"Custodians of Tradition" Promote Positive Changes for the Health of Newborns

Annex E. Rapid Qualitative Assessment of the Ekwendeni *Agogo Approach*, Malawi

Grandmothers sing and dance to a song about the danger signs of pregnancy and delivery

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Table of Contents

Acronyms and Abbreviations

ANC	Antenatal Care
BCC	Behavior Change Communication
BF	Breastfeeding
EBF	Exclusive Breastfeeding
GF	Grandfather
GM	Grandmother
KMC	Kangaroo Mother Care
LEPSA	Learner-Centered Psychosocial Approach for Action
MCH	Maternal and Child Health
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SNL	Saving Newborn Lives
VHC	Village Health Committee

I. Introduction

A. Overview of the *Agogo Approach*

For more than one hundred years, Ekwendeni Church of Central Africa Presbyterian (CCAP) Mission Hospital (Synod of Livingstonia) has been involved in primary health care (PHC) programs in its catchment area in Mzimba District in Northern Malawi. Ekwendeni's PHC program addresses various maternal and child health issues. Past programs have focused almost exclusively on women of reproductive age. In the first phase of Save the Children's Saving Newborn Lives (SNL) initative (2001-06), Ekwendeni was a partner organization to Save the Children for implementation of community activities for newborn heath. Ekwendeni decided to involve grandmothers and grandfathers in its community mobilization and behavior change strategy, given their role and influence in household decision-making related to pregnancy and care of neonates. More than 4,000 grandparents (*agogo* in Tembuka, the local language) from 225 villages were trained and then expected to share their "state-of-the-art" knowledge on maternal and newborn care to promote improved practices within their families and communities.

B. Background to the *Agogo Approach*

It is difficult to determine exactly how and when the decision was made to develop the *Agogo Approach*. In fact, it seems that there are several elements, and the synergy between them, that contributed to the decision to explicitly involve grandparents in the newborn health promotion activities.

At the outset of the SNL project, in May 2001, a rapid qualitative inquiry on cultural factors related to newborn health was carried out by Karen Waltensperger, now SC/Africa Regional Health Advisor. The results of this rapid assessment clearly revealed the leading role played by grandmothers at the household level during pregnancy and with newborns. It also showed that these senior women serve as advisors to male family members on issues related to pregnancy and newborn care.

> *Whether a household is patrilineal or matrilineal, it is the grandmothers and other elder female relatives who commonly serve as key household advisors in all matters concerning care of the pregnant woman, neonate and new mothers, particularly with a firstborn child. Senior women also serve as first-line gatekeepers for care-seeking and influence male relatives' decision-making. (Waltensperger, 2001, p. 8)*

In late 2002, Save the Children SNL commissioned a more comprehensive qualitative study entitled, "Saving Newborn Lives Formative Study." It was carried out by Priscilla U. Matina, a local consultant. This investigation focused primarily on the beliefs and practices related to pregnancy and newborn care but gave some attention to household dynamics and decision-making. The report concluded that:

> *In Mzimba district, paternal grandmothers, or mothers-in-law, play an active role in influencing the care of mothers and newborns, especially for pregnant women and those having children for the first time. (Matina, 2002, p. 50)*

According to Kistone Mhango, PHC Coordinator at Ekwendeni Hospital, initial plans for the SNL project did not include activities with *agogo*. He and his team soon realized that "there was a missing" piece in their community strategy. Kistone recounts:

> *"At the outset of the SNL project the focus of the behavior change activities was on working with the village health committees and drama groups composed of younger people. There was no discussion of involving grandparents. But as time went by we realized that certain persons were missing, the agogo. We realized that they are the ones who teach the dos and the don'ts to younger women. We realized that our programs with communities would have more impact if the agogo were involved."*

Another important factor related to the decision to develop activities to involve the *agogo* was strong support for this idea from Stella Abwao, the SNL Project Manager at that time. Given Stella's background (Kenyan) and familiarity with the cultural organization of African families, she was very supportive of the idea of actively involving grandparents in SNL activities.

It is the synergy between these several factors that appears to have led to development of the *Agogo Approach* and the initial training of *agogo* in late 2004. According to Ekwendeni PHC staff, at the outset, their idea was to create "*Agogo* Clubs" that would be involved in promoting newborn health in families and communities. Several of the SNL documents later refer to the existence of "*Agogo* Clubs."

However, discussions with the PHC team revealed that, in fact, their approach to working with the *agogo* has not really involved organizing them into a more formal "club structure" but, rather, it has consisted of progressively integrating them into several existing community activities, namely the village health committees (VHC), the drama groups and other village development activities. For this reason, it was agreed with the PHC team in Ekwendeni that it is more accurate to refer to the activities with the *agogo* as the "*Agogo Approach*" rather than "*Agogo* Clubs."

C. Goal and objectives of the rapid assessment

Since the training of *agogo* in 2004, in a series of workshops held at Ekwendeni Hospital, there has been considerable anecdotal evidence on the positive community response to the *Agogo Approach* and of its positive influence on the grandparents' attitudes and practices. However, prior to this rapid assessment, no previous systematic review or evaluation of the approach had been carried out. For this reason, and given Save the Children's interest in documenting and packaging the *Agogo Approach* as part of its Malawi Newborn Health Program with funding from USAID/GH/HIDN/NUT/CSHGP and SNL, it was determined that a critical review of the approach should be carried out in close collaboration with Ekwendeni PHC staff.

The purpose of the assessment, as defined in the Scope of Work, was to assist the Ekwendeni PHC team to assess the strengths and weaknesses of the *Agogo approach* with a view to refinement, expansion, documentation and packaging.

The objectives for the assessment, developed with the PHC team in Ekwendeni, were:

- to assess the relevance of the *Agogo Approach* for the communities in Ekwendeni's catchment area
- to assess the results of the approach based on qualitative information
- to identify the key factors that have contributed to the positive results
- to identify the strengths and weaknesses of the approach
- to identify the most effective incentives to motivate the *agogo*
- to formulate recommendations for strengthening *Agogo* involvement and learning within the catchment area
- to formulate recommendations for expanding the *Agogo* approach beyond the catchment area
- to formulate recommendations for documenting and "packaging" the approach (in order to be able to share it with others)

II. Methodology

Given the purpose and objectives of this review, a qualitative and participatory approach was used to carry it out. The consultant worked closely with Ekwendeni and Save the Children staff in order to develop the methodology, collect and analyze the information and formulate conclusions and recommendations.

A. Data collection: instruments and sample of interviewees

Data was collected through group and individual interviews and also through review of existing documentation (secondary data.)

Focus group discussions using semi-structured interview guides (specific to each category of interviewees) were conducted with a total of 451 community members consisting of: grandmothers (148); grandfathers (79); young women with children under 1 year of age (88); VHC members (92); and drama group members (44); and 14 Ekwendeni staff members who have been involved in *agogo* activities in one way or another. (See Table I. below.) Interviewees were selected using convenience sampling.

Individual interviews using a structured questionnaire consisting of 8 questions were carried out with 76 grandmothers and 38 grandfathers in order to test their knowledge of priority messages related to the care of pregnant women and of newborns. Interviewees were selected using convenience sampling. [The fact that the sample has twice as many grandmothers (GMs) and grandfathers (GFs) reflects the fact that about twice as many GMs attended the community meetings called by Ekwendeni staff in the context of this review.]

Review of available documentation on the Agogo Approach was also carried out though this was of limited scope given that the available documentation on development and implementation of the approach is very limited.

