REPORT OF THE PLANNING MEETING ON THE PARTNERSHIP FOR MATERNAL, NEONATAL AND CHILD HEALTH

SUN AND SAND HOLIDAY RESORT- MANGOCHI

16TH TO 19TH April, 2007

Compiled by Dorothy Lazaro

Chair: Jean Mwalabu (Reproductive Health Unit)

The meeting started at 8:50am with a prayer and introductions made. A few changes were made to the programme and that included shifting the presentation on Evaluation plan by Jennifer Bryce from 9:30 am to 3:30pm.

1. Presentation on PMNCH Grant proposal by Bernadette Daelmans

The aim of the grant is to achieve the maximum reduction in maternal, newborn and child health within four years. Grant will benefit three countries of Malawi, Mozambique and Burkina Faso. The specific objectives are:

- To reduce child mortality by 25%
- To provide independent evaluation of progress outcome and impact in implementing country specific plans
- To support rapid expansion of high impact interventions

Principles:
1. Commitment to national capacity building- within national frameworks and under government leadership.
2. Involvement of broadest range of possible actors- leverage additional resources
3. Efforts to promote equity and addressing inequities- Identifying economic and other inequities and addressing them.
4. A phased up approach to scaling up- a few interventions to achieve high impact.

Funding: 7.5 million dollars to be dispersed through WHO, UNICEF and WHO.

Interventions should be those identified in the Child Survival Framework for Africa and those highlighted in the Roadmap for Maternal and Newborn.

Malawi was chosen because of poor child health indicators in terms of both under-five and neonatal mortality and morbidity. For example Malawi has not made any improvements in the area of child nutrition (Stunting has been constant for the past three DHS’s).

Countries are expected to:
1. By 4th month develop a consensus model for implementation
2. By sixth months develop plans and monitoring and evaluation framework including budgets.
3. By 9th month start implementation and quarterly report produced for government and partners.
4. Month 12, 24 and 36 produce summaries of implementation
5. Month 30 plans should include sustained coverage
Next steps:
Summaries the situation and document current coverage
Agree on interventions
Set coverage targets
Set out outputs and inputs target
Assess required costs

2. Maternal and Neonatal Health in Malawi: Presenter Dr. Bailah (RHU)

Presentation started by giving a global picture on issues of maternal and neonatal health with 600,000 women and 4 million neonatal dying each year. In Malawi the maternal mortality ratio is 984/100,000 live births translating to 6,000 deaths each year and 16 deaths per day. The Contraceptive Prevalence Rate of 28%

Contributing factors to maternal deaths:
- Critical shortage of human resources
- Weak political commitment
- Late utilization of antenatal care (ANC) services
- Inadequate financial support
- Low status of women and lack of decision making
- Inappropriate strategies more focus on risk assessment.

Government is focusing more on delivery than antenatal care services, improving availability of Emergency obstetric care, skilled attendance at birth, facility based basic emergency obstetric care (BEmOC) focusing on the six UN indicators and also the comprehensive emergency obstetric care (EmOC).

What next
- Upgrading health centres for BEmOC
- Strengthening partnerships with Christian Hospital Association of Malawi (CHAM) for service level agreements (SLA)
- Review curricula of training institutions to include BEmOC
- Review policies to ensure mid-level health workers e.g. enrolled nurses are able to provide bemoc services
- Strengthen the logistic system
- Behaviour change communication including male involvement
- Strengthen the referral system including use of motor cycle ambulances
- Monitoring and evaluation of national roadmap
- Support Maternal and neonatal deaths audits at health facility and community level
- The Reproductive Health Unit (RHU) has come up with indicators for monitoring the implementation of the road map.

Discussions:
It was emphasized that the ministry does not have an operation plan for the road map because the roadmap is not implemented as a project. The district needs to take the interventions highlighted in the roadmap and integrate them in the District Implementation Plans.

