



## Capacity Statement



**WE WANT A WORLD WHERE ALL WOMEN, CHILDREN AND YOUNG PEOPLE CAN SURVIVE AND THRIVE.**

**WE ARE PIONEERS AT EMPOWERING LOCAL COMMUNITIES TO TAKE THE LEAD IN ACHIEVING THIS VISION. OUR WORLD-CLASS APPROACHES ARE EFFECTIVE AND RECOMMENDED GLOBALLY.**

**BY THE END OF 2021 WE WILL SAVE THE LIVES OF 10,000 WOMEN, CHILDREN AND YOUNG PEOPLE AND ENABLE 1 MILLION MORE TO CHOOSE THEIR FUTURES.**



**WOMEN, CHILDREN AND YOUNG PEOPLE IN THE POOREST COUNTRIES IN AFRICA, ASIA AND LATIN AMERICA, FACE PROBLEMS THAT KILL THEM, HARM THEM OR HOLD THEM BACK.**

**PROBLEMS LIKE SEVERE COMPLICATIONS IN PREGNANCY AND CHILDBIRTH, DEADLY DISEASES AND UNACCEPTABLE VIOLENCE.**

## **GLOBAL PROBLEMS**

### **Sustainable Development Goals (SDGs)**

The 17 SDGs are a universal call to action that guide international policy and practice to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.<sup>i</sup> We will focus on challenges under two goals, although all are interconnected:

- Goal 3 – Promote healthy lives and wellbeing for all at all ages.
- Goal 5 – Achieve gender equality and empower all women and girls.

### **Life course approach**

Across the life course, women, children and young people face a range of problems. We will focus on issues including:

- Women's health – SRH; malnutrition; GBV; pre-conception
- Pregnancy, childbirth and postnatal care – pregnancy health; maternal / newborn complications; pre-term birth; PMTCT
- Child health and development – infectious diseases; malnutrition; accidents / injuries; early child development
- Adolescent health and development – SRH, GBV; mental health

### **Where we work**

We currently have programmes in Africa (Ethiopia, Malawi, Sierra Leone, Uganda), Asia (Bangladesh, Myanmar) and Latin America (El Salvador, Guatemala, Honduras, Nicaragua). We will work wherever inequalities exist in the ability of women, children and young people to survive and choose their futures.

**LOCAL COMMUNITIES HAVE THE ANSWERS.**

**THEY CAN COME UP WITH LIFE-SAVING IDEAS LIKE HOME-MADE EMERGENCY STRETCHERS, SOURCING AND DISTRIBUTING MOSQUITO NETS, AND CLEANING WATER SOURCES.**

## **LOCAL ANSWERS**

Simple answers, tailored to the local context, and designed and resourced by the communities themselves, that can prevent maternal and newborn complications, improve nutrition, improve sexual and reproductive health, prevent diseases and reduce gender-based violence. These include:

- **Transport to health facilities** – like donkey-carts in Ethiopia and crisis transport funds in India.
- **Businesses to raise money for health expenditures** – like fish ponds in Malawi and macadamia nut growing in Myanmar.
- **Lobbying health services** – like lobbying for improvements in quality in Latin America and for outreach clinics in Malawi.
- **Raising awareness** – like how to have a balanced diet in Bangladesh and prevent HIV/AIDs in Sierra Leone.
- **Challenging cultural norms and values** – sensitising and mobilising men regarding their responsibilities Sierra Leone and referring early marriage cases to authorities in Bangladesh.
- **Distributing commodities** – like mosquito nets in Malawi and iron tablets in India.
- **Constructing infrastructure** – like pit-latrines in Ethiopia, maternity waiting shelters in Malawi and protection of water sources in Uganda.
- **Other answers** – including: tracking, supporting and referring pregnant women at risk, growing and distributing vegetables, establishing child creches, advocating for changes in policy.

**BUT TOO OFTEN LOCAL COMMUNITIES ARE TOLD WHAT TO DO,  
TREATED AS THE PROBLEM OR IGNORED.**

**NOT BY US. NOT BY YOU.**

**OVER THE LAST 18 YEARS WE HAVE LEARNT HOW BEST TO  
SUPPORT LOCAL COMMUNITIES.**

**THEY DON'T NEED PEOPLE TO GIVE THEM THE ANSWERS,  
LECTURE THEM OR PROVIDE SHORT-TERM FIXES. THEY WANT TO  
BE EMPOWERED TO COME UP WITH THEIR OWN ANSWERS.**

**SO THAT'S OUR ROLE.**

## **SUPPORTING COMMUNITIES**

### **Participatory Learning and Action (PLA)**

The PLA methodology is a sustainable<sup>ii</sup>, cost-effective<sup>iii</sup> and equitable<sup>iv</sup> way of supporting communities to come up with their own answers. The methodology works best in rural settings<sup>v</sup>, but there is increasing evidence in urban and humanitarian settings. It can be scaled through local volunteers<sup>vi</sup>, community health workers<sup>vii</sup>, NGOs<sup>viii</sup> or hybrid systems. The methodology is rooted in work by Save the Children in Bolivia and developed in collaboration with partners: BADAS-PCP (Bangladesh), Ekjut and SNEHA (India), MaiKhanda and MaiMwana (Malawi), MIRA (Nepal) and UCL (UK).

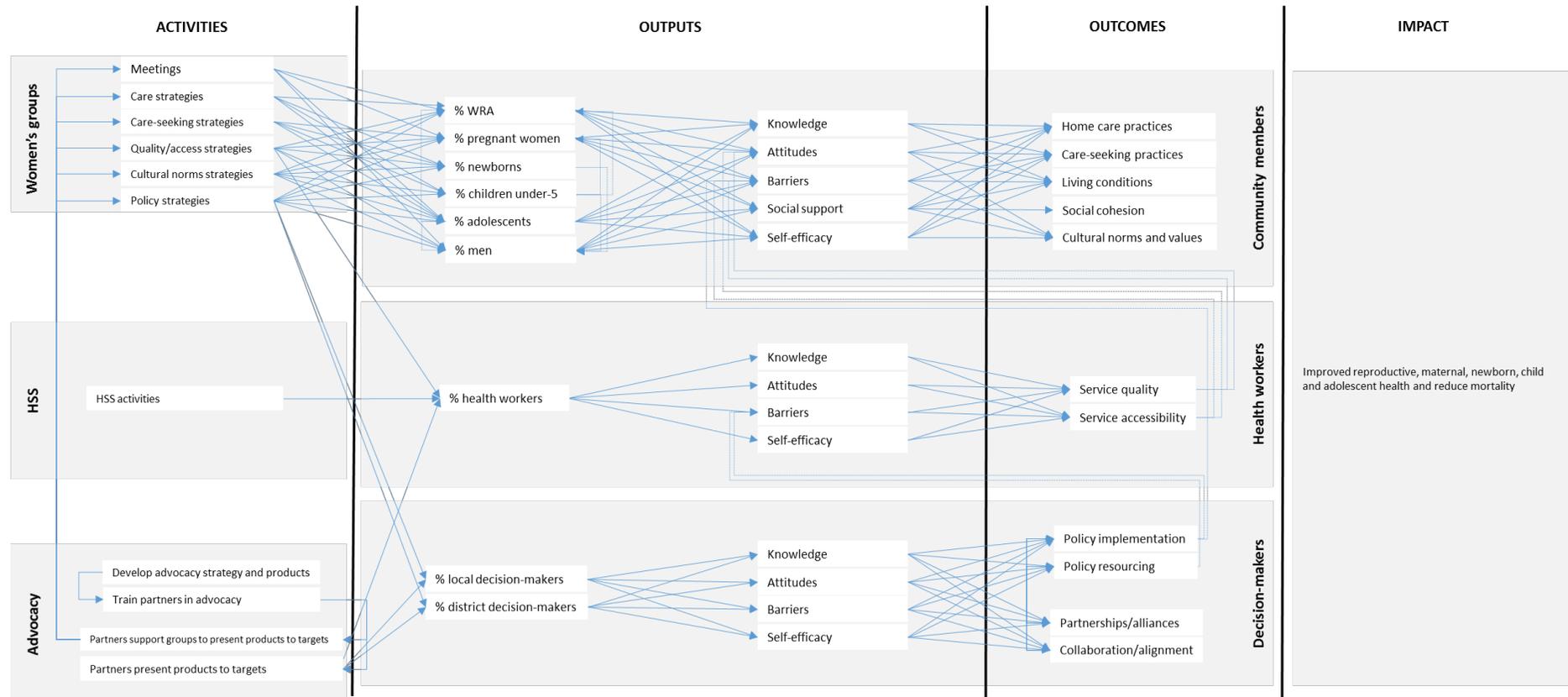
### **Community support tools** *(for more information see Appendix 1)*

We have developed four tools based on the PLA methodology:

- Maternal and Newborn Health – reduces maternal mortality by up to 49% and neonatal mortality by up to 33%.<sup>ix</sup> This tool has a WHO global recommendation.<sup>x</sup>
- Family Planning – increases knowledge, support and uptake of family planning methods and services.<sup>xi</sup>
- PMTCT – increases adherence to the PMTCT service cascade.<sup>xii</sup>
- Life course – under pilot test in Uganda.