Table I. Focus group interviewees by category

	Persons interviewed

Village	*Agogo*		Drama groups	Village Health Committees (VHC)	Women w/ children < 1 year	Ekwen-deni staff
	Grand-fathers	Grand-mothers				
Vyalema Kumwenda	3	6	10	9	6	14
Mopho Jere	6	17	6	7	16	
Lazaro Jere	15	18	-	10	12	
Madang'ombe Mumba	6	12	10	10	12	
Sunduzwayo Tembo	17	28	-	13	13	
Mugulumu Kamanga	6	11	9	10	11	
John Kaunda	9	20	9	10	12	
Yotamu Nkhambule	17	36	-	23	6	
Total by category	79	148	44	92	88	14
Total number persons interviewed = 465						

B. Data collection team

The data collection and analysis was coordinated by Judi Aubel, consultant for the assessment and Founder of The Grandmother Project, a US-registered NGO. The interviews of both groups and individuals were carried in the local language by: Kistone Mhango, Rose Gondwe, Maggie Munthali, Evelyn Zimba and Agness Hara. Community visits and interviews took place between December 8 and 12, 2006.

C. Data analysis

During the data collection phase, on a daily basis, following the community visits, the assessment team sat together, reviewed the notes taken and discussed the main themes and trends that emerged from the data. All focus group interview notes were typed and additional analysis of the data was also done by the consultant.

III. Findings

A. Results of the *Agogo Approach*

The initial rationale for involving *agogo* in community newborn health activities was to promote improvements in their knowledge and changes in their attitudes and advice regarding the care of pregnant women and of newborns. However, anticipated results of *agogo* involvement were not defined in terms of *behavioral outcomes.* The Behavior Change Communication (BCC) strategy (planning chart), developed in mid-2003 for SNL, does not include any anticipated results related to *agogo* knowledge, advice or practices. All relate to women's knowledge and practices.

Since the *agogo* training sessions took place in the fall of 2004, there has been very limited formal monitoring and follow-up to assess the effect of the training and other community-based newborn health activities on the knowledge, advice and practices of the *agogo* and their families. Monitoring visits were not included in the original plan and neither was there time nor resources to do systematic follow-up in the more than two hundred villages in the Ekwendeni catchment area. On the other hand, in the course of other community activities and contact with community members at the hospital, considerable anecdotal information was collected by Ekwendeni staff that has consistently shown both the enthusiasm of communities toward *agogo* involvement and the positive changes in *agogo* attitudes and practices. Unfortunately, no system was developed for collecting feedback from communities and the anecdotal information and observational data was not recorded in any way.

The information collected during this assessment, though essentially qualitative in nature, clearly suggests that there have been positive changes in *agogo* knowledge, attitudes and advice. (Those findings are discussed below.) In addition to the results related to newborn care practices, the *Agogo Approach* has had some very positive and unanticipated results related to improvements in intergenerational communication and collaboration between younger and older community members.

1. Increased knowledge, improved advice and practices related to maternal and neonatal health

- *Learning by agogo*

The information collected both from community members and Ekwendeni staff clearly suggests that there has been considerable learning on the part of both GMs and GFs and that in many cases their new knowledge on care of pregnant women and newborns has been put into practice.

Individual interviews were carried out with 114 *agogo* (38 grandfathers and 76 grandmothers) to assess their knowledge of key messages communicated during training and in other community activities related to: antenatal care (ANC); danger signs of pregnancy and with newborns; timing of the first bath; modes of mother-to-child transmission of HIV; and Kangaroo Mother Care (KMC).

Results of the interviews showed: on five of the ten parameters (messages) assessed, fifty percent or more of the *agogo* have mastered the priority information; the *agogo* have particularly high levels of knowledge regarding *early ANC* (85%) and *KMC* (76%) while their knowledge of HIV mother-to-child transmission remains inadequate (11%) as does their knowledge of newborn danger signs (35%); and levels of knowledge of grandmothers and grandfathers are similar on all topics except for those related to delaying the first bath where grandmothers' knowledge is significantly better than that of grandfathers.

The information collected through **focus group interviews** supported these findings regarding knowledge acquisition on the part of the *agogo*. During the group interviews, both grandmothers and grandfathers who spoke up tended to be those who had higher levels of knowledge. This is frequently the case in group interviews that

those who speak up tend to be those who have more confidence in their own experience and learning.

During the group interviews, both with *agogo* and women with young babies, there were numerous testimonies regarding how the new knowledge of the *agogo* has been put into practice related to: early and frequent ANC; transport of premature babies to the hospital using KMC; rapid referral to the hospital of women and newborns with danger signs; use of exclusive breastfeeding (EBF); and delaying the first bath of newborns.

Testimonies from Ekwendeni hospital staff also support the conclusion that *agogo* have learned and are putting into practice priority messages. Hospital nurses reported: a considerable increase in early ANC visits (i.e. at three months of pregnancy); decreased use of traditional medicine to accelerate labor; babies transported to the hospital especially by men or grandfathers using KMC; improved newborn care; and increased EBF.

2. Improved communication and collaboration between elders and youth

In all communities where interviews were carried out, community members reported that the *Agogo Approach* has also contributed to an unanticipated, but very positive, result related to improving intergenerational communication and collaboration between younger and older community members.

Past community health and development programs in Malawi, implemented both by Ekwendeni and by other organizations, have involved and trained young people and have not systematically involved the *agogo*. Both youth and grandparents reported that in the past they always felt uncomfortable with the *youth-focused approach* first, because of the expectation that young people should teach their elders and secondly, because it excluded grandparents who are the designated "teachers" in the local culture.

One of the young members of a village health committee explained how difficult it was for them to try to teach their elders:

> *"It was always very uncomfortable for us trying to communicate new health concepts to our elders. When we were trained, we were told to do so, but we knew that culturally it was not appropriate for younger people to be teaching older ones."*

And one of the very old grandmothers explained how the elders reacted to the youth-focused approach:

> *"All of the programs choose young people to be trained. When they return, they come to us to tell us what they have learned. When they do this, I scream at them and tell them that we will not listen because it is not appropriate in our culture for youth to teach elders."*

A grandfather, who has recently become a member of the VHC in his community as a result of the *Agogo Approach*, described the "cultural conflict" that exists when programs target youth and exclude elders:

> *"When youth try to teach their elders, they are showing a lack of respect for our cultural values regarding the role of elders in the society."*

On the other hand, now that the *agogo* have also been "officially trained," both they and younger community members feel that grandparents' culturally-designated place, as *teachers of the younger generations,* has been restored. The *agogo* reported that now they feel more respected in the community and more comfortable being involved in community activities and collaborating with younger people in the VHCs, drama groups and other community activities.

Conclusion: The information collected during this assessment clearly shows that the *Agogo Approach* has had two very positive results: first, there have been positive changes in *agogo* knowledge, attitudes and advice related to the care of pregnant women and of newborns; and second, the *Agogo Approach* has contributed to some very positive, but unanticipated results related to improvements in intergenerational communication and collaboration between younger and older community members.

B. Factors that have contributed to the results of the *agogo* approach

One of the objectives of the assessment was to identify key factors that have contributed to the positive results of the *Agogo Approach*. This is important both in order to know what existing activities should be strengthen and/or expanded and in order to be able to systematically orient others who are interested in understanding and possibly using the approach. Through both community level interviews and discussions with Ekwendeni staff the following factors were identified as having contributed to the positive results.

