Improved Utilisation and Opportunities for Reproductive Health for Women and Youth Project, Nkhotakota District, Malawi (November 2012-March 2016)

Final Evaluation

"Concern has made our lives better than before. Our VDC has grown like a plant into a big tree….Concern has been our right hand organisation" (VDC Member)

Prepared by Lisa Natoli
Consultant

March 2016

Contents

Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal care
BLM	Banja La Mtsogolo
CBDA	Community based distribution agent
CCAP	Church of Central Africa Presbyterian
CCPF	Chipatala Cha Pa Foni
CDA	Community development assistants
DHO	District health office
DMPA	Depot medroxyprogesterone acetate (long acting contraceptive)
DSA	Donor subsistence allowance
ETAF	Elizabeth Taylor AIDS foundation
FOCCAD	Foundation for Community Capacity Development
FP	Family planning
GAIA	The Global AIDS Interfaith Alliance
GRS	Grassroots Soccer
HICAP	Health Institution Capacity Assessment Process
HIV	Human immune deficiency virus
HoH	House of Hope
HSA	Health surveillance assistants
IEC/BCC	Information, education, communication/behavior change communication
ICCO	Interchurch Organization for Development Cooperation
KPC	Knowledge, practice, coverage
MOH	Ministry of Health
MMR	Maternal mortality ratio
NGO/INGO	(international) Non government organisation
PC	Peace Corps
PNC	Post natal care
SG	Scottish government
SSDI	Support for Service Delivery Integration
SO	Strategic objective
SOP	Standard operating procedure
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendants
TA	Traditional area
VCT	Voluntary counselling and testing (for HIV)
VDC	Village development committee
YFHS	Youth friendly health services
YRHA	Youth reproductive health agents

Acknowledgements

This project evaluation would not have been possible without the active participation of the volunteers, project beneficiaries, district officials, and project management team who gave so generously of their time. Lisa Natoli (Australia) was the external facilitator of this evaluation, but Allain Joram (Project Manager), Tiwonge Kisyombe (SKILLS Girls coordinator)- and Shaibu Malasa and Mavuto Billy who were hired to assist with this process were the ones who really made it possible! Thanks for being so diligent in note taking and translation, and for being organised so that everything went to plan.

Executive summary

With funding from the Scottish Government, Merck for Mothers, and the Elizabeth Taylor AIDS Foundation, Concern Worldwide has been implementing a maternal and reproductive health project in Nkhotakota district, Malawi from November 2012 – March 2016. The purpose of the project was to reduce maternal morbidity and mortality through three strategic objectives:

- ✓ Improve utilization of high quality maternal and reproductive health services through increased availability and accessibility of services
- ✓ Improve utilization of high quality community-based family planning services, including youth-friendly reproductive health, through increased availability and accessibility of services
- ✓ Improve capacity of government and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities

The specific purpose of this end evaluation is to: take stock of project achievements against targets; identify key successes and challenges associated with project implementation; and, serve as a learning exercise to inform the design of Concern's future maternal, reproductive, and adolescent health initiatives in Malawi and beyond. While this end evaluation will consider overall project implementation and achievements, emphasis is placed on assessing the following project components and their overall impact on the target population: the social and behaviour change activities implemented under Objective 1; and, the adolescent health interventions under Objective 2.

Several project components have already been evaluated: a mid-term review was performed in May 2015; the Health Institution Capacity Assessment Process tool – a key methodology under Objective 3, was evaluated in August 2015; and, the Chipatala Cha Pa Foni hotline service scaled-up under this project was evaluated in 2013. In addition, midterm (May 2015) and endline (March 2016) knowledge, attitude and coverage surveys were undertaken. Key findings from earlier evaluations are incorporated into this overall report, but those documents should be considered a reference point for more detailed discussion of specific findings.

The end evaluation used a mixed methods approach which comprised of the following strategies: A desk review of monitoring data and projects documents provided by Concern; interviews (6) and focus group discussions (9) with key project staff, partners and beneficiaries; and, a brief review of associated literature.

This end project evaluation took place in March 2016. The evaluation was guided by the Organisation for Economic Co-operation and Development's Development Assistance Committee criteria for evaluating development assistance with key findings as follows:

Effectiveness

Strategic Objective 1: The project has strengthened the quality of maternal health services (via provision of critical equipment and skills training) and this is reflected in overall client satisfaction. Access has been improved through the bicycle ambulances; knowledge of emergency transport increased from 45%-69% of 15-49 year old women between midterm to endline, and all 45 Village Development Committees (VDCs) that have received a bicycle ambulance have a standard operating procedure to guide utilisation. Project data also indicate some improvement in the percentage of births occurring with a skilled attendant (78% at midterm increasing to 83% at endline).

There was excellent improvement on the indicator of attendance for ante-natal care (ANC) but no change in the indicator on attendance for post-natal care (PNC). The percentage of women with a child 0-23 months who attended at least four ANC visits during pregnancy increased from 36.2% at baseline to 52% at endline, while the percentage receiving PNC remained unchanged (51% at both midterm and endline). Substantial improvement was also seen in consumption of iron tablets for 90 days during the last pregnancy (increasing from 10% of mothers of children 0-23 mths at midterm to 22% at endline).

There has been considerable improvement in relation to knowledge of danger signs during pregnancy and knowledge of newborn danger signs; the percentage of women aged 15-49 years with correct knowledge of at

least two maternal danger signs increased from 34% at baseline to 65% at endline, and the percentage of women aged 15-49 years with correct knowledge of at least two newborn danger signs increased from 23.5% at baseline to 71% at endline. Knowledge in this area was similarly reflected in focus group discussions (FGDs).

The Chipatala Cha Pa Foni hotline appears to be an important source of health information for women of childbearing age, receiving an average of 392 callers per month in 2015, with an initial surge in demand in early months that has now slowed. In addition, adult drama volunteers were noted as another important source of health information

Strategic Objective 2: The project has contributed to gains in knowledge of family planning (knowledge of three or more FP methods increased from 82% of 15-49 year olds at midterm to 95% at endline) and behaviour change is also apparent; the percentage of women of reproductive age using a modern method of contraception has improved from 39.7%% at baseline to 46% at endline.

Unfortunately use of modern methods of FP among women aged 15-19 years remains low (21% at midterm and 22% at endline); as some reflection of this, the percentage of 15-19 year olds that have begun childbearing is largely unchanged. However, there are high levels of awareness among young women of the benefits of delaying pregnancy. The percentage of girls 15-19 years that can state at least one benefit of delaying pregnancy increased from 70% at midterm to 79% at endline, and this was supported in the FGDs with SKILLZ Girls graduates.

Interestingly, qualitative data indicated that while attitudes of heath service providers towards young people requesting FP assistance have improved, adults in general are still judgemental towards sexually active youth, and young people generally don't attend health services to request FP. In addition, discussion with volunteers and beneficiaries confirmed that unwanted pregnancies and unsafe abortion continue to occur, especially among younger women.

Importantly, the project has been successful in strengthening community based FP services. Discussing of FP with a field worker or at a health facility in the past year increased from 27% of women aged 15-49 years at midterm to 43% at endline. In addition, the percentage of women aged 15-49 years who report accessing their FP supplies from a community based worker increased from 20% at midterm to 29% at endline. Qualitative data suggested that FP uptake among young people is better at the community level, suggesting that the introduction of Youth Reproductive Health Agents (YRHAs) and availability of FP supplies through peers has been an important intervention.

While there have been a number of challenges/delays in implementation of the youth drama component of this Strategic Objective, the idea of using peer communication/drama as a strategy is positive, and early signs of progress are promising.

Project monitoring data indicate that 61% of targeted communities have at least one peer counsellor trained in HIV and FP. The project has greatly exceeded expectations, reaching 12, 168 young people through the SKILLZ Malawi/SKILLZ Girls program. SKILLZ coaches and beneficiaries demonstrated great enthusiasm and a high level of knowledge on the various topic areas, and the fact that 93% of participants continued to graduation suggests suitability of this approach for the intended audience. Uptake of HIV testing has been high by SKILLZ graduates, and the Ministry of Health attributes the substantial increase in HIV testing in the district (from 26,011 in 2013/14 to 37,083 in 2014/15) to project activities. It is also likely that the program has contributed to cultural shifts in relation to gender and HIV, with young FGD participants commenting on a girls right to ask a boy to take a HIV test.

Strategic Objective 3 focussed on building the capacity of government and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities. Prior to 2010 there had been limited involvement of these strucutures in improving health services, let alone in holding the health system accountable to the communities it serves. Since that time however, Concern has been working to build the capacity of VDCs to be more involved in targeted health initiatives. The project worked with VDCs in targeted Traditional Areas (TAs) of Nkhotakota to raise awareness of important sexual and reproductive health (SRH) information, and foster greater ownership and develop accountability systems to improve the availability, accessibility and utilization of maternal health services.

To a large extent, the VDC capacity building was a pillar of this strategic objective. Capacity building of VDCs also re-enforced links between Strategic Objective 3 and the other Strategic Objectives (1 and 2), enabling a more comprehensive approach. To this end, VDCs were encouraged to and seemed to perform well in relation to providing oversight to community volunteers, building SRH awareness raising into their action plans, and administering bicycle ambulances.

Qualitative findings suggested that a number of traditional/culture based beliefs and practices that negatively impact on women of childbearing age appear to be shifting. It is difficult to say whether this is just a reflection of ongoing social change, or whether the project (and notably the advocacy of VDCs) has had some influence.

Overall, programme logic was thoughtfully considered and each Strategic Objective and component interventions either had an explicitly articulated theory of change or a sound evidence base. Efforts to tackle inequality and address the interests of the most marginalised were evident in the planning and implementation of a number of project interventions (such as the SKILLZ Girls program and the broad programme coverage- extending to the remotest TAs within the district).

Key successes and challenges as they relate to achievement or non-achievement of objectives were explored throughout this end evaluation and can be summarised as they relate to 'stakeholder engagement', 'strategic partnerships', 'health system strengthening', 'operational challenges', and 'traditional and cultural beliefs and practices'. These are detailed in the body of the report and relevant lessons are noted.

Efficiency

Participation of partners (in particular the District Health Office, Banja La Mtsogolo, Grassroots Soccer and Village Reach) and community level stakeholders (especially VDCs) has been entrenched and is central to project success. The decision to seek out strategic partnerships greatly influenced (mostly in a positive way) what could be achieved in the three year funding period.

It is extremely difficult to comment on whether resources were "well used" given the brief timeframe allocated to review this project, although it is apparent that considerable effort was spent on gathering information and making a thorough assessment of the operating environment and needs prior to spending. In addition, efficiencies gained through the partnership approach (e.g. cost sharing in relation to training of volunteers with Mai Khanda), meant that savings in the early years enabled a partial extension of activities (SKILLZ Malawi and CCPF hotline) to 3 additional TAs in the south and purchase of more bicycle ambulances than originally planned.

Superficially (without any cost/benefit assessment), several activities stand out as being good value for money. These include: the SKILLZ program, and in particular the promotion of HIV testing, challenging of gender norms, and training of YRHAs to extend access of FP supplies to the younger age group; and, the capacity building of VDCs and raising the profile of maternal health and gender concerns at the community level.

The commitment to monitoring and evaluation throughout the project has been commendable and rigorous. There was a definite effort to go beyond reporting against process related indicators, and to measure results or outcomes over time. Unfortunately however, while the KPC Baseline and Endline Survey Report for Dowa and Nkhotakota Districts (March 2013) was intended to provide baseline data for the project, there was considerable variation between the indicators used in the 2013 report, and those selected for the current project- and this made comparison over the long term difficult.

Relevance

The project has responded effectively to local needs, and the emphasis on maternal and reproductive health aligns completely with Ministry of Health (national and district) strategies and priorities. It has been based on sound development practice and thorough needs assessment at various stages in the project- based either on analysis of available data (district level data if available and if not, national level data), or if necessary, formative research.

Sustainability

It is difficult to articulate the likelihood of lasting activity, though effort has been made to summarise the various influences on sustainability for each of the smaller project components (within the body of the report). However- it might be questioned whether long term sustainability is indeed a realistic expectation- particularly in the context of such an inherently weak health system, with funding over a relatively short time period (3 years), and where some of the expected (behaviour) changes are quite complex. In addition, the heavy reliance on allowances (lunch allowance of MK2500 per person and reimbursement of transport costs or payment for fuel to enable DHO involvement) sets precedence for future engagement with such activities.

Impact

The 'Improved Utilisation and Opportunities for Reproductive Health for Women and Youth Project' has no doubt made a valuable contribution to improving maternal and reproductive health outcomes for women and youth in Nkhotakota District.

It is difficult to determine impact on maternal mortality and morbidity, although a range of project activities are likely to have impacted in a positive way; this is because the project has addressed a number of the root causes of maternal mortality and morbidity such as early marriage and pregnancy, lack of access to family planning supplies, and because access to emergency transport has been strengthened.

The project has assisted beneficiaries in the following ways:

- ✓ Improving knowledge and access to information (via CCPF hotline, the volunteer network, SKILLZ program and VDC's) regarding safe motherhood, newborn health and sexual and reproductive health.
- ✓ Contributing to behaviour change with respect to: consumption of iron tablets during pregnancy; use of modern contraception and accessing supplies at the community level; attending ANC and giving birth with a skilled attendant; and, uptake of HIV testing.
- ✓ Improving access to quality maternal health services at hospital and health facility level.
- ✓ Improving access to FP supplies and more youth friendly services, through YRHAs and building the skills of health service providers in terms of their attitudes towards young people.
- ✓ Improving capacity of VDCs and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities.

In addition, a number of traditional/culture based beliefs/practices that negatively impact on women of childbearing age appear to be shifting. It is difficult to say whether this is just a reflection of ongoing social change, or whether the project has been directly responsible.

1. Background

Malawi has one of the highest maternal mortality rates in the world, where one out of every 36 women dies due to pregnancy-related complications. Despite having made significant progress over the last 25 years, the 2015 maternal mortality ratio is 510 / 100,000 live births; significantly higher than the Millennium Development Goal target of 280[1]. While evidence-based, reproductive health interventions to address maternal mortality are being implemented in Malawi, the quality, availability, and accessibility of these services – especially for poor and vulnerable populations – remains a challenge[1]. Adolescent pregnancy is of particular concern in Malawi. By the age of 18, 50% of girls have married[2], and one quarter has had their first child[2]. Adolescents are estimated to account 20% of maternal mortality in Malawi.[3]

With funding from the Scottish Government (SG), Merck for Mothers, and the Elizabeth Taylor AIDS Foundation (ETAF), Concern Worldwide has been implementing a maternal and reproductive health project in Nkhotakota district, Malawi from November 2012 – March 2016.

Project objectives

The purpose of the project was to reduce maternal morbidity and mortality through three strategic objectives (SOs):

- ✓ Improve utilization of high quality maternal and reproductive health services through increased availability and accessibility of services
- ✓ Improve utilization of high quality community-based family planning services, including youth-friendly reproductive health, through increased availability and accessibility of services
- ✓ Improve capacity of government and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities

A total of 33,515 women of reproductive were targeted to benefit from a full package of facility and community-based interventions in three of seven Traditional Areas (TAs) in the district: Malengachanzi, Mwadzama, and Mwansambo. Selected activities (SKILLZ programme and CCPF hotline) were extended to the remaining four TAs and thereby extended the intended reach.

