

# Implementation Science Alliance for Maternal Health in Malawi

## Overview of CARE's Intervention & Evaluation Plan



### The Alliance for Maternal Health

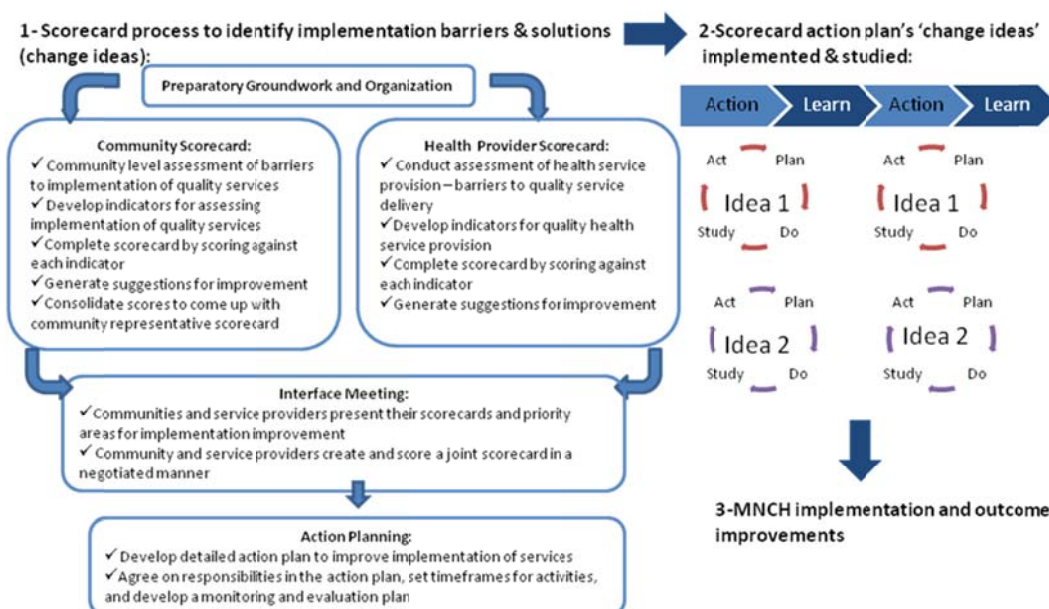
As a global community we know that the science around *what* to deliver in maternal and newborn health is well-established, but the science on *how* to do it effectively and efficiently for the greatest impact, is not. Implementation science can help inform the development of sound strategies for successful, sustainable and scalable program implementation. CARE is collaborating with others on the development of fast and flexible methods to improve the science of implementation and to share learning for rapid scale up. As part of this collaboration, we hope to demonstrate the value of working together in Malawi on a maternal and newborn health implementation science project. The overall goal of the Implementation Science Alliance for Maternal Health in Malawi is to identify broadly applicable *strategies, approaches and methodologies* for systematically improving implementation of evidence-based maternal and newborn health interventions.

### CARE's Role

CARE is leading the development, implementation and evaluation of one key approach--participatory governance. The health system, properly understood, includes not only the health institutions that deliver health care, but also the community system, where health is produced or inhibited. CARE's experience has shown that participatory governance is a key strategy to addressing important barriers to health, including socio-cultural barriers as well as coverage, quality, and equity in service delivery. Our approach to participatory governance brings together the community and the health care providers, as well as key stakeholders from the local and district authorities, in a mutual process of identifying needs, concerns, and barriers to effective service delivery and healthy outcomes. Working together to identify the problems and develop and implement solutions generates buy-in and motivation, leading to improved implementation and outcomes, as well as accountability and sustainability. To facilitate this process we use a tool called the Community Score Card (CSC), an internationally recognized participatory governance tool developed by CARE Malawi. (See <http://health.care2share.wikispaces.net/alliance>).

### CARE's Intervention in Malawi

The CSC, outlined in the diagram below, cultivates participatory governance by bringing together community members, health service providers and local authorities, to work together to identify barriers to implementation of quality health services. Together, these groups identify challenges, generate solutions (called 'change ideas'), and implement and track the effectiveness of those solutions in an ongoing process of quality improvement. The CSC helps support the development of a sustainable and equitable system for communities and power-holders to identify areas for improving implementation, generating locally applicable and innovative solutions, and holding each other mutually accountable for achieving quality.



