End-of-Project Evaluation: Mama Na Mwana – Mother and Baby in Malawi and Zambia

St John International

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Mama Na Mwana – Mother and Baby
in Malawi and Zambia
End-of-Project Evaluation

Implemented by St John Malawi and St John Zambia
in collaboration with St John International

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Abbreviations & acronyms

ANC	Antenatal care
ART	Anti-retroviral treatment
DHS	District health survey
DHO	District health office
EoP	End of project
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
HIV	Human immuno-deficiency virus
IGA	Income generating activities
KII	Key informant interview
M&E	Monitoring and evaluation
MNCH	Maternal, newborn and child health
PMTCT	Prevention of mother to child transmission
PNC	Postnatal care
SDG	Sustainable Development Goal
SMAG	Safe Motherhood Action Group
SOP	Standard operating procedures
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
TBA	Traditional birth attendant
UTH	University Teaching Hospital
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Executive summary

Mama Na Mwana ('Mother and Baby') is a three-year project implemented by St John Malawi and St John Zambia in association with St John International, and co-funded by the Big Lottery and St John International. It was implemented between December 2014 and November 2017 in urban, peri-urban and rural sites in Malawi (Lilongwe and Blantyre Districts) and Zambia (Lusaka and Chibombo Districts), with additional pilot projects in Uganda and Zimbabwe. The overall aim is to contribute to reducing preventable infant and maternal morbidity and mortality; the project has three key outcomes:

1. Improved knowledge, community-based support and referrals to health services for pregnant women, contributing to improved health during pregnancy and safe delivery.
2. Increased postnatal care and support to new mothers and their babies, contributing to improved health and a reduction in preventable infections for women and babies, increased access to family planning and increased practice of good newborn care at community level.
3. Increased access to local health services and provision of antenatal care, postnatal care and family planning for pregnant women, new mothers and their babies, resulting in increased uptake of these services.

This report synthesises key findings from an independent end of project evaluation. The methodology involved a desk-based review and analysis of routine monitoring and evaluation (M&E) data and project documentation, together with in-country fieldwork in Malawi and Zambia.

The evaluation concluded that *Mama Na Mwana* is tackling high priority issues in maternal and newborn child health in two severely affected countries, and that the project strategies - including community mobilisation, health education, volunteerism and ensuring linkages to and strengthening of existing public health systems - are relevant to scale-up to new areas.

The evaluation findings support the recommendation to expand the project's coverage to reach more people with a similar package of essential MNCH support by expanding to new areas and scaling up the 'satellite outreach clinic' model for hard-to-reach and under-served districts.

The evaluation identified a number of key highlights and strengths including:

People reached

- ✓ **Exceeding project targets to reach a total of 23,423 primary beneficiaries**; 10,680 pregnant women; 7,245 new mothers with infants; and 5,498 men.

Outputs

- ✓ **Training St John volunteers to conduct home visits** improved access to information on safer motherhood and strengthened community-based referrals for MNCH.
- ✓ **Supporting local health services, including establishing outreach clinics to expand clinical services to 'hard to reach areas' increased access and uptake of ANC, PNC and FP services** in rural districts of Malawi.

Outcomes

- ✓ **High levels of engagement from a broad range of community stakeholders** including Government health staff at local and district levels, St John volunteers, religious leaders and village chiefs, in addition to project beneficiaries.
- ✓ **Earlier and more frequent access to ANC and more women visiting ANC in their first trimester.** Over half the women who participated in the end of project (EoP) survey reported going to ANC earlier than in previous pregnancies, while 46% of women in Zambia and 36% in Malawi reported going to ANC more often. Women accessing ANC in their first trimester of pregnancy increased to 36% for both countries by the project end date.
- ✓ **Increasing numbers of pregnant women testing for HIV during their current pregnancy,** which is critical to the integration of PMTCT interventions into safer motherhood activities and reducing the likelihood of HIV transmission from mother to baby. An impressive 98% of women in the EoP survey indicated that they had tested for HIV in their current/most recent pregnancy.
- ✓ **More women giving birth in a health facility, particularly in Zambia.** 90% of women in the EoP survey in Zambia reported giving birth in a health facility, compared to 67% in DHS data. Amongst women who delivered at home, those who reported visiting a health facility the same day the baby was delivered was 72% in the EoP survey, significantly higher than the 11% reported through DHS data.
- ✓ **More women breastfeeding their baby within the first hour after delivery, and exclusively breastfeeding their baby for six months, particularly in Zambia.** 88% of women cited breastfeeding the baby within the first hour in Zambia, an increase of 40% over the baseline. Across both countries, 56% of new mothers enrolled in the project exclusively breastfed their child for more than 6 months, substantially higher than the 20% of DHS respondents.
- ✓ **Very high numbers of women accessing PNC at least once after leaving the health facility having given birth.** In Zambia, almost all women (99%) in the EoP survey had done so (10% higher than the corresponding DHS data), while in Malawi this was 89% (50% DHS data).
- ✓ **Very high numbers of women reporting that they are currently using a FP method;** 80% of women in Malawi (36% higher than DHS data and a 10% increase on the baseline); 92% in Zambia (57% higher than DHS data and a 42% increase on the baseline).[1]

The evaluation identified a number of key areas for further development in order to continue to build upon the project's successful results to date:

- **Improve care for newborn infants by strengthening uptake of referrals to health facilities**. Address the current gap identified through project monitoring data to ensure that parents of babies referred with danger signs to a health facility actually take up this referral, which is at a lower rate than other referrals.
- **Strengthen capacity and accountability of health-care providers** as critical factors impacting upon uptake of health services. Examples could include: sharing lessons-learned from *Mama Na Mwana* with the national SMAG programme in Zambia;

[1] The DHS data relate to all women of reproductive age while the project data captures new mothers who adopt family planning after delivery. The two sources are therefore not totally comparable, however the result is clearly very positive.

developing the capacity of St John staff and volunteers in rights-based approaches; and supporting local accountability mechanisms, such as health facility committees, to promote accountability of health staff and resourcing of local health services.

- **Explore strategic partnerships and linkages with other organisations,** for example those already working in project sites and/or on specialist themes such as HIV/AIDS; adolescent SRHR programming; income generation; and advocacy to improve health service provision. This offers the potential to improve project reach and impact, ensuring that resources are used most effectively and efficiently, and avoiding potential duplication.
- **Continue to build on positive efforts to catalyse male involvement in MNCH**. Strategies could include: recruiting more male volunteers; adapting volunteers' schedules to conduct visits at weekends when men are home; and to change the 2nd visit from a group setting to a home visit; reaching men in male environments – such as large workplaces in urban settings - and through influential local and religious leaders; and working with health care providers to make clinics 'male friendly'.
- Review the **volunteer recruitment and selection process** with a view to increasing the number of male volunteers to ensure a more equitable gender balance; and recruit younger volunteers to ensure a more peer-led approach to reaching adolescent mothers. Re-assess volunteer allowances in Lilongwe District to ensure that these are comparable across the project.
- **Use the project's significant learning in terms of project management to benefit future scale up efforts.** This is particularly true in relation to more accurate target setting, which is now possible based on experience of implementing different volunteer models across a mix of urban, peri-urban and rural sites in the two countries. Learning from the project will also contribute to a revised M&E framework with a reduced number of core and relevant indicators.

A summary of indicators of positive change is shown on the following pages for each of the two country programmes.

Summary: positive changes demonstrated among project beneficiaries

Table 1: Positive change among project beneficiaries in Zambia

	ZAMBIA	DHS data: 2014-15	Baseline 2015	Women in the project	Increase over DHS data	Increase over baseline
1	Women who report going to ANC earlier than in previous pregnancies			53%		
2	Women who report going to ANC more often than in previous pregnancies			46%		
3	Women visiting ANC in the first trimester of their pregnancy *	24%		36%	12%	
4	Women who had an HIV test during their pregnancy **	84%		98%	14%	
5	Women who did not deliver in a health facility ***	33%		10%	-23%	
6	Women who put the baby on their bare skin in the first hour after delivery		48%	88%		40%
7	Women who breastfed the child within the first hour after delivery		52%	85%		33%
8	Women who exclusively breastfed their child for at least 6 months ^	23%	36%	59%	36%	23%
9	New mothers who received PNC at least once after leaving the health facility ^^	89%		99%	10%	
10	Women who are currently using a method of family planning ^^^	35%	45%	92%	57%	47%
11	Women who want to wait at least 2 years before their next pregnancy		69%	88%		19%

* DHS data for women age 15-49 who had a live birth in the five years preceding the survey by number of antenatal care (ANC) visits for the most recent live birth, and by the timing of the first visit, and among women with ANC, median months pregnant at first visit.

** DHS data among women age 15-49 who gave birth in the 2 years before the survey, percentage who received an HIV test during antenatal care for their most recent birth by whether they received their results and post-test counselling, and percentage who received an HIV test during ANC or labour for their most recent birth by whether they received their test results.

*** DHS data for distribution of live births in the 5 years before the survey by place of delivery and percentage delivered in a health facility.

^ DHS data for percentage of youngest children under age 2 who are living with their mother by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under age 2 using a bottle with a nipple, according to age in months.

^^ DHS data among women age 15-49 giving birth in the two years preceding the survey, the percent distribution of the mother's first postnatal check-up for the last live birth by time after delivery, and the percentage of women with a live birth in the two years preceding the survey who received a postnatal check-up within 0-41 days after giving birth.

^^^ DHS data of women age 15-49 by contraceptive method currently used.

Table 2: Positive change among project beneficiaries in Malawi

Malawi		DHS data: 2015-16	Baseline 2015	Women in the project	Increase over DHS data	Increase over baseline
1	**Women who report going to ANC earlier than in previous pregnancies**			56%		
2	**Women who report going to ANC more often than in previous pregnancies**			36%		
3	**Women visiting ANC in the first trimester of their pregnancy ***	24%	17%	40%	16%	23%
4	**Women who had an HIV test during their pregnancy ****	89%		99%	10%	
8	**Women who exclusively breastfed their child for at least 6 months ^**	17%	38%	52%	35%	14%
9	**New mothers who received PNC at least once after leaving the health facility ^^**	50%		89%	39%	
10	**Women who are currently using a method of family planning ^^^**	44%	70%	80%	36%	10%

* DHS data for women age 15-49 who had a live birth in the five years preceding the survey by number of antenatal care (ANC) visits for the most recent live birth, and by the timing of the first visit, and among women with ANC, median months pregnant at first visit.

** DHS data among women age 15-49 who gave birth in the 2 years before the survey, percentage who received an HIV test during antenatal care for their most recent birth by whether they received their results and post-test counselling, and percentage who received an HIV test during ANC or labour for their most recent birth by whether they received their test results.

^ DHS data for percentage of youngest children under age 2 who are living with their mother by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under age 2 using a bottle with a nipple, according to age in months.

^^ DHS data among women age 15-49 giving birth in the two years preceding the survey, the percent distribution of the mother's first postnatal check-up for the last live birth by time after delivery, and the percentage of women with a live birth in the two years preceding the survey who received a postnatal check-up within 0-41 days after giving birth.

^^^ DHS data of women age 15-49 by contraceptive method currently used.

1. Background and introduction

The *Mama Na Mwana* ('Mother and Baby') project has been implemented by St John Malawi and St John Zambia, in association with St John International over a three-year period between December 2014 and November 2017 in Malawi (Lilongwe and Blantyre Districts) and Zambia (Lusaka and Chibombo Districts), with additional pilot projects in Uganda and Zimbabwe. The project has been co-funded by the Big Lottery and St John International, with the overall aim of making a contribution to reducing preventable infant and maternal mortality and morbidity in these high priority countries. Project start-up began in December 2014 with the recruitment and training of volunteers, and outreach activities began in February 2015.

Responding to the challenges of maternal, newborn and child health

Mama Na Mwana aims to respond to the high levels of maternal, neonatal and infant mortality in Malawi and Zambia, based on the theory that skilled health care during pregnancy, childbirth and in the postnatal period (immediately following birth) facilitates early detection and management of problems and can save the lives of both women and newborn babies.[2] Worldwide in 2016, 2.6 million babies died in the first 28 days of life (the neonatal period). Every year, 46% of all child deaths under five years old occur during this period, and three quarters of all newborn deaths occur in the first week of life.[3] The vast majority of newborn deaths take place in developing countries where access to health care is low. Most of these newborn infants die at home, without skilled care that could greatly increase their chances of survival. The World Health Organization (WHO) estimates that up to two thirds of newborn deaths could be prevented if skilled health workers perform effective health measures at birth and during the first week of life.[4]

Despite significant progress in reducing infant mortality by 47% globally over the past 25 years, from 5.1 million infant deaths a year, there has been slower progress across countries in sub-Saharan Africa[5] and morbidity and mortality for both mothers and children remain critical concerns in both Malawi and Zambia.