A range of activities were implemented at the district, facility, and community levels, both through direct implementation and partnership. The principal partner was the Ministry of Health (Nkhotakota District Health Office- DHO). Other core partners and collaborating organisations were as follows:

Core partners

- Village Reach- delivery of Chipatala Cha Pa Foni (CCPF) hotline
- Grassroots Soccer (GRS)- technical support to SKILLZ programme
- Banja La Mtsogolo (BLM)- support to Youth Reproductive Health Agents (YRHAs)
- Interchurch Organization for Development Cooperation (ICCO)- implementation of health facility reform activities

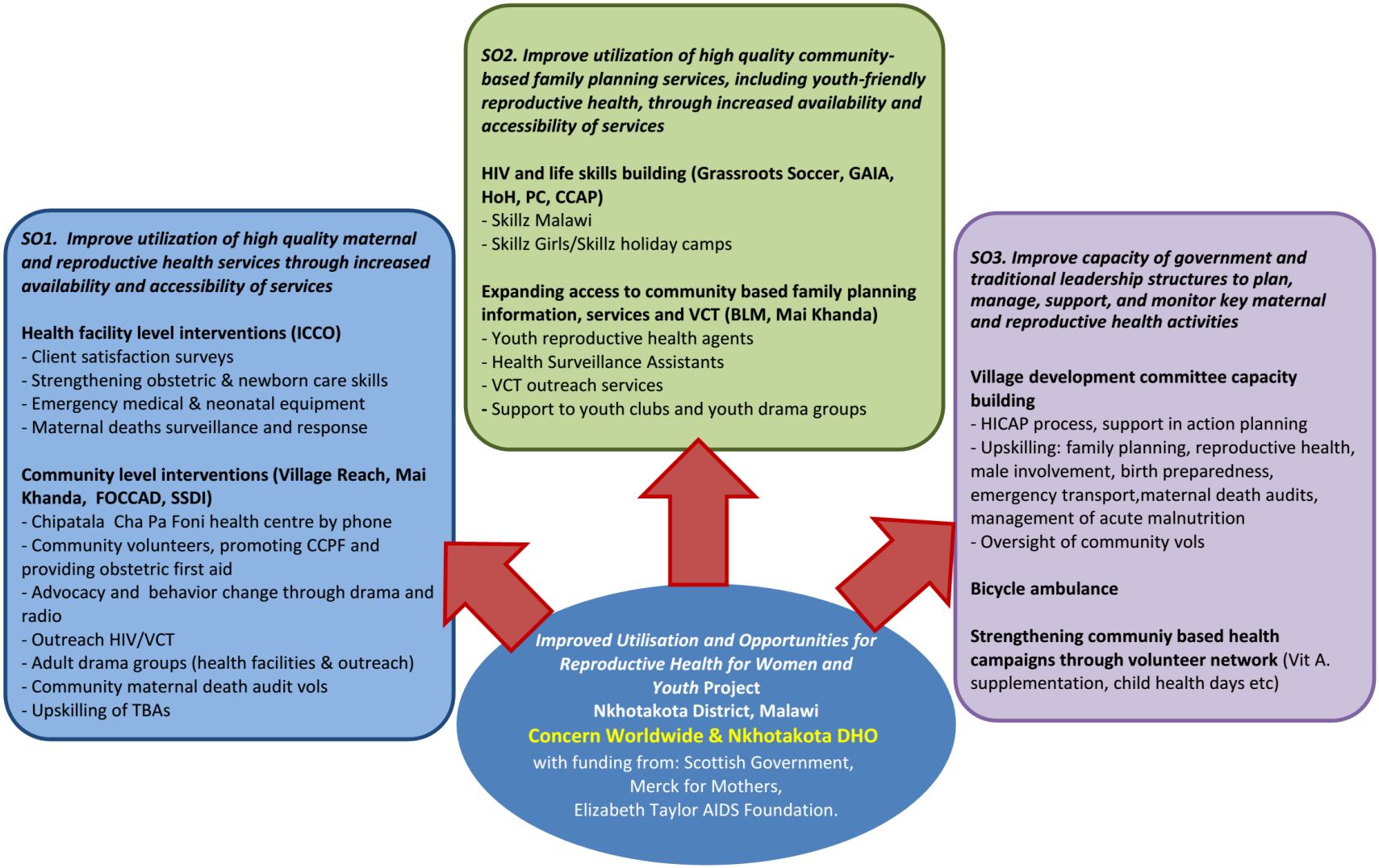
Collaborators/supporting organisations

- Mai Khanda- pooling of volunteer training costs
- Support for Service Delivery Integration SSDI- support to volunteers in areas of geographic overlap
- Foundation for Community Capacity Development (FOCCAD)- outreach VCT/HIV
- The Global AIDS Interfaith Alliance (GAIA)- SKILLZ training of coaches in their catchment area
- Church of Central Africa Presbyterian (CCAP)- source of SKILLZ participants
- Raising Malawi/House of Hope (HoH)- camp venues for SKILLZ participants
- Peace Corps (PC)- support to SKILLZ implementation

Figure 1. summarises each strategic objective and partner/collaborating organisations.

[1] Countdown to 2015, Maternal, Newborn and Child Survival: The 2015 Report Malawi
[2] Population Reference Bureau: Malawi Population Data Sheet 2012: http://www.prb.org/pdf12/malawi-datasheet-2012.pdf
[3] https://www.usaid.gov/malawi/fact-sheets/usaid-malawi-maternal-neonatal-and-child-health-fact-sheet-2012-13

Figure 1: Core components (strategic objectives) of project and partners/collaborating organisations



2. Purpose of end evaluation

The specific purpose of this end evaluation as detailed in the Terms of Reference is to:

- take stock of project achievements against targets;
- identify key successes and challenges associated with project implementation- from the perspectives of stakeholders at all levels[4]; and
- serve as a learning exercise to inform the design of Concern's future maternal, reproductive, and adolescent health initiatives in Malawi and beyond.

While this end evaluation will consider overall project implementation and achievements, emphasis is placed on assessing the following project components and their overall impact on the target population:

- **the social and behaviour change activities implemented under Objective 1**; this refers to the training of community volunteers, and dissemination of advocacy and health communication through drama and radio.
- **the adolescent health interventions under Objective 2;** that is, the Grassroots Soccer program, training of Youth Reproductive Health Agents, and the engagement with youth clubs and youth drama groups.

Several project components have already been evaluated: a mid-term review was performed in May 2015; the Health Institution Capacity Assessment Process (HICAP) tool – a key methodology under Objective 3, was evaluated in August 2015; and, the CCPF hotline service scaled-up under this project was evaluated in 2013. In addition, midterm (May 2015) and endline (March 2016) knowledge, attitude and coverage surveys were undertaken. Key findings from earlier evaluations are incorporated into this overall report, but those documents should be considered a reference point for more detailed discussion of specific findings.

Key evaluation questions:

Effectiveness

1. To what extent were the three strategic objectives achieved?
2. Was the programme logic well thought through and how did the project interventions contribute to the achievement of the three strategic objectives?
3. What were the key successes and challenges that lead to the achievement or non-achievement of the objectives?
4. What steps were taken to address issues of inequality and ensure the interests of the most marginalised were taken on board during programme planning, implementation and monitoring? How effective was this?

Efficiency

1. How did the implementation of key activities through partners affect project implementation and achievement of project objectives?
2. How did collaboration with partners and other district-level stakeholders contribute to opportunities for further scale-up of project approaches within a broader context?
3. Were financial resources well used? Could things have been done differently and how?
4. Was the programme M&E system fit for purpose? What evidence is there of effective Results Based Management in the programme?

Relevance

1. Were the project activities designed to the unique needs of target population based on appropriate contextual analysis or formative research?
2. To what extent were the strategic objectives and associated activities relevant to and in support of district and national-level Ministry of Health strategies and priorities?

Sustainability

1. Is there evidence that project outputs and outcomes will contribute to lasting benefits beyond the life of the project?
2. What are the key factors which may positively or negatively influence the likelihood of the project's overall sustainability?

Impact

1. Overall, what real difference has the project made to its intended beneficiaries (women of reproductive age)?
2. What has changed as a direct result of the project?

[4] including beneficiaries, volunteers, community leaders, health workers, district officials, project staff and partners

3. Design and methods

Design

The end evaluation used a mixed methods approach which comprised of the following strategies:

- **A desk review** of monitoring data and projects documents provided by Concern (including project proposals, donor reports, SKILLZ Malawi and SKILLZ Girls curriculum, the radio scripts and IEC materials which were included in the health communication and advocacy strategy under Strategic Objective 1, and the earlier evaluations/reviews detailed in Section 2. of this report).
- **Interviews (6) and focus group discussions (9) with key project staff, partners and beneficiaries.** A complete list of these consultations is provided in Annex 1. (data collection schedule) and the various question guides are attached as Annex 2.
- **A brief literature review** of maternal mortality related literature and appropriate interventions (with a particular emphasis on young women and within the context of a high HIV/AIDS prevalence and within a resource poor setting), health service strengthening and country specific data.

The evaluation team included an external consultant (Lisa Natoli), the Project Manager (Allain Joram), Tiwonge Kisyombe (SKILLS Girls coordinator), and two enumerators/translators (Shaibu Malasa and Mavuto Billy) who were hired to assist with this process. Field work took place between 5-12th March 2016.

Sampling

Purposeful sampling was used to ensure that the voice of all stakeholders involved with or affected by the health programme could be represented in the evaluation. Where relevant, efforts were made to achieve a gender balance in consultations (with males/females consulted separately for discussion of more 'sensitive' topics), and to meet with community members spanning a broad age range and from different traditional areas. Table 1 reflects the sampling frame. No consultations could be undertaken in Mwansambo TA due to time constraints and travel distances. In addition, traditional leaders were consulted by the project team prior to any formal consultations occurring in their TA of authority.

Table 1: Sampling frame

Lilongwe	**Nkhotakota District**		
Concern project staff	**Malengachanzi**	**Mwadzama**	**Mwansambo**
	Concern project management team		
	Partners: • District health officer, Safe Motherhood coordinator, Family Planning coordinator, Youth Friendly Health Service coordinator, District Nursing Officer.		
	• Banja La Mtsogolo (BLM) manager		
	Community volunteers: • SKILLZ coaches/YRHAs • CCPF, Maternal death surveillance and response (MDSR) volunteers, adult drama group members (Mpamantha) • Youth drama group members (Denje)		
	Beneficiaries: • Village Development Committee (VDC) members (Malengasanga) • SKILLS Malawi males (Chididi) • SKILLS Girls (Nkhotakota)	**Beneficiaries:** • VDC members (Kapiri) • Pregnant women and caregivers of children 0 – 23 months (Malowa)	

Limitations

The time/resources allocated for field work limited the number and breadth of consultations that could be performed, and data collection did not occur to the point of 'saturation'. However, evaluations such as this are an expensive undertaking and a pragmatic approach is always necessary to balance the need for strong evaluation with financial realities.

Qualitative data analysis occurred in partnership with the evaluation team and some may consider this a source of bias. However, it is the experience of the consultant that analysing data in this way allows for a more nuanced interpretation of data that does not occur when an expatriate/consultant performs data analysis on their own.

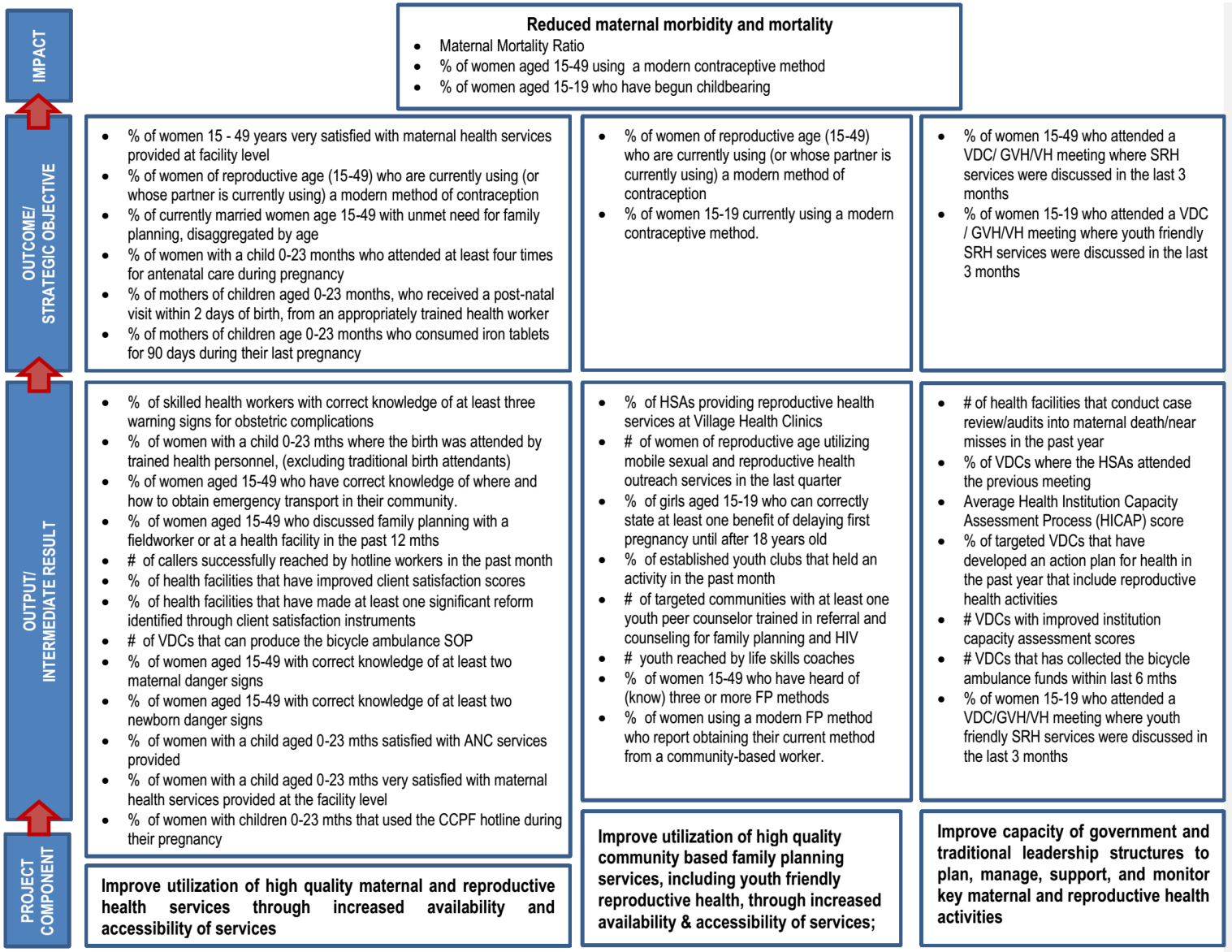
No effort is made to directly or indirectly attribute changes in knowledge and behaviour etc. to project interventions. As the project strategic objectives directly aligned with Ministry of Health priorities, and several other NGOs (such as Mai Khanda and Banja La Mtsogolo) are also working in the area of maternal and reproductive health, it would be inappropriate to do so.

Finally, the synthesis of findings from earlier evaluations and monitoring reports is limited by the unique limitations already acknowledged in those respective documents (for example, data sources for a number of monitoring indicators vary from baseline to midterm/end line).

Summary of key monitoring and evaluation indicators

A large number of indicators were used for monitoring and evaluation purposes and to facilitate reporting to the three donors (Merck for Mothers; Scottish Government; Elizabeth Taylor AIDS Foundation). These indicators are summarised in Figure 2. below.

Figure 2: Program logic/key indicators used to track project progress



4. Findings

Effectiveness

For further information and clarity on quantitative indicators and data collection across the life of the project please see the Endline Survey Report for the Nkhotakota Health and Nutrition Programme (2013-16). While monitoring and evaluation indicators were largely consistent between midterm and endline, they commonly differed at baseline (informed by the end evaluation of the predecessor health project in the district- KPC Baseline and Endline Survey Report for Dowa and Nkhotakota Districts March 2013). For this reason emphasis has been placed on changes between midterm and endline. Where indicators are comparable between the baseline KPC survey (March 2013) and midterm or endline, comparison has been drawn.

