose of SP.
5.	Pregnant women	Take 120 tablets Fe/folate supplements during pregnancy	<ul style="list-style-type: none"> ▪ Increasing knowledge on importance of taking FeFo supplements at stated intervals (prevention of anaemia). ▪ Encouraging health workers to explain the importance of FeFo at stated intervals (prevent anaemia in pregnancy and its related complications). ▪ Counseling on side effects of 	<ul style="list-style-type: none"> ▪ Health education. ▪ Counseling women. ▪ In-service training for health workers. ▪ Regular record checks of women's cards/booklets.

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
			FeFo ingestion.	
6.	Pregnant women, Spouses, Mothers-in-law	Prepare for birth (birth planning)	<ul style="list-style-type: none"> ▪ Focusing on cultural beliefs surrounding birth planning. ▪ Increasing community awareness on related gender roles and responsibilities (decision making, provision of money, transport, etc.). ▪ Initiating community support mechanisms (household, family, community). ▪ Increasing awareness on the benefits of birth planning. ▪ Increasing knowledge and awareness on necessary elements of birth planning. ▪ Ensuring thermo-protection; to bring 2 wrappers (<i>chitenje</i>) and other clothes. ▪ Ensuring clean delivery practice: to bring new razor blade, a piece of soap, clean strings and a clean plastic sheet-for provision of a clean birth surfaces. 	<ul style="list-style-type: none"> ▪ Community discussions-target community influentials. ▪ Fee listing related ideas. ▪ Life planning skills training (?). ▪ Health education sessions. ▪ Counseling-women, family. ▪ Standardize elements of birth planning (delivery kit, place to deliver, who to assist delivery, transport, etc.).
7.	Pregnant women	Seek care from trained personnel	<ul style="list-style-type: none"> ▪ Increasing awareness of danger signs among women of CBA. ▪ Sensitizing pregnant women and women of child bearing age to seek care from trained personnel when have danger signs. ▪ Sensitizing spouses, grandmothers on importance of seeking care 	<ul style="list-style-type: none"> ▪ Discussions with men, grandmothers, mothers-in-law. ▪ Health education of women of CBA. ▪ Counseling pregnant women. ▪ Decision-making skills training (?). ▪ Train health providers and TBAs on danger signs and course of action.

	AUDIENCE In order to help	BEHAVIOR To:	KEY FACTORS We will focus on:	ACTIVITIES Through (Still under revision)
			<p>when a pregnant woman is in danger.</p> <ul style="list-style-type: none"> ▪ Increasing awareness of danger signs among TBAs and health workers. ▪ Addressing cultural issues that have effects on seeking care. ▪ Increasing access of pregnant women to trained personnel. ▪ Empowering women to make decisions in seeking care when in danger. 	
8.	Pregnant women	Continue receiving at least 2 doses of TTV	<ul style="list-style-type: none"> ▪ Encouraging pregnant women to continue to receive 2 TTV doses. ▪ Improving clinics in areas with high populations. 	<ul style="list-style-type: none"> ▪ Health education on importance of TTV. In-service training for health workers on TTV schedule. ▪ Provide services in needy areas. ▪ Inspect TTV cards. ▪ Reinforce use of cards.

ANC-antenatal care; BF-breastfeeding; BFHI- Baby Friendly Hospital Initiatives; COs-clinical officers; IPCC-interpersonal communication and counseling; ITNs-insecticide treated nets; PLWAs-people living (positively) with AIDS; SP-sulphadoxine/pyrimethamine (Fansidar); TBAs-traditional birth attendants, TTV-tetanus toxoid vaccine.