Both countries currently fall well below the targets outlined in Sustainable Development Goal (SDG) 3 (focusing on health and wellbeing) to reduce both maternal and neonatal mortality rates. An accelerated response will be required in both countries in order to secure these new ambitious SDG targets:

- *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births (SDG Goal 3, target 3.1).*

Zambia has one of the highest maternal mortality rates globally, at 591 per 100,000 live births, with just 47% of births attended by skilled health workers. In Malawi, maternal mortality is also very high at 574 per 100,000 live births.[6]

[2] WHO. 2017. Factsheet on Newborns: reducing mortality http://www.who.int/mediacentre/factsheets/fs333/en/
[3] Ibid
[4] ibid
[5] UNICEF. 2016. https://data.unicef.org/topic/child-survival/neonatal-mortality/
[6] USAID. 2017. https://www.usaid.gov/malawi/fact-sheets/malawi-maternal-neonatal-and-child-health-fact-sheet

- *By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births* (SDG Goal 3, target 3.2).

In Zambia, infant, neonatal and under five deaths are also unacceptably high at 70, 34 and 119 per 1000 live births respectively.[7] In Malawi, rates for infant, neonatal and under five deaths are 43, 22 and 68 per 1000 live births, respectively.[8]

Against this context of increasingly ambitious targets in maternal, newborn and child health (MNCH), St John developed the *Mama Na Mwana* project to contribute to reducing preventable infant and maternal mortality and morbidity in selected sites in Malawi and Zambia, recognising that the health interventions needed to save infants are closely linked to care that is needed to protect maternal health.

Mama Na Mwana Project Approach

The project approach was based on providing **community-based outreach, support and referrals for pregnant women, new mothers, their husbands, partners and newborn infants to increase access to information and services on safer motherhood and strengthen uptake of referrals to clinical services, including ant-natal care (ANC), safe delivery, postnatal care (PNC) and family planning (FP)**. It aimed to address the '3 delays' that are critical to improving care for mothers and infants: recognising the danger signs and deciding to seek care; reaching an appropriate source of care; and getting adequate treatment when you reach the health facility.[9] The project has been implemented in a total of seven sites across four districts in Malawi and Zambia:

	Project sites	Type
Malawi	Lilongwe District – Chiuzira and Kauma	Rural; peri-urban (respectively)
	Blantyre District – Ndirande and Mbayani	Urban
Zambia	Lusaka District – Chunga	Urban
	Chibombo District – Shifwankula and Naluyanda	Rural

Mama Na Mwana project interventions:

Developing Standard Operating Procedures (SOPs) and training St John volunteers to ensure quality standards and consistency of visits, including discussion topics and key messages. SOPs were adapted to follow clinical advice in each country, and linked to the project's indicators.

[7] UNICEF. 2017. https://www.unicef.org/zambia/5109_8457.html
[8] UNICEF. https://data.unicef.org/country/mwi/
[9] Save the Children. 2013. Applying the Three Delays Model

Delivering home visits by trained St John community volunteers to pregnant women, new mothers and their newborn infants and husbands/male partners. The first and fourth visits to pregnant women take place at home, and all visits to new mothers.

Conducting peer group discussions for pregnant women began mid-way through the project, intended to provide support from peers in addition to household visits by trained volunteers. Peer group discussions are held, covering topics in visits 2 & 3.

Strengthening two-way referrals between the community and local health services. Community-based referrals from St John to local health facilities are a critical component of the project.

Establishing new outreach clinics for ANC and PNC in Lilongwe district (Chiuzira and Kauma) with no local health centres to increase accessibility and promote referrals to these services.

Providing targeted support to strengthen health services to increase the accessibility of clinical care services, including: supporting additional staff to run dedicated ANC and PNC clinics; transportation to conduct outreach clinics; and providing basic equipment and supplies to ensure that health facilities meet basic standards.[10]

Engaging with local health services and district health authorities, including delivering training for health service providers and St John participating in district health meetings.

Sensitising and engaging local leaders (including village chiefs and religious leaders) on the project's activities and ensuring their 'buy-in' to encourage community members to participate. Volunteers also provide health talks at the local leaders' meetings.

The project volunteers also carry out **basic health education on safe motherhood for community members.**

St John recruited and trained a total of 180 volunteers (120 in Malawi; 60 in Zambia). Over the course of the project 33 volunteers from Malawi (15 from Lilongwe; 18 from Blantyre) and 10 volunteers from Zambia dropped out, with an additional volunteer passing away in Zambia. With an average annual drop-out rate of 8% overall, volunteer turnover is lower than might be expected, and additional volunteers were recruited and trained to replace those who dropped out. The volunteers receive St John uniforms so that they are easily identifiable when they conduct their outreach in the community, and a very modest 'allowance' (intended to cover basic costs e.g. transport, washing uniforms), paid monthly in Zambia and Blantyre, and quarterly to volunteers in Lilongwe District in Malawi. St John conducts weekly supervision and support for the volunteers in the community and discusses progress and challenges through quarterly project review meetings.

Volunteers receive accredited first aid training together with training on a set of Standard Operating Procedures (SOPs), developed by St John to standardise and ensure the quality of information and the support provided by the volunteers during their visits. The SOPs outline the main tasks to be undertaken, key topics to be covered, and the specific messages to be delivered during each community visit, depending on the timing/focus of the visit. Health staff were consulted and the SOPs adapted to ensure that they were in line with national guidelines and reflected advice given at local health facilities. Topics covered in the SOPs include: the importance of early antenatal care and attending the recommended four visits; birth preparedness; basic

[10] While the overall project was funded by the UK Big Lottery, the low-cost inputs to health services were paid fully by St John with additional, unrestricted funds.

household savings prior to delivery; danger signs during pregnancy, after delivery and in newborn infants, and what to do in an emergency; antenatal care; HIV testing and access to PMTCT; and general healthy practices during pregnancy and after birth.

The volunteers conduct community outreach, visiting pregnant women, new mothers, their husbands, partners and newborn infants, and sharing health promotion information, referring people to relevant health services, and ensuring additional follow-up as required. The volunteers work in pairs, conducting four visits to pregnant women during their pregnancy. These visits are scheduled to coincide with the cycle of recommended visits to antenatal care, with the aim of increasing uptake of appropriate services and care during pregnancy and delivery, and after the child's birth. The first visit takes place at home, the second and third visits are conducted in a peer group setting, and the fourth and final visit at home before delivery takes place. Mothers with new infants are visited two or three times at home, depending on the local health service provision and need, with volunteers conducting further follow-up with higher-risk individuals. St John volunteers also reach out to expectant fathers and new fathers, with the aim of promoting male involvement as an important factor in supporting maternal and newborn health.

Volunteers collaborate closely with local health centres to strengthen referrals and improve the uptake and quality of services. Volunteers provide additional support at the outreach and static clinics run by Government health staff, completing initial check-ups for women attending ANC, for example weighing and taking blood pressure. A two-way referral system ensures community-to-clinic referrals and adequate follow-up after women return home. The volunteers also provide health education on maternal and newborn child health to the wider community, including sensitising and involving community leaders in the project.

In Zambia, *Mama Na Mwana* was designed to build upon the existing Government Safe Motherhood Action Group (SMAG) model to address maternal and newborn deaths in priority areas with low socio-economic status and weak health services. *Mama Na Mwana* built upon existing lessons learned from SMAG, including developing a proper monitoring system and strengthening the support and motivation of community volunteers to improve the implementation of the programme in Lusaka. The project works in close partnership with the public health system; St John volunteers receive SMAG training (in addition to first aid training provided by St John) and their community outreach efforts complement those of SMAG volunteers, whose numbers are few and face high turnover.

In Malawi, the project has supported the establishment of outreach clinics to extend clinical services to hard-to-reach and underserved rural communities in Lilongwe District that are located far from existing health facilities. Government staff from Kang'oma Health Centre and Area 18 Health Centre provide the clinical outreach, test kits and medication, with transport and other associated costs, equipment and supplies supported by the project. In other health facilities in project sites in both countries– including Mbayani clinic in Blantyre and Chunga health post in Lusaka- the project has provided low-cost support for a nurse's time (and additional HIV counsellor in Mbayani) to conduct dedicated ANC and PNC clinics to meet the increased demand for these services as a result of the community awareness and mobilisation activities of St John volunteers. The project also offered some basic support to strengthen local health facilities, particularly in Malawi, where the District Health Office recognised that Mbayani clinic in Blantyre did not meet the basic standards required of a health facility. Here the project supplied essential equipment

including scales to weigh mothers and babies and blood pressure machines, and supported training for health care staff. In Zambia, the project paid for needed repairs to a rural health facility's water tank.

Implementing pilot projects: Uganda and Zimbabwe

Additional pilot projects were implemented in Buikwe District, Uganda and Zvimba District, Zimbabwe over a two-year period. St John International worked with local health services to adapt the Standard Operating Procedures (SOPs) used in Malawi and Zambia to follow country-specific guidelines and local health advice. This approach expanded the reach of the programme to promote recognised good practice on safe motherhood and care of newborn infants to new areas, developing new partnerships with local health services and working closely with them to promote programmatic sustainability, and recruiting and training new groups of St John volunteers. The Uganda project managed to exceed the majority of targets set, while implementing the programme with just half the number of volunteers originally proposed. Indeed, the Uganda project succeeded in reaching more primary beneficiaries with just 10 volunteers, compared to the numbers reached in Zimbabwe with 78 volunteers. This finding highlights important lessons in relation to setting targets for coverage and volunteer recruitment that can be applied across the project.

In **Uganda**, the project was implemented in four villages, working closely with six local health facilities; each with a designated focal point supported by the project, responsible for coordinating the volunteers and establishing two-way referrals from the community to health facilities and follow-up care when women return home. 10 volunteers were trained in the SOPs and carried out household visits to 1,914 pregnant women (177% of the target); 1,104 new mothers and their newborn infants (102% of the target); and 1006 men (93% of the target). A further 12,658 people (an impressive 239% of the target) were educated on maternal and newborn issues and practices during household and community activities. The project has also trained 15 counsellors in PMTCT.

The project also supported the establishment of a quarterly outreach clinic in Butembe – a remote village on the shores of Lake Victoria with no health facilities – providing a comprehensive range of services including: ANC; PNC; growth monitoring; child immunisations; HIV counselling and testing; malaria screening and treatment; and general health education services offered to pregnant women, mothers and their children. Medical supplies and drugs, allowances for the 10 person medical team, transport, hiring of a large tent (seating 100), and accompanying tables, chairs etc. have all been provided through the project.

In **Zimbabwe**, a similar pilot project was implemented in 15 villages in Mt Hampden, with 78 trained St John volunteers reaching 1,166 pregnant women (117% of the target), 467 new mothers and their newborn infants (93% of the target), and 1,338 men (an impressive 268% of their target) in their homes through community based outreach and a further 4,828 people educated on maternal and newborn issues and practices during household and community activities. In Zimbabwe, the project initiated a new collaboration between local health staff at the Mount Hampden Health Facility, government-appointed Village Health Workers and newly recruited St John volunteers, resulting in the establishment of four new monthly outreach clinics, in surrounding rural areas with no nearby health facilities. The project supported basic health equipment for the Mt Hampden Clinic, the only health facility in the area, including an examination couch, baby scales, bathroom scales, blood pressure machines and thermometers. It also supported the construction of a maternal waiting shelter with basic kitchen facilities, attached to the health facility to encourage expectant mothers to arrive early before they give birth, avoiding emergencies. Monthly supplies of gloves, linen savers, soap and face towels were also provided for women giving birth in the health facility.

In both countries, the project also strengthened organisational capacity of St John staff in the areas of: project budgeting, financial reporting, data collection and reporting.

2. Methodology

The end of project evaluation aimed to assess the project's impact using the project indicators and a combination of quantitative and qualitative data collected through two key processes:

1. **Desk-based review** of project reports; project monitoring data; annual surveys conducted with project beneficiaries; documented focus group discussions; and documentation of most significant change stories, assessed against the baseline & DHS surveys.
2. **Field-based research and in-country project reviews in Malawi and Zambia** covering four project sites, using participatory methodologies to review stakeholder engagement and assess the impact of the project on primary beneficiaries and partners. In Malawi, fieldwork took place in Chiuzira, Lilongwe District (rural) and Mbayani, Blantyre District (peri-urban); while in Zambia the two sites were Chunga in Lusaka (urban) and Naluyanda, Mungule in Chibombo District (rural). Key components of the in-country reviews included:

    - **4 project review meetings** with key community stakeholders in Blantyre, Lilongwe (held prior to the field work), Lusaka and Chibombo districts.
    - **18 key informant interviews** (KIIs) conducted with health facility staff, volunteers, community and religious leaders, and St John staff.
    - **9 focus group discussions** (FGDs) with pregnant women and new mothers.