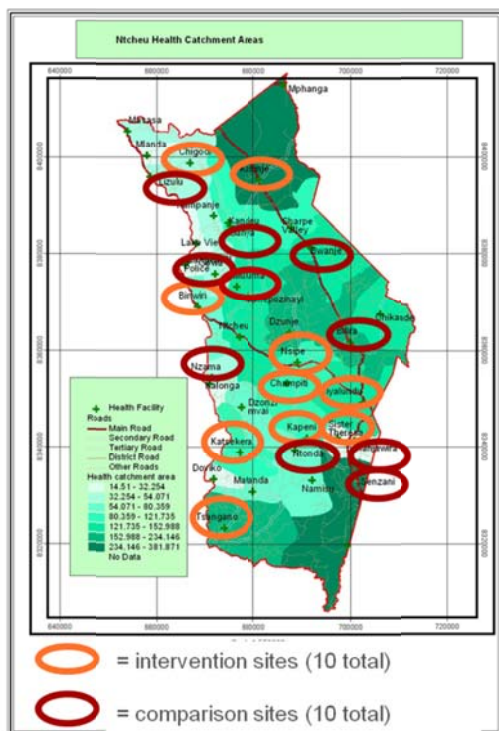
Solid implementation and robust monitoring and evaluation (M&E) of the Community Scorecard approach in Malawi will allow us to achieve the following:

- 1) fully demonstrate the value of the Alliance,
- 2) demonstrate in a compelling way the impact of CARE's unique implementation science approach, the Community Scorecard, on maternal and newborn health implementation and outcomes,
- 3) develop a menu of high impact implementation improvement ideas, and,
- 4) improve maternal and newborn health implementation and outcomes in Malawi.

## CARE's Monitoring and Evaluation Plan

CARE's hypothesis is that the CSC process will cultivate participatory governance, including: 1) empowered citizens—citizens who are aware of their healthcare rights, have a stronger voice and contribute to change; 2) health service providers and local government who are effective, accountable, and responsive; and 3) spaces for negotiation between power-holders and citizens that are expanded, inclusive, and effective. With these elements in place, there will be a sustainable and equitable system for communities, service providers and local government to identify priority maternal and newborn health areas for improvement and generate locally applicable innovative solutions—in other words, community- and facility-level changes to improve maternal and newborn health service

implementation, which in turn leads to improvements in maternal health coverage, quality and equity.



CARE is using a cluster-randomized control design to test this hypothesis. We chose the health center and its catchment population as our cluster unit for randomization because the allocation and loci of delivery of the intervention is at that cluster rather than individual level. The intervention and evaluation is being carried out in Ntcheu district in Malawi. The 20 health center/catchment areas that were eligible for inclusion in the study were matched into 10 pairs (matching characteristics included: services provided, health center administration, proximity to the Mozambique border, and catchment population size). After pairing, we randomly allocated one cluster in each pair to either intervention or comparison as outlined on the map.

Intervention and evaluation activities will be distributed across the treatment and comparison sites. Across the 10 *intervention* health facility/catchment population sites, 20 group villages (GVHs) in total were selected using probability proportional to size (PPS) methodology. Communities in these 20 selected intervention GVHs, will participate in the CSC process with their respective health facilities. In the *comparison* health facility/catchment population area, 20 GVHs in total were selected using PPS for evaluation. Further, to examine spillover effects of the CSC intervention on those communities within the intervention catchment area but not participating in the CSC, an additional 20 GVHs were selected for evaluation. Women aged 15-19 who have given

birth within the last 12 months will be surveyed at baseline and follow-up in 60 GVHs (treatment, comparison, and spillover). Further, all health workers associated with both the treatment and comparison health facilities will participate in baseline and follow-up surveys.

The evaluation will be done through two cross-sectional surveys and a medical chart review at baseline (2012) and endline (2015):

Component	Target	Sample	Outcomes of Interest
<b>Women's Survey</b>	Women aged 15-49 who have given birth within the last 12 months and	Across the selected GHVs, a PPS sample of 650 women in the intervention villages, 650 women in the comparison villages, and 650 women in spillover villages.	<ul style="list-style-type: none"> <li>• Governance <ul style="list-style-type: none"> <li>-empowered communities (ex. social cohesion, social capital, knowledge of rights, collective action, social participation)</li> <li>-accountable and effective service providers (ex. perceptions of health service quality)</li> <li>- spaces for negotiation between service providers and communities</li> </ul> </li> <li>• Women's empowerment (ex. gender attitudes and beliefs, self efficacy)</li> <li>• Maternal health, PMTCT, and family planning coverage, quality, equity (for ex. skilled birth attendants, health facility deliveries, postpartum care, family planning use, respectful care, male involvement)</li> </ul>
<b>Health Worker Survey</b>	Doctors, clinical and medical officers, nurses, nurse/midwives, patient attendants, and community based health workers.	Census of all health workers within the intervention and comparison clusters (~400)	<ul style="list-style-type: none"> <li>• Governance- <ul style="list-style-type: none"> <li>-empowered service providers (ex. knowledge of patient's and provider's rights, relationships with co-workers, social cohesion, social capital, perceived efficacy of health services, perceived quality of services, health system inputs)</li> <li>- accountable and effective service providers (collective efficacy, attitudes towards clients, participation in social groups)</li> <li>-spaces for negotiation between service providers and communities</li> </ul> </li> <li>• Maternal health, PMTCT, and family planning coverage, quality, equity (for ex. skilled birth attendants, health facility deliveries, postpartum care, family planning use, respectful care, male involvement)</li> </ul>
<b>Labor &amp; Delivery Medical Record Review</b>	Record review of women who have delivered in a facility in the last month	Subset of women's survey (~10%)	<ul style="list-style-type: none"> <li>• Skilled, quality care during labor and delivery</li> </ul>