How is the RHU using the results of the Health Management Information Systems (HMIS), it appears the indicators are getting worse- Most of indicators for monitoring the road map are not being collected by the HMIS. However discussions are underway and a meeting has been scheduled to review the HMIS indicators and include those indicators which will be used to monitor the implementation of the Roadmap. The road map also includes indicators for monitoring interventions targeting the neonate.

3. Malawi’s Newborns, Progress, Opportunities and Gaps- By Evelyn Zimba

In Malawi, we do have 22,000 still born in a year and one third of these babies die during labour. There are 16,000 neonatal deaths each year. Well known interventions are being implemented and have reached over 90% of the target population. There has been a steady reduction in under-five and infant mortality rate but there has been very slow progress in reducing neonatal mortality. 26% of under-five deaths are due to neonatal deaths. Most neonatal deaths occur at home and are not accounted for due to delay in recognising problems, financial limitation, lack of transport and delay in receiving care while in the health facility.

50% of the neonatal deaths occur during the first 24 hours with most of the deaths due to prematurity.

**Progress:**
Malawi is almost eliminating neonatal tetanus, has got strong health sector planning processes, high ANC attendance, skilled attendance at 56% but poor post natal care at 9%

**Missed opportunities:**
ANC- Over 90% of women in Malawi attends ANC. This is a missed opportunity for integrating some of the health interventions, more investment in skilled attendance and all facilities that provide emergency care for mothers should also provide emergency care for babies

**Gaps:**
Post natal care is very low, community and family care not emphasized, no extra care for small babies and no adequate treatment for neonatal infections.

4. Independent Evaluation of the PMNCH rapid scale up plans by Jennifer Bryce-
John Hopkins School of Public Health

Presentation based on second objective- refer to first presentations
Why the independent evaluation.

- Countries and partners are demanding proof of the concept, that interventions can be scaled up and can produce impact
- Urgent need to learn about what works in scaling up and in what context
- Independence increase objectivity
- Technical excellence in implementation and in evaluation

Workplan
1. Country assessment including at least one visit to learn about plans including geographical scope of interventions
2. Assess available and planned data and potential country research collaborators
3. Develop series of design options for all countries. Evaluation not ready to start now although the milestone is end of April because the plans are not yet in place
4. Prepare programme and policy
5. Prepare, present and discuss summaries of preliminary results. Team to be involved in annual reviews
6. Compare and contrast finding across the different countries, conduct special studies, respond to questions and prepare and submit manuscripts and other reports.

The evaluation team will work independently but with regular scheduled feedback to implementing team. Implementing teams also need to give feedback to the evaluation team. The first stage will be planning, provision of services, utilization of services, scale-up and then evaluating impact. Through out the whole process the evaluation team will be involved. There has to be a conceptual framework for implementation starting at the national, district and community level.

A team of seven people has been instituted to be responsible for evaluation. The focal people for Malawi are Abdulla Baqui and Robert Black and will work with country research institutions.

5. Main Conclusions Reached in the Initial Discussions in February and Update on Completion of Preparatory Steps- Presented by Dr. Marthias Joshua- Director Clinical services.

Dr Joshua started his presentation by informing members that a Core Group was established by Ministry of Health (MOH) in February 2007 under MOH leadership to plan for the development of the proposal for the partnership. There was a high-level mission that visited Malawi in February to discuss with various stakeholders: The main findings of the mission were:
1. There are many stakeholders involved in the area of maternal, newborn and child Health (MNCH)
2. Programme of Work is available
3. There is predictable funding under sector wide approach (SWAp)
4. There is need to accelerate community-based health services
5. Child, reproductive and maternal health policies and strategies are in place such as ACSD and the Roadmap

Bottlenecks:
Human resource crisis
Limited capacity of planning and management at district level in the context of SWAp
Possible overloading of Health Surveillance Assistants (HSAs) by developing a broader menu of services beyond their capacity
Insufficient supervision for maternal and neonatal services

The grant will be implemented under the SWAp plan of work (POW) and activities will be selected based on Essential Health Package (EHP). The grant will be used to accelerate delivery of a small set of high impact MNCH interventions.