ANNEX XV
Newborn Health BCC Materials

**Pokonzekera Mwana Wathanzi,
Dziwani Zizindikiro Zoopsyazi
Kwa Mayi Wapakati Ndipo
Muyenera Kuchitapo Kanthu**

Kutentha thupi

Zinjenje kapena kukomoka

**Kutupa manja,
nkhope,
miyendo ndi mapazi**

Kuchepa kwa magazi

Kusanza mopitiriza

Kutaya madzi kapena magazi

**Mukaona chimodzi
mwazizindikirozi pitani
kuchipatala mwansanga.**

Konzekerani Mwana Wathanzi

SNL
The World As We See It

Wonetsetsani Kuti Mwapezeratu Zonse Zofunikira Tsiku Lobereka Lisanakwane



Musankhiretu chipatala choti mukaberekereko



Sopo, chingwe chauhondo chomangira mchombo ndi lezala latsopano

Konzekeranitu zamayendedwe anu tsiku lobereka lisanakwane



Ngolo



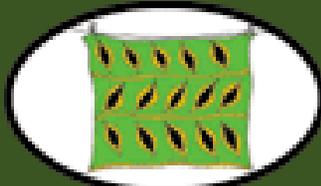
Zovala za mwana



Pepala la pulasitiki



Njinga



Chitenje kapena nsalu ya mayi



Sungani ndalama

**Posamalira khanda
lobadwa masiku asanakwane
m'njira yofungatira, mutha
kugwira ntchito
zosalemetsa monga...**

**Kupita ku
msika**



**Kukonza
ndiwo**



Kupeta nsalu



**Pumani, ndipo bambo
ndi achibale thandizani
mayi kusamalira
mwana wotereyu**



Zizindikiro Zoopsya Kwa Mayi Wapakati



Kutentha thupi



Zinjenje kapena kukomoka

Kuchepa kwa magazi



Kutupa manja, nkhope, miyendo ndi mapazi



Kutaya madzi kapena magazi



Kusanza mopitiriza



Mukaona chimodzi mwazizindikirozi pitani kuchipatala mwansanga.



Posamalira khanda lobadwa masiku asanakwane m'njira yofungatira, mutha kugwira ntchito zosalemetsa monga...

Kupita ku msika

Kupeta nsalu

Kukonza ndiwo

Pumani, ndipo bambo ndi achibale thandizani mayi kusamalira mwana wotereyu

Kusamalira Khanda Lobadwa Masiku Asanakwane M'njira Yofungatira

SNL
Save the Children Malawi

M'mene Tingasamalire Ndi Kukulira Khanda Lobadwa Masiku Asanakwane



1. Ikani khanda pakati pa mawere

3. Mangani nsalu mozungulira khanda ndi mayi wake



5. Yamwitsani khanda bere lokha pafupi-pafupi



2. Mangani khanda ndi nsalu



4. Valani zovala zanu

6. Gonani chagada



Zizindikiro Zoopsya Kwa Khanda

Kukomoka kapena manjenje

Maso achikasu

Kubanika

Kutentha thupi

Kukana kuyamwa

Kufiira pa mchombo

Mukaona chimodzi mwazindikirozi pitani kuchipatala mwansanga.

Kusamalira Kwa Khanda Likangobadwa

SNL
Join Hands to Save Newborn Lives

Kusamalira Kwa Khanda Likangobadwa

1. Pukutani khanda longobadwa kumene.



2. Muyikeni pa khungu la mayi pa chifuwa.



3. Musasambitse khanda longobadwa kumene pokha-pokha patatha tsiku limodzi.



4. Yamwitsani khanda longobadwa kumene pasanathe ola limodzi.



5. Pitani mukawonane ndi adotolo kuchipatala pakatha mulungu umodzi, mwana atabadwa.



Zizindikiro Zoopsya Kwa Khanda

Kukomoka kapena manjenje



Maso achikasu



Kutentha thupi



Kubanika

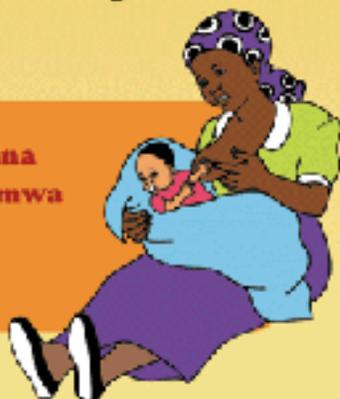


Kufiira pa mchombo



Mukaona chimodzi mwazizindikirozi pitani kuchipatala mwansanga.