A total of 180 community stakeholders participated in the field-based research and in-country reviews; the schedule is included in Appendix 1, together with a detailed breakdown of those interviewed and consulted in Appendix 2.

Key evaluation questions included:

1. How relevant were the project's objectives in addressing the main issues relating to maternal and newborn health in the communities?
2. To what extent/in which ways has the project benefitted pregnant women and new mothers?
3. To what extent/in which ways has the project led to improved care of newborn babies at community level?
4. To what extent/in which ways has the project improved family planning outcomes for new mothers?
5. To what extent has the project strengthened referrals to and uptake of health services i.e. ANC, PNC, family planning? How could this be further improved?
6. How has the project encouraged male involvement in pregnancy and safe delivery? To what extent has this been successful and how could this be strengthened?
7. What worked well, what didn't go well, what could be done to improve the project in future?
8. To what extent was the project able to put in place the conditions for sustainable gains?
9. To what extent have resources been converted to results for women targeted?

Limitations

A rigorous assessment of the management of the programme in Malawi and Zambia, including financial analysis, did not form part of the Terms of Reference for the evaluation, and was consequently not undertaken. No financial data has been reviewed and consequently issues relating to financial management, budget execution, cost effectiveness and value for money are not

addressed here. However, lessons-learned that were identified during the desk-based review and through KIIs that related to programme management were noted and are reflected in the report.

Although an indicator framework was originally developed for the Big Lottery proposal, a number of significant changes were made to the project between the development of the proposal and the project start-up. Notably, there were changes to the indicators as well as an increased focus on providing additional support to clinics, including outreach clinics supported by St John. However, it was not possible to modify the targets under the Lottery agreement. While St John recognised this discrepancy, including through internal project reports, this has resulted in the lack of an agreed overarching indicator framework that accurately captures the objectives and outcomes of the programme. This presented a key challenge in terms of structuring the evaluation against an agreed indicator framework. The project tracked over 50 detailed indicators (the majority additional); this evaluation reports on those that focus on information/referrals relating to key MNCH services and prioritises those indicators that focus on outcomes.

The process and rationale to establish the original project targets of people to be reached in each of the countries is unclear. This is particularly the case for Malawi, where project targets are significantly lower than those for Zambia, despite the final numbers reached by both countries being comparable. Finally, although a baseline was conducted in both countries at the outset by external consultants, some of the baseline data in Zambia was carried out by interviewing pregnant women outside ANC clinics. Consequently this resulted in a significant 'bias' in the data as these pregnant women were already known to be accessing services and were unlikely to be representative of women more generally. This report has therefore drawn upon relevant 2015 DHS data for pregnant women in Zambia, as this likely provides a more realistic 'baseline' from which to assess and measure any change. Baseline and/or DHS data was also not available for all the indicators, making it difficult to measure change against those indicators.

3. Summary of key findings

Project design

- The Mama Na Mwana project is **tackling high priority issues in maternal and newborn child health, in countries severely affected**.
- It has an **appropriate design**, and implementation strategies are relevant, including community mobilisation, health education, volunteerism, and ensuring linkages to and strengthening of existing public health systems.
- The project has **exceeded its targets** to reach primary beneficiaries with information and community-based referrals to improve maternal and infant child health in Malawi and Zambia. A total of 23,423 primary beneficiaries benefitted from these interventions, significantly exceeding the target of 17,110. This includes: 10,680 pregnant women; 7,245 new mothers with infants; and 5,498 men.
- The project's central strategy of **working through trained St John volunteers to visit pregnant women, new mothers and their husbands, partners and newborn infants in their homes has demonstrated impact** on improving access to information on safer motherhood and strengthening community-based referrals for MNCH.
- Supporting the **expansion of clinical services through the establishment of outreach clinics has increased access and uptake of ANC, PNC and FP services** in 'hard to reach' areas located far from existing health facilities in rural districts of Malawi.

- Working in **partnership with Government health facilities has helped to strengthen existing services, build capacity of staff and improve their motivation.** *Mama Na Mwana* has increased community-based referrals for services; St John volunteers have supported health care workers to run ANC and PNC clinics; project-supported outreach clinics have expanded service provision to rural areas, resulting in a more manageable workload for existing health centre staff; and the project has delivered basic repairs and supplies to strengthen health facilities.
- The project benefits from **high levels of engagement from a broad range of community stakeholders**, including Government health staff at local and district levels, St John volunteers, religious leaders and village chiefs, in addition to project beneficiaries. It has also increased the profile of St John Malawi and Zambia.

ANC

- There was a **demonstrable increase in the number of women accessing earlier ANC in their first trimester**, in line with WHO and national health guidelines. This rose from a baseline of 19% of women in Malawi and 24%[11] of those in Zambia at the beginning of the project to 36% for both countries by the project end date. Over half the women (53% in Zambia; 56% in Malawi) who participated in the EoP survey reported going to ANC earlier than in previous pregnancies, while 46% of women in Zambia and 36% in Malawi reported going to ANC more often than in previous pregnancies.
- Project monitoring data revealed **significant differences between Malawi and Zambia in the number of referrals and uptake of ANC and delivery at health services.** In Malawi 4,210 women were referred to ANC, against only 717 in Zambia, with a corresponding 3,870 women in Malawi against 491 in Zambia actually taking up these services. Stakeholder feedback raised concerns about the accuracy of the Zambia data and possible under-reporting due to volunteers failing to adequately complete forms, resulting in challenges for the referral system to accurately record data, track referrals through the project and demonstrate concrete results, despite consistent feedback from stakeholders of the project's impact on the uptake of services.

HIV testing

- Increased access to and uptake of ANC through the project resulted in **increased numbers of pregnant women testing for HIV during their current pregnancy**, rising from 86%[12] at the project outset to 98% in the end of project survey. Efforts to promote VCT during pregnancy are critical to support the integration of PMTCT interventions into safer motherhood activities and reduce the likelihood of HIV transmission from mother to baby. A total of 9,981 pregnant women were informed of HIV testing as part of ANC; with an additional 5062 husbands/male partners also receiving information on HIV testing through *Mama Na Mwana*.

Male involvement

- *Mama Na Mwana* **catalysed male involvement in project sites in relation to safer motherhood activities**, generating good initial progress from a low starting point and providing a solid foundation on which to build. 5,498 men (primarily husbands/male partners) were reached through the project and information was provided on ANC, HIV

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[11] DHS data used as challenges acknowledged with external baseline conducted in Zambia.
[12] DHS data

testing, preparing for delivery, developing an emergency plan, and danger signs during pregnancy and in newborn infants. However, prevailing gender-based norms means that MNCH continues to be regarded as 'women's issues,' and promoting male involvement requires continued effort.

- Key stakeholders and primary beneficiaries highlighted **increased numbers of men accompanying their wives to ANC and supporting them to buy the necessary supplies to prepare for delivery.** The need to buy basic items was also cited as a previous source of conflict in the home, and in both rural and urban sites in Zambia this was given as an example of how the project "increased harmony" among spouses.

Safe delivery and PNC

- The **percentage of women giving birth in a health facility was significantly higher amongst women enrolled in the project compared to DHS data, particularly in Zambia.** 90% of women in the EoP survey conducted in Zambia reported giving birth in a health facility, compared to 67% in DHS data. In Malawi sites, baseline data indicated existing low levels of home deliveries in these sites, which is also consistent with national DHS data.
- **Women involved in the project and who delivered at home were significantly more likely to visit a health facility for the baby's check-up compared to DHS data.** Amongst women who delivered at home, those who reported visiting a health facility the same day the baby was delivered was 72% in the EoP survey, significantly higher than the 11% reported through DHS data. Similarly, 92% of women across both countries reported visiting a health facility during the baby's first week of life, very substantially higher than the 17% reporting this through DHS data.
- Key stakeholders **cited a reduction in infant and maternal mortality in project sites** as a result of access to safer motherhood information and services, although clinical data was not consistently available to verify this. Knowledge of danger signs during pregnancy, following delivery and in newborn infants; taking appropriate action to seek help at a health facility immediately; and ensuring safe delivery by skilled personnel in a health facility are reported to have had an impact.

Exclusive breastfeeding

- 7,187 new mothers received information on the importance of immediate and exclusive breastfeeding for a minimum of 6 months, and **56% of new mothers enrolled in the project exclusively breastfed their child for more than 6 months, substantially higher than 20% of DHS respondents.**

Family Planning

- A total of 6,993 women received information about the importance of starting family planning (FP) at 6 weeks following delivery, and **significantly exceeded targets set for new mothers referred for FP and those completing referrals**. 44% of new mothers enrolled in the project in Zambia were referred or self-referred for FP, with 44% of new mothers taking up FP through both referral and self-referral. 35% of new mothers in Malawi were referred to FP, with 31% of new mothers taking up FP through both referral and self-referral. This compares favourably to targets set for the end of the project of 20% of new mothers referred for FP. Clinical staff consistently highlighted a substantial increase in the numbers of women seeking FP, with clinical data from Area 18 health centre in Lilongwe demonstrating this: from 5,133 women receiving FP in

2014, this figure had increased to 8,657 for 2017. While the project is unlikely to be responsible for all of this increase, health staff clearly cited the contribution of new volunteer efforts in the community.

4. Progress towards project outcomes

This section will analyse the progress of the project towards achieving the three key results areas:

1. Ensuring healthy pregnancy and safe delivery for pregnant women
2. Improving health and support for new mothers and their newborn infants
3. Increasing access to and uptake of maternal and newborn child health services

TABLE 3: TOTAL BENEFICIARIES REACHED IN ZAMBIA AND MALAWI PROJECT SITES

	Malawi sites	Malawi Target	Zambia sites	Zambia Target	Total reached: Malawi & Zambia	Target: Malawi & Zambia	Fully met/ partially /not met
Primary beneficiaries: Pregnant women, new mothers with newborns, husbands and partners							
Pregnant women	5,479	1,830	5,201	4,650	10,680	6,480	**Fully**
New mothers with infants	2,804	1,830	4,441	3,600	7,245	5,430	**Fully**
Men	2,466	1,200	3,032	4,000	5,498	5,200	**Fully**
Total primary beneficiaries	**10,749**	**4,860**	**12,674**	**12,250**	**23,423**	**17,110**	**Fully**
Secondary beneficiaries: Community health education on maternal and newborn child health							
People educated in household & community activities	30,229	14,500	16,944	16,325	41,008	30,825	**Fully**
Number of volunteers trained in MNCH	120	115	60	45	180	160	**Fully**
Number of health care professionals trained	289	No target	0	No target	289	No target	**n/a**
Total people reached	**41,387**	**19,475**	**29,678**	**28,620**	**71,065**	**48,095**	**Fully**

The numbers of people reached through the project's activities exceeded all the targets set, with the exception of the Zambian target to reach men, which was partially met at 76%. However, the

rationale and process for setting the original targets is unclear. In Malawi, beneficiary targets are very low in comparison to Zambia, despite the fact that Malawi planned to recruit more than twice as many volunteers to reach these beneficiaries than Zambia. Final numbers of beneficiaries reached by both countries are in fact comparable and more realistic target-setting is now possible based on the project's experience of both the Malawi and Zambia volunteer models.

Tables summarising the positive changes demonstrated among project beneficiaries in Zambia and Malawi respectively are included in the Executive Summary (page 5).

Further information on numbers of people reached with specific interventions is available for Malawi and Zambia in Appendices 3 and 4 respectively.

Ensuring healthy pregnancy and safe delivery for pregnant women

Outcome 1: Improved knowledge, support and referral to health services for pregnant women, contributing to improved health during pregnancy and safe delivery

Key achievements:

- ✓ **10,680 pregnant women were successfully enrolled in the project** (5,479 in Malawi and 5,201 in Zambia) significantly exceeding the target of 6,480.
- ✓ **Earlier and more frequent access to ANC and more women visiting ANC in their first trimester**. Over half the women who participated in the end of project (EoP) survey reported going to ANC earlier than in previous pregnancies, while 46% of women in Zambia and 36% in Malawi reported going to ANC more often than in previous pregnancies. Women accessing ANC in their first trimester of pregnancy increased to 36% for both countries by the project end date.
- ✓ **Increasing numbers of pregnant women testing for HIV during their current pregnancy**, which is critical to the integration of PMTCT interventions into safer motherhood activities and reducing the likelihood of HIV transmission from mother to baby. An impressive 98% of women in the EoP survey indicated that they had tested for HIV in their current/most recent pregnancy.
- ✓ **More women giving birth in a health facility**, particularly in Zambia. 90% of women in the EoP survey in Zambia reported giving birth in a health facility, compared to 67% in DHS data. Amongst women who delivered at home, those who reported visiting a health facility the same day the baby was delivered was 72% in the EoP survey, significantly higher than the 11% reported through DHS data.