A number of high impact activities at different levels such as national, district and health centre levels. Specific activities for service delivery under Human resource were identified. These are policy and guidelines, in service training, pre-service training, supportive supervision and on the job training.

Under Health system, support issues of health information system including coordination. There is a technical working group on sexual and reproductive health (SRH) but child health is covered by various working groups hence the need to establish a specific technical working group for child health.

Scaling up plans for accelerated child survival and development (ACSD) at district level have been prepared and awaiting costing.
There is need to develop an operation plan for implementation of the road map and Assist district health management teams (DHMTs) to integrate issues highlighted in the road map and ACSD in the district implementation plans (DIPs).

**Way forward:**
Strengthen zonal teams
Participate in the planning and review of the costing of the EHP
Review functions of the HSAs and review the curriculum to cover the new functions
Leverage additional resources
Map the work of partners in MNCH

**Assumptions:**
1. Steady progress in decentralization
2. Steady progress in implementation of the POW targets
3. Steady progress in the implementation of the EHP
4. Assignment of critical areas to different implementing partners

It was agreed that countries can decide on various type of options such as focusing on a number of districts or focusing on a number of high impact interventions and covering the whole country or identifying broad interventions.

**Discussions:**
Districts for implementation are not yet selected but selection will be based on availability of ACSD plans, Chitipa, Dowa and Thyolo will be included as these three districts have already been identified for piloting. Selection will also be based on indicators. Those districts with poor indicators will be given the priority. Government will access the Partnership funds through discrete funding. There is need to have more female HSAs so that they are used for maternal and neonatal health.

6. Report of the Marginal Budgeting for Bottlenecks

MBB is analytical tool for costing, planning and budgeting which has already been used in 20 countries. It identifies high impact intervention. The tool looks at the following:

1. What are the major bottlenecks?
2. How much money is needed and the expected results?
3. How much can be achieved in health outcomes by removing the bottlenecks.

It looks at service delivery mode and service package, family oriented community based services, population oriented schedulable services and individual oriented clinical services.

The bottlenecks are based on availability of commodities, availability of human resource, accessibility, initial utilization, timely continuous utilization and effective quality.

**Discussions:**
The tool is not very clear, who decides on the specific priority areas? How are we going to use this tool and how does this tool link with the impact model tool?

The priority areas identified by this tool are broad hence the need to tease them more,

The last presentation on the Situation of Child Health in Malawi was not ready as a result the meeting finished early at 4pm.

**Report of Day 2: 17th April, 2007**

**Chair: Dr. Marthias Joshua- Director of Clinical Services**
The day started at 8:15am with a prayer

7. Overview of IMCI/ASCD implementation in Malawi presented by Mr. Temani


**WHY IMCI?**
- To do away with vertical programmes
- Parents are the first care givers hence the need to empower them to manage simple conditions at home
- Children present with multiple conditions
- Health care is not only provided by health workers but communities as well

All districts have been covered and they are implementing all three IMCI component but in some districts some traditional authorities (TAs) have not yet been reached. A number of health workers and tutors have also been trained. Implementation is more focused taking consideration of high impact interventions. For example breast feeding will save 13% of the children, ITN will save 12% of the children and ORS will save 14% of the children, complimentary feeding 7%, antimalarials 8%, vitamin A 3%, water, sanitation and hygiene 3%, measles, TT 1%.

