


2018 MUTAMBARA MOTHER AND CHILD SURVIVAL PROGRAMME EVALUATION REPORT



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List of Acronymy

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Anti Natal Care
DDF	District Development Fund
DHO	District Health Officer
DMO	District Medical Officer
EPI	Expanded programme on Immunisation
FANC	Focused Antenatal Care
FGD	Focus Group Discussion
GoZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
KII	Key Informant Interview
MCHC	Maternal and Child Health Care
MCSP	Mother and Child Survival Programme
MOH	Ministry of Health
NHS	National Health Strategy
TBA	Traditional Birth Attendance
UMCN	United Methodist Church Norway
UMCZ	United Methodist Church Zimbabwe
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
SDG	Sustainable Development Goal
WATSAN	Water and Sanitation

Executive summary

The 2018 Mutambara Mother and Child Survival Programme (MCSP) endline evaluation was commissioned by the partnership of United Methodist Church in Zimbabwe and the United Methodist Church in Norway. The evaluation has its directive to establish if the programme had managed to achieve its set goals, been able to impact and transform the health and well-being of the communities it served in the 18 years that the programme has been in existence.

The Mother and child survival programme was established almost two decades ago, empowering communities and households to participate in the health care and nutrition of mothers, newborns and children. This was a logical way of enhancing the provision of health care, especially in communities where basic primary health care and environmental services are lacking. The programme has managed to penetrate in areas that were inaccessible, distant from health facilities bringing health care to the people. The main successes of the programme include; decentralization of health services, community empowerment, community participation, and ownership.

The UMCN provided financial support to the MCSP for 18 years. Looking at the achievements against the budget it is evident that the programme was efficiently run with a primary focus on delivery. The programme started with 6 outreach points in 2001. Key activities in the early life of the programme included growth monitoring for under-fives, health education for mother and caregivers as well as support for home-based care volunteers. By 2018 the outreach point had increased from 6 to 13 and reaching in some beyond the Mutambara mission hospital catchment areas with 106 trained caregivers. Between 2012 and 2017, 29 546 immunisations took place and 33 099 children attended to for growth monitoring under the same period. In 2017 alone 3 117 children under 5 were attended to during outreach and growth monitoring, 869 clients received VCT service at hard to reach outreach points and 357 visits done by the programme staff to home based care clients.

The enduring legacy of the programme, as far as the evaluation would establish, will be the institutionalisation of the community volunteer caregivers as well as the public health education programme. The evaluation established that the community based participatory recruitment process of caregivers was the key driver in selecting the calibre of passionate and genuinely dedicated caregivers who have vested interest in the health of the communities. The evaluation also revealed that the programme had to a significant extent contributed to the reconfiguration of relations and gender roles. Evidence from the study shows that both women and men have benefited with regards to shift in perspectives towards gender roles and inclusive participation. The most significant change has been amongst the female caregivers. Statements like 'increased confidence', 'improved decision-making capabilities', 'improved perspective' and 'changed mindset' were used by the caregivers to describe their experience in the programme.

Introduction

The UMC in Zimbabwe in partnership with Digni and the UMC in Norway started the Mutambara Mother and Child Survival Programme in 2001. The programme has been running for the past 18 years with this year marking the withdrawal of the financial aid by Digni and the UMC in Norway. The programme mainly concentrated on providing primary health care to expecting mothers, children under the age of five and home-based care patients especially those affected by HIV/AIDS through outreach. It also had an extension that catered for orphans and vulnerable children and WASH initiatives. Over the years the programme brought significant change as far as the above-mentioned issues were concerned.

In September 2018 the United Methodist Church in Norway who are the funding partners of Mutambara Mission Hospital, Mother and Child Survival Programme commissioned an endline evaluation. The purpose of the evaluation was to establish the impact that the activities carried out under the partnership has had on the Mutambara community. This evaluation is the third evaluation and is important in that it will make a determination of the value of the contribution by the UMC Norway partners.

This is an endline report assessing the delivery mechanism, the extent to which the Programme realised its set goals, spin-offs from Programme implementation as well as make some recommendations for the future.

Background

Maternal mortality ¹is a global concern and a consensus has been reached that the health of mothers and children is an important indicator of national health and the socio-economic development of countries. In 2000, the reduction of maternal mortality was adopted in the global action plan under the Millennium Development Goal (MDG) now known as the Sustainable Development Goals (SDG). The Partnership for Maternal, Newborn and Child Health and the Countdown to 2015 initiative, which track health systems and policy environments for improving maternal, newborn and child health have put maternity protection as part of global and national initiatives for improving maternal and newborn health.

A number of global initiatives seek to promote government leadership and inter-sectoral action for protecting pregnant and breastfeeding women and their infants, providing a strong call for collaboration between actors in health and labour sectors. Despite the commitment and achievement under Millennium Development Goals, maternal mortality remains unacceptably high in many parts of the world. In 2010, an estimated 285,000 maternal deaths occurred globally marking a decline in maternal mortality ratio (MMR) of 47% from the 1990 levels. Maternal health and well-being of newborn babies continue to be on the limelight of global development agenda. The Sustainable Development Goals successor to the MDGs continue to push for improved well-being of regardless of economic status, gender and other discriminators.

¹ Maternal mortality, is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management, is hard to measure in the absence of a complete registration of deaths and accurate ascertainment of cause of death.