Antenatal care

WHO guidelines recommend that women attend antenatal care (ANC) within the first trimester (three months) of pregnancy, and a further three times before delivery, to ensure timely checks; early prevention of mother to child transmission (PMTCT) if necessary; and safe monitoring of the pregnancy for both mother and the developing infant. Under this outcome, volunteers focused on improving women's knowledge about the importance of ANC, increasing their access to and uptake of early ANC within the first trimester, and supporting them to complete the recommended four ANC visits.

The project successfully enrolled 10,680 pregnant women (5,479 in Malawi and 5,201 in Zambia), significantly exceeding the target of 6,480. All of these women were reached with messages about the importance and recommended schedule of ANC visits. The baseline survey and DHS data highlighted differences between knowledge levels and uptake of early ANC in Malawi and Zambia.

Most pregnant women know they should attend ANC during their first trimester (74% in Malawi and 58% in Zambia). However, the baseline data in Malawi and DHS data in Zambia suggest significant challenges in accessing these services: in the general population, only 19% of pregnant women in Malawi and 24%[13] of pregnant women in Zambia actually achieved this. However, among the project beneficiaries in both countries 36% of women went to ANC in the first trimester. The project's beneficiary surveys also show that 60% of pregnant women attended the recommended four ANC visits, a modest improvement from the DHS (54%) and baseline data (56%).

Over the project, 46% of pregnant women who were visited at home, or a total of 4,927 women, had not been to ANC and so were referred through St John volunteers. Of these, 89% of these women followed up on the referral to access ANC services. Project monitoring data revealed significant differences between the countries, with 4,210 women referred to ANC from Malawi against only 717 in Zambia and a corresponding 3,870 women against 491 in Zambia actually going for ANC as a result. However, project staff in Zambia raised concerns about the accuracy of this data as a result of significant challenges in filling out referral forms and in ensuring that beneficiaries take the forms with them to the health facility. Without the referral forms, it is impossible to track referrals through the project, resulting in this data failing to be captured and presenting a significant challenge in terms of being able to demonstrate concrete results.

Qualitative feedback from a range of key stakeholders, including project beneficiaries in both countries, highlighted earlier access to ANC, usually during the first trimester, women accessing ANC more frequently than during previous pregnancies and a substantial increase in the number of women attending all four recommended ANC visits. Women who had older children stated that they had not done so with their earlier pregnancies. Key stakeholders attributed these changes to:

- **home visits and community-based referrals from St John volunteers** to motivate and encourage pregnant women to attend ANC;
- **establishment of new outreach clinics in under-served areas providing ANC**, for example in Chiuzira and Kauma (Lilongwe district) , promoting easier reach and access to these services in areas located far from health centres;
- **support for dedicated ANC clinics within existing health facilities**, such as those implemented in Mbayani Health Centre, Blantyre and Chunga, Lusaka.

These strategies have been successful in ensuring that increased numbers of women attend ANC at the recommended time and frequency in Malawi. One mother in Kauma highlighted the changes brought about by St John volunteers and the establishment of an outreach clinic in her community,

> "In my previous pregnancies I only attended ANC twice. In my third pregnancy, St John volunteers visited me and encouraged me to go for ANC early so I went when I was three months pregnant and also had an HIV test. This was easier because I didn't need to travel to the hospital which is 10-15 kms away for ANC services or HIV testing, because St John had organised a monthly ANC outreach clinic in our village. (Mother of three, Kauma, Lilongwe district)

KIIs with nurses at health centres cited significant increases in the numbers of women accessing ANC. For example, the nurse-in-charge at Mbayani clinic (Blantyre) noted that referrals for ANC had

[13] DHS data used as challenges acknowledged with baseline conducted in Zambia.

more than doubled during the course of the project, from 30-40 per month to 70-80, while the nurse-in-charge at Ndirande Health Centre, Blantyre (with a large urban catchment) cited one clinic where he received 204 women for ANC. In addition to the increasing numbers accessing ANC, he also highlighted that women were accessing ANC in their first trimester, whereas previously women came in their 2nd or even 3rd trimester, and an increase in the number of women attending all four recommended ANC visits. However, ongoing challenges continue to prevent some women accessing ANC at the recommended time and frequency. In Malawi, women in different sites reported that pregnancy tests are only rarely available, and women are often told they have to buy them, inhibiting early pregnancy testing.

In Zambia, qualitative feedback from key stakeholders also indicates that the project has resulted in **increased numbers of women accessing ANC**, despite monitoring data from the Zambia sites failing to reflect this. The district Community Health Team Leader noted a fourfold increase in the numbers of women attending ANC in Chunga, while the Neighbourhood Health Community Chair highlighted that so many women were accessing ANC at Matero Referral Hospital that hospital staff complain about the queues. However, despite key stakeholders in Lusaka and Chibombo districts noting some improvement, promoting **uptake of ANC within the first trimester remains challenging**. ANC attendance before 14 weeks in Lusaka district is still below 50% (cited as 49%). District health staff reported that cultural beliefs that discourage pregnant women from revealing the stage of their pregnancy continue; they fear miscarriages through witchcraft activities. Shortage of money, and distance between home and the health facility were also cited as limiting factors.

Increased access to ANC through *Mama Na Mwana* also had an impact on the numbers of women (and their male partners) accessing **HIV testing**. A total of 9,981 pregnant women were informed of HIV testing as part of ANC; with an additional 5,062 husbands/male partners also receiving information on HIV testing through *Mama Na Mwana*. EoP survey data also demonstrates clearly that this information resulted in increased numbers of women actually accessing VCT; 98% of women enrolled in the project tested for HIV during their current pregnancy, significantly higher than the DHS data of 86%. This is a critical outcome to support safer motherhood interventions as HIV diagnosis early in pregnancy enables women living with HIV to access PMTCT interventions to improve their health and reduce the risk of HIV transmission to their infant. In Malawi, *Mama Na Mwana* supported the addition of a dedicated HIV counsellor in the Mbayani clinic in Blantyre district, and outreach clinics established in Chiuzira and Kauma also facilitated easier access to and increased uptake of HIV testing for pregnant women. Clinical data received from Area 18 health centre in Lilongwe district demonstrates this; the numbers of people going for HIV testing rose more than threefold over the course of the project, from 8,069 in 2014 to 27,665 in 2017. Key stakeholders in Malawi and Zambia also highlighted the benefits of ANC in providing folic acid, iron tablets, Fansidar (to treat malaria), and TB treatment, although stock-outs of Fansidar in health facilities in Malawi were repeatedly highlighted in both project sites visited during the in-country review.

Addressing health problems in pregnancy and ensuring safe delivery

Ensuring that pregnant women enjoyed a healthy pregnancy and were well-prepared and supported to ensure safe delivery was a key focus of St John volunteers' community visits. Topics included ensuring that pregnant women, their partners and other members of the household had a good understanding of the danger signs during pregnancy; providing information on healthy eating and lifestyles during pregnancy; and providing advice and support to ensure that women were well-prepared for delivery, including saving money to cover transport costs to a health facility and having the necessary supplies ready for giving birth and for their newborn infant.

Understanding the **danger signs** during pregnancy and knowing what to do if they arise, including who to seek and where to go, is an essential component of best practice MNCH programmes (also referred to as 'complication readiness'). The *Mama Na Mwana* baseline revealed low levels of knowledge about danger signs in both countries: only 16% of pregnant women and new mothers in Malawi and 17% in Zambia knew four or more danger signs; for men, it was 7% in Malawi and 26% in Zambia. This is challenging because complications of some kind in pregnancy and labour are common, with the baseline report noting that one in four women experienced serious health problems in pregnancy or within two days after birth, while one in five women experienced complications during labour. At baseline, of the quarter of women respondents who had experienced postnatal complications in the two days following birth, only 60% had sought help.

The project has prioritised efforts to address this, with volunteers providing information on danger signs to all pregnant women enrolled in the programme and an additional 4,498 male partners. During the fieldwork, there was significant anecdotal evidence from a broad range of key stakeholders of the importance of these messages and their impact at community level. Beneficiaries – including pregnant women, new mothers and fathers in both countries – highlighted their ability to recognise danger signs and reported that they had learned to seek help immediately at a health facility. One mother had suffered a miscarriage at 6 months during her first pregnancy and suffered from anaemia in her second and third pregnancies, accessing ANC late at eight months. When she became sick with swollen feet, arms and face seven months into her pregnancy, St John volunteers gave her a referral card to Kamuzu Central Hospital, where she was diagnosed with high blood pressure and admitted for three weeks. Her baby was later delivered safely and she notes, "*…had I known early about safe motherhood and danger signs, I wouldn't have had a miscarriage with my first pregnancy or health challenges with my other pregnancies".*

Health facility staff also noted that women are seeking help promptly from health facilities; the matron at Matero Referral Hospital in Lusaka reported that women come straight to the hospital now if they experience danger signs, rather than seeking advice first from a prophet or grandmother. Project monitoring data clearly demonstrates achievements in this area. A total of 1,054 women with danger signs were referred from the community to health facilities through the project, with 1,560[14] or 15% of pregnant women with danger signs (both referred and self-referred) reaching the health facilities in the project sites. Data in Malawi illustrates particular progress in this area, with 855 women with danger signs referred and 1,398 or 25% of pregnant women accessing health facilities upon experiencing danger signs.

Volunteers also provided information to pregnant women on **nutrition** during pregnancy – including the importance of eating a balanced diet including each of the five key food groups; the importance of general hygiene; and advice on healthy lifestyles, including taking light exercise but avoiding heavy work and lifting. One pregnant woman shared the experience of losing her first baby when she was doing lots of heavy lifting as she had not previously understood the importance of avoiding doing so, but is taking precautions during her current pregnancy.

Field work in Malawi and Zambia also highlighted the importance of St John volunteers' discussions with pregnant women (and their male partners) to encourage **planning ahead and preparing for delivery**; including **saving money** to cover transport to a health facility; ensuring that they have

[14] This number exceeds the total number of women with danger signs referred to health facilities as it also includes those attending through self-referral

bought the necessary supplies to take with them (including *chetenje*/wrappers, sheets, soap, bucket, pads, razor blades, clip etc); and buying nappies and clothes for the baby. Women in both countries identified that, through the volunteers' visits, men now understand the need for these supplies and help to provide them. In most cases women stated that the advice from St John volunteers to save a little money regularly to buy these items had made it possible to do so, however in Malawi some women continue to identify challenges in saving this money, as one pregnant woman in Chiuzira, Lilongwe noted, '*There's no point in keeping money back if we have no food to eat'*. Women in Chunga, Zambia also emphasised the importance of very practical advice received from the volunteers, for example to have their supplies ready in bag, which they carry with them at all times as their due date approaches, and having at least three different numbers for taxi drivers to hand so that they have a 'back up' if one is not available.

This support provided by St John volunteers contributes to ensuring that women are actually able to access **safe delivery and skilled care at birth in a health facility**. Over the course of the project, 3,328 women were directly referred for safe delivery (956 in Zambia, with a significantly higher number of 2,372 in Malawi), with 91% or 3,038 of these actually taking up this referral (936 in Zambia, 2,102 in Malawi). This data may not reveal the full picture; in Zambia significant challenges were identified with volunteers failing to complete referral forms adequately. Additionally, women may go directly to health facilities when labour starts and women in rural areas such as Naluyanda often choose to stay with relatives in Lusaka near the time of their delivery in order to give birth in the well-equipped Matero Referral Hospital. FGDs and stakeholder consultations with pregnant women and new mothers certainly reiterated that all women had either given birth in a health care facility or planned to do so.

Key stakeholders, including health facility staff, local leaders and St John project staff and volunteers, highlighted that very few women continue to visit traditional birth attendants; the matron in Chiuzira, Lilongwe district cited that only one traditional birth attendant (TBA) continues to practise in Kauma, with far fewer women now visiting her - these births accounting for just 1-2 births out of every 100. In line with the Government's campaign to support safe motherhood and promote giving birth in health facilities, village chiefs in Malawi have imposed by-laws prohibiting women to give birth with TBAs and imposing fines on women who deliver babies at home, on the way to a health facility, or even within the grounds of a health facility if the baby is delivered before a skilled health care worker arrives to tend them. In such cases, women are not given birth certificates for their babies, but have to return first to their home, explain the situation to the village chief who charges a fine (in some places, a goat) and then return later to the health facility for the birth certificate. Such punitive measures have consequently succeeded in dramatically reducing the number of home deliveries in Malawi.