1. The basis for the approach is culturally-defined roles and relationships

The strong support for the involvement of *agogo* in maternal and neonatal health activities from both community members and Ekwendeni staff stems from the fact that the *Agogo Approach* builds on cultural roles and responsibilities. At both the household and community levels, *agogo* influence decision-making and practices related to maternal and neonatal health. By explicitly acknowledging the role of the *agogo* as family advisors and teachers the approach has been a strong source of motivation for them to be more involved in community programs than in the past. In the *Agogo Approach,* the roles that the *agogo* are expected to play mirror their culturally-defined advisory roles. Community interviewees, young and old, stated that past development programs that have given youth a central role have been at odds with the culturally-designated roles where elders are the advisors and teachers of youth, and not the reverse.

- ***Builds on the respective roles of grandmothers and grandfathers at the household level***

At the household level, both earlier studies and the information collected during this assessment clearly show that grandmothers and grandfathers play complementary, but different, gender-specific roles related to maternal and neonatal health.

Grandmothers (e.g., mothers-in-law in this part of Malawi which is patrilineal) are the direct advisors of young women and direct care-givers of young children. Grandmothers are responsible for ensuring close follow-up both of pregnant women and newborns on a day-to-day basis. Given both their experience, related to pregnancy and infant care, and their intimate involvement with women and new babies, if a problem arises, they are aware of it before any male family members get involved and they are the *first-line decision-makers* about what should be done. Given their role and intimate involvement with both pregnant women and newborns, it is extremely relevant for them to be involved in community activities in order to strengthen their knowledge and the advice they give not only to younger women but also to their husbands and sons.

Grandfathers are usually not directly involved with pregnant women and newborns, on a day-to-day basis, and play a secondary and supportive role in a rather detached way. For example, culturally it is not acceptable for grandfathers, the fathers-in-law, to communicate directly with their daughters-in-law. According to both community members and Ekwendeni staff, when GFs are advised by their wives, or other senior women in the family, that special resources or logistical support are required for either pregnant women or newborns, then they take on a more active role. In these instances, based on grandmothers' advice in most cases, they often make "official decisions" regarding transport and other aspects.

Grandfathers and men are officially regarded as household "decision-makers," but, in fact, as regards issues related to women and children's health and well-being, in most cases they are *second line decision-makers* who provide support to grandmothers when required. Given the role of grandfathers in organizing emergency transport, it is particularly important that they be aware of the urgency of such evacuations when grandmothers observe danger signs with either a woman or newborn.

While the roles of GMs and GFs are complementary, clearly GMs are more directly involved than GFs in maternal and neonatal health activities at the household level on a day-to-day basis. In the past it seems that activities were developed for "grandparents" without any attention to the difference in their roles. For the purposes of developing future *agogo* activities, the distinction between the roles of GMs and GFs should be kept in mind in terms of role descriptions, training content and activities developed with the two sub-groups. The greater involvement of GMs in maternal and neonatal health may warrant investing more resources in reinforcing grandmothers' knowledge, for example, by providing more in-depth and longer training for them than for GFs.

- ***Contributes to changing community norms***

As Kistone frequently says, "grandparents are the custodians of tradition." Specifically regarding the care of pregnant women and of newborns, grandmothers and grandmother peer groups, or *social networks*, play a key role in communicating and enforcing community norms of behavior. Involving *agogo* in health education

activities can increase their knowledge of priority (modern) practices that can, in turn contributes to changing community norms that are communicated to younger women. This is another factor that supports the need to continue to involve the *agogo* in health education and communication activities.

Most communication strategies dealing with maternal and child health topics aim to change individual behavior, and in order to do so they focus on women of reproductive age. Often these strategies lead to increases in women's knowledge but do not result in changes in their behavior because it is difficult for them to adopt practices that go against community norms and advice of senior women, or GMs, in the family. The *Agogo Approach* contributes to changing community norms by working through *agogo* groups, those who are involved in setting such norms.

2. Inherent motivation of agogo to learn

Another factor that has significantly contributed to the results of the *Agogo Approach* is their inherent motivation to learn, which was clearly and repeatedly revealed in the community interviews. In all communities visited both grandmothers and grandfathers expressed a strong interest to learn more about maternal and child health. Ekwendeni staff who facilitated the *agogo* workshops also stated that during training virtually all of the *agogo* demonstrated an eagerness to learn. GMs and GFs alike stated that the opportunity to learn more about the "modern concepts" related to the health of women and children equips them to be able to better teach their children/ grandchildren and to save lives.

There is an often-heard saying in the Tembuka language that "an old potato cannot be bent." However, in all communities the *agogo* said that they reject this widespread and negative belief regarding the capacity of older people to learn and change. The group interviews with them regarding priority practices promoted in the SNL project clearly showed that they are capable of learning. And in all communities they insisted that they want to learn more, not only about newborn care, but also about other aspects of maternal and child health.

3. Training of agogo at Ekwendeni

Another determining factor related to the results observed from the *Agogo Approach* was the training they received at Ekwendeni. The mere fact that the *agogo* were "invited to Ekwendeni to be trained" was a landmark event for them. It alone appears to have contributed greatly to increasing their own confidence in their role and importance in the family and community. For Ekwendeni staff who facilitated the training sessions, the experience was significant insofar as it helped them to modify their attitudes toward the *agogo*. It helped them to begin to see grandparents more as "partners" than as "obstacles," the attitude that many of them held prior to the training.

The second important aspect of the training was the approach, or methodology, used to train the *agogo*. No training manuals or detailed reports on the training events were prepared that describe in detail the methodology used. According to the PHC team members, "for each of the topics addressed, the *agogo* were asked to share what they know and then the Ekwendeni facilitators told what they know." From the

information provided to the assessment team, it appears that the approach used was: very participatory; built on participants' past experience and knowledge; and based on a dialogue between community members and health providers. During the assessment it was not possible to find out exactly how the training was done due to the absence of documentation on the training. In future training events an explicit attempt should be made to document both the activities used and the reaction and feedback on them received from participants.

[Note: After my departure from Malawi the PHC team informed me that they had used the Learned-Centered Psychosocial Approach (LEPSA) in the training. Additional information on LEPSA approach was not available before the completion of this report. This information might help to understand exactly how the training was carried out.]

Several weaknesses were identified with the training, specifically related to documentation of the event. All future training events could be strengthened by ensuring that the following elements are defined and used: training goals and objectives for the workshop sessions; post-tests carried out (orally) with participants to assess their learning; and a detailed training plan for each training event to include detailed feedback from community members, observations from facilitators and lessons learned for the future.

In conclusion, the training of the *agogo* at Ekwendeni produced very positive results, not only in terms of learning but also in terms of increasing the status of the *agogo* in their communities and their motivation to contribute to community health improvements and change.

4. Community organization and leadership in the Ekwendeni catchment area

For any community intervention, in addition to the characteristics of the intervention itself, another critical factor that influences the effects of the approach is the community context into which it is introduced. Since 1980, Ekwendeni PHC programs have been active in the catchment area, where the *Agogo Approach* was introduced. These programs have included extensive training of community leaders and groups both on various health topics and on leadership, VHC development etc. These efforts, over the years, have contributed greatly to strengthening the *social* infrastructure, or community organization and capacity in the Ekwendeni area. Compared to many other parts of Malawi, it appears that the level of community organization and responsiveness to development initiatives is quite high in this part of Mzimba District. During the assessment an attempt was made to collect information on the key principles and elements of the community capacity building activities that Ekwendeni carries out but it was not possible to get any specific information in this regard. [Note: Perhaps with more time one could interview the facilitators who conducted such training, as well as participants in past workshops in order to discover its content, methods used etc.]