1. To what extent were the three strategic objectives achieved?

Strategic Objective 1 sought to strengthen the quality of maternal and reproductive health services and increase availability, accessibility and utilization of these services. Comparison of the recent (Feb 2016) endline survey with that at midterm (May 2015) reflects substantial improvements in relation to: consumption of iron tablets for 90 days during the last pregnancy (increasing from 10% of mothers of children 0-23 mths at midterm to 22% at endline); and discussing of family planning (FP) with a field worker or at a health facility in the past year (increasing from 27% of women 15-49 years at midterm to 43% at endline). Knowledge of emergency transport increased from 45%-69% of 15-49 year old women from midterm to endline, and all 45 VDCs that have received a bicycle ambulance have a standard operating procedure (SOP) to guide utilisation. Satisfaction with maternal and ante-natal care (ANC) services is also very good, and at endline 51% of respondents were 'very satisfied' with maternal health care services and 52% were 'very satisfied' with ANC services); at endline, and in the case of maternal health services, when taking into account those who were 'satisfied' or 'very satisfied' this figure increases to 91%.

Qualitative data collected during the end evaluation supports these findings, and reflected high levels of knowledge among volunteers and beneficiaries regarding local availability of bicycle ambulances. Those consulted were also able to mention a range of FP options (injections, pills, loop, condoms and implants) and access points (referring to health centres, Health Surveillance Assistants- HSAs, YRHAs, and the hospital); in addition, there appeared to be a thorough understanding that condoms and abstinence are the only methods that afford protection from sexually transmitted infections (STIs).

Some improvement has also occurred in relation to the percentage of women of reproductive age using a modern method of contraception (39.7% on baseline KPC survey increasing to 46% at endline). These figures vary somewhat from DHO data, where in 2014/15 the percentage of women of childbearing age accessing FP services was 60%- however this figure represents health service utilization, and as such, may double count some users. Discussions with BLM also reflect increased utilization of FP services, with it being suggested that 12-20 clients used to attend each week, but that with an increase in referrals from YRHAs, this figure is now 50-70 per week.

Project data also indicate some improvement in regard to the percentage of births occurring with a skilled attendant (78% at midterm increasing to 83% at endline). At the same time, DHO data suggest that the percentage of deliveries occurring with a skilled attendant is much lower, fluctuating slightly between 53-55% since 2011/12. This variation may be explained by the fact that DHO data is district wide and includes TAs not involved in the project. Volunteers and beneficiaries were well informed about the importance of delivering with a skilled attendant, and VDCs in particular seem to be doing a good job of advocating for this:

> **"*..we teach them* [pregnant women] *that whenever they are about to deliver they have to go to the hospital……we also tell them not to rely on the TBAs and have been visiting TBAs and ask if they see pregnant women to send them to the hospital".*** (VDC Member)

The CCPF hotline seems an important source of health information for women of childbearing age, receiving an average of 392 callers per month in 2015, with an initial surge in demand in early months that has now slowed. In addition, adult drama volunteers were noted as another important source of health information:

"when we phone CCPF they let us know in time that you have to be ready this month, that you are going to deliver. I am saying this because I called when I was 6 months **[pregnant]** ***and they have been giving me directives. For example, in the 8th month they told me that I should not be carrying heavy things".*** (Mother)

"the health workers and the volunteers are spreading the message through drama to end this type of harmful behaviour [referring to traditional beliefs and practices that negatively impact on maternal/reproductive health]. ***We get this information at ANC and they also come to the villages."*** (Mother)

Focus group discussion with pregnant and lactating mothers

Several very good materials were developed to support health communication by the various volunteer groups. These included a safe motherhood booklet and a series of CCPF/hotline posters focussed on different target groups (pregnant women, parents/caregivers, adolescent women etc.)- but unfortunately neither were able to be printed in the time required. Fortunately, considerable effort was also put into radio communication, which resulted in radio spots (repeated once each month) over the course of approximately one year. These programs touched on a range of relevant topics and were either interviews with volunteers, SKILLZ coaches, clinicians from DHO, or radio drama (informed through an earlier behaviour change survey). They sought to reach a range of target audiences (through a mid-week morning time slot and a Saturday afternoon spot), and with only two radio signals (national and district) and the district station being the most preferred, this strategy is likely to have been an invaluable part of the overall approach to health communication.

Unfortunately there continues to be a large unmet need for FP at endline (45% of women aged 15-49 years), and there has been excellent improvement on the indicator of attendance for ANC but no improvement on the indicator of post-natal care (PNC). The percentage of women with a child 0-23 months who attended at least four ANC visits during pregnancy increased from 36.2% at baseline to 52% at endline, while the percentage receiving PNC remained unchanged (51% at both midterm and endline).

Considerable improvement can be seen in relation to knowledge of danger signs during pregnancy and knowledge of newborn danger signs. Accordingly, the percentage of women aged 15-49 years with correct knowledge of at least two maternal danger signs increased from 34% at baseline to 65% at endline, and the percentage of women aged 15-49 years with correct knowledge of at least two newborn danger signs increased from 23.5% at baseline to 71% at endline. There also seemed to be a good level of knowledge about maternal and newborn danger signs within the focus group discussions

While monitoring data on health sector reforms was not available, interviews with DHO staff suggest that a number of changes have been made to address early survey findings. For example, one health centre (Mwansambo) is in the process of instituting a maternal waiting room at the clinic, where women from more remote village can stay in the last weeks of their pregnancy. Staff in the labor ward are making a greater effort to initiate breastfeeding within the first hour of life, and outreach ANC clinics are being provided to remote villages where pregnant women may otherwise not access these services.

Capacity building of health facility staff (including upskilling in obstetric and newborn care) did occur during the project. However, it was difficult to determine assessment/monitoring of outcomes in this area from project documents, and observation of clinical knowledge and skills was not a focus of this evaluation. As such, it would be improper to comment on this component of health system strengthening.

Strategic Objective 2 sought to improve utilisation of high quality community-based FP services, including youth-friendly reproductive health, through increased availability and accessibility of services. Comparison of the recent endline survey with that at midterm reflects substantial improvement in relation to: knowledge of three or more FP methods (increasing from 82% of 15-49 year olds at midterm to 95% at endline); the percentage of women of reproductive age using a modern method of contraception (39.7% at baseline, and 39% at midterm increasing to 46% at endline); discussing of family planning with a field worker or at a health facility in the past

year (increasing from 27% of women 15-49 years at midterm to 43% at endline); and the percentage of women aged 15-49 years who report accessing their FP supplies from a community based worker (increasing from 20% at midterm to 29% at endline).

Unfortunately, the percentage of young women aged 15-19 years using a modern method of family remains low (21% at midterm and 22% at endline). As some reflection of this, the percentage of 15-19 year olds that have begun childbearing is largely unchanged (31% at midterm and 32% at endline- although it is unlikely that we would see substantial change in this time period), and as this figure did not include those currently pregnant, it may be an underestimate. The 2010 DHS baseline reported that 25% of women 15-19 years had begun childbearing, although such a comparison between national and district data should be made with caution.

Qualitative data gathered during the end evaluation suggests that while attitudes of heath service providers towards young people requesting FP assistance have improved, adults in general are still judgemental towards sexually active youth. One representative from the DHO commented that young people generally don't come to facilities for FP services as they "***feel like they may not be assisted"***, however he did indicate that FP uptake among young people is better at the community level, suggesting that the introduction of YRHAs and availability of FP supplies through peers has been an important intervention. Discussions with young women confirmed that young people do go to YRHAs, and that other community level distributers (CBDAs) are for married couples only (perhaps not in intent but attitude).

The Youth Friendly Health Service (YFHS) coordinator at the DHO acknowledged that more needs to be done to make services more youth friendly, and to this end, a room has been identified at the District Hospital, and will be used in the future to deliver services to young people (service providers are yet to strategise the practical implications of this although the intent is there). In addition, greater attention is being paid to the need for youth disaggregated data, and we were shown a 'Monthly service provision form for YFHS' which seems to have been printed in 2008- but was recently rolled out through health facilities.

Discussion with volunteers and beneficiaries confirmed that unwanted pregnancies continue to occur, and that ***"mostly the ones who have this problem are under 18"*** (Mother of small baby). We were also told about the practice of unsafe abortion (again, mainly among younger women), and reference was made to drinking a tea made from toxic herbs (aloe vera).

Project (quantitative) evaluation data also indicate an increase in the percentage of girls 15-19 years that can state at least one benefit of delaying pregnancy (70% at midterm increasing to 79% at endline). This was supported in the qualitative research, where SKILLZ Girls graduates (together with other beneficiaries and volunteers) were able to cite a number of possible consequences including: problems with delivery; being ill equipped to take care of a baby (for example resulting in malnutrition); dropping out of school; and, having trouble getting married in the future.

While there have been a number of challenges/delays in implementation of the youth drama component of this Strategic Objective (at endline only 28% of established youth clubs had been active in the last month- see Section 3 for discussion of challenges), the idea of using peer communication/drama as a strategy, is positive. While training has been fairly recent, the drama group that we consulted had a clear understanding of their role in health communication and the key messages to disseminate (relating to safe motherhood, FP, early marriage and pregnancy, STI/HIV transmission and prevention). They also show initiative using social media (facebook and whatsapp) and linking in with sporting events to share information.

Members of the end evaluation team consult with youth drama group volunteers.

Project monitoring data indicate that 61% of targeted communities have at least one peer counsellor training in HIV and FP. The project has greatly exceeded all expectations around the number (12,168 in total) of young people reached through the SKILLZ Malawi/SKILLZ Girls program; in Year 3 alone the program reached 5981 young people which is almost double the 3000 target. SKILLZ coaches and beneficiaries demonstrated great enthusiasm and a high level of knowledge on the various topic areas (evident in the pre-post test assessment that occurs during training), and the fact that 93% of participants continued to graduation suggests suitability of this approach for the intended audience.

SKILLZ Malawi graduates take part in a participatory exercise to establish their understanding of HIV transmission and prevention, and the extent of community stigma towards people living with HIV and AIDS.

One area of (likely) impact not picked up through existing project indicators is that of uptake of HIV testing, which was emphasised in the SKILLZ program and reach was further extended through outreach VCT provided at various community events. As such, it is interesting to note the substantial increase in HIV testing in the district, from 26,011 in 2013/14 to 37,083 in 2014/15. Indeed, the Ministry of Health's 2014 HIV Counselling and Testing Campaign Week report, which reported 52% uptake of HIV Counselling and Testing among youth in Nkhotakota district, the highest rate of youth uptake of all districts in the country and significantly higher than the national youth uptake rate of 36%, attributed the achievement to the "robust presence of youth-focused initiatives by Concern Worldwide." It is also likely that the program has contributed to cultural shifts in relation to gender and HIV, with young FGD participants commenting on a girls right to ask a boy to take a HIV test.

Strategic Objective 3 focussed on building the capacity of government and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities. Achievements within this component of the project have been particularly impressive. Comparison of the recent endline survey with that at midterm reflects substantial improvement in relation to: the percentage of women aged 15-49 and 15-19 who attended a village meeting in the previous 3 months where sexual and reproductive health (SRH) issues was discussed (14% of those aged 15-49 years at midterm increasing to 22% at endline, and 8% of those aged 15-19 years at midterm increasing to 16% at endline); the percentage of VDCs were the HSA attended the last meeting (83% at endline, not measured at midterm); the percentage of VDCs having a 2016 action plan that includes reproductive health (90% at endline, not measured at midterm); the number of VDCs that collected bicycle funds in the last 6 months (41 out of 45), and the average Health Institution Capacity Assessment Process (HICAP) score, which has increased from 2.4 at baseline to 4.2 at endline.

In relation to maternal death surveillance, this seems to be happening well at the health facility level (of the 11 maternal deaths in the district in 2011, one did not get audited). There seemed to be an understanding of the issues contributing to maternal deaths (for example delays in calling and receiving ambulance transport from a health centre to the hospital and delays in providing critical interventions at the hospital itself)- although it is unclear to what extent these have/are able to be addressed. The 11 maternal deaths in 2014/15 represents a maternal mortality ratio of 115/100,000 live births- and is a reduction on the 20 maternal deaths (MMR 202 per 100,000 live births) in 2013/14.[5] In the absence of knowing in which TAs these deaths occurred, it is difficult to attribute the overall reduction to the project.

[5] DHO data (please refer Annex 3)

From a qualitative viewpoint, we saw many signs of increased capacity of VDCs and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities. VDC members spoke of their strengthened abilities in relation to data collection to inform their work and annual planning, and commented how CCPF volunteers help them identify pregnant women in the community.

> ***"At first before our partnership we weren't able to collect enough data, but now we are able to collect good and enough data".*** (VDC member)

> ***"Before you do anything you must plan…we have an annual meeting where we do the planning and for the rest of the months we work according to that plan".*** (VDC member)

Maternal and reproductive health was spoken of as if it were an integrated responsibility of the VDC, and communication channels both upwards and downwards to the district level (via HSAs) and community (via volunteers and committee members) were apparent.

> ***"At the VDC/group village headman level they call the meetings for maternal health. We have two meetings each month and if we need the volunteers we ask them to come and share information and the HSA as well…. We also have other small committees at village headman level and we ask every member to come for our meetings and from these people they all spread the messages".*** (VDC member)

VDC members during community consultation

VDC members seemed to understand the importance of the maternal death surveillance process, although until now no maternal deaths audits have been performed at community level; it is unclear whether this is because no maternal deaths have occurred in the project TAs (both of the VDCs we consulted with denied any maternal deaths in their villages) or whether there has been a breakdown in the community audit process.

> ***"The VDC has a committee that looks into this matter*** [maternal death]. ***When anything happens they report to the HSA and then the HSA reports to the district hospital and they come for verification to find out what really happened, what caused the death".*** (VDC member)

Administration of bicycle ambulances seems to be going well, and the VDCs consulted had both established processes to ensure community contribution, but also to ensure that individuals lacking capacity to pay would not be excluded in an emergency.

> ***"No-on pays for the bicycle, it's for free, but we have got a plan that the community must contribute*** [MK20 per month] ***so that when there is a problem we are able to fix it. We have never asked anyone to pay because it is an emergency."*** (VDC member)

VDC members appeared to have a good understanding of girls' rights (to education for example) and of the need to advocate on their behalf. One of the VDCs claimed that they had managed to reverse marriage arrangements for 6 girls (aged under 18 years) and have them return to school.

> ***"Some of the parents they don't want to allow their daughters to come home after the delivery and chase them away. The girls might want to go back to school but the grandparents don't want to look after the baby….After seeing this with our team we've been visiting these homes and teach the parents about girls' rights..There are also some beliefs that promote girls getting married, but the VDCs are trying to deal with these behaviors and we can do it if we try".*** (VDC member)

They also seem to have been empowered in relation to countering harmful beliefs and practices and gender stereotypes, especially those that impact on maternal and reproductive health. For example, VDC members

spoke about working with traditional birth attendants (TBAs) to encourage them to refer women for skilled deliveries, encouraging fathers to take a more active role in birth preparedness, and reducing risks for HIV transmission and pregnancy associated with the traditional dance ceremony.

> ***"We have met with the chiefs about the genital circumcision that we do traditionally*** [encouraging this be done at health facilities under sterile conditions]***, and they also practices some dances that go all night long. We are trying to change these things- it is better doing it in the day time as it avoids young people being involved in sex."*** (VDC member)

2. Was the programme logic well thought through and how did the project interventions contribute to the achievement of the three strategic objectives?

Overall, programme logic was thoughtfully considered and each Strategic Objective and component interventions either had an explicitly articulated theory of change or a sound evidence base.