The ACSD policy is in place and was launched in November 2006. It is being implemented by various ministries and has the following strategies:

- Home/family and community based interventions
- Home visits by HSAs
- Village clinics by HSAs
- Health facility based interventions
- Mass campaigns
- Community based child care centres

**Way forward:**
There is need for speedy scaling up of all interventions to reach all TAs.

**Discussions:**
The idea of a village clinic came about because a survey conducted in 2004 revealed that 54% of the children were dying before reaching a health facility. The village clinic has assisted to reduce the caseload at health centre. HSAs have been given drugs for one year however these drugs were supposed to be given to the DHOs but during delivery the drugs went direct to the HSAs in some cases. The HSAs are to assist older children and not the neonates. The HSAs are supposed to register neonates and refer them to the next level. There is need for further discussions as to whether HSAs can be allowed to give the first dose of antibiotic at community level before referring the neonate.
Can we learn more about the Village Action Plans- After training the districts take on the role of developing the village action plans.

How are these interventions linked to other interventions on MNH. In the ACSD document the interventions are already integrated, all maternal high impact interventions and child high impact interventions are well articulated but it is at the implementation level where there is no integration.

8. Access Program Support to Malawi- By Sheena

This is a USAID funded global programme on maternal and neonatal health which is being implemented in 16 countries.

The objective of the programme is to expand high impact evidence based interventions in Malawi. The program is still at the planning stage. It will be implemented for 3 years with funding of 2.5 million during the first year and 2 million in the next two years.

The programme intends to work more to expand BEmOC in the country. ACCESS will focus on the following
- Improving availability and utilization of quality maternal and neonatal care including PMTCT.
- Revise health workers curriculum
- Train tutors and lectures
- Provide community based MNH interventions such as (birth preparedness, focused ANC, IPT), Preventing hypothermia, scaling up kangaroo mother care
- Expand post abortion health care services.

Discussions:
This is a very good opportunity for maternal and neonatal health as the PMNCH programme is also focusing on partnerships.

9. Introduction to group work: By Bernadette Daelmans

To develop an implementation plan that takes a phased approach of fast tracking interventions within a broader package of scaling up, taking into consideration of activities already planned by other partners.

Come up with the coverage targets taking into consideration of the current situation in terms of human resources and workload

Come up with some mechanisms of monitoring and evaluation

Main Tasks:
Identify high impact interventions – Not more than 10 interventions
Review current levels of coverage,
Come up with realist targets

Members were divided into three groups of Maternal, Neonatal and Child Health. The group work started at 10:20 am and finished at 1:30 pm

**Plenary Session:**

**Neonatal group**
Nine interventions were identified and these are Hygiene, Early and exclusive breast feeding, temperature management, special care for LBW, prompt identification and management of neonatal sepsis, PMTCT (ARV prophylaxis, resuscitation of asphyxiated babies, post natal check and BCG and Polio.

During discussions the group was advised to look at the targets again.

**Child Health**
Ten interventions were identified by the group and they included ITN, exclusive breast feeding, provision of ORS, immunizations

During discussions there was emphasis on the need for the group to look at the targets again and come up with realistic figures taking into consideration that some indicators were based on behaviour change and may take a number of years before results are realized.

**Maternal Health:**
The group identified 12 interventions such as FP, focused ANC, clean delivery and cord care, skilled delivery, referral system, EmOC, maternal death reviews, PMTCT, management of malaria in pregnancy, ART in pregnant women and post natal care.

During discussions it was agreed that the interventions and the targets were so many hence the need to look at the list again and reprioritize, there is need to look at fast tracking interventions and consider issues of human resources.

Parking issues
1. HSAs are currently referring the sick neonates to the health facility. There is a suggestion to allow the HSAs to administer the first dose of antibiotics before referral. This has a policy implication
2. More HSAs should be recruited to provide Essential Health Care at the community level. There was a recommendation to employ more female HSAs who can provide post natal care at the community level and be able to supervise TBAs.

The day’s deliberations ended at 5:15pm with a prayer

**Report of Day 3: Chair Mrs. Rachel Maganga**
The day started 8:20 am with a prayer and then a recap of the previous day proceedings

10. Introduction of Group work 2 by Dr. Leslie Ngalula WHO AFRO.

- Of the 10 interventions identified yesterday prioritise which ones are fast track and come up with 5 interventions
- Discuss the interventions and
- Enter information in worksheet 3 which is basically looking at the intervention selected, identify the bottlenecks at policy level, health systems, capacity building community level. Identify objective to deal with the bottleneck, activities to be implemented, timeframe, responsible person, cost and source of funding.