The *Agogo Approach* was "planted" in a very fertile place where community leadership is quite strong, as are community groups such as VHCs. The impressive results of the approach are undoubtedly due to the combination of the innovative and

culturally-adapted approach that builds on community resources, i.e, the *agogo*, and the strong community leadership and organizations that existed prior to the introduction of this approach. If this innovative approach is introduced in a place where the social infrastructure is very weak, most likely the results would be considerably less.

- ***Support for agogo activities by village headmen***

During the rapid assessment it was observed that in communities where the village headman strongly encourage the *agogo,* they do appear to be more involved in community activities and, in turn, more committed to modifying some of their practices related to pregnancy and newborns. Encouragement of the *agogo* by the village headman is clearly an important factor in motivating them to participate in community activities and to share their knowledge within their families and with others in the community.

5. VHC collaboration with and support for agogo

Generally, the president of the VHC is the village headman and, in most cases, he is an *agogo*. Prior to the training of the *agogo,* VHC members did not include any other *agogo*. This is largely explained by the fact that one of the initial criteria for the choice of VHC members was that they be literate, which automatically eliminated most *agogo*. According to younger VHC members, before the *agogo* were integrated into the committees, it was difficult for the VHC, composed almost entirely of younger people, to make it heard in the village.

Since the *agogo* training, the grandparents have progressively been integrated into the VHCs and now virtually all of the committees have several *agogo* members. According to elder and younger community members alike, incorporation of the *agogo* into the committees has, on the one hand, increased the credibility and influence of these structures in the community while, on the other hand, it has strengthened communication and collaboration between younger and elder VHC members.

Prior to the *agogo* training the VHCs were trained on the basic essential newborn care messages/information related to the care of pregnant women and newborns. This was an important starting point for preparing them to work more closely with the *agogo* to promote those priority practices. Under the leadership of the village headmen, it appears that most of the VHCs are promoting maternal and neonatal health activities in collaboration with the *agogo*. In most cases, too, the VHCs are also collaborating with the drama groups, particularly to help mobilize community members and organize community drama performances.

6. Drama performances on essential newborn care themes

Another activity initiated under SNL-1 that has definitely contributed to increasing the involvement and reinforcing the learning of the *agogo* is the drama group performance. The performances of the drama groups are very effective insofar as they allow community members to "have fun while learning," as many community interviewees reported.

The drama groups were trained by a specialist in popular theatre and most of the plays that are being used were designed during the training workshop. This approach to developing the plays seems to be an excellent one as it helps ensure that the technical content being disseminated is accurate. The original six plays that were written and distributed during training have been repeatedly used, the high quality of the presentations is excellent, and communities appear to enjoy seeing them multiple times. At some point in the future, however, it would be good to have additional plays developed to ensure variety and also to incorporate other topics, namely, Prevention of Mother to Child Transmission (PMTCT) and other HIV/AIDS topics, EBF and the importance of warming and drying (including delay of first bath for the newborn). Monitoring data on levels of knowledge of both *agogo* and young women, such as that collected in the individual interviews during the rapid assessment, can be used to identify topics/messages that need to be further reinforced and for which additional scripts could be developed for the drama groups.

At the beginning of SNL-1, all of the drama group members/actors were young people. They presented the plays on the various topics related to pregnancy and newborn health. In a number of communities there were negative reactions to this and protests from village headmen who felt that: 1) it was not appropriate for taboo topics, such as pregnancy, to be presented on the stage in front of everyone; and 2)) in was not appropriate for young people to be teaching the elders about these topics. This feedback from communities was useful and after the *agogo* training it was decided to incorporate *agogo* into all of the drama groups. The inclusion of *agogo* has had several positive consequences: 1) now elders and younger people are working together presenting the dramas; 2)) the fact that both youth and elders are involved has greatly increased the interest of the *agogo* in the performances; and c) *agogo* involvement has made it more acceptable to discuss previously-taboo topics on stage.

The drama groups seem to be highly motivated and community interest in their performances appears to be a key in encouraging them to continue the presentations, a factor contributing to their motivation. It seems that in most cases the village headmen and VHCs encourage them to perform and take charge of mobilizing communities for the performances. It is fantastic that these drama activities have been sustained by the communities themselves over the past three years, as most were initially trained in 2003.

7. Dancing to songs on priority topics

Another activity/tool that contributes to reinforcing *agogo* interest and learning regarding maternal and newborn care are the songs that have been developed on various priority life-saving topics. It appears that the songs, all in the local language, are almost always accompanied by dancing which increases the "enjoy while learning effect." According to community informants, the songs are used at various times in the community, when meetings of various types are held, during mobile clinics and at other types of gatherings.

As an educational tool, songs are very effective insofar as they are culturally-adapted, participatory and inexpensive and they can be used by communities themselves. It appears that the songs primarily deal with "priority technical messages" regarding

practices that are promoted by Ekwendeni, i.e, proposed changes in harmful cultural practices. It seems that the songs give limited attention to the positive cultural roles, values and practices. It was not possible, during the short period of the assessment, to determine if there are songs to address all of the topics.

8. Posters and brochures

Three posters and very simple and attractive brochures were developed under SNL-1 on: priority practices during pregnancy and danger signs; newborn care; and KMC for premature babies. It is difficult to assess how much these materials have contributed to learning on the part of the *agogo*, who are mostly illiterate. During all of the interviews with *agogo*, VHCs, drama groups and young mothers, practically no mention was made of the brochures or posters. As compared with other communication activities and influences discussed above, it does not appear that these print materials have had a significant impact on the *agogo*.

Conclusion: As discussed earlier, the assessment team concluded that the encouraging results of the *Agogo Approach* can be attributed to the synergy between the various factors discussed above, some related to the context in which the *Agogo Approach* was implemented and others associated with the characteristics and components of the approach itself.

D. Weaknesses and constraints related to implementation of the *agogo* approach

1. Very limited monitoring and supervision

Follow-up visits for monitoring and supervision of *agogo* activities were not included in the SNL-1 work plan, resources were not allocated for such visits and, consequently, they did not take place. Occasional informal follow-up was done. In all of the communities visited during the assessment, the *agogo* themselves said that they wished that there had been supervision visits to "encourage us" and to "make sure we are on the right path."

2. Very limited documentation

As with many organizations involved in community programs, the efforts of the PHC team at Ekwendeni in the context of the newborn health program were focused on "implementing activities at the community level." According to Kistone, his team members all had very heavy workloads under SNL-1 and "documentation" was not viewed as a priority relative to "implementation." It also seems that for the PHC team members the rationale for documenting ongoing community activities was not entirely clear. Now that the value of the innovative *Agogo Approach* has been recognized, it is becoming clearer to Ekwendeni staff that in order to be able to share the approach with others within Ekwendeni district and beyond, there is a real need to systematically document it.

One of the assessment objectives was to collect all available documentation on the *Agogo Approach* including: periodic monitoring reports that include lessons learned; training modules and reports; and educational/ communication materials developed. But unfortunately, very little written material was found. At present, no filing system has been established for organizing documentation on *agogo*-related activities and the

PHC team does not have a clear idea of "what should be documented" and "how it should be documented." Key pieces of the "documentation process" should include: 1) descriptions of major activities carried out (objectives, steps, strengths and weaknesses of activity implementation); 2) feedback from both community members and development workers on activities carried out; and c) periodic development of "lessons learned" with community and development actors based on strengths and weaknesses in the implementation of activities.