Kukana kuyamwa



ANNEX XVI
USAID Letter Requesting Additional Information in the Final Revised DIP



June 15, 2007

Mr. Eric Starbuck
54 Wilton Road
Westport, CT, 06880
USA

Ref: Agreement No. GHS-A-00-06-00016
SC Malawi
Detailed Implementation Plan

Dear Mr Eric Starbuck:

We are pleased to inform you that the Detailed Implementation Plan for **SC Malawi** is **approved** with the revisions (defined below) provided in the final DIP submission due August 15, 2007. It was a pleasure meeting with SC representatives during the DIP review. We would like to commend all the developers of the DIP including the close involvement of the Ministry of Health.

Please provide the following additional information in the final DIP:

- Incorporate all SC's responses to DIP reviewer comments as presented at the DIP review meeting on 6/6/07 and provide a copy of the DIP presentation in the final DIP
- When submitting the final revised DIP, please provide a cover sheet to identify where changes/additions/clarifications were made in the document with corresponding page numbers
- Please further delineate the steps in the process for the training plan, please include information on material, human resources, etc. input needed. Describe the training of trainers exercise that SC will be involved in and the way in which the project will function as an extension to the MOH/PHU with respect to training
- Also provide a timeline (even if tentative) for these trainings
- Please detail the actual interventions package being promoted
- Describe how the project will use the lessons learned from the 3 OR pilots to inform scale-up of community based newborn care practices; please describe who and where utilization of this information will occur
- Delineate specific TA activities anticipated with respect to the national scale-up plan for the MOH
- Explain the dissemination plan for BCC materials and approach to scale-up of the BCC strategy

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1300 Pennsylvania Avenue NW
Washington DC 20523
www.usaid.gov



USAID
FROM THE AMERICAN PEOPLE

- Provide a process for documentation of the evolution of the partnership; include benchmarks
- The agreed number of beneficiaries is ~500,000 (pregnant women and neonates); please describe what these beneficiaries will really be reached with (i.e. improved capacity of health workers)
- Propose a plan for submission of an annual workplan.

We look forward to seeing the results of this important work.

Sincerely,

A handwritten signature in black ink, appearing to read "Jill Boezwinkle".

Jill Boezwinkle
CTO
Child Survival and Health Grants Program
USAID/GH/HIDN

CC: Namita Agravat, USAID/CSHGP
Catherine Chiphazi, USAID/Malawi

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Annex XVII Mini-University Slides

Malawi Newborn Health Program

Save the Children

USAID/CSHGP Mini-University DIP Review
Baltimore, 6 June 2007

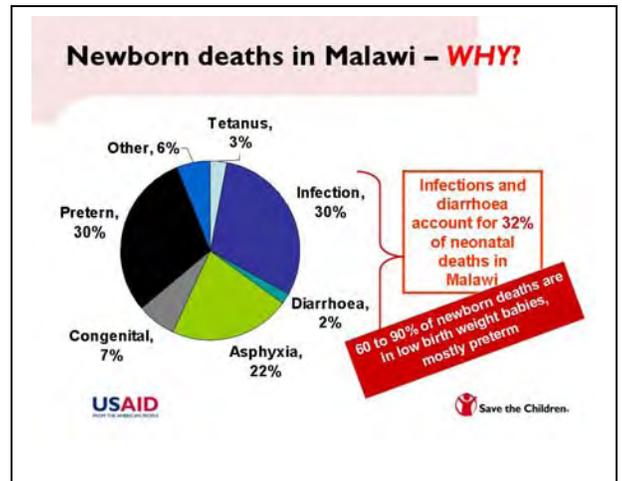
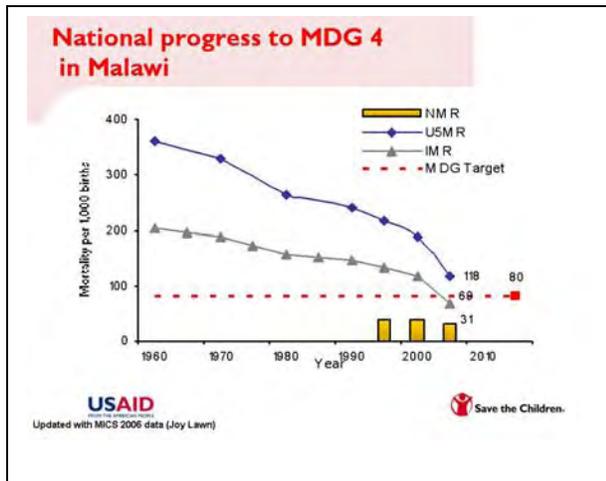
Evelyn Zimba, NBH Program Manager, SC Malawi
Fannie Kachale, Deputy Director, Malawi MOH/RHU