We will develop new tools to support communities to find answers to other problems across the life course. Our tools will be delivered alongside health systems and advocacy activities. We will manage grants and provide consultancy to ensure the most effective tools are scaled to reach the communities where the needs are greatest.

## THEORY OF CHANGE



**OVER THE LAST 18 YEARS, WE HAVE REACHED OVER 12 MILLION PEOPLE, IN 13 COUNTRIES AND SAVED OVER 6,000 LIVES – AND COUNTING.**

## **EVIDENCE**

### **Measurement**

What sets us apart is our evidence. We are committed to learning, celebrating achievements and working hard to improve.

### **Results**

Since 2001, we have delivered 40 international projects in 13 different countries. These projects have reached over 12 million people and supported over 5,000 communities:

- Saving over 6,000 lives; and
- Improving the health and wellbeing of over 250,000 women, children and young people, enabling them to choose their futures.

A recent example is a project in Bogra District, Bangladesh, in partnership with BADAS-PCP and funded by UK Aid.<sup>xiii</sup> The project supported 196 communities to develop answers that:

- Increased early antenatal care (by 42%), attendance of 4 or more antenatal appointments (65%), skilled delivery (15%) and postnatal care seeking (21%)
- Ensured 99% of babies had bathing delayed for 24 hours (71% at baseline) and 97% had their umbilical cord undressed (51%)

As a result, the health of over 28,000 women, children and young people was improved and newborn mortality and stillbirths were reduced by 34% and 19% respectively.

**MANAGED GRANTS PORTFOLIO 2001 – 2019** (for more information see Appendix 2)

**Women and Children First**

**Grant management**



**Women and Children First**

Women and Children First is a world leader in supporting communities to come up with answers for global problems facing women, children and young people.

Since 2001, we have delivered over 40 projects, in 13 countries, supporting over 5,000 communities and saving over 6,000 lives – and counting.

**Tools**

Our support tools include:

- MNH tool, which can successfully improve mother and newborn health and survival. This approach is recommended by the WHO.
- FP tool, which can successfully improve family planning.
- PMTCT tool, which can promote HIV prevention activities during pregnancy, delivery and after birth..

**Grant management**

Women and Children First is experienced in managing grants from a range of institutional donors and trust and foundations including:

- Big Lottery Fund
- Comic Relief
- Positive Action for Children Fund
- UK Aid

[www.womenandchildrenfirst.org.uk](http://www.womenandchildrenfirst.org.uk)

**Our grants**

We build strong, long-term partnerships with leading local NGOs. We manage grants to and build capacity of these NGOs. We are small, creative, efficient, and highly experienced.

**Bangladesh**

Since: 2002  
Total grants: 4  
Total funds: £1.7 million

Communities supported: 1,213  
Population reached: 2,596,985

**India**

Since: 2008  
Total grants: 5  
Total funds: £1.4 million

Communities supported: 855  
Population reached: 4,973,969



**Ethiopia**

Since: 2012  
Total grants: 2  
Total funds: £850,000

Communities supported: 168  
Population reached: 139,224

**Malawi**

Since: 2005  
Total grants: 9  
Total funds: £3 million

Communities supported: 1,223  
Population reached: 998,580

**Uganda**

Since: 2014  
Total grants: 3  
Total funds: £1.3 million

Communities supported: 368  
Population reached: 239,300

CONSULTANCY PORTFOLIO 2014 – 2019 (for more information see Appendix 3)

Women and Children First

Technical Assistance



Women and Children First

Women and Children First is a world leader in supporting communities to come up with local answers for the global problems facing women, children and young people.

Since 2001, we have delivered over 40 projects, in 13 countries, supporting over 5,000 communities and saving over 6,000 lives – and counting.

Our services are:

Tailored and delivered to build the capacity of our partner organisations in the design, implementation, management and evaluation of the community support tools. We are small, creative, efficient, and highly experienced.

Tools

Our support tools include:

- MNH tool, which can successfully improve mother and newborn health and survival. This approach is recommended by the WHO.
- FP tool, which can successfully improve family planning.
- PMTCT tool, which can promote HIV prevention activities during pregnancy, delivery and after birth..

Our active partnerships include:

Malawi

Partner: MaiKhanda Trust  
 Donor: PACF  
 Communities: 120 (96,077)  
 Service provided: Design, implementation, management and evaluation of PMTCT tool

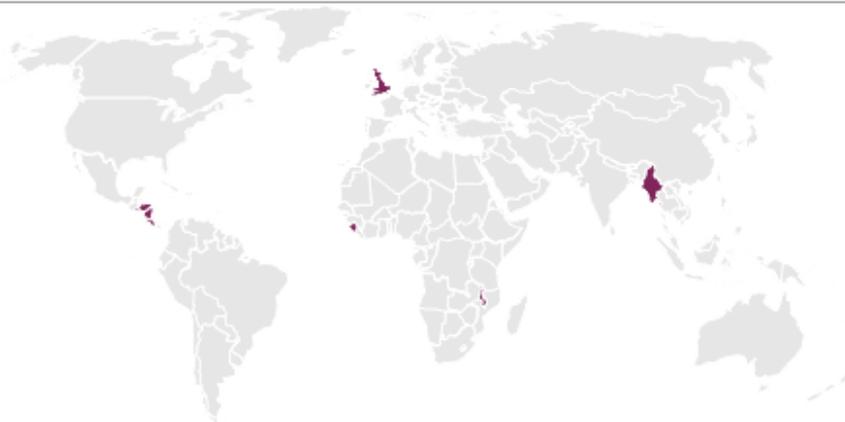
Technical Assistance services

Women and Children First is experienced in providing technical assistance to partners seeking to successfully support communities to tackle global problems. We offer a high quality package of assistance – short-term or long-term – which can be delivered as a sub-grantee and consultant.

[www.womenandchildrenfirst.org.uk](http://www.womenandchildrenfirst.org.uk)

Myanmar

Partner: Health Poverty Action  
 Donor: UK Aid  
 Communities: 118 (88,500)  
 Services provided: Adaptation, implementation, management and evaluation of MNH tool



Latin America

Partner: Health Poverty Action  
 Donor: European Commission  
 Communities: 124 (93,000)  
 Services provided: Adaptation, implementation, management and evaluation of MNH tool

Sierra Leone

Partner: Welbodi Foundation  
 Donor: UK Aid  
 Communities: 100 (100,000)  
 Services provided: Adaptation, implementation, management and evaluation of MNH tool

UK

Partner: UCL  
 Donor: NIHR  
 Communities: 4 (2,000)  
 Services provided: Design, implementation and evaluation of an infant nutrition and care-practice tool

## PERSONNEL

Women and Children First has five members of staff. Key staff include:

### *Dr. Mikey Rosato – CEO*

Mikey's expertise is in empowering local communities to find solutions to prevent mothers and babies dying from preventable conditions. Mikey has experience of working in Africa, Asia and Latin America and is responsible for overseeing the charity's strategy and development and providing technical advice on community-based approaches. Mikey has a PhD in Global Health from UCL.