In Zambia, stakeholders reported similar progress in promoting safe delivery in health facilities; a reduction in women giving birth in the community with 'African medicines'; and cited a subsequent reduction in maternal deaths. In Naluyanda, the nurse identified that more women were now delivering at the Health Post, although some women – including those with complications – travel to Lusaka to attend either Matero Referral Hospital or University Teaching Hospital (UTH). This was reiterated in a FGD with new mothers in Naluyanda; four out of fourteen said that they had previously given birth at home but had delivered their most recent infant at the Health Post, attributing this directly to the awareness-raising and community mobilisation activities of St John volunteers. In Chunga, Tendai had her first three children at home but her fourth child in the health facility as a result of her interactions with St John volunteers.

> *"The visits by St John volunteers helped me and my mother-in-law to change our mind set of delivering at home; I had not known that I was putting my life and my baby's life at risk when I deliver at home."* (Mother of three, Chunga, Lusaka district)

This is compelling feedback on the ability of St John volunteers to reach those in their community and ultimately change the health-seeking behaviour of their neighbours. Nevertheless, stakeholders in both countries emphasised the importance of continuing to promote safe delivery messages as some women continue to visit TBAs. Long distances from health facilities equipped for delivery, poor roads and lack of transport (particularly at night) also remain ongoing challenges for women in both countries, particularly those living in rural areas.

Male involvement

Engaging men in SRHR and MNCH programmes is critical to support behaviour change and increase health-seeking behaviour for mothers and their newborn infants, given the impact of men's attitudes, behaviours and decision-making on women's health in general, as well as maternal health and child health. *Mama Na Mwana* established clear targets from the outset of the project for St John volunteers to reach out to men in the community, primarily through home visits. The importance of male involvement was emphasised from first engagement with the beneficiaries and highlighted specifically within the SOPs, with a detailed SOP later developed to strengthen this work and to provide specific guidance on strategies to reach husbands and male partners, and the key issues to discuss in these meetings.

By the end of the project's final year, a total of 5,498 men had been reached through the project, achieving the ambitious target set of 5,200. However, there were significant differences between Malawi and Zambia's targets for the programme. While Malawi's target was 1,200 husbands/partners, the same target for Zambia was more than three times higher at 4,000. Consequently, although the figures of men reached in both countries are comparable (2,466 for Malawi; 3032 for Zambia), the Malawi volunteers succeeded in reaching almost double their target to engage men in the programme, while Zambia fell significantly short of theirs. Quarterly reporting data reveals that very high numbers of men engaged in the programme were reached with messages emphasising the importance of attending ANC with their female partners/wives; the importance of HIV testing through ANC; and the importance of developing an emergency plan during pregnancy, delivery & after delivery.

Male involvement was cited as a positive development in both countries, in particular through husbands' support for purchasing basic items for delivery and the new baby. The need to buy basic items was also cited as a previous source of conflict in the home, and in both rural and urban sites in Zambia this was given as an example of how the project "increased harmony" among spouses. The ANC midwife nurse in Chunga suggested this could also contribute to a wider strategy to reduce gender-based violence. Health care providers identified that more women are coming to project health facilities with all the items necessary to give birth; this has also had a positive impact on how women are treated by staff as previously they were chastised or shouted at if they came without the necessary supplies. Women in Mbayani also noted that men now make more effort to be home on time after work to help out; new mothers in Lusaka highlighted that men had supported them to eat a balanced diet.

Mama Na Mwana has also had an impact on increasing the number of men who attend ANC with their wives/female partners, although key stakeholders identify this as a continuing challenge requiring additional efforts. One father from Chunga, Zambia shared his experience,

> *"Through St John volunteers I learned that, as a man, I should also get involved in the pregnancy of my wife. I gained knowledge and started helping my wife with house chares. I gained courage and escorted my wife for her second antenatal appointment and was tested for HIV and other STIs. I was so impressed with the reception I received at the clinic and I advised all men to start going for ANC with their partners."*
> (Father of two, Chunga, Lusaka district)

Although health staff in Lilongwe and Blantyre districts in Malawi and those in Lusaka, Zambia cited receiving more women accompanied by their male partners, this amounted to approximately 20% of women. Gender-based norms continue to mean that men shun women-dominated environments like health centres, particularly where there may be nowhere for them to sit; women sit on mats on the floor or on benches depending on the location of ANC, but there is no place for men to sit. The lack of privacy in health facilities means that men do not want to discuss issues during consultations in front of other women who are waiting, and men are not allowed to attend when women deliver. Fathers consulted through a stakeholders' meeting in Chibombo district, Zambia, recognised that male involvement remained difficult as a consequence of 'traditional values' and men's busy work schedules making it difficult to take time off to attend appointments.

As part of national efforts to promote male involvement, women who are accompanied by male partners are prioritised and seen first at health facilities. This has proven a successful incentive to increase the number of men attending ANC in both countries. A pregnant woman in Chunga, Lusaka noted, '*I was the 13th lady there, but the 3rd to be seen as our husbands were with us. My husband was able to go back to work after the appointmen*t'. She noted that receiving the messages about attending ANC with her husband had enabled them to plan ahead so that he was able to ask well in advance for time off from work to attend the appointment. While this undoubtedly served as an incentive for some women, others who could not persuade their husbands/male partners to attend noted feeling isolated.

Notably, key stakeholders – including St John volunteers, pregnant women and new mothers and health facility staff in Naluyanda, Chibombo district – cited significantly higher numbers of men accompanying their wives to ANC, estimated to be 7 or 8 out of every ten women visiting the clinic, and contrasted to the 20-25% in other project sites in both Zambia and Malawi. This finding is interesting because half the volunteers in Naluyanda are men, the only project site to achieve this gender balance in volunteer recruitment. Male volunteers noted that they had also changed their schedules so that they conducted home visits at the weekend when men were usually at home. Increasing the number of male volunteers to achieve a more consistent gender balance across project sites appears to be a key strategy to reach out to more men through the project, and potentially also to increase the impact of the messages they deliver to other men. This builds upon findings from FGDs conducted as part of a mid-term review of the project, where men proposed the recruitment of more male volunteers, potentially due to their reluctance to discuss sexual and reproductive health (SRH) issues with female volunteers. Increasing male involvement requires ongoing effort to sensitise men in safe motherhood through home visits to further improve their participation.

Improving health and support for new mothers and their newborn infants

Outcome 2: Increased postnatal care and support to new mothers and their babies, contributing to improved health and a reduction in preventable infections for women and babies, increased access to family planning and increased practice of good newborn care at community level.

Key achievements:

- ✓ **Very high numbers of women accessing PNC at least once after leaving the health facility** having given birth. In Zambia, almost all women (99%) in the EoP survey had done so (10% higher than the corresponding DHS data), while in Malawi this was 89% (compared to 50% in the DHS data).
- ✓ **More women breastfeeding their baby within the first hour after delivery**, and exclusively breastfeeding their baby for six months, particularly in Zambia. 88% of women cited breastfeeding the baby within the first hour in Zambia, an increase of 40% over the baseline. Across both countries, 56% of new mothers enrolled in the project exclusively breastfed their child for more than 6 months, substantially higher than the 20% of DHS respondents.
- ✓ **Very high numbers of women reporting that they are currently using a FP method**; 80% of women in Malawi (36% higher than DHS data of all women, and a 10% increase on the baseline of recent mothers); 92% in Zambia (57% higher than DHS data and a 42% increase on the baseline).
- ✓ **Women who want to wait at least 2 years before their next pregnancy increased by 19%** from the baseline in Zambia.

Postnatal care for new mothers

Mama Na Mwana volunteers conduct a minimum of two visits with new mothers and their babies in their homes (usually at 6-7 days and at 6 weeks), in addition to supporting their referral to PNC clinics. Additional home visits are conducted in cases where the women or babies have complications, for example low-birth weight babies or women who have experienced problems during delivery. These visits follow the volunteers' SOPs. Over the three years, the project reached a total of 7,245 new mothers (2,804 in Malawi; 4,441 in Zambia), exceeding the target figure of 5,430 by 133%. The project met its overall target of new mothers adequately 'informed' about PNC (1,980 against a target of 1,830 in Malawi; and 3,538 in Zambia, just below a target of 3,600).

The project baseline found very high numbers of women already accessing PNC, with 90% of women who had delivered in the previous two years in Zambia reporting they received PNC within the first week, while DHS data shows a much lower figure of 44%. In Malawi the DHS data indicated 50% of women attended at least one PNC visit, and among project beneficiaries this was 97%. In Zambia the DHS showed 89% of new mothers attending PNC at least once, and among women registered in Mama Na Mwana it was 99%.

Recognition of postnatal danger signs and referral to health facilities are critical interventions in improving maternal and neonatal morbidity and mortality. By the end of 2017, project staff in Malawi had referred 519 new mothers with danger signs to a health facility, a fifth of those enrolled in the project (19%). The number of new mothers actually seeking treatment exceeded this number (534) due to referrals and self-referrals by women who had received information from the project. The project's efforts to involve men and educate them about postnatal danger signs are likely to also have contributed to this. A total of 1,582 men in Malawi and 3,627 men in both countries were informed about postnatal danger signs in new mothers and advised to seek medical help immediately in an emergency.

End of project FGDs in Malawi and Zambia demonstrated that the information on PNC is well-received and having an impact on health-seeking behaviour and uptake of services. All new mothers reported having complied with the recommended PNC schedules for visits and check-ups, with new mothers in Chiuzira, Lilongwe district emphasising the impact of being able to access PNC services locally through the project's outreach clinics and thus avoid travelling. New mothers with more than one child reported that they had not previously accessed PNC services with their older children.

Neonatal care

During PNC visits, Mama Na Mwana volunteers provided information to new mothers and fathers on: umbilical cord care; good thermal practices; danger signs in newborn infants; general hygiene, including keeping the baby clean; exclusive breastfeeding; and 'kangaroo care' (skin to skin contact where the baby is placed on the mother's stomach for warmth, with its head positioned between her breasts to aid feeding) for low birth weight babies below 2.5kg. In addition to meeting its targets to inform women of PNC, the project also reached a total of 3,585 new fathers (1,557 in Malawi; 2,028 in Zambia), with information about care for newborn infants.

The project's demonstrable results in PNC for mothers is not consistently mirrored in data relating to urgent care for newborn infants with danger signs. In Malawi, 228 newborn infants with danger signs were referred from the community to health facilities and only 122 are recorded as actually having received care at a health facility. This data demonstrates a concerning gap in relation to fully meeting this outcome and the project's potential contribution to reducing infant morbidity – and potentially mortality. Corresponding data in Zambia shows 55 infants with danger signs were referred and 56 women took their infants to have a danger sign checked (both referrals and self-referrals).

Exclusive breastfeeding

Mama Na Mwana project volunteers promote exclusive breastfeeding for six months, in line with WHO guidelines. Exclusive breastfeeding for the first six months of a child's life is strongly recommended for all women, and there is an additional emphasis on this for women living with HIV, as part of an essential package involving ART and designed to avoid mother to child transmission. Volunteers provide advice and support on breastfeeding techniques (including 'latching on'), emphasise the importance of breastfeeding the baby within the first hour after delivery and the need to breastfeed the baby often ('on demand'). Volunteers in Mbayani in Blantyre also identified referring women who suffered from breast engorgement/pain to health services.

Baseline data found that the majority of babies were not benefitting from exclusive breastfeeding for the first 6 months, with only 17% (DHS) / 38% (baseline) of mothers in Malawi and 23% (DHS) / 36% (baseline) of those in Zambia doing so. EoP survey data showed a rise in figures to 52% in Malawi and 59% in Zambia. Through the project, a total of 7,187 new mothers (4,441 in Zambia and 2,746 in Malawi) received information about the importance of immediate and exclusive breastfeeding; this included all new mothers enrolled in the project in Zambia, and over 97% in Malawi (a few women moved out of the area after having initially enrolled in the project).