Strategic Objective 1 aimed to strengthen the quality of maternal and reproductive health services and increase availability, accessibility and utilization of these services. Delivery by skilled attendants is integral to this project component, given that roughly 15% births are complicated by a potentially fatal condition, but that women supported by trained attendants are more likely to receive treatment early[6]. In addition, ANC and PNC can have a significant influence on maternal health and morbidity outcomes.[7]

In support of this component was recognition by the Nkhotakota DHO that despite there being interventions to address the major underlying causes of maternal mortality, that availability and access to such services in Nkhotakota was inadequate.[8] In addition, findings from a Ministry of Health (MOH) survey suggested that the quality of available services was insufficient.

Barriers that prevent women accessing lifesaving care for themselves and their infants are many and complex, including limited awareness of life threatening complications, postponing the decision to seek care, delays in reaching appropriate care, and receiving substandard or delayed care on arrival at health facilities[9]. Indeed-barrier analysis conducted by the project suggested that knowledge about the importance of maternal health care, financial challenges and distances to health services play an important influence on health seeking behaviour. In 2010, the MOH conducted a large facility-based survey of emergency obstetric and newborn care. Among the many gaps identified, health staff knowledge of and capacity to recognise and address obstetric and newborn complications was very poor. Further, a recent review of Malawi's maternal death audits identified shortcomings in their approach such as fear of blame, poor record keeping, and lack of knowledge and skills to properly conduct maternal death reviews[10]. A critical key to reducing maternal mortality is an understanding of why women die during pregnancy and childbirth.[11]

Interventions implemented by the project logically included a focus on health service strengthening (largely through provision of critical equipment and strengthening obstetric and newborn care skills) and a range of community level interventions (including the CCPF hotline scaled up and informed by earlier and successful implementation in Balaka District, and the use of community volunteers) that focussed on advocacy and health and behaviour change communication- both to extend access to preventative and curative care and generate formal health service demand and accountability.

---

[6] UNFPA 2004

[7] Gay et al. What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions January 2003. **POLICY Project** Module 1. Safe Motherhood

[8] Nkhotakota District Social Economic Profile, 2010

[9] Thaddeus S, Maine D, *Too far to walk: maternal mortality in context*. Soc Sci Med. 1994, 38(8):1091-110.

[10] E.J.Kongnyuy and N. Van den Broek, *The difficulties of conducting Maternal Death Reviews in Malawi*, BMC Pregnancy and Childbirth. 8(42)(2008)

[11] van den Akker T, van Rhenen J, Mwagomba B, Lommerse K, Vinkhumbo S, et al. (2011) Reduction of Severe Acute Maternal Morbidity and Maternal Mortality in Thyolo District, Malawi: The Impact of Obstetric Audit. PLoS ONE 6(6): e20776. doi:10.1371/journal.pone.0020776

Strategic Objective 2 sought to improve utilisation of high quality community-based FP services, including youth-friendly reproductive health, through increased availability and accessibility of services. The underlying premise for this project component is that a large proportion of maternal mortality and morbidity are attributable to an unmet need for contraception. It has been estimated that meeting the existing demand for FP would reduce pregnancies in developing countries by 20% and maternal deaths and injuries by a similar degree or more[12]. This is especially relevant for younger women, who often have reduced access to FP and maternal health services once pregnant, and for whom pregnancy related risks are heightened.[13] The high prevalence of HIV/AIDS in Malawi adds further relevance to this project component, with pregnancy risks exacerbated in this context.[13]

Adolescents are estimated to account 20% of maternal mortality in Malawi, where by the age of 18, 50% of girls have married, and one quarter has had their first child[2,3]. In Nkhotakota, discussions with key stakeholders in the project design phase revealed that youth in particular remain underserved by sexual and reproductive health (SRH) services[14], and related literature suggests that many young people lack knowledge about contraception or how to access FP services, feel uncomfortable seeking SRH services, and lack the financial capacity to do so.[15] Women in general lack access to basic family planning services and one third of married women report an unmet need for family planning. Key barriers to utilization of family planning services include lack of FP counselling and poor client-provider relations[16].

The Grassroots Soccer (GRS) program, a core element of Strategic Objective 2, is based on a HIV and life skills curriculum (SKILLZ Malawi and SKILLZ Girls) that builds resilience and critical life skills related to HIV prevention, delaying of marriage and pregnancy, and encourages appropriate health care seeking behaviour. The GRS intervention was complemented via a partnership with BLM (routinely involved in broader awareness raising and family planning service provision- free of charge for those < 25 years), which expanded access to FP supplies and information at the community level, through training of YRHAs- many of whom also volunteered as SKILLZ coaches, and upskilling of HSAs. Additionally, efforts were made to strengthen the supply of FP commodities through the MOH and BLM, and to make available FP services more youth friendly.

Strategic Objective 3 focussed on building the capacity of government and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities. Traditional leaders and local government structures, such as VDCs, are very influential and have an important role to play in ensuring the health of communities. Prior to 2010 there had been limited involvement of these strucutures in improving health services, let alone in holding the health system accountable to the communities it serves. Since that time however, Concern has been working to build the capacity of VDCs to be more involved in targeted health initiatives. As a result, there has been greater engagement of community members in health activities and strengthened communication between health service providers and communities. Building on this experience, the project sought to work with VDCs in targeted TAs of Nkhotakota to raise awareness of important SRH information, and foster greater ownership and develop accountability systems to improve the availability, accessibility and utilization of maternal health services.

To a large extent, the VDC capacity building was a pillar of this strategic objective, and was facilitated by the Health Institution Capacity Assessment Process (HICAP). The HICAP is a self-assessment tool based on the appreciative inquiry process, and has been adapted and used by Concern in a number of other country settings, but also in Malawi from 2009. The HICAP tool consists of five capacity areas, based on the roles and responsibilities established in the Decentralisation Policy: participatory planning; leadership (governance); resource mobilisation and management; collaboration and coordination, and monitoring and evaluation.[17]

Capacity building of VDCs also re-enforced links between Strategic Objective 3 and the other Strategic Objectives (1 and 2), enabling a more comprehensive approach. To this end, VDCs were encouraged to provide oversight to community volunteers, build SRH awareness raising into their action plans, manage and administer

[12] UNFPA 2004

[13] http://esaro.unfpa.org/topics/adolescent-pregnancy?page=1

[14] MOH, Standards Youth Friendly Health Services, 2007

[15] Biddlecom, AE et al. 2007. *Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi, and Uganda.* Afr J Reprod Health 11(3).

[16] University of Southampton, UNFPA, Barriers to use of family planning services in Malawi: Findings from FDGs

[17] Evaluation of the Health Institution Capacity Assessment Process (HICAP), Sept 2015

bicycle ambulances and advocate to health facilities to audit maternal deaths. There is very limited peer reviewed literature to demonstrate the impact of bicycle ambulances on obstetric referrals[18], although the approach seems logical.

3. What were the key successes (S) and challenges (C) that lead to the achievement or non-achievement of the objectives?

Stakeholder engagement

- The project initially experienced some difficulty in recruiting staff, delaying start-up by approximately 6 months. However, the interim period allowed more time to engage with district staff and enabled greater involvement in planning of activities. Staff turn-over within Concern, the DHO and among VDCs members (with re-elections occurring in year 2 of the project) have also been disruptive. **C/S**
- Involvement of key district staff in the development of questionnaires, data collection and analysis of the Knowledge, Practice & Coverage (KPC) survey, Barrier Analysis survey, Health Facility Assessment and Client Satisfaction survey not only built the capacity of district staff in designing surveys but also resulted in a greater understanding of the importance of such surveys and encouraged greater ownership of the process and resulting data. **S**
- Funding of an exchange visit by high level district and community stakeholders to see the CCPF Hotline at Balaka District Hospital and meet with community volunteers was instrumental in ensuring buy-in and support of the hotline by Nkhotakota District. **S**
- Meaningful engagement with VDCs is key to ensuring the success of community initiatives. As the VDCs' capacity to implement and monitor community health activities continues grew, their support for HIV Counselling and Testing campaigns, World AIDS Day, and other critical community initiatives expanded commensurately. The VDCs are a critical entry point for community health and the capacity built with these sustainable community structures will remain long beyond the end of the project. **S**
- Actioning of maternal death audits at community level didn't happen as well as hoped (mainly occurred at facility level). There has been some suggestion that lack of involvement of village headmen during training (which has since been remedied) was problematic, and as result there has not been so much buy in at village level. **C**

Lesson: Planning to allow a slower start-up of project activities [requiring longer funding periods] and meaningfully involving partners and stakeholders in planning, data collection and analysis may have lasting benefits- building capacity, strengthening engagement and ownership and potentially sustainability.

Strategic partnerships

- Strategic partnerships help bridge gaps on adolescent SRH issues and result in more efficient use of scarce resources. **S**
- Engaging the community as a partner focuses attention on reproductive health and its importance including promotion of utilisation of services. **S**
- Partnering with CCAP enabled the SKILLZ curriculum to be delivered to a much wider audience (during a youth conference), but condom messaging and language had to be modified. **S/C**
- Having BLM support YRHAs made good sense from a programming perspective, but support processes had to be negotiated. For example, BLM wanted the YRHAs to bring reports into town for them, but this was an expensive undertaking for volunteers. It was negotiated that BLM would pick up from health facilities on routine visits. **S/C**
- The partnership with GRS proved invaluable. Sport is a valuable entry point or platform for peer education and behaviour change with young people. **S**

[18] Lungu K et al, Are bicycle ambulances and community transport plans effective in strengthening obstetric referral systems in Southern Malawi? Malawi Med Journal, 2001, 13:2; 16-18

Lesson: Collaboration with like-minded organisation maximizes resources and enables greater reach and impact, but sometimes requires compromise and negotiation.

Health system strengthening

- Provision of medical equipment and training in maternal and newborn life-saving skills was an important intervention to improve patient outcomes, but also built confidence within the DHO and strengthened the relationship with Concern. **S**
- Achieving ongoing commitment from DHO counterparts was challenging at times. Late salary payments to government staff and staff strikes served as a barrier to coordination of project related meetings and trainings. In addition, the Donor Subsistence Allowance directive (DSA- from the donor community) negatively impacted on participation in planned trainings, especially in the case of government staff. **C**
- Unavailability of key district staff (sometimes due to staff turnover- e.g. the Safe Motherhood Coordinator) and the leadership necessary to drive certain project activities has delayed implementation in some cases. **C**
- The 'stop' order from the District Youth Office slowed progress in relation to youth focussed activities and negatively impacted on the extent of achievements evident at the end of the project. **C**

Lesson: Partnering with a weak health system in a resource poor setting is inherently challenging, although ultimately affords the greatest potential for sustainability

Operational challenges

- Delays in MOH approval of IEC materials and procurement meant that a number of very useful communication materials (pretested and finalised in Sept 2015) were unavailable to support implementation. Timelines for this activity might have been more generous (but recognising the time/resource constraints on the project management team). **C**
- High demand on the CCPF hub has at times result in extended wait time and loss of callers. **C**
- Operational challenges with both ICCO and BLM highlight mis-communications and misunderstandings around allocated roles and responsibilities. Partner meetings (in the field, not in Lilongwe) may have been beneficial at regular intervals. **C**
- The stop order from the District Youth Office severely impacted on progress, although provision of assistance with the Youth Club mapping process generated further trust between Concern and the DHO. **C/S**

Delays in MOH approvals and procurement meant that a number of useful IEC materials were not available to support health communication

Traditional and cultural beliefs and practices

- We were told about the common belief among young people that the use of FP in adolescence will prevent future child bearing. Another belief relates to the wearing of a string (made from a local plant) around the belly, with an associated belief that it will protect against pregnancy. **C**
- Arranging for an older man to sleep with a younger/adolescent girl (termed "clearing the dust") has been promoted traditionally to prove an adolescent girl's readiness to be a woman. **C**
- It is common for wealthy businessmen, contract workers on large development project and visiting fishmongers (who spend several weeks in Nkhotakota buying and then drying fish to sell elsewhere) to buy sex from younger and vulnerable women. **C**

- Influence of religious groups: **C**
  - religious opposition to condoms and FP;
  - opposition to accessing of health care (by Zion church)
  - emergence of 'satanic' churches that make people fearful to call the CCPF hotline. It was explained that these churches try to recruit followers by spying on people and then calling them and assuming (mysteriously) to know all about them. As CCPF staff know a lot about pregnancy and are able to predict delivery dates etc., some villagers worry about a connection with the 'satanic' churches.
  - that often require 'sanitising' of sensitive words such as penis ('John') and vagina ('Mary'). Whilst it is important to find suitable translations without causing offence, it is also important that words are carefully chosen, especially if they have a double meaning that may confuse the message being conveyed.
- Fining families for using TBAs. It became apparent that some VDCs fine families that give birth with the help of TBAs. It is possible that these families are the most poor and vulnerable, and that this practice further impacts on vulnerability. **C**
- Prevailing gender inequalities that undermine behaviour change efforts at gender equality. For example, were told of one private clinic that charged MK5000 for the birth of a male baby and MK3500 for the birth of a female baby. **C**
- Poor availability of government services in some remote areas, making people reliant on expensive private services if they wish to deliver with a skilled attendant. **C**

Lesson: Traditional beliefs and practices may undermine efforts at behaviour change. It is essential that these are understood and addressed through key messages (and to a large extent the project has been very thorough in understanding and responding to such challenges through health communication activities).

4. What steps were taken to address issues of inequality and ensure the interests of the most marginalised were taken on board during programme planning, implementation and monitoring? How effective was this?

Efforts to address inequality and ensure the interests of the most marginalised were addressed was evident during the end evaluation and can be summarised as follows:

- Programme planning appeared to be based on a thorough assessment of need and through consultation with a broad group of stakeholders, both male and female and including young people.
- The SKILLZ curriculum is underpinned with a deliberate effort to tackle gender inequalities, and this becomes apparent in a range of topic areas and through the use of male/female paired coaches. In addition, focussed attention was taken to reach young people in and out of school (recognising the burgeoning out of school population and the high proportion of girls within this group), and to target girls specifically (and their unique needs in relation to life skills) through a SKILLZ Girls component. When questioned, SKILLZ coaches said that they targeted young people regardless of difference (such as ethnic or religious group, disability or HIV status), although it is difficult to verify this. In addition, with HIV being a large component of the curriculum it would make sense to involve people living with HIV and AIDS both as coaches and participants. However, there remains an undercurrent of fear and stigma, and with few openly (HIV) positive people or related support groups, it would have been difficult for the project to seek this involvement and for it to be verified during the end evaluation.
- Broad programme coverage, extending to the remotest TAs within the district suggests that effort was made to overcome the bias of working with communities that are easy to reach but often ignoring equity considerations.
- Where possible, sex and age disaggregated data was collected during monitoring and evaluation, acknowledging the way in which topics of interest impact differently on women and men of different ages.
- A number of gender and youth related inequalities were tackled in the various topics addressed by volunteers and through the various behaviour change tools. For example, there was clear recognition of young women's vulnerability when it comes to being taken advantage of by older men, their ability to negotiate condom use and HIV/STI testing with partners, to accessing FP and relevant maternal and reproductive health services, and their vulnerability in relation to unplanned pregnancy and the many

negative consequences of this. In addition, it was apparent that efforts were made to recruit both male and female volunteers of suitable ages, to ensure that males and females of different ages could be appropriately reached through their peers.

Efficiency

1. ***How did the implementation of key activities through partners affect project implementation and achievement of project objectives?***
2. ***How did collaboration with partners and other district-level stakeholders contribute to opportunities for further scale-up of project approaches within a broader context?***

The decision to seek out strategic partnerships greatly influenced (mostly in a positive way) what could be achieved in the three year funding period. In summary:

Grassroots Soccer: the partnership with GRS which led to adaptation of the HIV and life skills curriculum (SKILLZ) for use in Malawi was a critical success- with delivery/reach further extended and enhanced through the various implementing partners (GAIA, HoH, and PC). The partnership was complemented further through the Foundation for Community Capacity Development-FOCCAD, a local NGO which provides outreach HIV counselling and testing services to adolescents.