3. Limited focus on positive cultural roles and practices

In the interviews with community groups, a predominant theme that emerged was that they have learned that there are various "harmful cultural practices" related to the care of pregnant women and newborns that they should abandon. For example, in the otherwise wonderful dramas and songs that are being used, the focus is primarily on encouraging community members to "stop certain harmful practices" and to "adopt recommended ones." In these education/communication activities, there is relatively little discussion or focus on "positive roles and practices" that are part of the culture and that people should be encouraged to feel proud of and that they should be actively trying to preserve. For example, songs could be developed that praise the role of grandparents as advisors of the younger generation.

In fact, in behavior change communication (BCC), as the term suggests, the focus is on getting people to change certain (harmful) behaviors. This focus and orientation was adopted by the Ekwendeni PHC team that was followed to develop the BCC strategy in SNL-1 using the BEHAVE framework. The BEHAVE methodology is being widely promoted in child survival and other health programs.

In these times when rural Malawian communities are suffering both from severe poverty but also from much illness and death associated with HIV/AIDS, and where cultural traditions and values are at risk of being lost, it seems particularly important that development programs explicitly aim to acknowledge and value the positive features of local cultures. Another example would be that, in the songs and dramas developed, the role and commitment of elders related to maternal and neonatal care in the family could be featured as a positive resource.

IV. Conclusions

Innovative MCH strategy in Malawi

The *Agogo Approach* developed at Ekwendeni Mission Hospital is an innovative and promising approach to community health promotion that is grounded in cultural values and roles. It appears to be the first time that grandparents have been viewed as key actors and explicitly involved in community maternal and child health promotion in Malawi. Past maternal and child health programs have focused almost exclusively on women of reproductive age, and occasionally on women and their husbands. The reaction to the *Agogo Approach*, on the part of both community members and health workers, has been very positive and both believe that the approach is both culturally-relevant and an effective way to promote change in family attitudes and practice related to maternal and newborn care.

Limitations of past "youth-focused" community programs

Past community health and development programs in Malawi, implemented both by Ekwendeni and other organizations, have primarily involved and trained young people and have not systematically involved the *agogo*. Both youth and grandparent interviewees reported that in the past they always felt uncomfortable with the *youth-focused approach* first, because of the expectation that young people should teach their elders and secondly, because it excluded grandparents who are the designated "teachers" in the local culture.

Cultural-relevance of the *Agogo Approach*

At both the household and community levels, *agogo* influence decision-making and practices related to maternal and neonatal health. The *Agogo Approach* builds on their culturally-designated roles and responsibilities. There is a broad consensus among community members and health/development staff that it is very relevant to involve the *agogo* in programs aiming to promote newborn care and well-being for two major reasons. First, grandmothers are directly involved in the care of pregnant women and of newborns and grandfathers play a supportive role related to these activities. Second, *agogo* involvement can contribute to changing community norms that can, in turn, promote sustained behavior change.

Anticipated results of the *agogo* involvement

The information collected during this assessment, though essentially qualitative in nature, clearly suggests that there have been positive changes in *agogo*' knowledge, advice and practices, especially related to: ANC ; danger signs of pregnancy and in newborns; newborn care; breastfeeding; and KMC for small babies requiring extra attention.

Unanticipated results of *agogo* involvement

The *Agogo Approach* has also contributed to an unanticipated, but very positive result, related to improvements in intergenerational communication and collaboration between younger and older community members. All communities stated that in the past, grandparents felt excluded from and frustrated by the prevalent *youth-focused development programs.* They stated that, by acknowledging the culturally-designated role of the *agogo* as teachers of younger community members, and by strengthening the knowledge of the *agogo*, they have been encouraged to work together with young people, in a spirit of mutual respect, to promote community health and development.

Factors related to encouraging results of *agogo* intervention

The assessment team concluded that the very encouraging results of the innovative *Agogo Approach* cannot be attributed only to the formal *agogo* training at Ekwendeni, but rather to a combination of factors that include that training. On the one hand, there are two important pre-exiting contextual factors that appear to have contributed to the positive results of the approach, namely, the strong leadership and high level of community organization that exists in most communities in the Ekwendeni catchment area, and the skills of Ekwendeni field staff in community facilitation, participation and capacity-building. On the other hand, various components of the intervention, or approach, itself have clearly contributed to the positive results, namely: 1) the participatory and culturally-sensitive training methodology used with the *agogo*; 2) the fact that the *agogo* were for the first time officially invited to a training session at Ekwendeni; 3) the frequent drama performances over the past three years that convey information on priority maternal and newborn practices; 4) the frequent use of songs,

accompanied by dancing, that reinforce key messages on priority practices; 5) the training of VHCs on essential newborn care topics and their role in disseminating them to other community members; and 6) the inclusion of *agogo* into both the VHCs and drama groups, of which they were not previously a part. In conclusion, the positive results of the *Agogo Approach* can be attributed to the synergy between the several factors listed above.

Prospects for sustainability

There are several features of the *Agogo Approach* that support the prospects for sustainability, both of the community education/communication activities and of the changes in health-related practices that they promote. The community education/communication activities - namely drama, songs, dance and community discussions - are all simple, culturally-adapted, participatory and community-lead activities that require very little ongoing outside support. Some follow-up is required to be sure that the messages being disseminated are correct. It is very encouraging that almost all communities appear to be continuing these activities on their own. Another advantage of the *Agogo Approach* is that it contributes to promoting changes in community health norms, by working through grandmother groups and leaders. Most health communication/education strategies aim to change the practices of women of reproductive age and often meet with limited support because the proposed changes go against community norms. The *Agogo Approach* aims to "get to the root of the issue" by promoting change among those, i.e, the grandmothers, who have the responsibility within the culture for defining and communicating the cultural norms, i.e, "the way things should be done." Changing cultural norms is like changing the operating system on the hard disk of a computer.

Weaknesses in implementation of the *Agogo Approach*

While overall implementation of the approach has been very effective, a few weaknesses were identified related to: 1) limited monitoring and supervision of the approach; 2) very limited documentation of the approach used including accomplishments, feedback received from different stakeholders, lessons learned in the course of implementation; and 3) insufficient recognition and encouragement of the positive cultural roles and practices in the community activities and communication materials. Regarding this last point, the communication/ education strategy to promote improved maternal and newborn care focuses primarily, as behavior change strategies (BCC) invariably do, on discouraging harmful traditional practices. Limited attention is given to reinforcing the positive cultural roles and traditions. Community interviewees often stated in a rather apologetic way, "We have learned that many of our traditional cultural practices are harmful and that we should abandon them." In this regard, the content of the songs and dramas focuses primarily on the "harmful" practices to be forgotten and "good" practices to be adopted while limited attention is given to positive features of the cultural heritage.

Untapped community resource: informal grandmother leaders

In all communities there are informal grandmother leaders who have status in the community and who influence the attitudes and practices both of younger women and of other senior women, i.e, their peers. The grandmother leaders stand out in any community because they are confident, articulate and open to new ideas and they are often looked to for their opinions and advice. For any effort that seeks to promote changes in community health-related norms and practices, these senior women can

play a leading role in motivating others to change. Based on cultural tradition, grandfather leaders are officially recognized, as the village headmen and his advisors, but the grandmother leaders are not. Acknowledging the importance of the grandmother leaders and giving them a specific role in the organization of community activities could strengthen efforts to promote change among other women, both young and old.