End of project FGDs with new mothers and pregnant women indicated that women were aware of the importance of exclusive breastfeeding for at least 6 months and were planning to follow this recommendation. Community volunteers confirmed that most women in the project are following this advice as a result of the counselling and support received. New mothers reported no problems

following the exclusive breastfeeding advice, and community-based maternal and newborn child health coordinators reiterated this, emphasising that the support available has helped to create a culture where women are expected to breastfeed. New mothers in Chunga, Zambia who participated in FGDs highlighted that increased awareness about exclusive breastfeeding through the project had resulted in them 'doing things differently' with this baby. With their older children women reported giving them a little porridge from 3 months, giving water in addition to breastfeeding and feeding for less than 6 months, whereas all reported exclusively breastfeeding this baby.

> *"I learned the importance of exclusive breastfeeding from St Johns Zambia volunteers. When they told me I was hesitant at first but one of the volunteers encouraged me with exclusive breastfeeding… I am thankful because my baby boy has not been sick… whereas my four previous children suffered from diarrhoea from the age of 4 months. With my first 4 pregnancies, my mother-in-law used to advise and give the babies an orange saying that the baby will be moving his or her bowels easily. I also used to give my babies porridge at the age of 2 or 3 months.* (Mother of five, Zambia)

Postnatal family planning

The spacing of pregnancies has a major impact on maternal and child health: WHO guidelines recommend women space their pregnancies by at least two years. Current guidelines recommend that women begin using a family planning (FP) method at six weeks following delivery.

A total of 6,993 women were informed about the need to start FP six weeks from delivery and advised on different options. The EoP survey showed that women using FP had risen from 70% at baseline to 80% in Malawi, and 45% at baseline to 92% in Zambia.

KIIs and FGDs provided some insights into these findings. Beneficiaries and other key stakeholders highlighted that the establishment of new outreach clinics in previously under-served areas, for example in Chiuzira, Lilongwe district, and the addition of dedicated ANC and PNC clinics within existing health facilities in both Malawi and Zambia, had significantly improved access to FP. They also reported that through community-based outreach, volunteers had improved women's understanding of the importance of beginning FP six weeks following delivery. One stakeholder noted that the Family Planning Coordinator in Bwaila District Hospital (Lilongwe district) commented that he is now over-worked as so many women are coming to him from project areas! Clinical data from Area 18 health centre in Lilongwe demonstrated a clear increase in women accessing FP, from 5,133 women in 2014, to 8,657 for 2017.

This was reiterated by nurses in both Chunga (Lusaka, Zambia) and Mbayani (Blantyre, Malawi), who have seen a significant increase in women coming to them for family planning – around 700-900 each month. St John volunteers, beneficiaries and other key stakeholders also noted that most women now planned to have 2-4 children, whereas previously some families had 8-10 children. One woman noted,

> *"I have since done tube ligation and my husband and I are so grateful for what St John Volunteers have done for our family".* (Mother of nine children, Ndirande, Blantyre)

Despite significant progress in addressing attitudes towards FP and increasing access and uptake, there remains a continued need to educate and empower both women and men. Although

community misconceptions are being addressed through the project, traditional beliefs (for example, that women should not use contraception if they only have one child) and cultural and gender-based norms continue to exist that dictate men's ultimate decision-making in family planning and a preference to bear male children. Other barriers identified – particularly in Malawi – were regular stock-outs of contraceptive methods, including popular contraceptive pills and implants. Finally, the fieldwork revealed worrying findings regarding the reported lack of acceptability of condoms and the 'dual protection' they provide in preventing both unplanned pregnancy and STIs, including HIV. Despite recent progress in reducing HIV infections, prevalence rates in both countries remain high – 12.4% amongst adults in Zambia and 9.2% in Malawi, with significantly higher rates in some areas.[15] Integrating more focused efforts to promote condom use as a family planning method, in addition to HIV prevention method, are necessary to address the prevailing view expressed that '*only people with HIV use condoms*.'

Increasing access, support and uptake of maternal and newborn health services

Outcome 3: Increased access to and support for community-based health services and provision of antenatal care, postnatal care and family planning for pregnant women, new mothers and their babies, resulting in increased uptake of these services

Key achievements:

- ✓ **Improved access to information on safer motherhood, and strengthened community-based referrals for MNCH** through in-depth training of St John volunteers.
- ✓ **Increased access to and uptake of ANC, PNC and FP** through establishing outreach clinics to expand clinical services to 'hard to reach areas' in rural districts of Malawi.
- ✓ **Basic support to strengthen health service provision and capacity building to health centre staff**, with a view to increasing uptake of MNCH services
- ✓ **Reduced waiting times at established health facilities in Lilongwe district** as a result of the establishment of project outreach clinics in rural and hard to reach areas.

Increasing women's access to and uptake of health services to ensure healthy pregnancy, safe delivery and appropriate care for both new mothers and their newborn infants are central to the *Mama Na Mwana* project. Access to services remains a critical factor, particularly in rural districts in Malawi and Zambia that lack health facilities. Strengthening MNCH services to ensure that women receive appropriate, quality care once they actually reach the health facility is also crucial, with levels of satisfaction impacting on future uptake of services. To address this factor, and recognising that many health facilities in Malawi and Zambia still lack the basic resources to be able to provide appropriate (or even adequate) provision of care, the project provided modest investment to strengthen health facilities and ensure basic equipment and supplies are available for women accessing ANC, PNC and FP services. This is a cross-cutting outcome of the project and lays

[15] UNAIDS, 2017 cited: https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zambia

the foundation for success in outcomes 1 and 2, however no specific targets or indicators were set under this outcome.

Community outreach services

Community volunteers

Community volunteers have provided a strong foundation to promote sustainable change for *Mama Na Mwana*. A total of 180 community volunteers (120 in Malawi; 60 in Zambia) were trained by St John. This exceeded the target of 160. Training included initial first aid by St John and the SoPs delivered by Safer Motherhood Coordinators (and aligned with SMAG training in Zambia), with refresher courses also provided. Volunteers work in pairs to provide community-based outreach, health education, counselling, support and referrals to pregnant women, new mothers and their male partners in their homes, with the aim of promoting greater uptake of ANC, PNC and FP services. St John Malawi and Zambia conduct weekly supervision of volunteers and organise project review meetings with volunteers on a quarterly basis. Volunteers succeeded in improving women's and men's knowledge and understanding of the benefits of accessing health services early, and strengthening their capacity to do so.

Stakeholders identified this as an effective mentorship approach to improve uptake of health services for poor and under-serviced communities. Home visits have also proven an effective approach to reach men, who are traditionally reluctant to participate in MNCH initiatives as a result of cultural and gender-based norms, although continued emphasis to reach out to men and promote their involvement remains a priority in both Malawi and Zambia. Stakeholder feedback consistently praised the work of the volunteers and emphasised the importance of continuing to motivate and support them.

Outreach clinics

In rural districts of Malawi, *Mama Na Mwana* also supported staff from participating health centres to establish three monthly outreach clinics (focusing on ANC; PNC; and integrated health, respectively) in the areas of Chiuzira (Lilongwe district) and Kauma (Blantyre district), located far from health centres. This has been an effective strategy to support government health facilities to expand their reach to cover new and hard-to-reach areas, resulting in increased uptake of services. Health facility staff also appreciated that these outreach clinics had reduced their workload at the health centre, as many women were accessing their services through the outreach clinics. As an unexpected outcome key stakeholders, including the Safer Motherhood Coordinators, reported that the project provided additional motivation and developed a sense of team spirit amongst the health facility staff, who take it in turns to conduct the outreach clinics.

In addition to their role in community-based outreach, the volunteers also provide vital assistance at the health centre, supporting on average two clinics every week. Volunteers conduct initial checks on pregnant women in ANC clinics, for example weighing them and taking their blood pressure. Two volunteers are trained voluntary counselling and testing (VCT) counsellors supporting Naluyanda Health Post. Clinical staff at all health facilities appreciated the volunteers, noting the positive impact on the staff's workload and the reduced waiting times for women accessing the clinic.

Ongoing demand and challenges in locating and paying for transport led to stakeholders in Chiuzira, Lilongwe stressing the need to increase the number of outreach clinics. Stakeholders in both countries were also concerned about transport costs. Women in the rural district of Naluyanda, in Chibombo District in Zambia, said transport posed challenges, particularly if labour starts at night.

The nurse-in-charge at Naluyanda health post was concerned that women face dangers walking distances from their villages to the health post during the night, while those who are referred to Lusaka have to find and pay for transport and face a long journey over a bumpy road. These issues lead to some women delivering their babies in vehicles on their way to the hospital. Stakeholder feedback consistently highlighted the need for permanent health facilities to be located where the outreach clinics have been established, including facilities for safe delivery.

Capacity building of health centre staff and support to health facilities

Under outcome 3, the project also provided capacity building to health centre staff, as well as basic support to strengthen health service provision, with a view to increasing uptake of MNCH services. Health centre staff in Malawi and Zambia were trained on completing referral forms to track the uptake of services through the project; however, frequent turnover of health centre staff means this training needs to be regularly repeated, and additional sessions scheduled for those staff who may be absent or on leave. All stakeholders in Malawi believed that the referral system between the community volunteers and health facilities was working well. However, in Zambia – particularly in Chunga - significant problems were identified with both volunteers and clinical staff failing to complete the referral forms properly, and this is clearly reflected in the data reported.

In Blantyre, *Mama Na Mwana* collaborated with district health officials to provide additional training to health centre staff on the use of partographs to monitor the progress of labour. In Malawi, a total of 289 health care staff were trained in providing community-friendly services. The most intensive support was provided in Mbayani, where the District Health Office recognised that the existing health facility did not meet the required standards. The project supported the refurbishment of the clinic to a basic standard, including painting, providing benches for patients, basic clinical equipment (stethoscope, scales, blood pressure machine and examination couch), buckets and bed sheets. The project also covered the costs of a part-time midwife and HIV counsellor to provide services at the ANC clinic, and supported the re-stocking of basic supplies, including syphilis test kits and urine dip sticks. In Ndirande, where there were no existing health facilities, the project worked in partnership with the district health office to establish outreach clinics. The project covered the costs of renting a basic space to conduct the outreach clinics; essential equipment and supplies to equip the clinic (medical boxes to carry drugs, table, chairs for clients, water bucket and gloves); transport for clinical staff to travel from the health centre to the outreach clinic; and St John volunteers mobilised community members to attend the clinics. The district health office arranged for clinical staff from the health facility to facilitate the outreach clinics, and supplied test kits and medication.

Stakeholder feedback indicates that this has been an effective strategy to increase access and uptake of MNCH services in areas where these either did not exist previously, or where health facilities were so poor as to inhibit access. Nevertheless, the outreach clinics – conducted in rooms attached to a school – offer little privacy and few facilities, with some services having to be undertaken outside. Despite the support provided by the project, Mbayani health facility remains in need of further strengthening. Staff are over-stretched; the infrastructure is unfinished; there are no beds; the facility is not equipped for delivery; medical equipment is not disposed of properly; and there are regular stock-outs of essential drugs including malaria drugs, iron tablets and contraceptive pills – sometimes for up to eight months. Stakeholder feedback highlights these as ongoing challenges for MNCH, particularly regarding access to safe delivery in Mbayani as these services are not available locally.

In Zambia sites, the health infrastructure and services provided are generally better developed than in Malawi sites, and consequently required less investment from the project. In Lusaka, the project

provided additional basic support to strengthen health service provision at Chunga health post, which covers the largest, most densely populated area reached in Zambia. This included supporting transport costs for a nurse to establish a new weekly ANC clinic, installing electricity, replacing the worn linen and providing a blood pressure monitor. In the rural district of Chibombo, the project provided some basic support to Naluyanda health post, including replacing broken water pipes to ensure running water. Stakeholder feedback during field work indicates a higher degree of satisfaction with services than in Malawi; facilities were generally agreed to be well-stocked, although Naluyanda health post lacks electricity, oxygen supply and adequate disposal facilities – the lack of an incinerator means that placentas are buried in a pit. These factors mean that in practice, many women prefer to give birth in Matero main hospital – recently refurbished to a high standard and located an hour by vehicle from Naluyanda over bumpy roads.