Village Reach: the strong partnership with Village Reach and the decision to use the existing CCPF telephone service hub in Balaka (rather than create a parallel/additional hub) made financial sense. Village Reach provided on-going technical support to Concern during project implementation, enabling effective implementation and scale-up of the existing CCPF hotline, including addition of family planning information and an automated tip and messaging service.

Interchurch Organization for Development Cooperation (ICCO): this partnership was established with the view that ICCO would monitor and support implementation of the health facility reform activities. While this is reported to have begun well, unfortunately commitment diminished over time, and meant that achievements in this component of the project fell well short of what might otherwise have been possible.

Banja La Mtsogolo (BLM): is a large and successful locally registered NGO and senior partner of the Marie Stopes International (MSI) global partnership. BLM is an important provider of family planning services (free of charge for young people < 25yrs) in Malawi and is active in the same TA's as Concern Worldwide in Nkhotakota District. BLM provided support to YRHAs and took responsibility for monitoring and supervision and payment of incentives.

Mai Khanda: is a local NGO implementing maternal and child health activities (often through a volunteer network) in Nkhotakota District. When it was realised that Mai Khanda planned to conduct training with its volunteer network, Concern joined forces to co-ordinate with their training plans for HSAs (refresher training in RH and provision of DMPA) so that training/transport costs could be shared between the two organisations. The partnership enabled training of more HSAs than were originally planned.

Support for Service Delivery Integration (SSDI): SSDI, supported by USAID, is an integrated program supporting capacity strengthening of health service delivery points at community and health facility levels. The program has a presence in the northern part of Nkhotakota where Concern scaled up activities. The volunteers trained by Concern (CCPF, maternal death audit, and obstetric first aid volunteers) were supported to disseminate their messages through care groups supported by SSDI, and in some areas SSDI provided support and supervision to these volunteers on behalf of Concern.

DHO and key counterparts (safe motherhood coordinator, FP coordinator etc): the partnership with the DHO made good development sense so was necessary but also challenging in a number of ways. Reliance on key counterparts meant that momentum slowed at times (for example in the event of staff turnover), but ultimately the partnership afforded the greatest chance of sustainability.

3. Were financial resources well used? Could things have been done differently and how?

It is extremely difficult to comment on whether resources were "well used" given the brief timeframe allocated to review this project. A snapshot of budget and expenditure across the various donors and funding periods is provided in Table 2. below.

Table 2: Annual budgets and expenditure of donor funds

ETAF	TOTAL Budget 1.1.14- 31.12.15	Expenditure 1.1.14- 31.12.14	Budget 1.1.15- 31.12.15	Expenditure 1.1.15- 31.12.15		
	USD $56,381	USD $26,601	USD $29,780	USD$29,780		
SG	Budget/Year end 31.3.14	Expenditure Yr 1	Budget/Year end 31.3.15	Expenditure Yr 2	Budget/Year end 31.3.16	Expenditure Yr 3 (to 29.2.16)
	GB £73,268	GB £73,268	GB £164,268	GB £136,082	GB £190,650	GB £169,505
Merck	Budget 1.11.12- 31.10.13	Expenditure 1.11.12- 31.10.13	Budget 1.11.13- 31.10.14	Expenditure 1.11.13- 31.10.14	Budget 1.11.14- 31.3.16	Expenditure Yr 3 (to 29.2.16)
	USD$282,606	US$122,244	US$247,498	US$252,560	US$364,239	US$336,575

Review of donor reports suggest that devaluation of the US dollar in early years coupled with delays in start-up and staff recruitment contributed to a considerable underspend at that time.

It is apparent that considerable effort was spent on gathering information and making a thorough assessment of the operating environment and needs prior to spending. For example:

- the assessment of mobile phone coverage in target TAs highlighted reasonably high coverage (70%) and a decision was made not to purchase mobile phones for CCPF volunteers;
- when the idea of funding bicycle ambulance operators was discussed with VDCs it was felt that a more sustainable model of funding could be created through community contributions;
- plans to refurbish a room at the District Hospital to deliver Youth Friendly Health Services were halted when it was realised that more could be gained from training of staff to improve attitudes and skills in working with young people.

In addition, efficiencies gained through the partnership approach (e.g. cost sharing in relation to training of volunteers with Mai Khanda), meant that savings in the early years enabled a partial extension of activities (SKILLZ Malawi and CCPF hotline) to 3 additional TAs in the south and purchase of more bicycle ambulances than originally planned.

The question could be asked whether or not the large reliance on payment of the DSA has further contributed to donor dependency? This is a very complex issue in an environment where payment of government salaries can be erratic, and high rates of unemployment mean that small amounts of per diem make a valuable contribution to the household income. Similarly, the need to implement planned activities and spend funds in allocated time frames places a certain amount of pressure on INGOs to pay allowances- if this is what is required in order to get the job done. Perhaps one way around this would be to have much lengthier funding periods, allowing for deeper community engagement and development, and to take this approach in areas of great need but where there has been limited INGO/donor involvement in the recent past. Superficially (without any cost/benefit assessment), several activities stand out as being good value for money. These include: the SKILLZ program, and in particular the promotion of HIV testing, challenging of gender norms, and training of YRHAs to extend access of FP supplies to the younger age group; and, the capacity building of VDCs and raising the profile of maternal health and gender concerns at the community level.

4. ***Was the programme M & E system fit for purpose? What evidence is there of effective Results Based Management in the programme?***

The M & E system underpinning the project was complex and rigorous, and this was partly a factor of there being multiple donors (ETAF, SG and Merck) each with their own reporting and accountability requirements. The periodic use of external evaluators (mid-term and endline) and performing of community based surveys at similar time points reflects a serious commitment to M & E. Unfortunately, while the KPC Baseline and Endline Survey Report for Dowa and Nkhotakota Districts (March 2013) was intended to provide baseline data for the project, there was considerable variation between the indicators reported against in the 2013 report, and those selected for the the current project. This possibly related to staff change over at critical time points.

There was a definite effort to go beyond reporting against process related indicators, and to measure results or outcomes over time. There were a large number of indicators, and over time it became apparent that some were too difficult to measure and they were subsequently revised or removed. There is perhaps a lesson relating to selection of indicators in the first place, and including those that will be measurable without too much effort and reliance on implementing partners.

It was especially positive to hear of the quarterly review meetings that were built into project implementation. While these may be resource intense and perceived by some as a distraction to overall implementation- taking the time to reflect on progress, challenges and lessons learned is critical and reflects good development practice.

Relevance

1. ***Were the project activities designed to the unique needs of target population based on appropriate contextual analysis or formative research?***

Project activities specifically responded to the unique needs of the target population (in particular women of reproductive age with emphasis on those aged 15-19 years). In brief, the strategic objectives focussed on responding to identified maternal and reproductive health needs including late commencement of ANC (after the 1st trimester), infrequent utilisation of PNC, the ongoing tendency for some to delivery at home with a TBA, and the low uptake of modern contraceptives and the ongoing unmet need for FP- especially among young women. In this regard, the SKILLZ program and training of YRHAs were an important step towards better addressing the sexual and reproductive health needs of younger women.

Needs assessment at various stages in the project was based on analysis of available data (district level data if available and if not, national level data), or if necessary, formative research. Examples include:

- Concern performed a situational analysis specific to the project in 2009. In addition, the organisation had a history of working in the district and therefore a good understanding of needs based on implementation experience.
- Gathering of baseline data to inform project implementation and help evaluate results at midterm and endline. In this instance, data collection focussed on: (a) assessment of community knowledge, attitudes and practices, (b) health facility service delivery and client satisfaction, and (c) formative research to guide behaviour change interventions, which included identifying key barriers to behavior change and surveying radio ownership and utilisation.
- Implementation of a Youth Club mapping exercise in partnership with the District Youth Officer and the District Sports Officer to determine capacity gaps and needs.
- Pre testing of BCC materials and messages with target audiences and involvement of those (such as chiefs, grandmothers and religious leaders) with the potential to influence acceptance and uptake of behaviour changes messages.

It is important to note that where new data was gathered (for example barrier analysis) it was then used to inform the range of project activities.

2. To what extent were the strategic objectives and associated activities relevant to and in support of district and national-level Ministry of Health strategies and priorities?

The District Health Officer explained that partnerships between the DHO and INGOs are only agreed to when donor intent aligns with DHO and/or national priorities. As such, the project emphasis on maternal and reproductive health completely aligned with Ministry of Health (national and district) strategies and priorities. While it was not possible to review district level documents, project objectives and activities are tightly aligned with the Government of Malawi Health Sector Strategic Plan (2011-16)

Sustainability

1. ***Is there evidence that project outputs and outcomes will contribute to lasting benefits beyond the life of the project?***
2. ***What are the key factors which may positively or negatively influence the likelihood of the project's overall sustainability?***

An attempt has been made to summarise the likelihood of lasting benefit and the various influences on sustainability for each of the smaller project components (Table 3). However, it probably should be considered whether long term sustainability is indeed a realistic expectation- particularly in the context of such an inherently weak health system, with funding over a relatively short time period (3 years), and where some of the expected (behaviour) changes are quite complex. In addition, the heavy reliance on allowances (lunch allowance of MK2500 per person and reimbursement of transport costs or payment for fuel to enable DHO involvement) sets precedence for future engagement with such activities.

Table 3: Project sustainability

Project component	Stakeholders involved	Likelihood of lasting benefit? Influences on sustainability
CCPF hotline	Village Reach Airtel Other NGOs VDCs/Volunteers	• For those who have accessed the hotline, it is reasonable to hope that some of the knowledge gained (such as the need to plan and prepare for delivery) will be retained and carried forward. • Whether the hotline itself is able to continue depends largely on the partnership with Airtel, and the idea that NGOs operating in certain districts will recognize the potential for the hotline as a source of health information, and pick up on the opportunity to fund implementation. • Ongoing commitment of CCPF volunteers will rely on ongoing support/supervision from VDCs and individual altruism to continue in this role in the absence of lunch allowances etc. during meetings.
Health service reforms	DHO and key positions within Clinical staff	• As long as the staff base remains stable, the capacity gained in obstetric and newborn skills should be retained, although the ongoing need for supervision and support and periodic refresher training should be acknowledged. • Whether the critical equipment provided to the HDU/DHO can be serviced, maintained and replaced if necessary will depend on DHO ability to resource this. • Concern staff lack confidence that the process of health service reforms and identifying areas for improvement are unlikely to be sustained. • While DHO staff demonstrated commitment to supervision/support of staff in peripheral facilities (doing this on a monthly basis in partnership with Concern staff over the course of the project), the likelihood that this will continue will depend on funding of fuel (and lunch allowances if travelling to more distant health services) by the DHO.
Grassroots Soccer	Coaches	• With a number of Master Coaches trained, there is potential to train more coaches should the need arise. • As coaches have an ongoing need to purchase equipment kits as they expand into new areas, and also routinely receive a stipend (MK7000 for SKILLZ Malawi and MK8400 for SKILLZ Girls) for the delivery of training programs, sustainability is largely reliant on commitment and resourcing from the District Youth Office. In addition, coaches had transport costs

		reimbursed when attending meetings, and refreshments were provided.
VDC involvement with maternal and reproductive health	DDCO/DHO CDAs HSAs VDCs	• Ongoing involvement of VDCs in awareness and advocacy relating to maternal and reproductive health issues will probably depend on the periodic provision (e.g. aligning with VDC member turn over/election cycles) of refresher training. Similarly, long term commitment to the HICAP process is likely to require overarching support from the DHO and CDAs. At this stage, motivation and commitment at the level of the VDC is evident. CDAs are apparently committed, but with only 1 CDA/TA with up to 20 VDCs to support, fuel and transport is a critical enabling factor. • During project implementation, Concern paid for fuel and lunch allowances to facilitate DHO involvement with meetings etc.
Youth reproductive health agents	YRHAs HSAs, BLM	• The BLM office in Nkhotakota seems committed to providing ongoing support and supervision to YRHAs (together with HSAs), although their financial capacity to support allowances (MK300/referral and MK800 each month on provision on reporting) is unclear. • With HSAs supporting 1-2 VDCs each, their role in supporting YRHAs seems feasible. • The supply of FP commodities to YRHAs via BLM and DHO seems secure.
Behavior change communication through adult drama groups	Volunteers DHO	• Adult drama group volunteers (attached to certain health services) existed before the project and under the support of the DHO. • During project implementation, upskilling was provided in certain maternal and reproductive health topic areas (suggesting need for periodic refresher training, especially as volunteers will turnover from time to time). In addition an incentive of MK2500 per person was provided every second month, and transport costs/refreshments were covered for any review meetings etc. • Sustainability will be function of individual commitment/altruism and the extent to which the DHO can continue to cover basic incentive costs.
Behavior change communication through youth drama groups	Volunteers DYO Youth Network HSAs	• Re-invigoration of Youth Clubs/drama groups through provision of basic equipment and training has been positive, although refresher training and updating of equipment should be planned for. • Sustainability is likely to be influenced by provision of ongoing supervision and support available through the DYO, Youth Network and HSAs. • Periodic meeting costs included payment of lunch allowance and reimbursement of transport costs.
Maternal death surveillance	DHO HSAs Volunteers	• The maternal death audit process at health facility level (which has been ongoing for a number of years before the project) seems to be embedded and sustainable. The ability of the DHO to support the audit process at the community level (because of fuel/allowance requirement) is less certain. In addition, with no audits having been undertaken at community level to date, the commitment/capacity of VDCs and volunteers in this domain is unclear.
Bicycle ambulance	CDAs HSAs VDCs	• Processes for funding and managing bicycle ambulances at village level seem robust in the absence of any major breakdowns etc. Communities have recognized the valuable role or emergency transport, and seem likely to prioritise support for the initiative through community funds on an ongoing basis.

Impact

1. ***Overall, what real difference has the project made to its intended beneficiaries (women of reproductive age)?***
2. ***What has changed as a direct result of the project?***

There is little doubt that the project has assisted beneficiaries in the following ways:

- ✓ **Improving knowledge and access to information (via CCPF hotline, the volunteer network, SKILLZ program and VDC's) regarding:**
  - safe motherhood: care during pregnancy (nutrition, ANC, STI/HIV testing, avoiding heavy work, sleeping under bed nets etc); danger signs; birth preparedness and importance of skilled delivery; post-partum care.
  - sexual and reproductive health: FP choices and where to access; risks of early marriage and childbearing; STI/HIV transmission and prevention; life skills for young people.
  - newborn health: danger signs; early exclusive breastfeeding; hand hygiene; sleeping under bed nets.

