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

St John Zambia

Mama Na Mwana – Mother and Baby – in Malawi and Zambia
Management response to the external evaluation

We welcome the findings and recommendations of this evaluation, and we are very heartened by the results given that this was the first maternal and newborn health project undertaken by St John Malawi and St John Zambia. The results exceeded our expectations, and the report provides us with insights and relevant recommendations for a future phase of this programming.

We are particularly grateful for the evaluation's two main conclusions of this three-year effort:

- Mama Na Mwana is tackling high priority issues in maternal and newborn health in two severely affected countries. The project strategies – including community mobilisation, health education, volunteerism, ensuring support for existing health services and strengthening community-clinic linkages – are relevant to scaling up in new sites.

- The evaluation recommends expanding the project's coverage to benefit more people by reaching new sites with a similar package of essential support, and scaling up the 'satellite outreach clinic' model for hard-to-reach and under-served zones.

The evaluation also noted important changes brought about by this project that have benefited the lives of the people reached. We believe that these are sustainable changes which, for many of the 23,000 primary beneficiaries, will support maternal and infant survival and health practices during the rest of their lives.

The project used a combination strategy of:

a) volunteer support for improving health practices in households,
b) increasing community demand for key health services, and
c) basic support for the operations of health services.

The project reached more than 73,000 people. This included more than 23,000 people who registered as primary beneficiaries – pregnant women, new mothers with infants, new fathers and expectant fathers (137% of the project's target). Almost 50,000 other people were also reached with community health education on safe motherhood (161% of target).

We are also happy to have confirmed that the project has resulted in strong engagement and collaboration with district and local health staff, village chiefs and religious leaders, as well as almost 180 St John volunteers and the project's beneficiaries.

Improving healthy practices and increasing community demand for key services

St John's initial project proposal to the UK's Big Lottery Fund focused on positively influencing health practices in households. This included training local St John volunteers to provide support to their neighbours during pregnancy, delivery and the postnatal period through home visits. Volunteer training in both Malawi and Zambia, and refreshers during the three-year project, were undertaken in collaboration with Ministry of Health's Safe Motherhood Coordinators. The volunteer home visits were planned to match the recommended frequency of health checks during pregnancy and after the new baby is born.

An early and successful effort was the development of volunteer standard operating procedures. These were initially based on materials from the Zambia Safe Motherhood Action Groups (SMAG) in order to align volunteer action with national health guidelines. The standard operating procedures were expanded and adapted for use in both Malawi and Zambia, and later were adapted in two more pilot projects in Uganda and Zimbabwe in collaboration with local health staff. This allowed for a standard approach to volunteer outreach in each country.

Volunteer outreach was also reinforced through a community-clinic referral system and the referral activities have proven to be very effective. We learned that, in some project sites, ongoing orientation of the referral system is required for health clinic staff due to relatively frequent turn-over, caused by their health post re-assignments. There have been some issues of tracking the referrals and monitoring their uptake, notably in Zambia, and this will be strengthened as we move forward.

Improving health service access

St John added further resources at project start-up to directly support health service access. Three partner clinics received a basic package of support in Malawi (Mbayani) and Zambia (Chunga and Naluyanda). In Malawi, two other health facilities also collaborated to run outreach clinics to areas where there were no health services. The public health services provided staff, test kits and medication, and St John provided transportation and volunteer support. Just in the final year of the project, this resulted in 72 outreach clinics that provided nearly 3,000 new consultations and clinical services.

Key outcomes

The external evaluation notes that project data shows the following positive health outcomes, and it validated these findings through feedback from 180 community stakeholders.

- **Earlier and more frequent antenatal care (ANC)**. More than half the women taking part in the end-of-project survey reported going to ANC earlier than in previous pregnancies (53% in Zambia; 56% in Malawi). Furthermore, 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 as follows: from 19% of women in Malawi and 24% in Zambia at the beginning of the project, to 36% of pregnant women in both countries by the project end date.

- **Very strong HIV testing during pregnancy**. Among pregnant women enrolled in the project, 98% had an HIV test during their current pregnancy.

- **More women giving birth in a health facility in rural Zambia sites**, where the gap was most clear. Among the project beneficiaries, 90% of women in Zambia reported giving birth in a health facility, compared to 67% of women responding to the national Demographic and Health Survey (DHS).

- **Exclusive breastfeeding** that starts earlier and continues longer, with 79% of women breastfeeding their baby within the first hour after birth. More than half of new mothers

enrolled in the project (56%) exclusively breastfed their child for 6 months, substantially higher than 20% of DHS respondents.