5. Lessons learned and recommendations

Access to health facilities and capacity of providers

- **Improve care for newborn infants by strengthening uptake of referrals to health facilities**. Address the current gap identified through project monitoring data to ensure that parents of babies referred with danger signs to a health facility actually take up this referral.
- **Strengthen the practice of health centre staff to ensure women's satisfaction with services and encourage referrals.** Although improving, unfriendly attitudes of health workers, who may chastise or even shout at pregnant women, remain a deterrent to women accessing services and negate volunteer efforts to increase community-based referrals. Building health centre staff understanding of the importance of developing respectful attitudes is critical.
- **Share challenges, lessons-learned and recommendations based upon *Mama Na Mwana* programme implementation with Government health providers to strengthen public health service provision**. Involve health facility staff in established monthly (Zambia) or quarterly (Malawi) meetings with volunteers to discuss progress and resolve any issues raised together; and invite community-based maternal and newborn care coordinators to support the supervision of volunteers on a quarterly basis. In Zambia, develop mechanisms to identify and share lessons learned between *Mama Na Mwana* and the national SMAG programme to contribute to building capacity of the national programme.
- **Build capacity of St John volunteers in rights-based approaches and strengthen mechanisms such as health facility committees to ensure the accountability of health facility staff and resourcing of services**. Strengthen volunteers' understanding of rights-based approaches to enable them to transfer this to community members and encourage them to report poor treatment and hold health facility staff accountable for their behaviour. Other potential strategies could include conducting exit interviews with clients to illicit feedback on services; including a suggestion box in health centres; developing quality standards; and inviting beneficiaries to attend meetings to provide direct feedback on services and strengthen accountability mechanisms.

Male involvement

- **Recruit more male volunteers** to build on existing progress and reach out to more men on issues relating to safe motherhood and newborn care and challenge gender stereotypes. Currently approximately 20% volunteers are men in both countries (in Malawi there are 25 male

volunteers and 95 female; in Zambia there are 12 volunteers are men and 47 are women). In Naluyanda (Chibombo district) where there are more male volunteers, this has enabled them to reach out to more men.

- **Adapt volunteers' visit schedules** to conduct visits at weekends when men are not at work; and change the 2nd scheduled visit – currently undertaken in a group setting with other pregnant women, and seen as inhibiting men's involvement – to an individual visit at home. Where volunteers have adapted their schedule to conduct visits at weekends – for example in Naluyanda – this has been an effective strategy to reach male partners and engage them in the project.
- **Reach out to men in male-focused environments and through influential leaders.** In urban districts, strategies could include working with large local employers to reach men at work and sensitise them to the project; and in rural settings working through established community 'structures' to engage and sensitise village chiefs/religious leaders to the project, and reaching men where they congregate in the community, such as to play *bawo*.
- **Work with health care providers to improve the environment of clinics and ensure that they are 'male friendly'**, for example providing chairs/benches for men to sit on and aiming to provide privacy where possible.

Project sustainability, expansion and scale up

- **Research and explore strategic partnerships with other organisations to expand project coverage, scope and impact.** Developing linkages with organisations already working in project sites and/or on specialist themes, for example, HIV/AIDS; adolescent SRH programming; income generation; and advocacy to improve health service provision, offers potential to improve project reach and impact, ensuring that resources are used most effectively and efficiently, and avoiding potential duplication.
- **Provide targeted support to women who test positive for HIV through ANC and their families in Zambia**. This could include working in partnership with relevant organisation(s) working in this field (for example, Mothers2Mothers; Centre for Infectious Disease Research Zambia) to deliver training on HIV/AIDS to volunteers to provide psychosocial support following HIV diagnosis; support to disclose their status to partners to avoid potential conflict and violence (for those not accessing VCT together during ANC); safer sex counselling, ART adherence support and referrals for PMTCT.
- **Integrate a strong component on rights-based approaches and community-based advocacy to promote increased quality and accountability for MNCH health services**. This is particularly relevant for Malawi, where the project has catalysed an initial awareness of the basic right to health, building on existing programming to further strengthen project outcomes and health service provision more broadly. Strategies for community-based advocacy have already been outlined and could be linked to district-level advocacy activities; supporting St John and clinical staff working on the project to attend district health meetings would ensure that the voices, needs and experiences of project beneficiaries are shared at this level. Their attendance would also improve knowledge-sharing on the project, identify potential opportunities and organisations to collaborate with on advocacy on health issues, and raise the profile of St John.
- **Support project scale up to reach more people with a similar package of essential MNCH support by expanding to new areas and scaling up the 'satellite outreach clinic' model for hard-to-reach and under-served districts**. In Malawi, intensifying current efforts within existing sites with large populations such as Ndirande in Blantyre district remains important to expand project reach. In addition, expansion to new areas could include both under-served rural areas located at some distance from existing health care services through expansion of the 'satellite'

outreach clinic model implemented in rural Lilongwe, in addition to expansion to new, more densely-populated areas such as Bangwe (central Blantyre) and Madzabango (west Blantyre), where DHO data reveals high number of births. In Zambia, any future expansion should prioritise sites where the national SMAG programme is not operational to increase potential impact and avoid duplication.

- **Strengthen efforts to promote male involvement and build upon these to address harmful gender-based norms**. Initial efforts to promote male involvement in both countries have had some demonstrable results, but remain a priority as it takes time to change these types of cultural/gender-based norms. The project provides a good basis to more concretely and explicitly address gender-based norms; for example, attitudes to family planning, fatherhood, masculinity and GBV in the community. The Government of Malawi has identified male involvement as a national priority; consequently any efforts to strengthen this at a community level would contribute to/link with national priorities.
- **Integrate MNCH programming with under-5s health programming**. Although MNCH remains a priority and under-served area compared to under-5s health programming, addressing priorities such as feeding and nutrition practices and childhood immunisations are relevant for under-5s programming.

Volunteer selection, training and support

- **Ensure that recruitment of St John volunteers includes appropriate 'representation' across the community.** For example, aim to increase the number of male volunteers to ensure a more equitable gender balance. Recruit some younger volunteers (particularly in Blantyre District) to ensure a more peer-led reach to adolescent mothers, highlighted as being particularly vulnerable and lacking in information about safer motherhood and newborn care. Incorporating volunteer turnover by year, gender and age group into the revised monitoring tools would also support effective local project management of volunteers.
- **Re-assess volunteer allowances in Lilongwe District to ensure that these are comparable across the project.** These were set based on a previous project and evaluation feedback highlights the need for St John Malawi to review the allowances in Lilongwe – currently paid quarterly, as opposed to monthly in Blantyre- to ensure that these are in line with volunteer allowances in Blantyre. Ensure creative strategies to continue to motivate volunteers – for example, providing certificates, nominating a 'volunteer of the quarter' award.
- **Ensure that recruitment and retention strategies for St John community volunteers are sustainable long-term and in line with national policies and practice.** The *Mama Na Mwana* programme implemented in urban districts of Lusaka complements the national SMAG programme. However, the St John volunteers are recognised to be better supported, better incentivised and consequently more active in their outreach activities; this may inadvertently undermine the efforts of the national programme (resulting in drop out of SMAG volunteers) and raise expectations that may be unsustainable long-term. Providing training to volunteers – for example to support future income-generation activities- and developing savings and loans schemes may offer a more sustainable and long-term incentive to reduce the dependence on 'allowances'. These strategies are also relevant for programme beneficiaries.
- **Broaden the volunteer training and accompanying SOPs to include new topics.** Topics could include: rights-based approaches on SRH and FP; STIs/HIV counselling; women's health including cervical/breast cancers; and practical advice on how to help a woman in labour, particularly as volunteers may be with women who deliver on their way to the health facility.

Project management[16]

- **Ensure a clear rationale to develop realistic project targets, particularly numbers of beneficiaries reached, based on lessons learned from implementing different volunteer models.** Project targets for the total number of people reached in Zambia are 1.5 times higher than those for Malawi, and for primary beneficiaries they are two and a half times higher in Zambia. However, there is little difference between their actual numbers reached and the basis for setting such low targets for Malawi at the project outset is unclear. This discrepancy in reach targets is further exacerbated by the fact that in Malawi there are more than twice the number of volunteers recruited by St John to support the project. This is only partially explained by the differences in their work schedules, with volunteers in Zambia expected to work an additional half day. *Mama Na Mwana* has clarified what is feasible to carry out in collaboration with 120 volunteers in four different sites in Malawi and 60 volunteers in three sites in Zambia and more realistic target-setting is now achievable.
- **Agree an established M&E framework including reduced number of core indicators at the outset of the project** to be applied consistently to monitor results and report on outcomes. Ensure that capacity is built to collect data to accurately measure and report on these indicators. The project currently tracks over 50 different and very detailed indicators, only a few of which actually focus on outcomes. This number is unrealistic in terms of tracking progress; developing indicators that focus on outcomes rather than process also helps to demonstrate impact of the interventions of the project.
- **Strengthen reporting processes to accurately track completed referrals to services.** Data collection and reporting in Zambia faced significant challenges associated with volunteers failing to fill out the relevant referral forms and referring women to services 'by word of mouth', while other women omitted to bring referral forms to health facilities. This had a serious impact on the project's ability to demonstrate increased uptake of ANC, PNC and safe delivery services in Zambia, despite consistent feedback from all key stakeholders that it had indeed done so.
- **Ensure greater transparency of project budgets so that staff responsible for programme implementation understand the budget and can respond flexibly to emerging needs**. This was evident particularly in Malawi – potentially exacerbated by the departure of the National Coordinator – where staff responsible for programme implementation in both Lilongwe and Blantyre had little knowledge or oversight of the budget and lacked the flexibility to respond to emerging issues highlighted over the course of the project. For example, staff reported an inability to provide financial support to health care staff to attend project meetings, or to mend community volunteers' bicycles as such costs were not included in the original budget.

[16] As noted, a focus on project management was not included within the Terms of Reference but these recommendations emerged strongly through the in-country review process

6. Conclusion

> *"The project is like a baby and needs to grow… No other health centres have a team of volunteers that they work with in this way, who can provide support and mobilise community members to access services."*
>
> (Community-based Maternal and Newborn Care Coordinator, Lilongwe)

Mama Na Mwana is tackling high priority issues in maternal and newborn child health in two countries severely affected. Levels of engagement by all key stakeholders are high and the objectives are clearly relevant to the community and 'add value'. Working through community volunteers, and in partnership with Government health facilities, the project has demonstrated some impressive results over the three year implementation period, exceeding project targets to reach primary beneficiaries with information and community-based referrals to improve maternal and infant child health in Malawi and Zambia. Most notably, the project has increased access and uptake of ANC (including increased numbers of women accessing these services earlier in their first trimester); increased numbers of women testing for HIV during pregnancy to integrate critical PMTCT interventions with safer motherhood; and increased access to safe delivery with more women giving birth by skilled health personnel. These results have been achieved through a combination of key strategies:

- **Home visits and community-based referrals from St John volunteers** to improve information on key topics through SoPs, and to mobilise and motivate pregnant women, new mothers and their families to attend safer motherhood services;
- **Establishment of new outreach clinics in under-served areas** to promoting easier reach and access to ANC, PNC and FP services in areas located far from health centres.
- **Support for dedicated ANC, PNC and FP clinics within existing health facilities** to accommodate increased demand from project sites.
- **Tailored basic support to strengthen specific health facilities, particularly in Malawi** where existing services did not meet the required basic standards of health care provision.

Mama Na Mwana also succeeded in catalysing male involvement on safer motherhood in project sites, with increasing numbers of men accompanying their wives to ANC and women reporting fewer conflicts at home as their husbands/male partners now understand the importance of preparing for birth and support them to buy the necessary supplies for delivery. Nevertheless, strengthening male involvement remains a priority upon which the project can usefully build.

Findings from this evaluation suggest that the project strategies are relevant to scale up to new areas and respond to identified community needs. Identifying sites where no existing safer motherhood interventions are currently implemented will ensure maximum impact and avoid duplication. Any project scale up should consider carefully potential partnerships with organisations already working in project sites and/or on specialist themes – including HIV/AIDS; adolescent SRH programming; income generation; and/or advocacy to improve health service provision – to increase project scope and impact, ensure that resources are used most effectively and promote value for money. Strengthening programme management, including establishing a robust M&E framework, paying greater attention to realistic target setting, developing a smaller set of indicators that can be measured consistently throughout the project to measure change, and

continuing to build local capacity of St John Zambia and Malawi in monitoring and reporting, are critical to support the future scale-up efforts.