Discussions:
The form was seen to be confusing to some and looking at each intervention and analyzing it will take too much time. The MBB already identified bottlenecks, identifying bottlenecks again may be a duplication.

After discussions a new form was introduced to the participants. Participants were asked to go back to groups, identify 5 interventions and complete a new form highlighting the following: interventions, objectives, indicators, baseline, activity, leading agent, funding source and cost.

Plenary:
The plenary started at 4:15pm.

Maternal Health Group.
The group identified the following priority areas:
1. Focus antenatal care: Activities included creation of awareness among women, men and community leaders on importance of birth preparedness, training providers in counseling including PMTC, develop and disseminate IEC materials.
2. Family planning focusing on young people. Activities include provision of YFHS, training of providers, training of peer educators and CBDAs and IEC.
3. Skilled delivery care: Activities include advocating for the implementation of the human resources plan, procure drugs, equipment and supplies, train and refresh health workers in life saving skills, develop systems to ensure 24 hour coverage of maternity services, sensitize communities on the importance of skilled attendance and the need for pregnant mothers to report early for delivery.
4. Emergency Obstetric care services: Activities identified include review and revise the Essential Drug List and equipment for BEemOC, train nurse technicians in emergency obstetric care, Review and revise pre-service curriculum, procure communication equipment, renovate health facilities, procure motor cycle ambulances, strengthen maternal death review at both health facility and community level
5. Post natal care: Activities are- sensitize women on the importance of post natal care, orient health workers on provision of post natal care, integrate post natal care in EPI services, provide prophylaxis to HIV+ women.

Discussions:
The group has come up with many activities hence the need to look at the activities again and come up with focused activities. The group was also requested to consider what other sources of funding are available. However, the group responded that the activities are interrelated hence the need to include them all.

Focused ANC is based on four visits but this is for a mother with no complications however women with complications will require more visits.

Some targets are very modest for example in 3 years we should be able to provide oxytocin in more than 30% of the health facilities.

ITN is also important, the group may consider including ITN as one of the activities.

Neonatal Health Group
The group identified the following interventions
1. Prompt identification and management of neonatal sepsis. The identified activities are quality improvement of pediatric care at health facility, procurement and distribution of antibiotics and related supplies, up date and print IMCI manual and guidelines for HSAs, train HSAs, pilot recognition of danger signs and administration of IM antibiotics by HSAs.
2. Special care of pre-term and low birth weight babies: Proposed activities are training HSAs to identify LBW babies, procure equipment such as sorter scales and thermometers. Train health workers in the management of LBW babies, train in kangaroo mother care (KMC) and initiate KMC in 80% of hospitals.
3. Resuscitation of asphyxiated babies. Activities are training of health workers, procurement and distribution of equipment and supplies.
4. Early initiation of exclusive breast feeding. The activities are support scaling up of BFHI, training in BF and HIV and infant feeding and establishment of support groups.
5. Post Natal care. Activities are: Develop training package for HSAs, train HSAs, pilot home visits by HSAs, issue circular on post natal care

The group also identified cross cutting issues such as behavioural change communication (BCC) (IEC materials, community dialogue and mass campaigns) and male involvement.

Discussions:
Why are we not covering 100% of health facilities with KMC since this is a simple intervention? The group was considering the fact that there are a number of activities that need to be implemented hence the need to put it at 80%.

Currently HSAs are not giving antibiotics at the community level hence the group put a baseline of 0% since this is an intervention that has not yet started.
What about provision of a kit to HSAs for resuscitation. This has been discussed and agreement has been reached that HSAs should not receive the kit because resuscitation is a very complex activity which needs trained health workers.