### *Joanna Drazdzewska – Grants Manager*

Jo is experienced in implementing reproductive health programmes in developing countries. Her focus is on increasing demand for health services, reducing gender inequality, and advocating for accessible quality care. Jo has an MA in Development Studies. She provides technical advice and management of our grants.

### *Annemijin Sondaal – Technical Officer*

Annie's key interest and expertise is in using community-based approaches to develop sustainable health projects within developing countries. She has an MA in Global Health and Development. She provides technical advice on the development, implementation, monitoring and evaluation of community-based approaches.

## BOARD OF TRUSTEES

WCF's ultimate decision-making authority is its board of trustees, which has full legal responsibility for running of the charity. The trustees act as the directors of the company for the purposes of the Companies Act 2006. Trustees are appointed in light of their commitment to Women and Children First and their experience and skills which enable them to undertake the responsibilities of trusteeship of a large and complex charity. The board meets at least four times a year and the CEO attends these meetings as non-voting observer to advise and inform the board.

The board has a number of committees that include staff members and co-opted individuals, as well as trustees. These committees have specific areas of responsibilities and provide recommendations for board consideration and approval: Finance, Fundraising and communications and Programmes.

Women and Children First's Chair of the Board of Trustees is *Carol Bradford*. Carol is an independent consultant in sexual and reproduction health, with field experience in Latin America, South Asia, Eastern Europe and Africa. With technical expertise in reproductive health, including family planning and abortion, maternal health, HIV/AIDS and the prevention of sexually transmitted diseases, Carol has extensive experience in organisational development, monitoring and evaluation and strategic planning.

## **VALUE FOR MONEY**

Women and Children First seeks to achieve the right balance between economy, efficiency, effectiveness and equity.

### *Economy – getting the best value inputs:*

- Employing sound budgeting practices
- Engaging in quarterly monitoring of partner spend
- Having clearly defined authorisation routines
- Establishing fundraising targets to support fundraising investment

### *Efficiency – maximising the outputs for a given level of inputs:*

- Leverage of general funds to pilot new programme opportunities
- Recruiting of quality staff
- building relationships with potential partners prior to funding
- Having strong internal control environment including asset management

### *Effectiveness – ensuring that the outputs deliver the desired outcome:*

- Using clear and tested community support tools. Randomised control trials have shown our programmatic approach to be highly cost effective by World Bank/WHO standards
- Having a strong focus on analytical monitoring and evaluation
- Employing a process for lessons learned from M&E within the institutional memory framework

### *Equity – ensuring that the benefits are distributed fairly:*

- Delivering programmes focused on poor and marginalised beneficiary groups.
- Using support tools that are equitable. Evidence from randomised controlled trials shows that the tools are pro-poor and drive equitable improvements in health.

## **PARTNERSHIP**

Women and Children First has one office in London, UK and implementation of our programmes is exclusively through in-country partners. These partners include communities, small and large national and international NGOs and local and national governments. We also work in consortia with other NGOs, technical agencies and academic partners.

## **TRANSPARENCY IN GOVERNANCE AND PROGRAMMING**

Women and Children First is a company limited by guarantee and a charity registered in England and Wales. It publicly discloses detailed information on its annual activities and financial transactions to the Charity Commission and Companies House in England and Wales.

**STRATEGY: 2019 – 2021**

<b>OBJECTIVE</b>		
<b>To become a world leader in putting communities first – supporting them to come up with local answers to the global problems facing women, children and young people</b>		
<b>GOALS</b>	<b>STRATEGIES</b>	<b>INITIATIVES</b>
<p><b>A. Live:</b> By the end of 2021, save the lives of 10,000 women, children and young girls</p> <p><b>B. Choose:</b> By the end of 2021, improve the wellbeing of 1,000,000 women, children and young people enabling them to choose their futures</p> <p><b>C. Support:</b> By the end of 2021, support 10,000 local communities to come up with answers to the problems facing women, children and young people</p> <p><b>D. Generate:</b> In 2021, raise £1.5 million of flexible income</p>	<p><b>1. Transform WCF</b> Build a strong, engaged and active team supported by appropriate structures, rigorous policies and efficient processes</p>	<p>a. Recruit, engage and motivate staff, trustee and ambassadors</p> <p>b. Strengthen structures</p> <p>c. Update policies</p> <p>d. Streamline processes</p>
	<p><b>2. Expand our portfolio</b> Expand our portfolio of community support tools and scaling mechanisms</p>	<p>a. Design new tools</p> <p>b. Design new mechanisms to deliver tools at scale</p>
	<p><b>3. Amplify our impact</b> Develop the evidence-base, partnerships and supporters needed to grow impact</p>	<p>a. Collate learning</p> <p>b. Expand partnerships</p> <p>c. Lobby for scale-up</p>
	<p><b>4. Grow our income</b> Pursue diverse streams to successfully generate unrestricted (UR) and restricted (R) income to transform our organisation, expand our portfolio, amplify our impact and deliver our programmes</p>	<p>a. Generate funds from individuals</p> <p>b. Encourage community fundraising</p> <p>c. Land major gifts</p> <p>d. Raise UR trust/ foundation funds</p> <p>e. Leverage corporate donations</p> <p>f. Win R trust/ foundation and institutional donor grants</p> <p>g. Bring in consultancy contracts</p>

### **Objective and goals**

In three years, between 2019 and 2021, our ambitious new strategy will ensure we accelerate the impact for women, children and young people, that we have achieved between 2001 and 2018. We will support 10,000 local communities to come up with answers (having supported 5,000 to date) that save the lives of 10,000 women, children and young girls (6,000 to date) and enable 1,000,000 women, children and young people to choose their futures (250,000 to date). To achieve this, we will increase our income, particularly raising our flexible income to £1.5 million in 2021. Achieving these goals will ensure we become a world leader in putting local communities first – supporting them to come up with local answers for the global problems facing women, children and young people.

### **Strategies, measures and initiatives**

To achieve our objective and goals, we will learn from our past experiences, build on our achievements and evolve the organisation for the future.

**First, we will transform the organisation.** We will build a strong, engaged and active team of staff, trustees, ambassadors and friends. These individuals will be supported by appropriate and effective team structures, rigorous organisational policies, and streamlined and efficient processes. **Second, we will expand our portfolio.** We will grow our toolbox of effective community support tools, by designing innovations to address additional global challenges and reach beneficiaries in new settings and designing alternative mechanisms to reach larger scale. **Third, we will amplify our impact.** We will collate learning generated through rigorous monitoring and evaluation of our projects, broaden our implementing partnerships and promote adoption to ensure our effective tools are implemented at scale. **Fourth, we will grow our income.** We will pursue multiple, diverse income streams to generate unrestricted and restricted income from individuals and organisations, that enables us to transform the organisation, expand our portfolio, amplify our impact and deliver our programmes.

## APPENDIX 1: COMMUNITY SUPPORT TOOLS

### Women and Children First MNH tool Ready for scale-up



#### The issue

Every year, predominantly in poor rural communities, 300,000 women die in pregnancy and childbirth and 2,500,000 children die before one month of age.

#### The MNH tool

It supports communities to come up with local answers to improve the health and survival of mothers and newborns. It engages community members concerned about maternal and newborn survival in groups and guides them through 11 monthly meetings in a four phase action cycle to: a) identify problems affecting women and children during pregnancy, childbirth and newborn period; b) identify local solutions to these problems; c) plan and implement these solutions; and d) evaluate these solutions. Local female facilitators use discussion prompts, picture cards and other tools to stimulate discussion.

#### Evidence

The MNH tool is effective:

- Reduces maternal mortality by 49% and neonatal mortality by 33%<sup>1</sup>
- Improves maternal and newborn home-care and care-seeking practices<sup>1</sup>
- Reduces moderate maternal depression<sup>2</sup>

#### The PLA methodology

The MNH tool is based on the Participatory, Learning and Action (PLA) a sustainable<sup>3</sup>, cost-effective<sup>1</sup> and equitable<sup>4,5</sup> methodology to support communities to find local answers for global problems.