Appendix 1: In-country schedule for Malawi & Zambia

November						
Saturday	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
4th	**5th**	**6th**	**7th**	**8th**	**9th**	**10th**
		KII Lilongwe	FGD Lilongwe	Writing/travel	KII & FGD Blantyre	Stakeholder review Blantyre
11th	**12th**	**13th**	**14th**	**15th**	**16th**	**17th**
Write up day	Travel to Lusaka, Zambia	Stakeholder review, Lusaka and Mungule	KII Lusaka	KII Mungule	FGD Lusaka	

Malawi:

6th November KII Lilongwe;
Chiuzira – chosen as most rural area

- 9.00 – 10.30; volunteers (2) Chiuzira
- 10.30 – 12.00; Matron Chiuzira
- 1.00-2.30; SMC safe motherhood coordinator/DNO Chiuzira
- 2.30-3.30; St john staff PO

7th November Beneficiary Feedback (Focus Group Discussion); 10-12 people each category
Chiuzira – chosen as most rural area

- 9.00 – 10.30; Pregnant women
- 11.15 – 12.45; New mothers with infants
- 2.00 – 3.30; Pregnant women with no husband/partner

8th November Travel to Blantyre/write up interviews

9th November KII Blantyre:

- 9.00-10.30; Focus group discussion new mothers- Mbayani community
- 10.30-11.45; Interview with volunteers (2)
- 1.00-2.30; Focus group discussion pregnant women- Mbayani community
- 2.30-3.30; Health staff interview (in-charge and ANC midwife) Mbayani Health clinic
- 30 minutes travel
- 4.00-5.00; Interview with SMC safe motherhood coordinator/DNO

10th November Stakeholder Review Blantyre:

- 9.00-12.30; Stakeholder Review Meeting (24 participants including 2 Blantyre DNO; 4 Health Centre representatives; 6 community representatives from Mbayani; 7 from Ndirande Community; 4 St John staff)
- 12.30-1.15; Interview with Nurse In charge –Ndirande
- 2.00-3.30; Interview with St John Staff (PO)

11th November; write up

12th November; Travel to Lusaka, Zambia

Zambia

13th November: KII Lusaka

- 8:00 – 12:00 at St John Zambia: St John staff, St John Volunteers; Dr Clara Mbwili, and Ivey Kekelwa Mbangu, St John Zambia Board Members
- 12:00 - 13.00 at Chunga Health Post: Chunga Health post midwife/nurse.
- 14:00 at Matero Ref: 14.00 – 14:45 Matero Ref matron, 15.15 – 16.00 NHC chair.

14th November: Stakeholder Review Meetings (Lusaka & Mungule)

9.00 – 12.30 Stakeholder Review Lusaka

- Neighbourhood Health Committee Chairperson; MCH coordinator from Matero Main; Matron from Matero Ref (SMAG trainer and coordinator for Matero); George health clinic – MCH head; Chunga health post – midwife/nurse; MCH Coordinator Mrs Banda (DHO), and beneficiaries (6).
- St John member Dr Mbwili and Mrs Mbangu Board members, selection of volunteers (4)

1.30 – 4.30 Stakeholder Review Mungule (also including stakeholders from Shifwankula)

- Traditional leaders (3) and religious leaders (3), midwife and In-charge from Naluyanda, In-Charge and Environmental Health Technician from Shifwankula, Neighbourhood health committee (2 chairs), beneficiaries (6), and selection of volunteers (4).

15th November: Beneficiary Feedback (Focus Group Discussions) & KIIs

FGD Mungule

- 8:00 – 12:00 Naluyanda; represent a range of beneficiary demographics including young, old, women without partners and women with >4 children.
- Pregnant women (12)
- New mothers (12)

KII Mungule

- 13:00 – 17:00 Naluyanda health facility; midwife and in-charge; Volunteers; NHC chair.

6 interviews

Thursday 16th: Focus Group Discussion

- 8.00 – 12:00 Chunga; Pregnant women (12) and New mothers (12) which will represent a range of beneficiary demographics including young, old, women without partners and women with >4 children.

Appendix 2: List of people interviewed/consulted

Malawi (total 93 stakeholders):

Matron Chiuzira, Area 18 Health Centre, Chiuzira, Lilongwe

Administrator, Area 18 Health Centre, Chiuzira, Lilongwe

Community volunteers (12), Chiuzira, Lilongwe

Pregnant women (9), Chiuzira, Lilongwe

New mothers (11), Chiuzira, Lilongwe

Community-based maternal and newborn care coordinator, Bwaila District Hospital, Lilongwe

Programme Officer, St John Malawi, Lilongwe

Pregnant women (15), Mbayani, Blantyre

New mothers (12), Mbayani, Blantyre

Community volunteers (2), Mbayani, Blantyre

Nurse-in-charge, Mbayani Health Centre, Blantyre

Safer Motherhood Coordinator, Blantyre

24 Representatives at Stakeholders' Meeting in Blantyre: representatives from Blantyre District Health Office (2), Chileka Health Centre (1), Mbayani Health Centre (1), Ndirande Health Centre (1), Chilomoni Health Centre 1), Mbayani Suya Community Chief, representatives Mbayani Community (6), representatives Ndirande Community (7) and St John staff (3)

Nurse-in-charge, Ndirande Health Centre, Blantyre

Programme Officer: Mana Na Mwana, St John Malawi, Blantyre

Zambia (total 87 stakeholders):

Nurse/midwife, Chunga Health Post, Lusaka

Matron, Matero Referral Hospital, Lusaka

Neighbourhood Health Committee Chair, Lusaka

15 Representatives at Stakeholders' Meeting in Lusaka: Maternal Child Health Coordinator from Matero Main; Nurse/Midwife form Chunga Health Post; Maternal Child Health Coordinator (District Health Office); St John Volunteers; pregnant women and new mothers

22 Representatives at Stakeholders' Meeting in Mungule (including stakeholders from Naluyanda & Shifwankula): Traditional leaders; religious leaders; midwife and in-charge from Naluyanda Health Centre; Nurse-in charge from Shifwankula; Neighbourhood health Committee representatives; pregnant women, new mothers and fathers; St Johns volunteers

Pregnant women (16), Naluyanda, Mungule

New mothers (14), Naluyanda, Mungule

Midwife/nurse-in-charge, Naluyanda Health Centre, Mungule

Environmental health technician/medical assistant, Naluyanda Health Centre, Mungule

Neighbourhood Health Committee Chair, Naluyanda, Mungule

Volunteers (2), Naluyanda, Mungule

Pregnant women (8), Chunga, Lusaka

New mothers (8), Chunga, Lusaka

St John Volunteers, Chunga (2)

St John Council Members (2)

Programme Staff: Mama Na Mwana, St John Zambia, Lusaka (2)

Appendix 3: Data by result area Malawi

Data by result area – Malawi				
Outcome 1: Improved knowledge, support and referral to health services for pregnant women, contributing to improved health during pregnancy and safe delivery				
	Indicator	**Total reached**	**Target**	**Fully/partially/Not met**
ANC	Number of pregnant women enrolled in project	5479	1830	**Fully**
	Number of pregnant women informed of ANC	7921	1830	**Fully**
	Number of pregnant women referred for ANC from the community to the health facility	4210		
	Number of pregnant women who sought/went for ANC after referral from the community to the health facility	3870		
	Number of women informed of HIV test as part of ANC	4893		
Safe delivery & serious health problems during pregnancy	Number of pregnant women referred for safe delivery from the community to the health facility	2372		
	Number of pregnant women who sought/went for safe delivery after referral from the community to the health facility	2102		
	Number of pregnant women informed of danger signs in pregnancy	5839		

	Number of pregnant women with danger signs referred from the community to the health facility	855		
	Number of pregnant women with danger signs who reached facility (both referred and self-referral)	1398		
Male involvement – husbands/ partners of pregnant women	Number of men enrolled in the project	2466	1200	**Fully**
	Number of men informed of ANC	2826		
	Number of men informed of HIV test as part of ANC	2322		
	Number of men informed of a possible emergency plan during pregnancy, delivery & after delivery	2543		
	Number of men informed of danger signs during pregnancy	1867		
Other community members	Number of people educated on maternal and newborn issues and practices during household and community activities	30,229	14,500	**Fully**
Outcome 2: Increased postnatal care and support to new mothers and their babies, contributing to improved health and a reduction in preventable infections for women and babies, increased access to family planning and increased practice of good newborn care at community level				
Postnatal – newborn health practices	Number of new mothers with newborns enrolled in the project	2804	1830	**Fully**
	Number of new mothers informed of PNC	1980	1830	**Fully**
	Number of pregnant women informed of umbilical cord care	2430	1830	**Fully**
	Newborn babies checked for signs of infections & action taken	1453	1830	**Partially**

	Number of new mothers informed of good thermal practices	2456	1830	**Fully**
	Number of new mothers informed of immediate & exclusive breastfeeding	2746	1830	**Fully**
	Number of new mothers with danger signs referred to care from the community to the health facility	519		
Postnatal – danger signs	Number of new mothers with danger signs who reached facility (both referred & self-referral)	534		
Neonatal – danger signs	Number of newborns with danger signs referred to care from the community to the health facility	228		
	Number of new mothers who sought care for newborns with danger signs at health facility (both referred & self-referral)	122		
Fathers of newborn babies	Number of men informed of newborn health practices	1557		
	Number of men informed of umbilical cord care	1419		
	Number of men informed of postnatal danger signs for mothers	1582		
Postnatal family planning	Number of pregnant women and new mothers informed about family planning	2874	610	**Fully**
	Number of new mothers informed about family planning are referred to FP services from the community to the health facility	983	451	**Fully**
	Number of new mothers who sought FP services at health facility (both referred and self-referral)	872	339	**Fully**
Outcome 3: Increased access to community-based health services and provision of antenatal care, postnatal care and family planning for pregnant				

women, new mothers and their babies, resulting in increased uptake of these services				
Volunteers trained	Number of volunteers trained in MNCH	120	115	**Fully**
Health workers trained	Number of relevant health personnel trained in delivering friendly services	289		

Appendix 4: Data by result area Zambia

Data by result area – Zambia				
Outcome 1: Improved knowledge, support and referral to health services for pregnant women, contributing to improved health during pregnancy and safe delivery				
	Indicator	**Total reached**	**Target**	**Fully/partially/Not met**
ANC	Number of pregnant women enrolled in project	5201	4650	**Fully**
	Number of pregnant women informed of ANC	5201	4650	**Fully**
	Number of pregnant women referred for ANC from the community to the health facility	717		
	Number of pregnant women who sought/went for ANC after referral from the community to the health facility	491		
	Number of women informed of HIV test as part of ANC	5088		
Safe delivery & serious health problems during pregnancy	Number of pregnant women referred for safe delivery from the community to the health facility	956		
	Number of pregnant women who sought/went for safe delivery after referral from the community to the health facility	936		
	Number of pregnant women informed of danger signs in pregnancy	5184		

	Number of pregnant women with danger signs referred from the community to the health facility	199		
	Number of pregnant women with danger signs who reached facility (both referred and self-referral)	162		
Male involvement – husbands/partners of pregnant women	Number of men enrolled in the project	3032	4000	**Partially**
	Number of men informed of ANC	2817		
	Number of men informed of HIV test as part of ANC	2740		
	Number of men informed of a possible emergency plan during pregnancy, delivery & after delivery	2952		
	Number of men informed of danger signs during pregnancy	2631		
Other community members	Number of people educated on maternal and newborn issues and practices during household and community activities	16,944	16,325	**Fully**
Outcome 2: Increased postnatal care and support to new mothers and their babies, contributing to improved health and a reduction in preventable infections for women and babies, increased access to family planning and increased practice of good newborn care at community level				
Postnatal – newborn health practices	Number of new mothers with newborns enrolled in the project	4441	3600	**Fully**
	Number of new mothers informed of PNC	3538	3600	**Fully**
	Number of pregnant women informed of umbilical cord care	4441	3600	**Fully**
	Newborn babies checked for signs of infections & action taken	4441	3600	**Fully**

	Number of new mothers informed of good thermal practices	4441	3600	**Fully**
	Number of new mothers informed of immediate & exclusive breastfeeding	4441	3600	**Fully**
Postnatal – danger signs	Number of new mothers with danger signs referred to care from the community to the health facility	88		
	Number of new mothers with danger signs who reached facility (both referred & self-referral)	84		
Neonatal – danger signs	Number of newborns with danger signs referred to care from the community to the health facility	55		
	Number of new mothers who sought care for newborns with danger signs at health facility (both referred & self-referral)	56		
Fathers of newborn babies	Number of men informed of newborn health practices	2028		
	Number of men informed of umbilical cord care	2045		
	Number of men informed of postnatal danger signs for mothers	2045		
Postnatal family planning	Number of pregnant women and new mothers informed about family planning	4119	3026	**Fully**
	Number of new mothers informed about family planning are referred to FP services from the community to the health facility	1944	740	**Fully**
	Number of new mothers who sought FP services at health facility (both referred and self-referral)	1944	740	**Fully**
Outcome 3: Increased access to community-based health services and provision of antenatal care, postnatal care and family planning for pregnant				

women, new mothers and their babies, resulting in increased uptake of these services.				
Volunteers trained	Number of volunteers trained in MNCH	60	45	**Fully**
Health workers trained	Number of relevant health personnel trained in delivering friendly services	0		