- ✓ **Contributing to behaviour change with respect to:**
  - consumption of iron tablets during pregnancy
  - use of modern contraception and accessing supplies at the community level
  - attending ANC and giving birth with a skilled attendant
  - uptake of HIV testing

- ✓ **Improving access to quality maternal health services at hospital and health facility level**
  - better capacity to manage and monitor critical patients through training in obstetric and newborn skills and provision of HDU equipment
  - bicycle ambulances

- ✓ **Improving access to FP supplies and more youth friendly services, through YRHAs and building the skills of health service providers in terms of their attitudes towards young people.**
  - range and reach of FP commodities with increasing referrals to BLM
  - commitment to gather youth disaggregated data at health facilities

- ✓ **Improving capacity of VDCs and traditional leadership structures to plan, manage, support, and monitor key maternal and reproductive health activities**
  - HICAP process/institutional strengthening
  - empowerment to be active in the area of health, MDSR and advocacy regarding girls' rights
  - traditional counsellors and TBAs in SRH/re-orienting the role of TBAs

In addition, a number of traditional/culture based beliefs/practices that negatively impact on women of childbearing age appear to be shifting. It is difficult to say whether this is just a reflection of ongoing social change, or whether the project has been directly responsible. These include:

- The role of TBA's is being reoriented away from assisting at delivery
- An awareness of girls rights such as access to education and understanding of what constitutes a safe environment in the community
- Changes in the timing of the traditional dance ceremony to reduce the risk of unsafe sex
- The notion of 'couple' HIV/STI testing
- Men helping with birth preparedness and attending delivery
- Women believing they have the right to ask men to have a STI/HIV test
- HIV testing being not just for adults

5. Conclusions and recommendations

The 'Improved Utilisation and Opportunities for Reproductive Health for Women and Youth Project' has made a valuable contribution to improving maternal and reproductive health outcomes for women in Nkhotakota District. The project has contributed to knowledge gains in relation to safe motherhood, sexual, reproductive and newborn health, has strengthened the quality of maternal health services and access to these, and has improved access to FP supplies at the community level. In addition, the project has supported capacity building of VDCs and traditional leadership structures, enabling them to better plan, manage, support and monitor key maternal and reproductive health activities.

While improvement is evident in a number of areas, there remains an ongoing need to support maternal, sexual and reproductive health initiatives within the district. In particular:

1. Family Planning

- While knowledge of FP is very high, the unmet need for FP is 45% among women aged 15-49 years. Unfortunately, the percentage of women aged 15-19 years using a modern contraceptive method remains low at just 22%, with minimal improvement in this area. As some reflection of this, the percentage of 15-19 year olds that have begun childbearing is also largely unchanged at 32%. Qualitative findings suggest that unwanted pregnancies and unsafe abortions continue to occur, mainly in this younger age group.
- However, qualitative data also suggest that uptake of FP by young people appears to be better at the community level, suggesting that the introduction of YRHAs and availability of FP supplies through peers has been an important intervention.
- Indeed, the percentage of women aged 15-49 years who report accessing their FP supplies from a community based worker has increasing from 20% at midterm to 29% at endline; while this data is not available for 15-19 years olds, triangulation of quantitative and qualitative data would suggest that there is real potential to improve access to FP supplies to young people through the continued support of YRHAs.
- At this stage there are 23 YRHAs attempting to cover 3 TAs which is inadequate if young people are to experience further improvements in access to FP supplies from their peers at the community level.

Recommendation: That ongoing commitment and support be provided to YRHAs with more YRHAs trained if possible. During the project, this support was provided through BLM, and it is understood that this support (and referral based stipend) will be ongoing.

2. Antenatal and postnatal care

- There has been excellent improvement on the indicator of attendance for ANC but no improvement on the indicator of PNC attendance. The percentage of women with a child 0-23 months who attended at least four ANC visits during pregnancy increased from 36.2% at baseline to 52% at endline, while the percentage receiving PNC remained unchanged (51% at both midterm and endline). These interventions are important to the overall achievement of better maternal and newborn health.
- There is scope for greater mobilisation and re-orientation of the TBA role to be one around promotion of healthy pregnancy.

Recommendation: That the DHO be encouraged to support TBAs, VDCs, drama groups and volunteers to maintain their important role in advocating for early attendance at ANC and PNC and raising awareness on safe motherhood more broadly. In the least, communication materials developed during the project should be distributed.

3. SKILLZ Malawi/SKILLZ Girls

- The HIV and life skills curriculum delivered through the SKILLZ intervention has been a critical success for the project. The program has contributed to knowledge gains in the area of sexual and reproductive health and life skills for young people, and a substantial increase in HIV testing in the district. It is also likely that the program has contributed to cultural shifts in relation to gender and HIV. As such it would be a shame for this not to be available in other parts of the country.
- The fact that 93% of participants continued to graduation suggests suitability of this approach for the intended audience. Limited observation of coaches and participants during the end evaluation suggested great enthusiasm for the approach and content.
- The approach of complementing the SKILLZ program through the BLM partnership, an organisation non-judgemental and sensitive to providing family planning services to young people, was strategic and positive. It expanded access to FP supplies and information at the community level, through training of YRHAs- many of whom also volunteered as SKILLZ coaches.

Recommendation: That Concern considers supporting expansion of SKILLZ to districts that have not had access to the program (in parallel to expanding access to YRHAs).

4. VDC capacity

- VDCs have been empowered to be more active in the area of health, and have obtained more knowledge on maternal and RH issues. They now need to step up and capitalise on gained knowledge and skills and be encouraged to do so.
- As VDCs often cover a very large area, coverage of bicycle ambulances is inadequate. However, given that provision of bicycle ambulances has been subsidised by Concern and part of a more broad capacity building process with VDCs, the consultant is hesitant to recommend purchase of additional ambulances, unless they are provided to VDCs that were involved in the project.

Recommendation: That the DHO be encouraged to provide ongoing support and motivation to VDCs.

5. Health system strengthening

- Capacity building of health facility staff (including upskilling in obstetric and newborn care) occurred during the project. It was difficult to determine assessment/monitoring of outcomes in this area from project documents, and observation of clinical knowledge and skills was not a focus of this evaluation. As such, it would be improper to comment on this component of health system strengthening.
- Capacity building also occurred in the area of youth friendly health services. The relatively poor attendance by young people at health facilities for sexual/reproductive health issues (acknowledged by key DHO staff), suggests more could be done in this area.
- The DHO appears to be facing numerous challenges in the context of decentralisation. Problems with essential drug supplies and other critical commodities (e.g we were told that they had minimal IV fluids in stock and any remaining stock was being held for emergencies) are ongoing. Ambulances sit in disrepair in the hospital car park, yet transport of women from health centres to the hospital during obstetric emergencies remains a challenge.
- While provision of critical monitoring equipment and reagents etc. was an important component of the project, it is unclear what will happen as this equipment breaks down and needs repair or replacement in the future.

Annexes

Annex 1: Data collection schedule

DATE (March 2016)	ACTIVITY (Document review plus….)	Location	
		Venue	TA
Sun 6th	• Reviewing IEC and Radio Programs		
Mon 7th	• Planning/training/confirm translation of question guides with evaluation team. • Staff Interviews (Project management team)	Office	Malengachanzi
Tue 8th	Interviews with: DHO staff (DHO, Safemotherood coordinator, FP coordinator, Youth friendly health service coordinator, district nursing officer) BLM Manager	DHO and BLM office	Malengachanzi
	FGD with SKILLZ coaches/YRHA's	Office	Malengachanzi
Wed 9th	FGD with VDC and VHC members;	Malengasanga	Malengachanzi
	FGD with CCPF and MDSR community Volunteers, Drama group	Mpamantha	Malengachanzi
	FGD with Community beneficiaries - Skills Malawi (boys)	Chididi	Malengachanzi
Thu 10th	FGD with VDC and VHC members;	Kapiri	Mwadzama
	FGD with Community Beneficiaries – Pregnant women and caregivers of children 0 – 23 months	Malowa	Mwadzama
Fri 11th	FGD with Community Volunteers (youth drama)	Denje	Malengachanzi
	FGD with Community beneficiaries - Skills Malawi (girls)		Malengachanzi

Annex 2: Question guides

ACTIVITY REVIEW GUIDED DISCUSSION (Concern project staff/outreach workers in Nkhotakota)

(reflect separately on each of the strategic objectives for all questions)

- What are we doing in relation to SO 1…2…3?
- Is this what we planned to do, or have we changed direction along the way? Why? (probe items from mid term review such as Helping health workers cope curriculum)
- Generally, how is it going? How do we know? What are the signs that we've seen, heard, noticed. Consider intended and unintended outcomes, both positive and negative.
- Have others in the community had involvement? In what way? How did the implementation of key activities through partners affect implementation and achievement of project objectives?
- How did collaboration with partners and other district-level stakeholders contribute to opportunities for further scale-up of project approaches within a broader context?
- What steps were taken to address issues of inequality and ensure the interests of the most marginalised were taken on board during programme planning, implementation and monitoring? How effective was this?
- What effect have we seen on gender and responsibilities?
- What lessons have we learnt in relation to doing this activity?
- What have been our biggest successes?
- What have been our biggest challenges? (probe stock outs FP supplies; allowance guidelines; prevailing beliefs/myths/attitudes of leaders etc??.....)
- What are we doing well?
- What could we be doing better or differently?
- Sustainability? What will positively /negatively impact on potential for sustainability? Are exit strategies in place? (probe: supervision and support to health facility staff and vols; $ to different components)
- Overall, what difference has this part of the project made to its intended beneficiaries (women of reproductive age/younger women)? What has changed as a direct result of the project?

IEC/BCC materials, radio scripts etc:

- What has been produced? Content areas? Basis for content (ie informed by….)
- Who has been targeted?
- Communication channels used? Frequency of reach.
- What was the process of development, were they pilot tested?
- Have traditional institutions and target groups been involved?
- Have PLWHA been involved where relevent?
- Is literacy a barrier to accessing IEC? Are women excluded?
- What will happen to activities when project closes?

INTERVIEWS WITH DHO STAFF (Family planning focus)/safe motherhood focus)/ (service delivery focus)…depending on their roles

- What activities have been happening in partnership with the project?
- To what extent have these activities been relevant to and in support of district and national-level Ministry of Health strategies and priorities.
- Generally, how is it going? How do we know? What are the signs that we've seen, heard, noticed. Consider intended and unintended outcomes, both positive and negative.
- Have others in the community had involvement? In what way? How did the implementation of key activities through others affect implementation and achievement of project objectives?
- What lessons have we learnt in relation to doing this activity?
- What have been our biggest successes?
- What have been our biggest challenges? (if relevant probe: availability/$ of various FP methods and stock outs….)
- What are we doing well?
- What could we be doing better or differently?
- Sustainability? What will positively /negatively impact on potential for sustainability? (probe re supervision to health facility staff and volunteers)

- What has changed as a direct result of the project? Overall, what difference has this part of the project made to its intended beneficiaries (women of reproductive age/younger women)? Have there been changes in the treatment/care that can be offered as a result of the project?
- Probe, specifically if it doesn't come up:
  - Access to contraceptives/ who pays? (esp if >25)
  - re quality- use of client satisfaction tools & annual reviews/planning for health reforms;
  - what has changed to make services more "youth friendly"; ? opening times? $
  - ? checklists for ANC, PNC, delivery care, efforts to strengthen male involvement
  - Maternal death audits, are they happening, main causes (are unsafe abortions still happening), what is the link between facilities and VDCs/community in terms of information feedback?
  - Use of VDC bicycle ambulances?
  - Access to basic/emergency EOC

INTERVIEW WITH BLM MANAGER

- What activities have been happening in partnership with the project?
- Generally, how is it going? How do we know? What are the signs that we've seen, heard, noticed. Consider intended and unintended outcomes, both positive and negative.
- Have others in the community had involvement? (Probe YRHAs, GRS ???) In what way? How did the implementation of key activities through others affect implementation and achievement of project objectives?
- What lessons have we learnt in relation to doing this activity?
- What have been our biggest successes?
- What have been our biggest challenges?
- What are we doing well?
- What could we be doing better or differently?
- Sustainability? What will positively /negatively impact on potential for sustainability? (probe re supervision to YRHAs etc)
- What has changed as a direct result of the project? Overall, what difference has this part of the project made to its intended beneficiaries (women of reproductive age/younger women)? Have there been changes in the treatment/care that can be offered as a result of the project?
  - ? stories of unwanted pregnancies, unsafe abortion
  - Supply chain/stock outs
  - Availability of permanent/long term methods

(Context: who pays for contraceptives? < 25/>25 yrs? Quality checklists; ? youth friendliness of available services; where do single young men/women access condoms and other contraceptive supplies)

The following were translated:

Nkhotakota Maternal and Reproductive Health Project End Evaluation **ACTIVITY REVIEW/GUIDED DISCUSSION** **Master Coaches/SKILLZ Malawi coaches/SKILLZ Girls coaches (including YRHA/CBDAs)**
"We greatly appreciate your agreeing to participate in this discussion about implementation of the Grassroots Soccer/SKILLZ program in Nkhotakota. There are no right or wrong answers to our questions and you may answer in any way. Your answers are completely confidential. Your name will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end the discussion at any time if you want to. However, your answers to these questions will help us better understand how the SKILLZ program has worked in Nkhotakota and how it could be improved. The discussion will take about 60 minutes or less. We will be taking notes of the discussion for the sake of accuracy and for review by the Concern team as we work to review and improve the quality of our work in Nkhotakota district. Thank you for your cooperation. First, let me introduce myself. I am…, and I will be asking you some questions today. <*Other observers now introduce themselves and state their roles.*> Remember there are no 'right' or 'wrong' answers-- please be honest and critical, as it will help us learn. We are here to learn from you. (? for warm up/ice breaker use condom cards or HIV risk cards)
1. Can we begin by asking about the kind of activities have been happening in partnership with Concern?
2. Is this what we planned to do, or have you needed to change direction along the way? Why? *(probe filtering session content)*

3. Generally, how is it going? How do we know? What are the signs that we've seen, heard, noticed. *(Consider intended and unintended outcomes, both positive and negative.)*
4. Have others in the community had involvement? In what way? How did the implementation of key activities through others affect implementation and achievement of project objectives?
5. What steps were taken to address issues of inequality and ensure the interests of the most marginalised were taken on board during programme planning, implementation and monitoring? How effective was this?
6. Have you seen any effects on gender and responsibilities?
7. What lessons have you learnt in relation to doing this activity?
8. What have been your biggest successes?
9. What have been your biggest challenges?
10. What do you think you are we doing well in relation to the planned activities?
11. What do you think you could we be doing better or differently?
12. What will positively or negatively impact on the potential for sustainability? Are exit strategies in place? (probe: ongoing supervision and support to vols; financial incentives for coaches)
13. Overall, what difference do you think the Grassroots Soccer program has made to its intended beneficiaries (younger women/men)? What has changed as a direct result of the project? Can you share any stories to help illustrate this impact?
That is the end of our questions, but is there anything else important you would like to share with us that hasn't been raised in our discussions?

Nkhotakota Maternal and Reproductive Health Project End Evaluation **FOCUS GROUP DISCUSSION** **Community volunteers (mix of CCPF vols, Maternal death audit volunteers, adult drama group members)**
"We greatly appreciate your agreeing to participate in this discussion about your work as a volunteer during the Nkhotakota Maternal and Reproductive Health Project. There are no right or wrong answers to our questions and you may answer in any way. Your answers are completely confidential. Your name will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end the discussion at any time if you want to. However, your answers to these questions will help us better understand your experience as volunteers and help us to review and improve the quality of our work in Nkhotakota district. The discussion will take about 60 minutes or less. We will be taking notes of the discussion for the sake of accuracy. Is everyone OK with that? Thank you for your cooperation. First, let me introduce myself. I am…, and I will be asking you some questions today. <*Other observers now introduce themselves and state their roles.*> Remember there are no 'right' or 'wrong' answers-- please be honest and critical, as it will help us learn. We are here to learn from you.
1. Can I begin by asking what kind of volunteers you are (CCPF, maternal death audit vols, drama group members, YRHAs etc)? (Do a count of how many of each)
2. What kind of health information do you provide to women (especially pregnant women and the younger women in the community)? *(Probes if this information doesn't get spoken about….what kind of information do they provide about: ANC visits?; immunization for pregnant women?; Nutrition during pregnancy?; danger signs during pregnancy?; emergency transport?; post natal care?; breastfeeding; danger signs in newborns?; family planning? ; delaying marriage and first pregnancy; availability of CCPF hotline?).*
3. How is your connection/relationship with nearby health services? What happens if you need to refer someone to care?
4. What kind of supervision and support have you received during your time as a volunteer?
5. In the last year or so, have you heard about any maternal deaths; unsafe abortion; early marriage; teen pregnancy? (*If yes, ask them to explain further…)*
6. What kind of a role do you have in offering family planning services? What kind of information and advice do you give people?
7. What kind of contraceptives do you distribute? Which ones will protect against STIs/HIV?
8. Do you ever have problems with the supply of contraceptives?
9. Do you manage to reach both men and women? Of different ages? Why or why not?
10. Can young, unmarried people access contraceptives from you? Do they?
11. In your community, what are the social, cultural and religious obstacles to family planning and delaying the first

pregnancy? Are these shifting in anyway?
That is the end of our questions, but is there anything else important you would like to share with us that hasn't been raised in our discussions?