Roles of grandmothers and grandfathers are different but complementary
Grandmothers and grandfathers play complementary but gender-specific roles related to maternal and neonatal health at the household level. Grandmothers are the direct advisors of young women and direct care-givers of young children. If problems arise they are the *first-line decision-makers* about what should be done and advise not only younger women but also their husbands and sons. Grandfathers usually play a distant and supportive role as regards issues related to pregnancy and the care of newborns and take on a more active role when extra resources are required. When there are special needs or problems, they are called upon to mobilize resources, transport, etc. The *Agogo Approach* has strengthened the knowledge of both grandmothers and grandfathers and, in so doing, it has reinforced their complementary support for pregnant women and newborns.

Incentives to motivate the *agogo*
The interviews and observations at the community level suggest that the *agogo* have an inherent and strong motivation to participate and to learn about maternal and newborn health. Unlike younger people who may be motivated by material gadgets such as t-shirts, it would appear that for the *agogo*, public recognition of their role and experience, and the opportunity to learn more about maternal and child health may be their strongest incentives for them to be actively engaged in community activities and to share their new knowledge with others in the family and community.

V. Recommendations:

Documentation of all future activities
In the future, the Ekwendeni PHC team needs to document all *agogo* activities to include: objectives; steps; lessons learned/advice for implementing each step in the process; feedback (including quotes) from both community and health outreach workers on activities carried out; and results in both quantitative and qualitative terms. A definite constraint to documenting *agogo* activities in the past was the lack of time to do so. In the future, documentation activities need to be included in the work plan to increase the chances that they will be carried out.

Guidelines for documentation of community activities
It was clear from discussions with the Ekwendeni PHC team that, while they are convinced of the value of documenting the *agogo* activity, it is not clear to them how to do so. It would be beneficial to provide them with simple guidelines on what should be documented and how.

Training of *agogo*
It would be beneficial to provide refresher training to the *agogo* and also to train additional *agogo* who have not already been trained. Factors that should be considered in organizing such training include: 1) deciding whether the number of *agogo* trained from each village should be the same or whether more should be trained from bigger villages and vice-versa; 2) whether the same number of grandmothers (GM) and grandfathers (GF) should be trained or if the proportion of GMs should be greater given their greater direct role in household maternal and newborn care; 3) whether the training for GMs and GFs should be the same length of time or whether GM training should be longer; and d) the need to review and adjust the training content to put more emphasis on topics given less attention in the initial training (such as PMTCT) or on gaps in current knowledge of GMs or GFs (based on results of individual interviews conducted during this assessment or conducted in the future).

Development of a training curriculum
In order to be able to share, or disseminate, the participatory and culturally-sensitive approach used in the *agogo* training with people outside of the Ekwendeni area, it is of critical importance that a comprehensive training curriculum be developed that includes: 1) training goals and objectives; 2) a detailed plan including learning activities and materials and instructions to facilitators for each learning activity; 3) a tool for pre- and post-assessment of participants' knowledge; and 4) a tool for collecting both participant and facilitator feedback on the training. The curriculum should include discussion of facilitator attitudes required for learning from and teaching grandparents. Most health sector staff is not used to working with grandparents and their attitudes toward them are a critical factor in motivating them to learn and to change.

Giving more explicit attention to positive cultural roles and practices
Certainly a major focus of community health programs should be on discouraging harmful practices and promoting acceptance of technically optimal ones. However, at the same time programs should be concerned that they are not only encouraging communities to change their "bad" practices but are also acknowledging and reinforcing positive cultural roles, values and traditions. This is particularly important in the current context of rural Malawi where communities are torn apart by AIDS, where there is widespread poverty, and where traditional values and practices are at risk of being lost. It is critical that programs not only work to improve the physical health of communities but also support their psychological health and their need to feel proud of their cultural heritage and identify. Recognition and praise of their cultural past, roles and traditions can easily be incorporated into the drama presentations and songs. For example, in several places in West Africa, songs of praise of the grandparents and their contribution to families and the younger generation have been developed and have had a very positive effect on elders and young people alike.

Acknowledging and encouraging GM leaders
The *Agogo Approach* acknowledges and involves grandparents as a group and the traditional community male leaders, who are invariably *agogo*, serve as spokespersons for the grandparent group with Ekwendeni staff. While the approach gives official recognition to the male *agogo* leaders, it does not explicitly

acknowledge the less formal, but nevertheless influential, grandmother leaders. Efforts should be made to identify and acknowledge the grandmother leaders in each community and to encourage them to play a more formal role as collaborators of the male community leaders and as intermediaries with Ekwendeni staff. This more "public" recognition will contribute to increasing the importance not only of the grandmother leaders in the community, but of the grandmother groups in general. This should in turn increase their motivation to be involved in community activities to promote priority maternal and newborn care practices.

Role of grandmothers and grandfathers in household and community health promotion

In the *Agogo Approach* community activities were developed for "grandparents" without any attention to the specificity of their roles. In the future, the distinction between the roles of GMs and GFs should be kept in mind in terms of role descriptions, training content and activities developed with the two sub-groups. The greater involvement of GMs in maternal and neonatal health may warrant investing more resources in reinforcing grandmothers' knowledge, for example, by providing more in-depth and longer training for them than for GFs.

Follow up support to drama groups

Available information suggests that the quality of the drama performances is very good and that the drama groups are very motivated. Refresher training of the groups should be anticipated at some point in order to present them with new plays on priority topics not systematically dealt with in the existing ones (on PMTCT, EBF and other topics, to be determined) and to provide additional motivation. It appears that one of the strengths of the approach used to develop the activities of the drama groups is the fact that "standardized" play scripts were developed and taught to them. This approach helps avoid the problem of multiple groups developing performances with inaccurate technical health content.

Guidelines on training of drama groups and techniques for developing plays

As suggested in the report done on the training of the drama groups, it would be useful to develop a "Drama Group User Manual" to enable people in other organizations and places to establish drama groups and to develop education plays. The consultant who coordinated the training of the drama groups could be a resource person for accomplishing this task.

Follow up to ensure technical accuracy of messages being disseminated

It is important that there be a system to ensure that the messages in the songs, dramas etc. are accurate. In one village we observed a drama presentation in which the Kangaroo Mother Care technique was demonstrated, however, a clothed baby was shown being wrapped onto a man's chest, i.e, the importance of skin-to-skin contact was not shown.

Expand song topics
At the same time that the content of the songs is verified to make sure of their technical accuracy, key topics/information that are not yet included in any of the songs should be identified. In addition, it would be very beneficial to develop some "songs of praise" of the grandmothers and grandfathers to acknowledge their important roles and experience and to provide some balance to the other songs asking people to stop certain traditional practices. All of the songs should also be translated into English so that they can be shared with other areas of Malawi (where languages other than Tembuka are spoken).

Additional participatory learning activity: stories to reinforce key practices
The current complementary use of drama, song with dance and the plans for refresher/additional training of *agogo* will all contribute to reinforcing *agogo* learning and adoption of new health practices and norms. An additional culturally-grounded activity that could be developed to further reinforce their learning would be open-ended, or problem-posing, stories used as a catalyst for discussion. Short stories-without-an-ending could be developed by Ekwendeni staff and community representatives, for example, drama group members, along with open-ended discussion questions. These could be used with and by groups of grandmothers, grandfathers, younger women and younger men. Stories and group discussion have proved to be very effective education/communication tools with both grandparents and younger people in other countries. Perhaps the local consultant who trained the drama groups could help organize a workshop in which such stories and questions would be developed.

