



RAcE Malawi Final Evaluation Results

RAcE 2015 Programme

**Multi-Country Results Dissemination
Meeting**

25 October 2017



RAcE Malawi Final Evaluation Results - Overview

- To demonstrate the plausible contribution of the RAcE project to changes in treatment coverage indicators and estimated mortality change, ICF assessed project and district data, estimated the change in child mortality in RAcE project areas using LiST, and documented contextual factors that may have influenced child health in project areas.
- Here we present findings that answer two evaluation questions:
 - Was there a reduction in childhood mortality, and were the lives of children ages 2–59 months saved, in the RAcE project area?
 - What was the RAcE project's contribution to the estimated changes in mortality?

Summary of Key Evaluation Findings (1)

- Many HSAs do not reside in their catchment areas, some of whom are consequently not trained in iCCM.
- Health surveillance assistants' (HSAs') availability is limited.
- Care-seeking overall did not change over the course of the project (~70%)
- Only about half of all sick child cases taken to an HSA at endline; a majority of caregivers sought care from other providers instead of HSAs.
- HSAs managed more than 1 million cases of malaria, more than 500,000 cases of cough with fast breathing, and nearly 300,000 cases of diarrhea in children under 5 years from 2013 through 2016.

Summary of Key Evaluation Findings (2)

- RAcE supported the introduction of mRDTs and replacement of cotrimoxazole with amoxicillin at village clinics.
- Increases in cases of fever tested for malaria likely due to the RAcE project's efforts to introduce mRDTs at the community level.
- Increases in cases of cough with difficult or fast breathing assessed for high respiratory rate likely due reinforcement via RAcE project's refresher trainings following treatment protocol updates.
- Contributions of other projects* to the improvements in care-seeking and sick child case management are likely small.
- RAcE project facilitated the incorporation of facility-level iCCM data in the district health information system-2, the national health management information system.

*Concern Universal, Population Services International, Save the Children's Quic Study (mRDT pilot)

Estimated Change in Child Mortality in RAcE Malawi Project Areas

- The LiST model estimated results based on the total population in HTRAs of the four original RAcE Malawi project districts at the start of the project in 2013 (1,906,136).
- Estimated change in U5MR in the project area:
 - 6 deaths per 1,000 live births
 - 5 percent decrease in U5MR from 2013 to 2016.

Table 1. Estimated mortality rates modeled in LiST for each project year.

RAcE Malawi	
Year	Under-five mortality rate (deaths per 1,000 live births)
2013	124.26
2014	122.24
2015	120.27
2016	118.54

Estimated Lives Saved in RAcE Malawi Project Areas

- An estimated total of 572 under-five lives saved by pneumonia, diarrhea, and malaria treatment from 2013 to 2016.
- An estimated 216 lives were saved due to treatment provided by HSAs.

Table 2. Estimated number of child lives saved per year by treatment interventions in Malawi project areas

RAcE Malawi	2013*	2014	2015	2016	Total	Percentage intervention treatment by HSAs	Estimated lives saved by HSA-provided treatment
Total lives saved among children 1–59 months (all interventions)	189	292	395	477	1,353		
Intervention	Estimated lives saved						
ORS for diarrhea	0	3	6	10	19	54%	10
Zinc for diarrhea	0	7	15	23	45	52%	23
Oral antibiotics for pneumonia	0	81	167	260	508	36%	183
ACT for malaria	0	0	0	0	0	49%	0
Total lives saved by year	0	91	188	293			
Total					572	-	216

LiST Model Limitations

- The accuracy of the model results is limited by the data input to the model.
- LiST does not account for the mode of delivery or source of care (with the exception of facility birth).
- LiST model does not account for changes in diagnostics, the quality of care, timeliness of pneumonia and diarrhea treatment, nor referrals made or completed.
- Holding fever treatment constant does not account for lives saved by the improvement in malaria case management following the introduction of RDTs and may therefore underestimate the total lives saved by the project.

Plausible Contribution of RAcE

- Observed increases in assessment of fever and cough with difficult or fast breathing are most likely due to RAcE project interventions including contributions to mRDT introduction.
- Other projects in the RAcE project districts may have contributed to the observed outcomes because they supported HSAs' iCCM work through trainings, supervisions, and review meetings, and to broader benefits to the iCCM programme.
- The results from this evaluation suggest that RAcE contributions strengthened the health system and supported efforts promoting HSAs as a source of care available to communities.

Conclusion

The LiST model estimates that from 2013 to 2016:

- 5 percent decrease in child mortality in RAcE project districts.
- Net 3,161 lives were saved among children under five
 - 1,020 lives lost due to decreases or stagnation in intervention coverage
 - 4,181 lives saved due to increases in intervention coverage
- 572 under-five lives (14%) saved by pneumonia, diarrhea, and malaria treatment.

ICF concludes that:

- An estimated 216 under-five lives were saved (5%) due to HSA-provided treatment
- It is highly plausible that the RAcE Malawi project strengthened iCCM services and support.

Acknowledgements

- ICF would like to thank Save the Children and the Malawi MOH for sharing their data, time, thoughts, and experiences in implementing the RAcE project in Malawi.
- We would also like to thank HSAs in Malawi, who work hard to provide services to caregivers and children in communities, and the caregivers who give so much to ensure and improve the health of their children.
- This work was made possible by the WHO through funding by Global Affairs Canada.

Thank You!