- **Very strong use of postnatal care** by project beneficiaries. In the end-of-project survey, 99% of new mothers said they sought further postnatal care at least once after leaving the health facility where they gave birth.

- **Very strong use of postnatal family planning**. In Malawi 80% of women adopted a family planning method in the weeks after giving birth (a 10% increase from the project baseline). In Zambia this was reported by 92% of new mothers (a 42% increase from the baseline).

FURTHER IMPROVEMENTS

We are glad to receive a number of recommendations for further development.

- **Newborns with danger signs.** The evaluation notes demonstrable results in post-natal care, but also that these are not consistently mirrored in referrals data for newborn infants with danger signs. In particular, the project data shows a gap in the rate of completion of referrals made by volunteers for baby danger signs. Further progress on this is an immediate priority for reinforcing volunteer action in the communities reached by the Mama Na Mwana project.

- **Strengthening public accountability of local health services.** We agree with the proposal to add support for local accountability of health-care services. In all of the project sites there are existing mechanisms responsible for this, such as village or neighbourhood health committees and health facility committees. However, initial feedback indicates that in current project sites these committees could benefit from further training and capacity building. Depending on local need, this could cover: better use of data from the Health Management Information System supplemented by good quality feedback from health staff and project volunteers, and improved community consultation; stronger identification of local priorities and issues; representation of these issues to authorities in order for health services to better meet local needs; and monitoring of progress.

- **Strategic partnerships and linkages with other organisations.** In the project's final year, contact was made with a number of other organisations to explore collaboration and potentially widen impact. The results of this will depend on a number of factors. For example, some District Health Officials have been keen for this project to start work in underserved zones, but in these areas the health services often have few other active partners. Another approach would be putting forward multi-agency consortium proposals for new programming, and these are dependent on available funding opportunities. However, given these constraints we will continue to welcome joint action with other organisations, since this has the potential to mutually benefit from complementary action on different health and development needs in communities reached by St John volunteers.

- **Reaching younger women and men.** The recruitment of younger volunteers is certainly applicable in some of the project sites in order to ensure a more peer-led approach to adolescent mothers' support. The project has consistently reached relatively large numbers of young pregnant women and new mothers, indeed at a rate that matches national data on

pregnancies among adolescents and young women up to the age of 24 years – almost 40% of pregnancies in both Malawi and Zambia. In addition, we have seen that separating peer group discussions for younger and older project beneficiaries has received a better response from pregnant women and new mothers overall.

Peer group discussions for pregnant women were introduced half way through the programme to reach more beneficiaries with the available volunteers, and to provide women with peer support in addition to volunteer support. This meant reducing the number of home visits. A specific suggestion was to reinstate more household visits to allow volunteers to reach more men at home, but this is not felt to be the most effective option. In fact, since peer group discussions started the number of men reached by the project has actually increased. Therefore, it is felt that weekend outreach to men is likely to be a more effective option.

The project has resulted in more expectant and new fathers playing a larger role during pregnancy and when the new baby arrives. This is recognised as a challenging area, and more needs to be done to expand the involvement of men. To continue building on these positive efforts, we welcome the evaluation's suggested strategies including: recruiting more male volunteers; adapting volunteer schedules to conduct visits at weekends when men are at home; reaching men in male environments (e.g. large workplaces in urban settings) and through influential local and religious leaders; and working with health care providers to make clinics more 'male friendly'.

- **Volunteer allowances.** The evaluation's recommendation to ensure volunteer allowances are comparable across the project has been considered. However, it was felt that different allowance levels are necessary to be consistent with local practice. Instead, we are looking at placing greater emphasis on non-monetary support to volunteers in order to increase the sustainability of volunteer action. This could include self-help savings groups or other economic strengthening opportunities. We believe these will be more successful in rural sites, but where this is feasible it will provide a more sustainable approach moving forward.

- **Changes to target-setting and project monitoring.** We agree that the project is now better placed to set more accurate targets across a mix of urban, peri-urban and rural sites in the two countries. We are also currently revising the framework for MEL (monitoring, evaluation and learning). At implementation level, volunteers are likely to continue keeping track of a number of specific delivery indicators to ensure consistency, but upward reporting will focus on a reduced number of key indicators.

In conclusion, the evaluation provided an extremely useful external view of the efforts of St John in Malawi and Zambia, and we look forward to implementing these constructive recommendations in order to continue serving our communities.