Health worker training to change attitudes about *agogo*
In many cases, health and development workers who are involved in community programs that promote changes in community practices and norms view grandparents as an obstacle in such programs, assuming that they are opposed to change. Prior to adoption of the *Agogo Approach*, Ekwendeni PHC staff report that they too tended to view grandparents as a constraint rather than as a resource. Anticipating expansion of the *Agogo Approach* beyond the Ekwendeni catchment area, a critical prerequisite for effectively working with the *agogo* is that the health/development workers respect their role in the community and their experience, and believe in their capacity to learn and contribute to promoting positive health practices. Changing health workers' attitudes is a challenging task and a training strategy should be developed that is based on experiential learning and adult education methods to help these workers to reassess their attitudes and approach to *agogo* in the community.

Documenting lessons learned: guidelines for doing so
An important part of documenting community programs is periodically analyzing program strategies, accomplishments and constraints and formulating lessons learned for ongoing/future program implementation. Such "lessons learned" exercises should be carried out periodically to capture the important details of the program implementation experience. The PHC team should be provided with simple guidelines on how to organize/carry out lessons learning exercises with program stakeholders.

***The Agogo Approach*: written and visual guidelines**

To help others to understand and to use the *Agogo Approach*, it would be useful to develop both a written manual that provides guidelines on all principles, steps, constraints and "lessons learned" related to all key elements of the approach. If resources permit, it would also be useful to produce a DVD that presents the principles, components, steps and outcomes of this innovative and promising approach.

Appendix I: Individual Interview Guide for *Agogo*

Individual Interview: Agogo **GM [ ] GF [ ]**

Name of Community ---------- Date: ----------

Name of Village----------

1. When should a pregnant woman have her first antenatal visit? [ ] [ ]

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2. During pregnancy mention at least two danger signs? [ ] [ ]

   [1] [2]

3. What are the two most important things to do with a newborn? [ ] [ ]

   [1] [2]

4. Mention at least two danger signs of a newborn? [ ] [ ]

   [1] [2]

5. When should the baby be given the first bath? [ ] [ ]

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6. Why at that time? [ ] [ ]

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7. How can HIV be transmitted from the infected mother to her baby? [ ] []

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8. How should you carry a premature baby to the hospital? [ ] [ ]

Appendix II:

Table II: Results of *Agogo* Interviews on their Knowledge and Advice for the Care of Pregnant Women and of Newborns

Question Number	Total No. of Grandfathers interviewed	Total % for GFs who answered correctly	Total No. of Grandmothers interviewed	Total % of GMs who answered correctly	Total number of GMs and GFs who answered correctly
(1) Early ANC	38	34/38 89%	76	70/76 92%	97/114 85%
(2) 2 danger signs of pregnancy	38	20/38 53%	76	40/76 53%	60/114 53%
(3) 2 danger signs of newborns	38	13/38 34%	76	27/76 36%	40/114 35%
(4) 2 priority practices w/ newborns	38	21/38 55%	76	35/76 46%	56/114 49%
(5) First bath delayed	38	18/38 47%	76	53/76 70%	71/114 62%
(6) Reason for delayed bath	38	8/38 21%	76	31/76 41%	38/114 33%
(7) 3 Modes of mother-to-child HIV transmission	38	5/38 13%	76	8/76 9%	12/114 11%
(8) KMC for premature baby	38	28/38 74%	76	59/76 78%	87/114 76%

Appendix III.
Key Conclusions of the Rapid Assessment and Lessons Learned & Recommendations
Developed by the Ekwendeni PHC team

Conclusions (That describe strengths/weaknesses/challenges)	**Lessons Learned & Recommendations** (What should be done in the future)
Choice of *agogo* in each village	
- Same number were selected in each village even though the number of *agogo* differs from village to village	-Selection of *agogo* is done at village level based on age (50 years +) however some villages have more *agogo* than the others.
- In some villages many *agogo* were not trained	-Conduct initial training for the untrained *agogo* and refresher courses for the trained *agogo*.
***Agogo* Training: content**	
- No goals and objectives for training have been found	-To include the goals and objectives for the training on the training manual which were omitted last time.
- The content focused primarily on: danger signs of pregnancy and of newborns, ANC, bad cultural practices related to pregnancy and newborns, early initiation of BF and KMC. Topics discussed to lesser extent were: EBF and PMTCT.	-To give more information on EBF and PMTCTT including positive cultural practices.
***Agogo* Training methods used**	
- Participatory approach where participants discussed traditional practices related to each topic and facilitators presented new/modern information. Community members appreciated very much this approach where both they and facilitators were sharing and learning.	-To continue the participatory approach used was **LEPSA** (Learner Centered Psychosocial Approach and Action Orientated) when training the *agogo*.
- There is no document that describes exactly how the participatory approach was used that others could follow to use the same approach	-Participatory approach included discussions, demonstrations, story telling, case studies, role-plays and others though no documented.
***Agogo* training duration**	
- Community members all said that the duration (two days) was too short	-Maximum 10 days.
***Agogo* training curriculum**	
- Facilitators were given a list of topics to cover but a detailed training curriculum was not developed	-Curriculum to be in place when funding is available.
Report/documentation of training	
- No report of the training activity (including lessons learned for future training sessions) was prepared.	-Training report was included in Quarterly reports but separate training reports can be written in future if necessary.

Sharing information learned during training	
- The grandmothers (GM) share their information with other GMs and with young women in the family and neighborhood. The grandfathers (GF) share their information with young men. GFs do not directly advise young women/daughters-in-law.	-Culturally grand fathers do not talk directly to their daughter-In-laws, instead they can talk directly to their sons. Other means of communication will still be available in the community to pass on information to respective groups.
Collaboration between *agogo* and VHC	
-Before *agogo* training, few VHCs had *agogo* members except for village headmen (VHC chairmen). Now almost all VHCs have *agogo* members. "Now the *agogo* and youth are working together."	-To continue strengthening their collaboration through supervision and training.
Collaboration between *agogo* and drama groups	
- Before the *agogo* training all drama group members were young people. This caused many problems because: a) they were talking about taboo topics in front of everyone; b) it was not appropriate for youth to be teaching elders in this way.	-The Drama groups should continue working with *agogo* frequently refreshed together.
- Now all drama groups have some members who are *agogo*. Youth and *agogo* are working together.	-To continue working together.
- **Encouragement/support for *agogo* from village headmen**	
- Encouragement of the *agogo* by the village headmen is an important factor in motivating them to share their knowledge and participate in community activities. Where the village headman strongly supports *agogo* and other community activities they appear to be more involved and have more knowledge of appropriate practices.	-Encourage all the village headman to be supporting the *agogo* activities in their community.
Motivation & capacity of *agogo* to learn	
- In all villages the *agogo* seem to be very motivated to learn. In all villages they said that they want to learn more about maternal and newborn health and about other health topics.	-To include other healthy topics for example family planning in their training.
- In all villages there were testimonials even from very old *agogo*/GMs talking about the practices they have changed.	-To encourage them to continue striking the balance between the harmless and harmful cultural practices.
Supervision/follow-up of *agogo*	
- No supervision of the *agogo* was done. In all communities they said they wished that there had been supervision to encourage them and to "make sure that we are on the right path."	-Make sure all *agogo* are supervised by developing the supervision plan and follow it.
Responsibility for teaching about pregnancy and newborn care	
- In the past almost all people sent for training were young people. The young people were expected to teach the elders. Both *agogo* and younger people interviewed said that the *agogo* did not want to listen to/learn from youth. According to cultural values, if young people try to teach old people they are showing disrespect.	-To continue training both the *agogo* and the youth together for good communication and participation in their villages.
- Now that the *agogo* have been trained they now have the knowledge required for them to play their culturally-defined role as teachers of the younger generation.	-Frequent refresher courses for additional knowledge and skills which should be easily be transferred to younger generation.