#### Application

PLA methods like the MNH tool work best in rural<sup>1</sup> settings, but there is increasing evidence that they can also work in urban and humanitarian settings. They can be scaled through local volunteers<sup>6</sup>, community health workers<sup>7</sup>, NGOs<sup>2</sup> or hybrid systems.

For maximum impact, delivery in parallel with supply side interventions is advised.

#### Policy

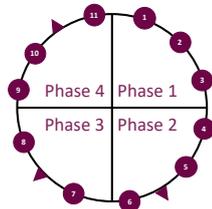
The MNH tool has a WHO global recommendation. The MNH tool is endorsed under the Every Newborn Action Plan (2014) and can promote community engagement, a key area in the WHO Global Strategy for Women's, Children's and Adolescents' health (2016-2030).

#### Other tools

Other tools based on PLA:

- FP tool, which can successfully improve family planning. [Ready for pressure-testing.](#)
- PMTCT tool, which can promote transmission prevention activities during pregnancy, delivery and after birth. [Ready for pressure-testing.](#)

Figure 1: The MNH tool



#### Phase 1: Identify problems

- 1: Group formation
- 2: Identify maternal health problems
- 3: Identify newborn health problems

#### Phase 2: Identify solutions

- 4: Identify prevention and management behaviours
- 5: Identify solutions
- 6: Community meeting 1

#### Phase 3: Implement solutions

- 7: Plan solutions
- 8: Mobilise resources

#### Phase 4: Evaluate solutions

- 9: Evaluate solutions
- 10: Plan for the future
- 11: Community meeting 2

Figure 2: Maternal and neonatal mortality



WHO Global Recommendation, 2014

"Implementation of community mobilization through facilitated participatory learning and action cycles with women's groups to improve maternal and newborn health is recommended, particularly in rural settings with low access to services"

#### Pilot > Transition > Scale-up

**Pilot:** Tool is ready for pilot testing.

**Pressure-testing:** Tool has been pilot tested and is ready for pressure-testing at scale.

**Scale-up:** Tool is effective and ready for scale-up.

#### The PLA methodology was developed in collaboration with partners

BADAS—PCP – Bangladesh; Ekjut and SNEHA – India; MaiMwana and MaiKhanda – Malawi; MIRA – Nepal; UCL – UK

#### References

- 1 Prost, A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013; 381: 1736-46.
- 2 Tripathy, P et al. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *Lancet*. 2010; 375: 1182-92.
- 3 Sondaal, A (2018). Sustainability of community-based women's groups: reflections from a participatory intervention for newborn and maternal health in Nepal, *Community Development Journal*, bsy017, <https://doi.org/10.1093/cdj/bsy017>
- 4 Houweling, et al 2015. Reaching the poor with health interventions: programme-incidence analysis of seven randomised trials of women's groups to reduce newborn mortality in Asia and Africa. *Journal of Epidemiology and Community Health*. 2015; (0): 1-11.
- 5 Morrison, J et al. Disabled women's attendance at community women's groups in rural Nepal. *Health Promotion International*. 2015; 1-11.
- 6 Fottrell, E. Community Led Evidence-based Action for Newborns (CLEAN) at scale through participatory women's groups and health workers in rural Bangladesh. Personal communication.
- 7 Tripathy et al. Effect of participatory women's groups facilitated by Accredited Social Health Activists on birth outcomes in rural eastern India: a cluster-randomised controlled trial. *Lancet Global Health*. 2016; 4(2): e119-e128.

#### More information

##### Films

Bangladesh – Reducing child mortality and improving maternal health – BADAS-Perinatal Care Project  
[https://www.youtube.com/watch?list=PLKY2vCmiZBr6d8Mzylfko\\_J6uFAP\\_Edbx&v=GDBn7WvZmAc&feature=player\\_embedded](https://www.youtube.com/watch?list=PLKY2vCmiZBr6d8Mzylfko_J6uFAP_Edbx&v=GDBn7WvZmAc&feature=player_embedded)

India – Improving maternal and neonatal health in rural India – Ekjut  
[https://www.youtube.com/watch?v=wesINtOAIQg&feature=player\\_embedded&list=PLKY2vCmiZBr6d8Mzylfko\\_J6uFAP\\_Edbx](https://www.youtube.com/watch?v=wesINtOAIQg&feature=player_embedded&list=PLKY2vCmiZBr6d8Mzylfko_J6uFAP_Edbx)

Malawi – Umodzi (Together) – MaiMwana Project  
[https://www.youtube.com/watch?feature=player\\_embedded&list=PLKY2vCmiZBr6d8Mzylfko\\_J6uFAP\\_Edbx&v=S3b2-O7zOgl](https://www.youtube.com/watch?feature=player_embedded&list=PLKY2vCmiZBr6d8Mzylfko_J6uFAP_Edbx&v=S3b2-O7zOgl)

Nepal – A lens on our lives – Mother Infant Research Activities (MIRA)  
[https://www.youtube.com/watch?feature=player\\_embedded&v=CESLKqRKM8g](https://www.youtube.com/watch?feature=player_embedded&v=CESLKqRKM8g)

Uganda - Participatory learning and action groups for maternal and neonatal health – Amref  
<https://www.youtube.com/watch?v=rMYgDqQCDaY>

##### Websites

[www.womenandchildrenfirst.org.uk](http://www.womenandchildrenfirst.org.uk)

[www.womensgroups.tumblr.com](http://www.womensgroups.tumblr.com)

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# Women and Children First FP tool Ready for pressure-testing



## The issue

Over 210m women and girls in developing countries wanting to avoid getting pregnant are not able to do so. This is often a barrier for them to thrive and achieve their potential.

## The FP tool

It supports communities to come up with local answers to support women and girls who want to plan their families. It engages community members concerned about family planning in groups and guides them through nine monthly meetings in a four phase action cycle to: a) understand family planning and why it is important; b) identify local solutions to promote family planning; c) plan and implement the solutions; and d) evaluate these solutions. Local female facilitators use discussion prompts, picture cards and other tools to stimulate discussion. In parallel community-based distribution of FP services and products.

## Evidence

The FP tool is an appropriate method that can engage men and women in discussion about FP<sup>1</sup>. It also:

- Increases contraceptive prevalence rate by 50%<sup>2</sup>
- Increases uptake of FP services<sup>2</sup>
- Increases comprehensive knowledge of FP by 9%<sup>2</sup>
- Improves support for FP by 21%<sup>2</sup>, including from men<sup>1</sup>
- Decreases perceived barriers to accessing FP by 42%<sup>2</sup>

## The PLA methodology

The FP tool is based on the Participatory, Learning and Action (PLA) a sustainable<sup>3</sup>, cost-effective<sup>4</sup> and equitable<sup>5,6</sup> methodology to support communities to find local answers to global problems.

## Application

PLA methods like the FP tool work best in rural<sup>4</sup> settings, but there is increasing evidence that they can also work in urban and humanitarian

settings. They can be scaled through local volunteers<sup>7</sup>, community health workers<sup>8</sup>, NGOs<sup>9</sup> or hybrid systems. For maximum impact, best delivered with behaviour change activities, products, services and advocacy.

## Policy

The FP tool can promote community engagement, which is a high impact practice in family planning<sup>10</sup> and a key area in the WHO Global Strategy for Women's, Children's and Adolescents' health (2016-2030). It can also accelerate progress on SRH, by creating a health enabling environment, as urged by the Guttmacher-Lancet Commission<sup>11</sup>.

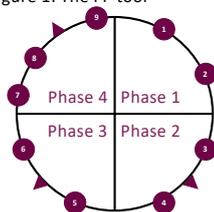
## Other tools

Other tools based on PLA:

- MNH tool, which can successfully improve mother and newborn health and survival. This approach is recommended by the WHO.