**Child Health Group:**
The group identified the following interventions:

1. Oral rehydration therapy. Main activities are procurement of supplies, establishment of more village clinics, recruit, train and procure drugs and kits for HSAs, train health workers in management of rehydration.
2. Breastfeeding. Train extension workers, increase BFHI, establish support groups, IEC on breast feeding.
3. ITN use. Activities include BCC, quantify requirements, procure and distribute nets, conduct re-treatment campaigns annually.
4. Malaria treatment. Activities are sensitize communities on the new malaria drugs, quantify and procure drug, train health workers in management of severe malaria
5. Treatment of pneumonia with antibiotics. Activities are train health workers in IMCI, recruit and train HSAs, quantify and procure cotrimoxazole, monitor supply chain, train health workers in standard case management
6. Immunizations. Strengthen IEC, improve cold chain, recruit and train more HSAs.

**Discussions:**
There is need to be specific on nets. The nets come with different prices depending on whether they are treated or not.

There also need to think about provision of health passports. Sometimes Ministry is not able to provide them. This is related to the provision of immunization.

Did the group think of provision of community based therapeutic care considering that the figures for malnutrition are quite high. The group was also asked to consider inpatient paediatric care.

There are so many activities that will be implemented by HSAs however we are aware that there are no health workers to supervise the HSAs. Are we thinking of who is going to follow the HSAs after training?

**Day 4: 19th April 2007 –Chair Mr. Edwin Nkhono**

The day started at 8:40am with a prayer and members were requested to go back to their individual groups and come up with the following:

1. Incorporate comments made by the larger group
2. Include the time line and
3. Discuss the next steps.

**Next Steps**
1. The following people should be added to the Core group: Dr. Joshua, Mrs. Maganga, Mrs. Lucy Kachapila and Mrs. Diana Khonje
2. The Core group to critically look at the document prepared and merge the components, cost the interventions by 15th May
3. divide the task among members or hire a consultant to finalise the document
4. Identify activities that can be implemented at national level such as health system, monitoring and evaluation
5. Identify coordination mechanism for the partnership including the flow of funding. The funds will be released as soon as the plan is available and approved.
6. Discuss how this programme will be linked to the SWAp review process. There is a suggestion to have meetings twice a year and SWAp also has meeting twice a year. There is need to link these two.
7. Identify districts where the partnership funds will be utilised
8. Partner mapping exercise, discuss how this should be done
9. Conduct a stakeholders meeting on 22nd May 2007
10. Submit the plan to the partnership by 25th May 2007.

**Day 5- 20th April 2007: Debriefing meeting at WHO**
A presentation of on the discussions that took place in Mangochi was made with the following Next steps:
- Map available partners and resources, and identify resource gaps
- Document the current epidemiological trends
- Agree the format of the implementation plan, quantify activities, and develop draft plan according to key objectives and with clear timelines
- Include activities of programme management, monitoring and evaluation
- Cost the plan
- Set criteria for selecting districts and orient district managers
- Identify the activities to be funded by the grant by Mid May when Malawi will be going to the World Health Assembly
- Start design of the independent evaluation
- Develop full grant proposal
- Conduct stakeholders meeting and
- Submit proposal for funding.

A discussion on how funds will be distributed revealed that UNICEF was to get 40%, WHO 40% and UNFPA 20%. But it was mentioned that this will depend on the planned activities.

The UN felt that WHO could coordinate the UN agencies during ‘project’ implementation at country level as the organisation is secretariat for the ‘project’ and team leader of the UN Health Group.

**Debriefing at Ministry of Health**
The presentation was the same as the one made at WHO. Key issues discussed were as follows:

- Malawi is implementing a SWAp so interventions to be implemented should cover the whole country.
- There is need to include child health interventions in the Service Level Agreements that are being signed between district health officers (DHOs) and CHAM institutions

### Names of participants

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<td>28</td>
<td>Ms Alleta Mphisa</td>
<td><a href="mailto:alletamphisa@yahoo.co.au">alletamphisa@yahoo.co.au</a></td>
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