Nkhotakota Maternal and Reproductive Health Project End Evaluation
FOCUS GROUP DISCUSSION
Village development committee

"We greatly appreciate your agreeing to participate in this discussion about your Village Development Committee and the work you have been doing around safe motherhood and reproductive health. There are no right or wrong answers to our questions and you may answer in any way. Your answers are completely confidential. Your name will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end the discussion at any time if you want to. However, your answers to these questions will help us better understand the experience if the VDV and help us to review and improve the quality of our work in Nkhotakota district. The discussion will take about 60 minutes or less. We will be taking notes for the sake of accuracy. Is everyone OK with that?

Thank you for your cooperation.

First, let me introduce myself. I am…, and I will be asking you some questions today. <*Other observers now introduce themselves and state their roles.*> Remember there are no 'right' or 'wrong' answers-- please be honest and critical, as it will help us learn. We are here to learn from you.

1.	Can I begin by asking how long each of you have been involved with the VDC?
2.	What kind of health information do you provide to women (especially pregnant women and the younger women in the community). *(Probes if this information doesn't get spoken about….what kind of information do they provide about: ANC visits?; immunization for pregnant women?; Nutrition during pregnancy?; danger signs during pregnancy?; emergency transport?; post natal care?; breastfeeding; danger signs in newborns?; family planning? ; delaying marriage and first pregnancy; availability of CCPF hotline?).*
3.	When/how do you weave these discussions into the work of the VDC?
4.	Does your VDC have an action plan for the year? Are there any health related activities? *(If so, what are they..)*
5.	How is the bicycle ambulance working? Do you have a plan for women who need emergency transport? Can you tell us about this..
6.	What are your financial arrangements for the bicycle ambulance (financing repairs etc, covering costs for women who cannot pay?)
7.	In the last year or so, are you aware of any maternal deaths? Is there some kind of process in place for auditing maternal deaths?
8.	What are your ideas about providing a safe environment for girls?
9.	How common is marriage of girls <18yrs these days? What about pregnancies in this age group?
10.	What are the social/cultural/religious obstacles to family planning and delaying first pregnancy? Are these shifting in anyway?
11.	How would you describe your relationship/link with the local health facilities and staff? Does the HAS have any involvement in your VDC?
	That is the end of our questions, but is there anything else important you would like to share with us that hasn't been raised in our discussions?

Nkhotakota Maternal and Reproductive Health Project End Evaluation
FOCUS GROUP DISCUSSION
Young women 15-19 yrs/from SKILLZ program

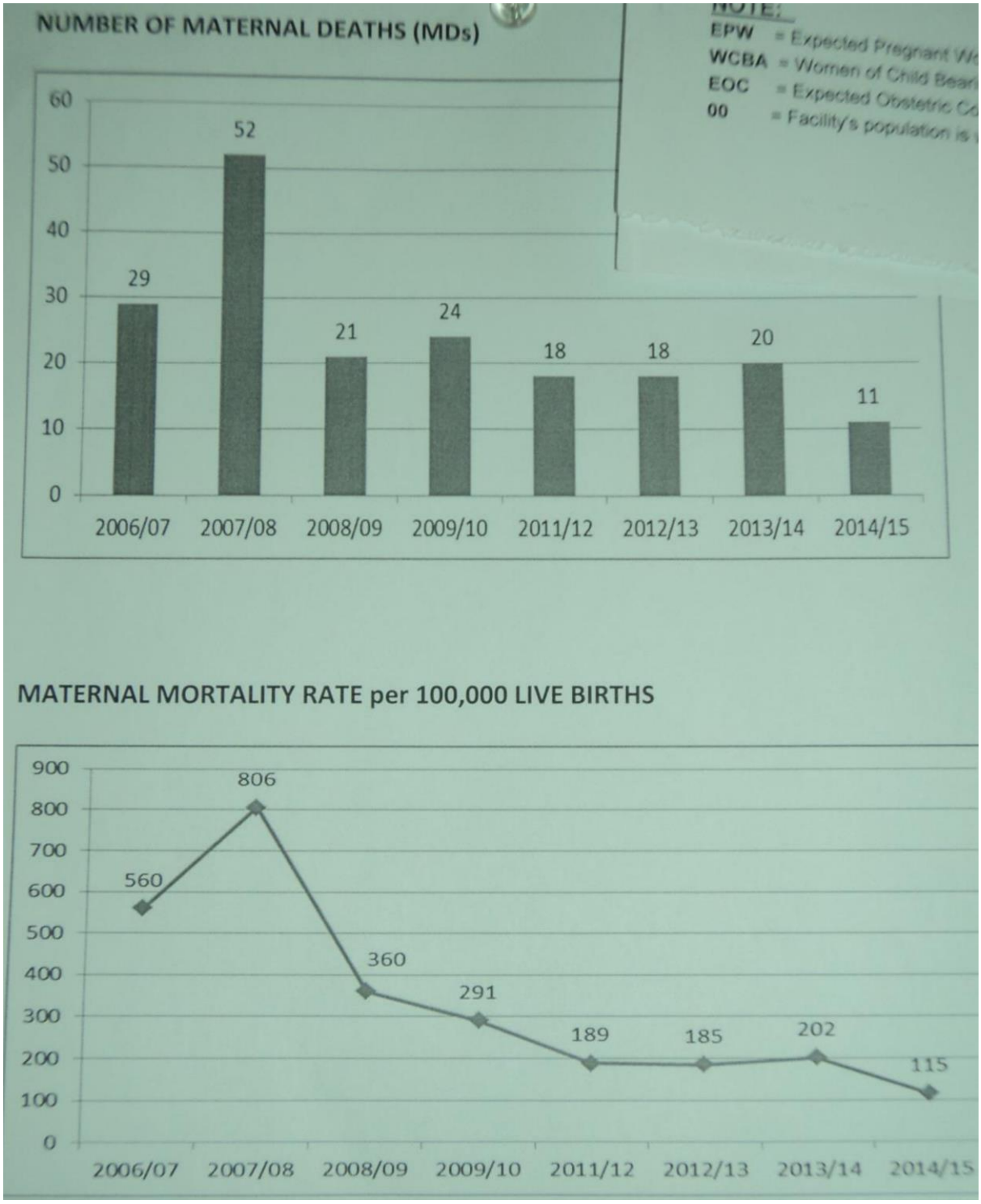
"We greatly appreciate your agreeing to participate in this discussion about your involvement in SKILLZ Malawi. There are no right or wrong answers to our questions and you may answer in any way. Your answers are completely confidential. Your name will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end the discussion at any time if you want to. However, your answers to these questions will help us better understand your experience within the program, and help us to review and improve the quality of our work in Nkhotakota district. The discussion will take about 60 minutes. We will be taking notes of the discussion for the sake of accuracy. Is everyone OK with that?

Thank you for your cooperation. First, let me introduce myself. I am…, and I will be asking you some questions today. <*Other observers now introduce themselves and state their roles.*> Remember there are no 'right' or 'wrong' answers-- please be honest, as it will help us learn. We are here to learn from you.
1. We would like to begin with a bit of a game about HIV. (To be confirmed: Use HIV risk cards)
2. OK, now we would like to talk a bit about family planning and what young women know about this. Invite them to break into two groups and tell them we have 10 minutes for this activity. Instructions (we will have written on large piece of paper): • draw a quick map of your village; • mark in where/who young women might visit for information about family planning and supplies; *(Probe..YRHAs, HSAs, SKILLZ, VDC/HVC…)* • when they are finished, invite each group to talk about their map and as they are doing this, ask questions 3-6
3. What kind of family planning choices are available in your community? *(probe: when they mention condoms, ask about male and female condoms and if these come with lubricant, if not, do they know what people use)*
4. Are they affordable for young people?
5. Do you ever hear stories of young people having trouble accessing family planning because they are not married?
6. Do you ever hear stories of young people wanting to access family planning supplies but the supplies are out of stock?
7. When young women have babies at an early age, what challenges might they face?
8. Do you ever hear about young women having unplanned pregnancies or needing to access unsafe abortion?
9. What are the social/cultural/religious obstacles to family planning and delaying first pregnancy? Are these shifting in anyway?
10. From the FP choices that we have talked about, do you know which ones protect people from STIs?
11. How might you know if you have an STI? What would you do?
That is the end of our questions, but is there anything else important you would like to share with us that hasn't been raised in our discussions?

Nkhotakota Maternal and Reproductive Health Project End Evaluation **FOCUS GROUP DISCUSSION** **(Pregnant women or those that have had a baby in recent year)**
"We greatly appreciate your agreeing to participate in this discussion about the health care you received during and after your pregnancy . There are no right or wrong answers to our questions and you may answer in any way. Your answers are completely confidential. Your name will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end the discussion at any time if you want to. However, your answers to these questions will help us better understand your experience within the program, and help us to review and improve the quality of our work in Nkhotakota district. The discussion will take about 60 minutes. We will be taking notes of the discussion for the sake of accuracy. Is everyone OK with that? Thank you for your cooperation. First, let me introduce myself. I am…, and I will be asking you some questions today. <*Other observers now introduce themselves and state their roles.*> Remember there are no 'right' or 'wrong' answers-- please be honest, as it will help us learn. We are here to learn from you.
1. First of all, we're interested to hear about what you can do to help ensure a healthy pregnancy and delivery? *(probe: ANC, nutrition, rest, immunization, birth planning etc)*
2. How did you find the care that was provided through the ante-natal clinic?
3. And what about during delivery?
4. For those that have had several pregnancies, can you tell us about the kind of medical care/support that was available for pregnant women 3 years ago, compared to now?
5. Have you heard anything about the danger signs during pregnancy?
6. What about the danger signs in a newborn?
7. When pregnant or postnatal women or their newborns are unwell or experience complications, who do they contact for help? *(Probe: CCPF hotline, if anyone has used it ask about their experience, why, what happened etc; bicycle ambulance)*
8. For those families wanting to space their babies, what options are available to them?

9. Where do women access family planning advice and supplies? Are they affordable? Are there ever problems with the supply? What about lubricant for condoms- what is available…what do people use?
10. These days- do you ever hear stories of women experiencing unwanted pregnancies or resorting to unsafe abortion?
11. What are the social/cultural/religious obstacles to family planning and delaying first pregnancy? Are these shifting in anyway?
That is the end of our questions, but is there anything else important you would like to share with us that hasn't been raised in our discussions?

Annex 3: Maternal Death data from Nkhotakota DHO



Innovations for maternal, newborn & child health

CONCERN worldwide (U.S.) INC

Concern Worldwide Malawi's Maternal and Reproductive Health Project, Nkhotakota district (2013-2016)

Mid-Term Evaluation Report

Prepared and submitted by:

Jean Christophe Fotso

Associate Director of Research, Monitoring & Evaluation

Concern Worldwide US, New York, USA

Report submitted to:

Jennifer Weiss

Health and Nutrition Coordinator, Concern Worldwide Malawi

May 2015

Section 1: Introduction

Background

With funding from Merck for Mothers, Scottish Government, and Elizabeth Taylor Foundation, Concern Malawi is implementing a maternal and reproductive health (MRH) project in Nkhotakota district, Malawi over the period 2013-2016. The project built on the *Innovations for Maternal, Newborn & Child Health* (*Innovations*) project implemented in Malawi from 2010–2013 known as *Chipatala Cha Pa Foni* (CCPF), and an integrated child health and nutrition initiative funded by Scottish Government and implemented in Nkhotakota district from 2010-2013. It is designed to reduce maternal morbidity and mortality through the following strategic objectives:

1. Improved utilization of high quality MRH services through increased availability and accessibility of services
2. Improved utilization of high quality community-based family planning services, including youth friendly reproductive health through increased availability and accessibility of services
3. Improved government and traditional leadership structures and community members to plan, manage, support and monitor key maternal and reproductive health activities

A total of 33,514 women of child-bearing age are expected to benefit from a full package of community-based health and facility level interventions in three of seven Traditional Authorities (TAs) in the district: Malengachanzi, Mwadzama and Mwansambo. The project is in direct support of Concern Worldwide Malawi's 2014 – 2018 country strategic plan; specifically Strategic Goal 2: *Women and girls are empowered and enabled to make decisions for the own well-being.* Equality, risk and vulnerability are explicitly being addressed through the project focus on expanding and improving sexual and reproductive health (including HIV and AIDS) knowledge, practices, and services for adolescent girls. With just over one year of implementation remaining, Concern Malawi seeks to conduct a midterm review of the project.

Mid-Term Review's Objectives

The objectives of the mid-term review are to:

1. Assess progress towards the achievement of project objectives, as measured by indicators in the monitoring and evaluation (M&E) framework
2. Identify priority activities required to accelerate progress towards the achievement of project objectives within the remaining one year of the project
3. Document promising practices and lessons learned

Jean Christophe Fotso, Associate Director of Research, Monitoring & Evaluation at Concern Worldwide US was commissioned to lead the review, and guide the identification of key approaches and opportunities for future scale-up or replication in areas beyond Nkhotakota. He travelled to Malawi on May 4-13, and worked with the team in Nkhotakota and Lilongwe to achieve the review's objectives.

The specific tasks assigned to Jean Christophe were to:

1. Design and facilitate midterm project review with Nkhotakota team and partners. Specifically, to:
    - Review project documents and resources to understand the project
    - Draft midterm review methodology and schedule (including the proposed number of and type of key informant interviews or focus groups discussions, and/or activity observations)
    - Lead the team to complete the collection, analysis, and synthesis of all data sources to assess project performance
    - Lead the interpretation of results and generation of programmatic implications and recommendations for priority actions in the remaining one year of the project
2. Identify key approaches for future scale-up and replication:
    - Drawing on one of Innovations' completed projects in Sierra Leone, provide advice and resources to Nkhotakota health team on interventions to address psychosocial support for health workers
    - Provide technical support to Health and Nutrition Coordinator and country leadership to prioritize key approaches and opportunities for future programming
    - Meet with VillageReach, MOH, and facilitate introductions to other potential partners for future MNCH programs
    - Facilitate dissemination meeting of African Population Studies journal supplement devoted to Innovations' mHealth pilot in Malawi (CCPF), if possible

Mid-Term Review Design and Methods

The review used a mix-methods approach, collecting, collating or reviewing and analyzing and synthesizing quantitative and qualitative data, reports and manuals. The data source and specific activities conducted during the mid-term review are presented in Table 1.

Table 1. Mid-term review's data sources and activities

Source	Description	Activities
Monitoring data and project documents	Monitoring data and project documents (e.g., proposals, donor reports, results frameworks)	Jenn and her team reviewed project documents and updated the project's monitoring data, to document progress against key process indicators. Discussions of the results and their implications were led by JC.
Knowledge, Practice and Coverage (KPC) survey	A midterm KPC survey was conducted. The questionnaire covered FP knowledge and practices, maternal and newborn care, community engagement, and CCPF awareness and use. A total of 641 women were interviewed, including 290 aged 15-19, 344 mothers of children under the age of two years.	The project team conducted the survey; Jenn conducted data analysis and presented a synthesis of the key results. Discussions of the key findings and their implications were led by JC.