**Ready for scale-up.**

Figure 1: The FP tool



### Phase 1: Identify problems

- 1: Group formation
2. Understand family planning and why it is important

### Phase 2: Identify solutions

- 3: Identify solutions
- 4: Community meeting 1

### Phase 3: Implement solutions

- 5: Plan solutions
- 6: Mobilise resources

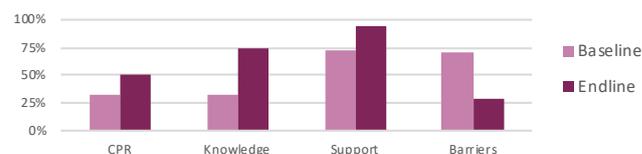
### Phase 4: Evaluate solutions

- 7: Evaluate solutions
- 8: Plan for the future
- 9: Community meeting 2

FP group member, Dedza, Malawi

*"After the meetings more men are encouraging their wives to use family planning. Men have had family planning explained so now they are supporting their wives. After [group members visited couples] door to door many woman are seeking implants.*

Figure 2: Impact of FP tool on CPR and knowledge, support and barriers to accessing FP



#### Pilot > Transition > Scale-up

**Pilot:** Tool is ready for pilot testing.

**Pressure-testing:** Tool has been pilot tested and is ready for pressure-testing at scale.

**Scale-up:** Tool is effective and ready for scale-up.

#### The PLA methodology was developed in collaboration with partners

BADAS—PCP – Bangladesh; Ekjut and SNEHA – India; MaiMwana and MaiKhanda – Malawi; MIRA – Nepal; UCL – UK

#### References

- 1 AHS, Women and Children First and USAID (2018). Increasing family planning uptake through community action groups: Learning Document. Women and Children First, London.
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#### More information

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# Women and Children First PMTCT tool Ready for pressure-testing



### The issue

In 2015, 150,000 children became infected with HIV – 400 children per day.<sup>1</sup>

### The PMTCT tool

It supports communities to come up with local answers that help to prevent mother-to-child transmission of HIV. It engages community members concerned about maternal, newborn and child health in groups and guides them through 12 monthly meetings in a four phase action cycle to: a) identify problems affecting mothers and newborns, including HIV; b) identify local solutions to these problems; c) plan and implement these solutions; and d) evaluate these solutions. Local female facilitators use discussion prompts, picture cards and other tools to stimulate discussion. In parallel community health workers (CHWs) are trained to share information to groups and

follow-up HIV exposed infants to encourage them to continue accessing care. Finally, health workers at facilities are trained in PMTCT guidelines.

### Evidence

Before birth the approach increases<sup>2</sup>:

- ANC in 1<sup>st</sup> trimester – 20%
- Women tested for HIV – 10%

During childbirth it increases:

- ARV prophylaxis – 26%

After birth, for HIV exposed infants it increases:

- HIV testing at 6-weeks – 38%
- Following-up 12-mths – 35%

### The PLA methodology

The group component of the PMTCT tool is based on the Participatory, Learning and Action (PLA) a sustainable<sup>3</sup>, cost-effective<sup>4</sup> and equitable<sup>5,6</sup> methodology to support communities to find local answers for global problems.

### Application

PLA methods like the PMTCT tool work best in rural settings, but there is increasing evidence that they can also work in urban and humanitarian settings. They can be scaled through local volunteers<sup>7</sup>, CHWs<sup>8</sup>, NGOs<sup>9</sup> or hybrid systems. For maximum impact, delivery in parallel with supply side interventions is advised.

### Policy

The PMTCT tool has the potential to promote community engagement, a key area in the WHO Global Strategy for Women's, Children's and Adolescents' health (2016-2030).

### Other approaches

Other tools based on PLA:

- MNH tool, which can successfully improve mother and newborn health and survival. This approach is recommended by the WHO.

Ready for scale-up.

Figure 1: The PMTCT tool

#### Phase 1: Identify problems

- 1: Group formation
- 2: Identify child health problems
- 3: Identify maternal health problems

#### Phase 2: Identify solutions

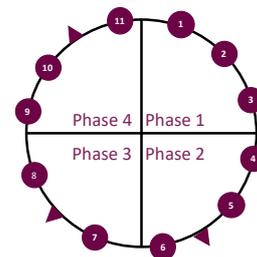
- 4: Identify prevention and management practices
- 5: Identify solutions
- 6: Community meeting 1

#### Phase 3: Implement solutions

- 5: Plan solutions
- 6: Mobilise resources

#### Phase 4: Evaluate solutions

- 7: Evaluate solutions
- 8: Plan for the future
- 9: Community meeting 2



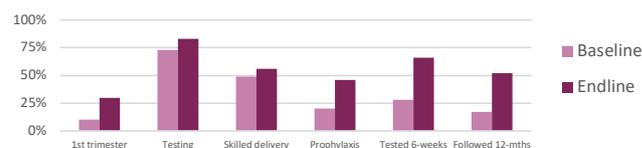
CHWs share information with groups and follow-up HIV exposed infants lost to follow-up.

Health workers at local facilities are trained in PMTCT guidelines

District Environmental Health Officer:

*"I feel there has been a big improvement in PMTCT during the project. We have made gains in 1<sup>st</sup> trimester ANC due to [the groups]. This has enabled early HIV screening. I believe [the project] has contributed to the district recording a lowest HIV prevalence rate of just 3%"*

Figure 2: Impact of PMTCT tool on key vertical transmission prevention interventions



Pilot > Transition > Scale-up

**Pilot:** Tool is ready for pilot testing.

**Pressure-testing:** Tool has been pilot tested and is ready for pressure-testing at scale.

**Scale-up:** Tool is effective and ready for scale-up.

The PLA methodology was developed in collaboration with partners

BADAS—PCP – Bangladesh; Ekjut and SNEHA – India; MaiMwana and MaiKhanda – Malawi; MIRA – Nepal; UCL – UK

#### References

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[http://www.unaids.org/sites/default/files/media\\_asset/FactSheet\\_Children\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/FactSheet_Children_en.pdf)

2 Women and Children First (2017). Addressing loss to follow up in PMTCT in the community and preventing unintended pregnancies in Salima District, Malawi Annual Report. WCF, London

3 Sondaal, A (2018). Sustainability of community-based women's groups: reflections from a participatory intervention for newborn and maternal health in Nepal, *Community Development Journal*, bsy017, <https://doi.org/10.1093/cdj/bsy017>

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More information

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# Women and Children First

## Life course tool

### Ready for piloting



#### The issue

Every year there are 289,000 maternal deaths, 2.6m stillbirths, 5.9m deaths in children under five (including 2.7m newborn deaths — and 1.3m adolescent deaths. Many more suffer illness and disability and fail to reach their potential.

#### The Life Course tool

It supports communities to come up with local answers to improve the health and development of women, children and young girls. It engages community members concerned about these issues in groups and guides them through 12 monthly meetings in a four phase action cycle to: a) identify problems affecting women, children and young girls; b) identify local solutions to these problems; c) plan and implement these solutions; and d) evaluate these solutions. Local female facilitators use discussion prompts, picture cards and other tools to stimulate discussion.

#### Evidence

The Life Course tool is currently undergoing rigorous pilot testing in Oyam District, Uganda in collaboration with Doctors with Africa CUAMM. Interim results are expected in 2019.

#### The PLA methodology

The Life Course tool is based on the Participatory, Learning and Action (PLA) a sustainable<sup>3</sup>, cost-effective<sup>1</sup> and equitable<sup>4,5</sup> methodology to support local communities to find local answers for global problems.

#### Application

PLA methods like the Life Course tool work best in rural<sup>1</sup> settings, but there is increasing evidence that they can also work in urban and humanitarian settings. They can be scaled through local volunteers<sup>6</sup>, community health workers<sup>7</sup>, NGOs<sup>2</sup> or hybrid systems. For maximum impact, delivery in parallel with supply side interventions is advised.

#### Policy

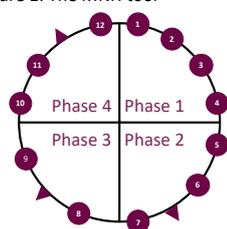
The Life Course tool can promote community engagement, a key area in the WHO Global Strategy for Women's, Children's and Adolescents' health (2016-2030).