Related health indicators

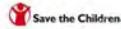
(DHS 2004 & MICS 2007)

Maternal mortality ratio per 100,000 live births	984
Stillbirth rate per 1,000 total births	39
Annual number of stillbirths	22,200
Neonatal mortality rate per 1,000 live births	27
Annual number of neonatal deaths	14,900
Newborns born with low birth weight	20%
Under 5 mortality rate per 1,000 live births	133

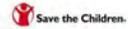
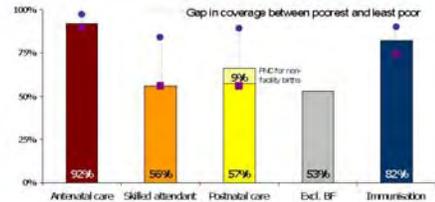



Newborns - crucial for further progress to MDG 4

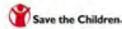
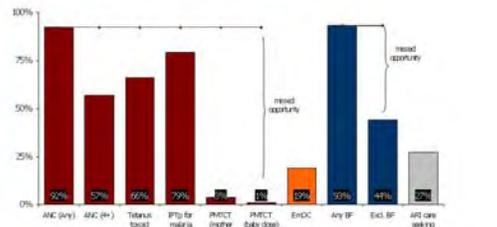
- Under five deaths are being reduced but progress slower in reducing neonatal mortality rates - more and more child deaths are in the neonatal period (first month)
- 26% of <5 deaths in Malawi are neonatal – 14,900 a year**
- The major causes of neonatal death are preventable



Coverage along the MNCH continuum of care in Malawi

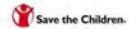


Missed opportunities for newborn care in Malawi



Program description

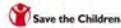
- The Malawi Newborn Health Project (NBHP) is funded by USAID/CSHGP and Saving Newborn Lives (SNL)/Bill & Melinda Gates Foundation
- 5-year CSHGP Expanded Impact project integrated into Malawi's multi-year (2005-15) National Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity
- Complemented by Saving Newborn Lives (SNL2) funding from Bill & Melinda Gates Foundation (match)



Save the Children's role

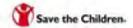
- in partnership with Ministry of Health (MOH) Reproductive Health Unit (RHU) and other Road Map partners -

- ❖ To serve as **reference, catalyst, and technical resource** for newborn health in Malawi
- ❖ To provide **leadership for demonstration, expansion, mainstreaming, and scaling up** quality neonatal care at all levels of health service delivery - with special focus on the community



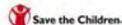
Overall program strategy

- NBHP uses Save the Children's four strategies to achieve intended impact



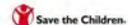
Strategy 1: Develop evidence-based replicable solutions

- Provide oversight, monitoring, and evaluation of research/operations research projects (funded by SNL)
- Disseminate research and programmatic results
- Collaborate with key stakeholders on decision making regarding OR for policy dialogue and programmatic strategies
- Along with other partners provide leadership and TA support to MOH for the design and implementation of CNBC pilot
- Facilitate definition, refinement, documentation, dissemination and packaging of grandparents strategy
- Conduct match-funded community MNC research and OR with strategic inputs of USAID funds



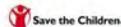
Strategy 2: Use experience to advocate and mobilize for better practices, programs & policies for children

- Collaborate with MOH and Road Map partners to design & implement national advocacy plan
- Support civil-society organization WRA to enable organizational growth and capacity development for leadership in the Road Map national advocacy plan & package
- Collaborate with MOH and other partners on conduct of newborn care policy review and dialogue
- Advocate and provide TA for revised PNC visitation schedule and other evidence-based strategies and interventions



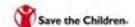
Strategy 3:
Support effective implementation of those practices, programs & policies