Source	Description	Activities
Focus group discussions (FGDs)	A total of six FGDs with key actors of the project: village development committee (VDC) members (3 FGDs), Grassroots soccer (GRS) coaches of SKILLZ Malawi (2 FGDs), and GRS coaches of SKILLZ Girls (1 FGD).	The project team conducted the interviews the week of April 27th and provided full transcripts. JC analyzed the transcripts and presented a synthesis of the key findings, and led the discussions on the implications of the findings.
In-depth interviews (IDIs)	IDIs with two staff from the District Health Office (DHO) (Safe Motherhood Coordinator and deputy FP Coordinator), and with two project staff (one current staff and the outgoing project manager)	JC conducted the interviews the week of May 4th, analyzed the data and presented a summary of the key findings, and led the discussions on the implications of the findings.
Field visits	As part of the evaluation, two field visits were organized the week of May 4th: a session of GRS SKILLZ Malawi, and a meeting of/with VDC members	The visits proved very useful as important issues relevant to the objectives of the evaluation were noted or discussed.
Innovations' Helping Health Workers Cope (HHWC) project documents	Implementation manuals and final evaluation report	JC made a presentation on the HHWC project and facilitated a session of discussion on its relevance and applicability to the Malawi context in general, and the MRH project in particular.

Limitations

The mid-term review had a few limitations. There were only limited monitoring data available, which restricted the investigation of the extent to which the project adhered to its work plan. Importantly, the time allotted for the review, from tool design to data collection and analysis, was utterly short. The FGD data in particular, were not analyzed with the level of thoroughness required – due to lack of time. The fact that FGDs data were collected and analyzed by the project team could be seen a source of bias. The bias is however of less concern, given the findings of the mid-term review are first and foremost for internal use. It is also important to note that the baseline values used in the analyses are from the 2010 Malawi demographic and health survey (DHS), and that a number of project indicators did not have set target values.

Section 2: Key Findings of the Mid-Term Review

Table 2 summarizes the data sources and indicators used to assess the progress towards the project's strategic objectives, document promising practices, and identify priority activities to accelerate the achievement of the set targets. The key findings are presented below, by objective.

2.1. Improved utilization of high quality MRH services through increased availability and accessibility of services

The quantitative data show that the project has made good progress against the following four indicators:

- % of women who can name 3+ FP methods[1] - about 83%.
- % of mothers of children 0-23m with correct knowledge of 2+ newborn danger signs[1] – about 81%.
- % of mothers of children 0-23m who received a PNC visit within 2 days of birth from a trained health worker[2] - about 60%, up from 32% at baseline, though the project team is doubtful that this change and the one on knowledge of danger signs could be attributed to the project's activities.
- % of births attended by trained health worker[2] – about 78%, compared to 59% at baseline.

The data suggest that efforts should be redoubled to improve the remaining indicators. In particular, contraceptive use was unchanged in comparison with the baseline; the awareness and use of CCPF remained low, despite the large potential of various community-level project activities; the intake of iron tablets during pregnancy stands at 10%, down from 32% at baseline – though supply side factors may be at play (the KPC data does not provide any clarifications on potential supply side effects). Discussion of FP with a health worker displayed reduced mid-term values compared to baseline (27% versus 48%), and a large gap with the target value of 65%. Unmet need for FP also shows disappointing results, but the very concept of unmet need is difficult to measure.

The DHO staff interviewed acknowledged and commended the level of engagement with the project, clearly indicating that Concern performs better on this front, than all other NGOs. The level of engagement with community-level actors was also highly commended. Importantly, they cited the setup of a high-dependency unit (HDU), the in-service training, and the recently launched death audits as critical milestones towards the reduction of maternal morbidity and mortality in the district – hinting to the point that the recent declines could be attributed to these activities. They regretted that the quarterly joint supervision visits have not been consistent, but admitted that it is due largely to the unavailability of DHO counterparts.

The interviews with DHO staff and project staff also pointed to the following critical areas that need to be addressed.

- Delivery of permanent FP methods: The DHO staff lamented on the fact that there are only two providers of permanent methods in the district, citing cases of women requesting a permanent method, but falling pregnant as a result of lack of access to the method. The need would be to have about 15 clinicians trained.
- Delivery of long-term FP methods: Some (if not many) of the facility health workers, HSAs and CBDAs have outdated or lack of appropriate knowledge on the delivery of these methods.
- Lack of supervision and motivation of CBDAs was seen as a major hindrance to FP service delivery
- Support is needed for outreach activities in a few hard-to-reach places with alarming levels of maternal deaths (e.g. in terms of fuel and transportation)

[1] No baseline value or target, but reasonably high level

[2] No target, but reasonably good improvement from the baseline values

Table 2. Data sources and indicators used to achieve the mid-term review's objectives

Strategic Objective (SO)	Data sources and indicators	
	Quantitative/Indicators	**Qualitative**
SO1: Improved utilization of high quality MRH services through increased availability and accessibility of services	1. % of women who can name 3+ FP methods 2. % of women using a modern contraceptive method 3. % of currently married women with unmet need for FP 4. % of women who discussed FP with a fieldworker or at a health facility in the past 12 months 5. % of mothers of children 0-23m with correct knowledge of 2+ maternal danger signs 6. % of mothers of children 0-23m with correct knowledge of 2+ newborn danger signs 7. % of mothers of children 0-23m who attended 4+ ANC visits 8. % of mothers of children 0-23m who received a PNC visit within 2 days of birth from a trained HW 9. % of mothers of children 0-23m who consumed iron tablets for 90 days during their last pregnancy 10. % of births attended by trained HW 11. % of women who have heard of CCPF 12. % of women who have used CCPF; reasons for use & non-use	IDIs with DHO staff; IDIs with project staff; Presentation on HHWC
SO2: Improved utilization of high quality CB-FP services, including YFRH through increased availability and accessibility of services	1. % of 15-19 using a modern contraceptive method 2. % of women using a modern FP method who report obtaining their current method from a CBW 3. % of 15-19 who have begun childbearing 4. % of 15-19 who can correctly state 1+ benefits of delaying first pregnancy until after 18 years old	FGDs with GRS coaches; IDIs with DHO & Project staff
SO3: Improved government and traditional leadership structures and community members to plan, manage, support and monitor key MRH activities	1. % of women who attended a VDC/ GVH/VH meeting where SRH services were discussed in the last 3m 2. % of 15-19 who attended a VDC/GVH/VH meeting where youth friendly SRH services were discussed in the last 3m 3. % of women who are aware of bicycle ambulance in the community	FGDs with VDC members; IDIs with DHO & Project staff

DHO staff burn out was identified by the project as a factor of poor health service delivery. The presentation of the Helping Health Workers Cope (HHWC), a project that was implemented in Sierra Leone by Innovations, generated a great deal of interest. On the one hand, there was the view that despite being designed for a post-civil war context, HHWC presented opportunities for replication in Malawi and within the current MRH project. Proponents of this argument cited the overwhelming schedules of health workers who are caught up frequently in many competing activities (training, outreach activities), and typically face a high demand for health services. On the other hand, there was the idea that the very intensive HHWC training and counselling schedules may not be well accommodated in the less than one year remaining period. In the subsequent discussions in Lilongwe, the team agreed to explore the incorporation in the MRH project, of a lighter version of the HHWC project.

2.2. Improved utilization of high quality CB-FP services, including YFRH through increased availability and accessibility of services

The KPC survey data show that about 21% of adolescents aged 15-19 are using a modern method of contraception, a 12-point increase from the baseline value. The proportion of adolescents who can correctly state at least one benefit of delaying the first pregnancy until after the age of 18, was estimated at 70%, well above the target of 60%. The GRS and other project's community-level activities may explain this improvement.

While there were no baseline and target values for the percentage of women using a modern FP method who report obtaining their current method from a community-based health worker, the KPC value of 20% seems reasonably good, given that only a few methods are provided by community-based health workers.

Despite these positive achievements of the project, early pregnancy and childbearing increased from 25% at baseline to 31%, more than 10 percentage point above the target (of 20%). However, the indicator used in the KPC survey should be viewed with caution. Indeed, by using the percentage of women aged 15-19 who have begun childbearing, we would include some women who were already pregnant before the project began in 2013 (e.g. a woman who was then 15 years old).

The FGDs with SKILLZ Malawi and SKILLZ Girls revealed the interest of coaches and participants to the programs. For SKILLZ Girls, the favorite practices included Our changing body, Sex & Gender, Know your rights, and Advocate for yourself. SKILLZ Malawi's coaches cited HIV Transmission, My Supporter, My Choices, Decision making, Find a ball, and HIV attacks.

Overall, the GRS activities were seen to have filled important gaps in meeting youth and adolescents SRH needs. However, a few practices were less welcome, to the extent that they were either modified or skipped. SKILLZ Girls' family planning-related sessions were clearly seen as inopportune, inappropriate and unpropitious for younger girls. These types of activities are thought to be one of the factors leading some community members to term the program as "encouraging prostitution". This

sentiment was apparent during the field visit. Some of the coaches reported changing the expression "multiple partners" with "abstain". SKILLZ Malawi's coaches identified a few difficult sessions: Micro move, VMMC – Coaches were not taught, Risk Field – not clear, and Practice 11 – difficult to implement due to untimeliness in the delivery of certificates.

Despite these few weaknesses, participants enjoyed the activities which were reported by a few coaches to have led to aroused interest in seeking reproductive health services and contraception methods in particular at health facilities. Regrettably, they noted, the services are not youth friendly.

The interviews also revealed major problems that urgently need to be addressed. The roles as YRHAs are still not well understood; the expectations around stipend are largely unclear, with travel cost to submit the report absorbing a large part of the stipend; YRHAs are asked by the sub-grantee (Banja la Mtsogolo) to carry out activities that are clearly outside of their scope of work (e.g. cleaning at facilities). Specific recommendation by coaches included:

- Increased number of holiday camps
- Quarterly review meetings organized as planned
- Intensified field supervision by project staff, and improved communication with the project team

2.3. Improved government and traditional leadership structures and community members to plan, manage, support and monitor key MRH activities

The three indicators for this objective do not have baseline or target values. The KPC data show that less than half of women age 15-49 who are aware of the bicycle ambulance in the community. It is important to note though that bicycle ambulances were only distributed to less than 50% of the VDCs (25 out of 58).

The proportion of women age 15-49 who attended a VDC/GVH/VH meeting in the last three months where SRH services were discussed was estimated at 14%, while the proportion of women age 15-19 who attended a VDC/GVH/VH meeting in the last three months where youth friendly SRH services were discussed, is as low as 8%. However, the analysis further shows that only 18% of women 15-49 attended a VDC meeting in the last 3 months, and of those, 77% said SRH issues were discussed. Similarly, only 13% of women 15-19 attended a VDC meeting and of those 58% said youth-friendly SRH services were discussed. Overall then, SRH issues are being reasonably well discussed during VDC meetings.

During the FGDs, VDC members were enthusiastic to report that thanks to the HICAP process, they now fully recognize that development is their core business. Some of them complained that the training was too dense to fully grasp the content, pointing to the need for refresher training and review meetings. The following issues were raised during the FGDs, some of which were confirmed during the field visit:

- Support in proposal writing for fund raising
- Exchange visits with other VDCs to share experience and good practices
- Bicycle ambulances to VDCs that do not have any

- Organization of quarterly review with, and supervision of VDC members, including where possible, their orientation on RH and nutrition, and on VS&L
- Orientation of new VDC members
- Training of HSAs and CDAs on HICAP

Section 3: Conclusions and Recommendations

Overall, in the first two years of implementation, the MRH project has made immense progress in laying the foundation for success. The engagement with DHO has been strengthened and is now considered a major pillar of the project. The recruitment, training and deployment of close to 100 grassroots soccer Coaches , including eight Master Coaches, 77 SKILLZ Malawi Coaches and 12 SKILLZ Girls Coaches, is a major achievement. By December 2014, they had trained about 4,000 adolescents (in groups of about 15 for a period of 10 weeks per group); as of March 2015, they had reached about 6,200 adolescents. These engagements with the adolescents are strategically complemented by the work of 25 youth reproductive health assistants (YRHAs), 21 of which are also SKILLZ coaches. The engagement of 58 village development committees (VDCs), the training of their members on the HICAP process, and the provision of bicycle ambulances, can be seen as another key pillar of the project, with high potentials, as the field visit confirmed. In a way, it was sad (from the perspective of the author of this report) to note that after this level of long-lasting footprint, Concern Malawi will likely be exiting from the district of Nkhotakota at the end of 2016. Indeed, the Nkhotakota district has been found to be one of the best-off districts in Malawi, and in line with Concern Worldwide's key operating principle, Concern Malawi will have to work in the future in the poorest and most vulnerable areas of the country.

With these foundational activities in place, the project will need to accelerate the progress towards its quantitative targets. The mid-term review identified five areas of focus which are detailed below. To kick-start these proposed activities or prepare the conditions for their fruitful implementation, the project team also identified a number of key, immediate action points, which are been acting upon.

1. Improving modern contraception use

To increase modern contraceptive prevalence rate (CPR) by six percentage points in about a year (from 39% to the target of 45%), the project should harness more intensively the potential of CCPF - both the hotline and the messaging services – and intensify targeted BCC through radio, drama, community volunteers, supported by male involvement activities, and using the VDC platform. On the supply side, it would be of paramount importance to organize refresher training for HSAs on FP methods, especially on the long term methods, and to train DHO clinicians to conduct sterilization – DHO staff proposed a number between 10 and 15 clinicians. The data did not raise any specific issues with management of stocks – presumably because the question was not asked directly. Supporting YRHAs through routine supervision and meeting their expectations regarding payment of stipend, will also contribute to increased modern CPR.

3. Fostering FP discussions with health workers

Through the proposed supervisory meetings and refresher training, health facility workers, HSAs and CDAs should be reminded to use every opportunity to initiate or support conversation about FP, especially during the postpartum period. Increased interactions with CCPF will also result in increased discussions on FP.

3. Reducing teenage pregnancy

We have already mentioned that the indicator used in the KPC may not be ideal, as it may not necessarily capture recent progress as the result of the project activities. This notwithstanding, more close supervision of YRHAs and GRS coaches, and clarifying and respecting the rules on stipend, would need to be implemented. Renovating or refurbishing a youth friendly health service (YFHS) unit at DHO, should also be considered, provided DHO's commitment and assurance on staffing and equipment are strong. The project should also work with faith leaders and VDC members and use radio jingles and drama groups as means to reach and sensitize the adolescents, and reinforce the type of learnings and experience from the SKILLZ Malawi and SKILLZ Girls.

4. Increasing knowledge of maternal danger signs

As for contraceptive use, CCPF has a great potential to improve knowledge of maternal danger signs. The project should use community mobilization, radio jingles, VDC meetings and other community-level gatherings to raise awareness about CCPF. Other strategies include the use of counseling cards/booklets (Safe Motherhood, Obstetric Danger Signs), community level sensitization by Volunteers, and radio messages. The orientation of VDC members on maternal danger signs should also be explored.

5. Promoting 4+ ANC visits

Given the relatively high levels of institutional delivery and frequency of first ANC visit, promotion of four or more ANC visits could be done through VS&L groups by community volunteers in FIM's areas of work, advising women to save funds to travel to clinics. Since husbands remain the primary point on the decision to seek and fund health care, they should be also be targeted, by the project or through VDC members.

With an active implementation of these sets of activities, supported by regular supervisory and monitoring meetings - as requested by almost all stakeholders interviewed – the MRH project would meet or exceed most, if not all of its key targets.

Annexes

- FGD Guide – prepared by Jenn
- IDI Guide – prepared by JC
- KPC Questionnaire – prepared by Jenn
- KPC summary results (Excel file) - prepared by Jenn
- Presentations by Jenn (2) and JC (2)