#### Other tools

Other tools based on PLA:

- MNH tool, which can successfully improve mother and newborn health and survival. This approach is recommended by the WHO. [Ready for sale-up.](#)
- FP tool, which can improve FP knowledge and attitudes and practices. [Ready for pressure-testing.](#)
- PMTCT tool, which can promote transmission prevention activities during pregnancy, delivery and after birth. [Ready for pressure-testing.](#)

Figure 1: The MNH tool



#### Phase 1: Identify problems

- 1: Group formation
- 2: Identify child health problems
- 3: Identify adolescent health problems
- 4: Identify women's health

#### Phase 2: Identify solutions

- 5: Identify prevention and management behaviours
- 6: Identify solutions
- 7: Community meeting 1

#### Phase 3: Implement solutions

- 8: Plan solutions
- 9: Mobilise resources

#### Phase 4: Evaluate solutions

- 10: Evaluate solutions
- 11: Plan for the future
- 12: Community meeting 2

Figure 2: Key problems facing women's, children's and adolescents' across the life course

#### Women's health

- SRH
- Malnutrition
- Communicable and non-communicable diseases
- Cervical and breast cancer
- Gender-based violence
- Pre-conception health

#### Pregnancy, childbirth, postnatal care

- Pregnancy health
- Maternal and newborn complications
- Safe abortion
- PMTCT
- Preterm birth

#### Child health and development

- Responsive caregiving and stimulation
- Infectious diseases
- Malnutrition
- Disabilities
- Accidents and injuries

#### Adolescent health and development

- Communicable and non-communicable diseases
- Malnutrition
- Mental health
- GBV
- SRH
- Accidents and injuries

Pilot > Transition > Scale-up

**Pilot:** Tool is ready for pilot testing.

**Pressure-testing:** Tool has been pilot tested and is ready for pressure-testing at scale.

**Scale-up:** Tool is effective and ready for scale-up.

The PLA methodology was developed in collaboration with partners

BADAS—PCP – Bangladesh; Ekjut and SNEHA – India; MaiMwana and MaiKhanda – Malawi; MIRA – Nepal; UCL – UK

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- 1 Prost, A et al. Women’s groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013; 381: 1736-46.
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- 6 Fottrell, E. Community Led Evidence-based Action for Newborns (CLEAN) at scale through participatory women’s groups and health workers in rural Bangladesh. Personal communication.
- 7 Tripathy et al. Effect of participatory women’s groups facilitated by Accredited Social Health Activists on birth outcomes in rural eastern India: a cluster-randomised controlled trial. *Lancet Global Health*. 2016; 4(2): e119-e128.

More information

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## APPENDIX 2: SELECTED CURRENT AND HISTORIC MANAGED GRANTS

### Women and Children First Improving maternal, perinatal and newborn health and reducing mortality in Oyam District, Uganda



Communities to be supported  
**200**

Expected lives to be saved  
**81**

Expected number of women,  
children and adolescents to  
benefit  
**55,767**

#### Problem

Uganda has a maternal mortality rate of 360 / 100,000 live births and newborn mortality rate of 19 / 1000 live births. This places it in the top 10 countries in the world with the highest maternal mortality rates and means that approximately 81 babies under 1 month die in the country every day. Teenage pregnancy rates are high at 24%. Poor women and babies in rural areas are particularly affected.

#### Approach

##### WCF Life-course tool

- 110 groups established to date with 4,817 members
- Starting in Year 2, build capacity of 400 teenagers to become sexual and reproductive health (SRH) champions – sharing knowledge with their friends and encouraging them to take care of their health

##### Social accountability

- Groups holding meetings with health workers to discuss how they can together improve local health services

##### Health Promotion

- Training volunteer Village Health Teams to effectively conduct health promotion activities

#### Advocacy

- Sharing learning to inform decision-making
- Community groups actively presenting their concerns to decision-makers and advocating for improvements

#### Vision

The project started recently but aims to improve reproductive, maternal and child health through changes including:

- Increased use of modern contraceptives
- Improved attendance of antenatal care appointments
- Increased number of deliveries with a skilled birth attendant
- Improved care of newborns
- Improved quality and accessibility of services
- Improved decision-making

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#### Partner

Doctors with Africa CUAMM

#### Funder

Comic Relief, Big Lottery Fund, Vitol Foundation

#### Dates

2017 - 2020

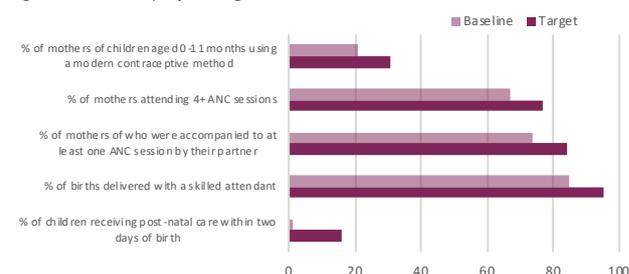
#### Project population

108,317

Oyam District, Uganda



Figure 1: Selected project targets



Pregnant group member

*"I felt sick. I did not know what was wrong, but thought it could be malaria. I knew the signs [...] through the health information I received from the group. I went to the health facility and they diagnosed me with malaria. I was given treatment and I recovered. The advice I received from the women's group was very useful. I was given treatment that saved my life and that of my baby."*

# Women and Children First

## Improving maternal and newborn health in Malga Woreda, Ethiopia



Communities supported  
**174**

Expected lives to be saved  
**111**

Expected women, children and adolescents to benefit  
**17,210**

### Problem

Ethiopia has a maternal mortality rate of 353 / 100,000 live births and newborn deaths account for 47% of under-five deaths. Poor women and babies in rural areas are particularly affected.

### Approach

#### WCF MNH tool

- 174 health groups established with 11,303 members.
- Developed local answers including: emergency transport funds, constructing pit latrines, awareness raising.

- Forums established for groups to meet with health workers to share concerns on service quality and accessibility.

#### Health systems strengthening

- Training and mentorship for 373 facility and community health workers.
- Provision of one ambulance, solar power to eight facilities and wells to six facilities.

#### Evidence for decision-making

- 78 decision-makers reached with project evidence.

#### Mid-term results

- Large improvements in care-seeking: knowledge of two or more pregnancy danger signs (35%), attendance of 4 or more antenatal care sessions (13%), delivery with a skilled attendant (21%) and newborn bathing delayed for at least 24 hours (31%).

- Decision-makers using evidence generated from the project to post additional health workers and construction of two maternity waiting homes.

#### Lessons learned

- Communities attribute work of the groups to significantly improve maternal, newborn, sexual and reproductive health (MNSRH).
- Many women felt more empowered to make decisions regarding their reproductive health.
- Decision-makers in the region applaud the approach for its close integration with the Ethiopia Health Extension Programme, potentially promoting greater sustainability.

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**Partner**  
Family Guidance Association of Ethiopia - FGAE

**Funder**  
Comic Relief (£787,000)

**Dates**  
2015 - 2019

**Project population**  
139,224

Malga Woreda, Southern Nations, Nationalities, and Peoples' Region (SNNPR), Ethiopia



Figure 1: Percentage of groups implementing strategies

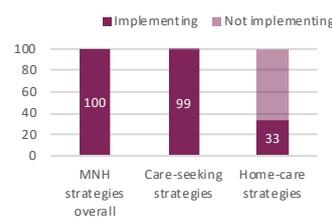


Figure 2: Comparison of care-seeking practices in rural areas

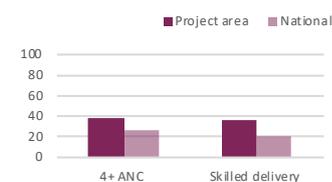
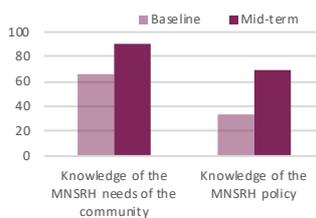


Figure 3: Woreda decision-makers' knowledge on MNSRH



#### Pregnant MNH group member

*"I have gained knowledge about maternal and newborn health and increased my awareness about skilled birth attendance. Being a part of [...] women group, I have developed socialisation and save money in preparation for institutional delivery"*

# Women and Children First

## Addressing loss to follow up in PMTCT in the community and preventing unintended pregnancies in Salima District, Malawi



Communities supported  
**120**  
Lives saved  
**53**  
Women, children and adolescents benefiting  
**26,267**

### Problem

At the time of the project Malawi had a total fertility rate of almost 6 per woman, an HIV prevalence of 13% and under-5 mortality rate of 85 / 1000 live births.