- Participate annually in RHU / District Road Map work planning cycle & collaborate with partners to operationalize FY08 plan
- Collaborate with partners to take the CBNC package to scale
- Lead the review, duplication and dissemination of BCC materials developed under SNLI
- Collaborate with partners to improve community & facility-level quality of MNC
- Collaborate with partners to harmonize RH training manuals to develop a comprehensive essential obstetric & newborn care manual
- Provide capacity building to districts to train and supervise providers in ENC
- Share KMC retrospective study results to partners to guide scale up
- Assist in the incorporation of ENC/KMC in pre-service module



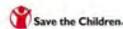
Strategy 4:
Work with alliance members, communities, government & other partners

- Participate in subsequent WHO/UNFPA missions for PMNCH
- Link with EU/WHO Safe Motherhood Initiative
- Collaborate closely with ACCESS and USAID Mission in the area of newborn health
- Revitalize ENC/KMC trainers network
- Support and strengthen WRA as a civil society membership organization committed to maternal and newborn health



Opportunities & partnerships

- Favourable social and political environment
- Strong health sector planning process
- Increased interest of Road Map partners in MNH
- USAID Mission through ACCESS in collaboration with MOH, Save the Children and JHPIEGO to support rapid implementation of the Malawi Road Map strategy
- PMNCH grant for implementation and scale-up of maternal, newborn and child health interventions in the next 3-5 years

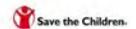


Malawi Newborn Health Program Results Framework

■ Goal: Neonatal mortality and morbidity reduced to meet Malawi's MDGs by 2015

■ Strategic Objective: Sustainable use of key maternal and neonatal health services and practices of essential MNC health behavior at household level increased

- IR-1: Availability of and access to key maternal and newborn care services increased
- IR-2: Quality of key maternal and newborn care services improved
- IR-3: Household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors increased
- IR-4: Policy and social environment for maternal and newborn health enabled

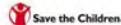


Intermediate Result - 1

- Increased availability of and access to key maternal and newborn care services

Illustrative Activities

- Collaborate with MOH & partners to implement the FY08 RHU work plan
- Participate in RHU annual work planning cycle and assist in DIP cycles
- Participate in quarterly Safe Motherhood (MNC) subcommittee meetings
- Collaborate with MOH, UNICEF and other partners on taking facility ENC/KMC and community-based newborn care package to scale in 28 districts
- Conduct KMC retrospective study to inform scale-up in 28 districts and share results with Road Map partners
- Support MOH/RHU to strengthen HIS and M&E in newborn health



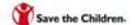
Intermediate Result - 2

- Improved quality of key maternal and newborn care services

Illustrative Activities

Revitalize ENC/KMC trainers network, conduct refresher trainings

- Collaborate with MOH and districts to train district ENC/KMC providers in 28 districts
- Assist in improving community-level strategies for MNH in partnership with ACCESS i.e. PNC, KMC
- Collaborate with partners to train and supervise HSAs on community MNC integrated into country's ACSD Strategy for IMCI
- Collaborate with MOH and partners in the implementation of newborn death audits and social-verbal autopsies
- Provide leadership and TA for design and implementation of the pilot community-based newborn care package in 3 districts (match)

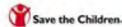


Intermediate Result - 3

- Improved household-level knowledge and attitudes related to key essential newborn care and related maternal care behaviors

Illustrative Activities

- Take lead to review BCC materials developed under SNL I and contribute to duplication and dissemination
- Collaborate with MOH and partners to apply community mobilization approach in the delivery of community MNC interventions with active participation of VHC, key community leaders, grandparents
- Promote community participation in the collection and feedback of newborn verbal death autopsies

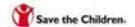


Intermediate Result - 4

- Improved policy and enabling social environment for maternal and newborn health

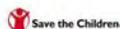
Illustrative Activities

- Invite stakeholders to participate in field visits to Mai Mwana for exchange of learning
- With partners incorporate MNC content to revised HSA training manual
- Disseminate OR results and collaborate with key stakeholders on decision-making for policy dialogue and programmatic strategies, e.g. PNC visitation, NB sepsis use of antibiotics and injectables by HSA's
- Work with MOH to increase recruitment of female HSAs
- Collaborate with MOH and other partners on newborn care policy review
- Collaborate with RHU, WHO and other partners to harmonize RH training manuals into a comprehensive essential obstetric and newborn care manual
- Assist MCHS to incorporate the ENC content into pre-service curricular
- Work with Ekwendeni to package agogo approach