Drama groups and performances	
- During the training the outlines for 6 plays were prepared and given to participants. They practiced acting them out. This approach helped ensure that the priority messages on each topic were included in the plays.	-Drama performances harmonized messages said by the *agogo* and fill the communication gaps where *agogo* cannot reach with their messages as they can move up and down with their bicycles.
- Many performances are conducted during outreach clinics. Often the groups of women who attend the dramas are 100 persons or more. In groups this large it is difficult for many of the participants to listen and to learn.	-Drama performances will be encouraged to both outreach clinics and villages levels for effective dissemination of information.
- In the report on the training of the drama groups it was recommended that a "Drama group user manual" be developed that could be followed by these groups to help them develop dramas that are both educational and entertaining. This has not been done yet.	-The drama group manual should be revised to incorporate the needs of the participants.
- The play on PMTCT was very cursory.	-Need for additional training of drama groups in PMTCT.
Use of (thematic) songs	
- Songs on each of the priority topics/themes related to maternal and newborn health were developed during the training of the drama groups and then learned by all of the participants.	-Songs are powerful tools for passing out information to the public.
- Songs are frequently used in communities during drama performances, when meetings are held and at under-5 clinics.	-Songs are powerful tools for passing out information to the public.
- Songs are almost always accompanied by dancing. These methods are very motivating as people love to dance and sing. Also while enjoying themselves the songs facilitate learning.	-Keep it up.
- All of the songs talk about harmful cultural attitudes/practices that need to be changed. No songs have been composed about the positive roles, values and practices in the culture that are valuable and should be preserved.	-Songs reflect both positive and harmful practices but the main emphasis is on harmful cultural practices.
Documentation/reports etc. on *Agogo Approach* and results	
- The available written information on different aspects of the *Agogo Approach* and results is very, very limited. The key principles and steps followed, and the feedback on *agogo* activities received from both community and Ekwendeni staff have not been systematically recorded either.	-This is the first of its kind initiative in the country of Malawi and it has been a learning process for Ekwendeni to involve the *agogo* in the maternal newborn care survival. As a result there has been much on practical than documentary because of limited resources/ literature review.
- Where follow-up visits **were** conducted, with the drama groups, and data was collected on their performance, this data was not systematically analyzed.	-Following the phasing out of first phase of SNL follow up was irregular done because of limited financial and technical support for monitoring and evaluation.

PMTCT	
- When drama groups were trained and songs developed there was less emphasis on PMTCT. The drama performance on PMTCTT & VCT is very short/limited. There are no songs on these topics.	- Under SNL1, PMTCT and VCT were not part of the proposal as a result they were limited messages on these topics.
Role of women *agogo*/GMs in promoting health in the community	
- In all communities there are informal GM leaders who stand out because they are confident, articulate and open to new ideas. While GF leaders are officially recognized (village headman and his advisors) the GMs are not. It would be good to find some ways to acknowledge and strengthen the role of the GM leaders within the GM groups.	-It is the responsibility of each community to designate their leader as so the wish and this can be done informally in their villages.

Appendix IV:

Individuals Interviewed at Ekwendeni Hospital

1. Grace Chunda – Enrolled Nurse/ Midwife
2. Edward Kasonkanji – Clinical Officer
3. Lennah Thole – Traditional Birth Attendant Coordinator
4. Deliwe Msiska – Registered Nurse
5. Elina Mwalwanda – Community Nurse
6. Jane Mwenitete – VCT Supervisor
7. Lean Mhango – Enrolled Nurse/ Midwife
8. Agness Hara – Child Survival Coordinator
9. Dr. Sekeleghe Kayuni – Hospital Director
10. Mr EH Msowoya – Hospital Accountant
11. Mr MJBA Msowoya – Principal Administrator
12. Kistone Mhango – Primary Health Care Director
13. Rose Gondwe – Newborn Health Coordinator
14. Maggie Munthali – Assistant Newborn Health Coordinator
15. Lucy Ngulube – Health Surveillance Assistant (HSA).

Appendix V.

Consultant Scope of Work
CS-22 Malawi

Agogo Club Rapid Qualitative Assessment
Ekwendeni Mission Hospital, Mzimba District

Consultant: Judi Aubel, PhD, MPH

Location: Malawi (Lilongwe and Mzimba District)

Duration: 21 days (includes 14 days in country, 2 travel days and 5 report writing days)

Dates: 4-18 December 2006 (in-country)

Deliverable: Report of *Agogo* Club Rapid Qualitative Assessment, including recommendations for expansion, packaging, and dissemination strategy - in final draft form with all appendices, references, etc. - (due 18 January 2007)

Background information: Under SNL-1 (the first phase of Saving Newborn Lives in Malawi), Save the Children partner Ekwendeni Mission Hospital in Mzimba District developed the "*Agogo* Club" approach as part of its community-level behavior change strategy. This innovative approach

- is assets-based
- engages grandmothers and grandfathers as key development partners
- appreciates the power of community norms
- works with and not against complex household decision-making dynamics
- leverages the considerable social capital of influential elders

Under SNL-1, as part of community mobilization, enthusiastic grandparents – informal and formal community leaders and influentials among them – volunteered and were trained in key maternal and newborn care messages, recognition of danger signs, and evidence-based best practices. These *agogo* then committed themselves to spreading the word, within their own families and communities. Under SNL-1, Ekwendeni trained more than 4,000 *agogo*. Under CS-22, Ekwendeni aims to increase the reach of this approach by doubling the pool of trained *agogo.* We hope to improve, expand, document, and package the approach to promote interest and uptake by PVOs, NGOs, CBOs, and others working in health and other sectors.

Purpose of Consultancy: The purpose of this consultancy is to assist the Ekwendeni to assess strengths and weaknesses of its innovative "*Agogo* Club" approach with a view to refinement, expansion, documentation, and packaging. The final report (deliverable) is to include recommendations that are simple, cost-effective, efficient, and appropriate to the context.

Day 1 (M) – Arrival in Lilongwe
Day 2 (Tu) – Briefing SC/Mw country office & travel to Mzuzu
Day 3 (W) – Introduction to Ekwendeni team/Development of questions to be answered
Day 4 (Th) – Development of data collection tools
Day 5 (F) – Tool development, cont'd.
Day 6 (Sa) – Tool development, cont'd./Exercises to test tools
Day 7 (Su) -
Day 8 (M) – Data collection
Day 9 (Tu) – Data collection, cont'd.
Day 10 (W) – Data collection, cont'd.
Day 11 (Th) – Data analysis
Day 12 (F) – Data analysis
Day 13 (Sa) – Wrap-up and departure/Return to Lilongwe
Day 14 (Su) – Write up preliminary findings (bullets)
Day 15 (M) – De-briefing with SC/Mw and departure

Illustrative questions to be answered:

1. *Agogo* are currently mobilized for multiple activities, e.g., VCT, PMTCTT, newborn health, child survival, etc. How best to integrate and ensure that messages are consistent?
2. What kinds of communication mechanisms could we develop to assist in two-way information sharing?
3. Can *agogo* become less messenger, more decision-maker?
4. What would be the most effective incentive(s) to motivate *agogo* (e.g., ID tags, t-shirts, etc.)?
5. Is the current 2-day training in maternal and newborn health adequate for *agogo*? How could training be structured and improved?
6. SNL-1 ended some 18 months ago. How well have the messages been retained and the "Agogo Clubs" sustained? What is the future sustainability potential?

Appendix VI: References

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