### Approach

#### WCF PMTCT tool

- 120 groups established with 6,701 members
- Developed local answers including: awareness raising campaigns; income generation and sharing; emergency transport funds; construction and support for maternity

Partner  
MaiKhanda Trust

Funder  
Positive Action for Children Fund (£349,997)

Dates  
2014 – 2017

Project population  
96,077

Salima District, Malawi



- waiting shelters; vegetable gardening, distribution and cooking demonstrations; lobbying for quality health services, outreach clinics and community distribution of FP.
- Community health workers trained to follow-up all defaulter HIV exposed infants and encourage them back to care
  - Over 50 frontline health workers trained and supervised on PMTCT guidelines

### Advocacy

- Groups and project staff routinely shared evidence from the project and lobbied with key decision-makers

### Results

- Pre-conception increases:
- Contraceptive prevalence rate – 50%

### Before birth increases:

- ANC in 1<sup>st</sup> trimester – 20%
- Women tested for HIV – 10%

### During childbirth increases:

- ARV prophylaxis – 26%

### After birth, for HIV exposed infants, increases:

- HIV testing at 6-weeks – 38%
- Following-up 12-mths – 35%

### Lessons learned

Community-based approaches can improve adherence within the PMTCT cascade:

- The PMTCT tool can increase uptake of family planning and reproductive health care-seeking during pregnancy and delivery
- HIV exposed infants who drop-out of care can be brought back by specifically tasked community health workers

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Figure 1: Impact on FP and key vertical transmission prevention interventions

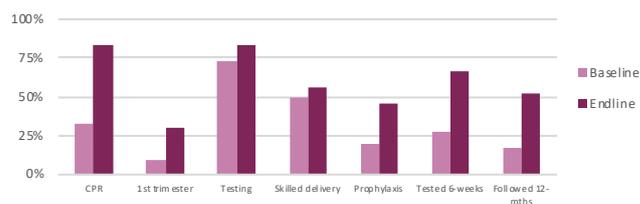
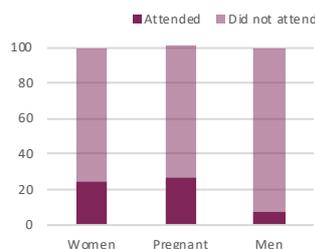


Figure 2: Group membership



District Environmental Health Officer:

*"I feel there has been a big improvement in PMTCT during the project. We have made gains in 1<sup>st</sup> trimester ANC due to [the groups]. This has enabled early HIV screening. I believe [the project] has contributed to the district recording a lowest HIV prevalence rate of just 3%"*

# Women and Children First

## Improving maternal and newborn outcomes in Ntchisi District, Malawi



Communities supported  
**320**  
Lives saved  
**156**  
Women, children and adolescents benefiting  
**47,665**

### Problem

At the time of the project Malawi had a newborn mortality rate of 22 / 1000 live births and a maternal mortality rate of 510 / 100,000 live births.

### Approach

#### WCF MNH tool

- 320 groups established with 9,146 members
- Developed local answers including: emergency funds; income generation and sharing; community distribution of FP and bednets; lobbying CHWs to provide health education;

### Partner

MaiKhanda Trust

### Funder

Comic Relief (£1,078,866)

### Dates

2014 – 2017

### Project population

227,735

Ntchisi District, Malawi



lobbying for provision of outreach clinics; vegetable gardening and sharing.

### Quality improvement (QI)

- 15 QI teams formed at all maternity facilities - designing and running projects to improve service quality

### Advocacy

- Groups and project staff routinely shared evidence from the project and lobbied with key decision-makers

### Results

- Improvements in care-seeking: attending 4 or more antenatal care appointments (increase of 18%), delivery with a skilled attendant (18%) and seeking postnatal care within 7 days (20%)
- For home deliveries large improvements in safe

newborn care: 75% of babies have nothing applied to the cord after birth (49% at baseline) and 59% delay bathing for more than 24 hours after birth (21%)

- Large improvements in service quality: 94% of facility births adhered to neonatal sepsis (55% at baseline) and 92% adhered to partograph protocols (50%) and reduced maternal and neonatal case fatality rates.
- Large improvement in knowledge of decision-makers about MNH needs of communities (50%)

### Lessons learned

- Funds, formed by groups to solve MNH problems, motivate membership and can sustain groups beyond the end of project funding

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Figure 1: Care-seeking practices

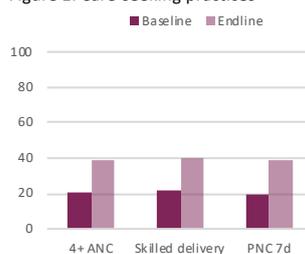


Figure 2: Home-care practices

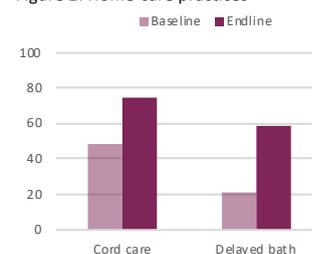
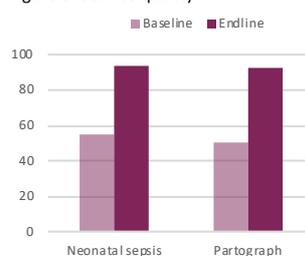


Figure 3: Service quality



### MNH group member

*“Overall, women are now proudly able to do other development activities such as backyard gardens and group funds compared to previous times when women could spend more time taking care of pregnancy and newborns. Many people have acquired knowledge and skills through the project and are able to easily access MNH services at nearby health centers.”*

# Women and Children First

## Improving maternal and neonatal health in Nkhotakota District, Malawi



Communities supported  
**295**  
Lives saved  
**176**  
Women, children and adolescents benefiting  
**83,297**

**Problem**  
At the time of the project Malawi had a newborn mortality rate of 22 / 1000 live births and a maternal mortality rate of 510 / 100,000 live births.

**Approach**  
*WCF MNH tool*

- 295 groups established 32,856 members
- Developed local answers including: bicycle ambulances; lobbying for establishment of outreach clinics; lobbying for institution of local by-laws on TBA delivery; vegetable

gardening and distribution; fishing to generate and share income; volunteering to clean local health facilities.

**Advocacy**

- Groups and project staff routinely shared evidence from the project and lobbied with key decision-makers

**Results**

- High level of attendance at group meetings: 29,279 women of reproductive age (28% of all) of which 18,769 were pregnant (57%) and 3,577 men (3%)
- Improvements in care-seeking: early antenatal care (11%), attending 4+ antenatal care appointments (9%), delivery with a skilled attendant (13%) and postnatal care within 7 days (15%).