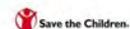
Monitoring & evaluation

- ❖ Save the Children will monitor the NBHP using DHS, MICS and HIS indicators and state-of-the-art measurements for NBH
- **Baseline:** DHS, MICS and HIS, HFAs, KPC survey, training assessments, and qualitative assessment of *agogo* approach
- **Mid-term:** HIS, Surveillance, tracking of input and output level data, expenditures, persons trained, changes in policies
- **End-line:** DHS, MICS & HIS, KPC survey and final evaluation
- **Operations research:** Results of CBNC package to be piloted taken to scale and completion of Mai Mwana controlled trial



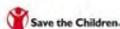
Management

- Malawi County Director and Deputy Country Director for Programs provide overall strategic leadership
- NBH Program Manager is responsible for the overall management of project implementation and TA; and coordination with MOH, donors, and local and international partners
- 2 Project Officers are responsible for liaison, coordination, capacity building, mentoring, and support to partners
- SNL-funded Evaluation and Research Officer supervises the M&E Officer who oversees assessments and surveys, documentation of results and achievements, M&E plan implementation, and coordination with the national HIS
- Project Assistant provides logistics, communication, and administrative support
- Malawi Country office administration staff provides support



Memoranda of understanding

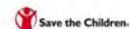
- MOH – Awaiting national agreement with government
- MOH/RHU and UNICEF for 3 district pilot – in final stages of development
- WRASM-Mw – Temporary agreement complete; to be revised when ACCESS funds become available for additional support
- Ekwendeni Mission Hospital – sub-grant agreement in development, pending final review of Ekwendeni proposal/program document



Lessons learned during DIP process:

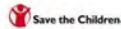
We believe we learned a number of important lessons during the DIP process. We want to share these up-front with reviewers and others thinking about partnering at the national-level:

- *Our timeline is not necessarily their timeline.*
- *It's not all about us.*
- *There are times we need to guide; there are times we need to lead; there are times we need to follow.*
- *When we work in true partnership, we cannot expect to maintain total control.*

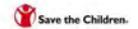


Lessons learned, cont'd.

- *We need to position ourselves to leverage every asset and every opportunity.*
- *It is critical to keep our eye on the long-term goal and understand the path to get there may have many twists and turns!*
- *Networking and communication are keys to success.*
- *We need to work within the system **PRO-ACTIVELY**.*
- *Our inputs, whether material or technical, must be strategic.*
- *We need to have something of value to bring to the table.*



Thank you!



Annex XVIII Districts Supported by USAID and Other Donors

	JHPIEGO PQI/RH	Save the Children	EU/WHO	Health Found.	MSH	PMNCH*	UNFPA	UNICEF**	ACCESS/ Malawi
North									
Chitpa		X						X+	
Karonga*						X		X	
Mzimba*	X	X			X	X		X	
Nkhata Bay			X				X		
Rumphi									X
Central									
Lilongwe*				X		X	X	X	
Dedza*						X	X		
Dowa		X						X+	
Kasungu*				X	X	X		X	
Mchinji		X					X		
Nkhotakota	X								X
Ntcheu*	X		X		X	X		X	
Ntchisi	X							X	
Salima				X	X			X	
South									
Balaka*	X				X	X			
Blantyre								X	
Chikwawa	X				X				
Chiradzulu*						X			
Machinga									X
Mangochi	X				X				
Mulanje	X				X				
Mwanza								X	
Nsanje*						X			
Phalombe*						X			
Thyolo		X						X+	
Zomba			X						

*“Top Ten” for PMNCH consideration.

** All the 12 sites are Accelerated Child Survival and Development districts. Those with crosses have also been trained in the ENC package.

Source: “ACCESS Maternal and Newborn Care Program in Malawi, 2007-2011”, proposal submitted July 2007 to USAID, p. 35.