- Large improvements in perceptions of services : 66% of women perceiving quality to be excellent (48% at baseline) and 68% of women perceiving services to be very accessible (59%)

**Lessons learned**

- MNH groups can successfully mobilise large numbers of women, particularly pregnant women. Men can also be mobilised
- MNH groups can be effectively facilitated by volunteers
- Health surveillance assistants (a cadre of community health worker) are too busy to effectively facilitate groups, but can successfully supervise facilitators, which is a lower intensity role

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**Partner**  
MaiKhanda Trust

**Funder**  
UK Aid (£250,000)

**Dates**  
2014 – 2016

**Project population**  
321,851

Nkhotakota District, Malawi



Figure 1: MNH group membership

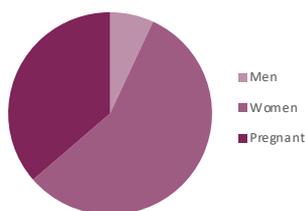


Figure 3: Service quality / accessibility

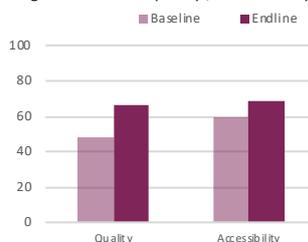
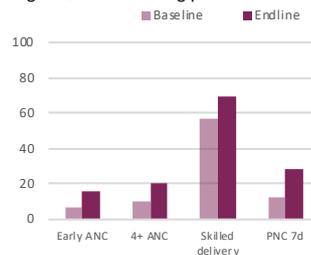


Figure 2: Care-seeking practices



**Male MNH group member**

*“Men within the project area were heavily involved right from inception, such that there was easy to get their buy-in on solutions developed to improve maternal and newborn health. These solutions included orienting men to accompany their spouses for antenatal care and taking responsibility for supporting birth preparedness”.*

# Women and Children First

## Improving the health of pregnant women and children in Malawi



Communities supported  
**144**  
Lives saved  
**99**  
Women, children and adolescents benefiting  
**35,546**

### Problem

At the time of the project Malawi had an under-5 mortality rate of 85 /1000 live births and maternal mortality ratio of 510 /100,000 live births.

### Approach

#### WCF MNH tool

- 144 groups established with 25,421 members
- Developed local answers including: breastfeeding clubs, emergency funds, income generation, kitchen gardens, village bylaws, health education campaigns, bicycle ambulances, WASH activities.

### Partner

Perinatal Care Project and Malawi Ministry of Health

### Funder

Comic Relief (£584,532)

### Dates

2010 – 2015

### Project population

80,900

Ntcheu District, Malawi



### Other community approaches

- Health promotion campaigns with members, men and leaders in 144 villages
- Community reviews of 90% of all maternal and neonatal deaths
- Volunteer led growth monitoring and referral for 44,935 children under-5

### Health systems strengthening

- Training and face-to-face and remote mentorship of 55 facility health workers
- Provision of essential medical equipment to district hospital
- Support for delivery of 12 mobile ANC clinics in remote areas

### Results

- Large improvements in care-seeking: early antenatal care (10%), delivery with a skilled

attendant (42%) and seeking postnatal care within 7 days of delivery (44%)

- Large improvements in quality of services: 47% of babies receiving KMC if indicated (2% at baseline), 71% reporting satisfaction with services (54%) and 89% of children receiving all vaccinations (67%)

### Lessons learned

- Community ownership and engagement is key
- Orientation of community leaders and men in mother and child health is essential
- Quality and accessibility of services must take place in parallel to community engagement, but is often compromised by inadequate systems, resourcing and governance

[www.womenandchildrenfirst.org.uk](http://www.womenandchildrenfirst.org.uk)

Figure 1: MNH group membership

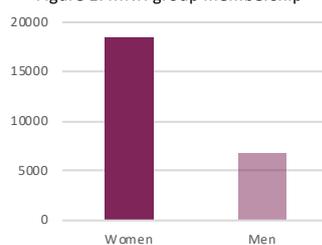


Figure 2: Care seeking-practices

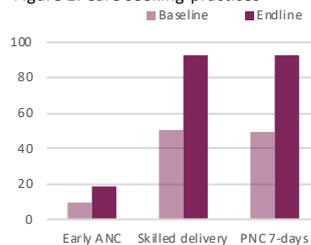
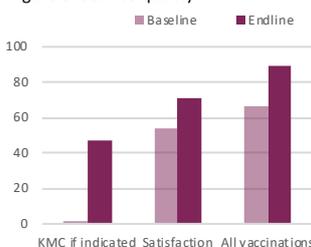


Figure 3: Service quality



### Mother from local community

*"In the past women gave birth right here in the village or on the way to the facility. When they developed complications, say retained placenta, transport was a problem and a woman would die on the way to the hospital on an oxcart. This time, now we have the groups, at eight months' pregnant, we go to the clinic to wait until delivery. So, I see that there is a big change"*

## APPENDIX 3: SELECTED CURRENT AND HISTORIC CONSULTANCIES

### Women and Children First



### Technical Assistance

#### Technical Assistance services

Women and Children First is experienced in providing technical assistance to partners seeking to support local communities to come up with answers to the problems facing women, children and young people. We offer a high quality package of short-term or long-term assistance. Our services can be tailored to your need and can be delivered as a sub-grantee and consultant.

#### Our services include:

1. Designing new community support tools
2. Implementing our tested and effective support tools:
  - MNH tool to increase maternal and newborn survival
  - FP tool to improve family planning uptake
  - PMTCT tool to promote HIV prevention activities during pregnancy, delivery and after birth.
3. Monitoring and evaluating the effect of support approaches

#### Value of our approach

We tailor and deliver services that build the capacity of our partner organisations in the design, implementation, management and evaluation of the community support tools. We strive for an integrated approach, tailored to the context, to increase sustainability. We are small, creative, and rigorously efficient, and have an excellent and experienced team.



#### Latin America

**Partner**  
Health Poverty Action

**Funder**  
EC (EUR2.2 million)

**Dates**  
2015 – 2018

**Challenge**  
Reproductive, maternal and newborn health

**Number of communities supported**  
124 – 93,000 people

**Services provided**  
Adaptation and training in implementation, management and evaluation of MNH tool

**Number of people trained**  
24 NGO staff – cascaded to >150 volunteers

#### Malawi

**Partner**  
MaiKhanda Trust

**Funder**  
PACF (£150,000)

**Dates**  
2017 – 2019

**Challenge**  
Prevention of mother-to-child transmission of HIV

**Number of communities supported**  
120 – 96,077 people

**Services provided**  
Design and training in implementation, management and evaluation of PMTCT tool

**Number of people trained**  
10 NGO staff – cascaded to >80 volunteers and community health workers

#### Myanmar

**Partner**  
Health Poverty Action

**Funder**  
UKAID (£1 million)

**Dates**  
2015 – 2018

**Challenge**  
Reproductive, maternal and newborn health

**Number of communities supported**  
118 – 88,500 people

**Services provided**  
Adaptation and training in implementation, management and evaluation of MNH tool

**Number of people trained**  
48 NGO staff – cascaded to >150 volunteers and community health workers



### Sierra Leone

**Partner**  
The Welbodi Partnership

**Funder**  
DFID (£249,945)

**Dates**  
2014 – 2018

**Challenge**  
Maternal and newborn health

**Number of communities supported**  
100 – 100,000 people

**Services provided**  
Adaptation and training in implementation, management and evaluation of MNH tool

**Number of people trained**  
4 NGO staff – cascaded to >75 volunteers

### Ethiopia

**Partner**  
Doctors for Africa CUAMM

**Funder**  
CR and BLF (£705,982)

**Dates**  
2017 – 2020

**Challenge**  
Maternal, perinatal and newborn health and stillbirths

**Number of communities supported**  
124 – 39,893

**Services provided**  
Adaptation and training in implementation, management and evaluation of MNH tool

**Number of people trained**  
20 NGO staff – cascaded to >100 community health workers

### UK

**Partner**  
University College London

**Funder**  
NIHR (£100,000)

**Dates**  
2017 – 2018

**Challenge**  
Infant nutrition and feeding practices

**Number of communities supported**  
4 – 2,000 people

**Services provided**  
Design and training in implementation, and evaluation of infant nutrition and care practice tool

**Number of people trained**  
4 volunteers

### Assistance service components

- A. Community support tools and implementation materials
- B. The community support modular training course, developed in collaboration with WHO, which covers:
  - Design and adaptation
  - Implementation
  - Monitoring and evaluation
- C. Tailored short- and long-term backstopping support
- D. Community support conference and virtual network

**Richard Horton –  
Editor of the Lancet**

*“It’s not a drug. It’s not a vaccine. It’s not a device. It’s women, working together, solving problems, saving lives.”*

For more information including our audited accounts please visit our website:  
[www.womenandchildrenfirst.org.uk](http://www.womenandchildrenfirst.org.uk)

or contact our CEO, Mikey Rosato:  
[m.rosato@womenandchildrenfirst.org.uk](mailto:m.rosato@womenandchildrenfirst.org.uk)



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