However, the decline has not been uniformed across the globe as Sub-Saharan Africa shoulders over half (56%) of the maternal mortality burden. For every woman who dies, roughly 20 suffer serious injury or disability. Babies and young children who have lost their mothers in childbirth are up to ten times more likely to die prematurely than their peers. Inequities and challenges such as armed conflict, natural disasters, and HIV/ AIDS hamper progress, with child and maternal mortality concentrated in the world's poorest countries, primarily in sub-Saharan Africa and South Asia. Zimbabwe is ranked among the 40 countries in the world with high MMR of over 960 maternal deaths per 100,000 live births.

Zimbabwe managed to make remarkable progress during the first decade of independence in improving access to health services through the Primary Health Care approach, which enabled access to basic health care services for about 85% of the population, resulted in a 20% decline in mortality rate.² Unfortunately, the country then failed to sustain this progress. As a result, the country has not made any progress from the 1990 MDGs base year maternal mortality levels. This is partly due to the prolonged political and economic crisis in the country and has been exacerbated by the HIV/AIDS epidemic for the last two decades. It is estimated that around 3000 maternal deaths occurred in Zimbabwe in 2010.³

It is within this context that the Mother and child survival programme was implemented and initiated. The Programme concentrated more on improving the health of pregnant mothers and children under the age of five. The Mother and child survival Program in partnership with the Ministry of health and childcare tackled these challenges head-on through the outreach program, a community initiative designed to promote community-based child and maternal health. Grounded in the philosophy that health is a product that can be produced by individuals, the Mother and child survival programme empowers communities to make informed decisions about their own health by equipping them with appropriate skills and knowledge.

² UN in Zimbabwe Issue Paper Series - Paper I; Maternal Mortality in Zimbabwe Evidence, Costs and Implications, (2013)

³ UN in Zimbabwe Issue Paper Series - Paper I; Maternal Mortality in Zimbabwe Evidence, Costs and Implications, (2013)

Programme Goals and Objectives

Goals:

- a) Improving the overall health status of the people in the Mutambara area of Zimbabwe.
- b) Empowering communities to take charge of their health as well as their lives through economic development, better nutrition, sanitation, and general education and awareness.

Objective:

- To improve the health situation of children below five years of age, pregnant mothers and the lives of people living with HIV particularly, patients and orphans.

Key interventions

An overarching aim of the Mother and child survival programme is to increase the potential of the local population to access health services and interventions. In addition, the programme managed to accelerate advances in behaviour change, improved health care practices and health care seeking. The programme has also achieved in empowering the communities and households to seek quality health services. Decentralization of health services and community penetration by the programme is one activity that has allowed the programme to reach and obtain its desired goals and objectives.

Objective of the study

The purpose of the evaluation was to assess the degree to which the Programme has fulfilled its planned goals and achieved planned levels of impact and explore the outcomes and impact of the programme. The evaluation would document lessons learned from the Programme to inform future projects in relation to mother and child health. In this regard, the study sought to address the following key objectives:

- i. To evaluate the extent to which the programme has contributed to changing lives of the participants using indicators in the terms of references.
- ii. To evaluate the extent to which the has MCSP contributed to increased capacities of the community health workers and in case management and Home Based Care (HBC) support and access to services by the most vulnerable groups i.e. women and children.
- iii. Evaluate the prudent use of resource and the processes that were employed to turn resources into outcomes.
- iv. Evaluate the sustainability of the programme post its lifespan and also assess how cross-cutting issues such as gender and women empowerment and environment were incorporated in the project.

With the Programme coming to an end this December 2018, UMC Norway commissioned a research team to carry out an end of term evaluation in accordance with conditions set out in the approved proposal document. The evaluation was carried out in September 2018 as part of the Programme reporting requirements. In the process leading to carrying out the evaluation, the research team developed terms of reference, a step which was followed by the design and development of data collection tools.

This report presents the findings from the end of term evaluation of the 18-year project. The report structure comprises of a brief background to the project, the methodology, research findings, conclusion and recommendations.

Purpose of evaluation

2018 marks the end of the Programme with a final evaluation with other evaluations have been conducted in 2007 and 2012 where recommendations and lessons learnt were used to develop the current programme which is coming to an end in December 2018. The United Methodist Church Norway commissioned an independent consultant team to conduct an end of term performance evaluation of the Mother and Child Survival Program. The evaluation sought to assess whether MCSP achieved its objectives and planned outputs as stated in the MCSP agreement's program plan, and also to determine the level of achievement of Programme objectives, strategies, identify best practices, lessons learnt, weaknesses, strengths and recommendations. The evaluation was aimed at broadly assessing the relevance, effectiveness, efficiency, effect/outcomes and sustainability of the Programme interventions and strategies.

Specifically, the final evaluation was conducted in order to:

1. Determine the extent to which the Programme has achieved its objectives.
2. Identify the constraints and challenges faced by the project, lessons learnt and good practices.
3. Assess the extent that gender was mainstreamed in the Programme and suggestions for improvement
4. To determine the effectiveness of the project.
5. To come up with recommendations that could be explored to further strengthen similar projects in the future.

Methodology

This chapter discusses the methodological framework that informed this report. It also discusses the research methods employed as well as an assessment of the efficacy, limitations and practical utility of each method. Different methodologies and methods of data collection were used for the purpose of gathering information which is essential to the understanding of the outcomes of the programme. Though qualitative methodology was the main data collection method used, both qualitative and quantitative methods were used. Unavailability and missing of crucial records and statistics made it difficult to rely more on quantitative data.

Focus Group Discussions

The assessment held four FGD sessions. The participants at the FGD were mainly beneficiaries especially women who have received antenatal and growth care, traditional leaders, caregivers both male and female, trying to understand realities experienced by either male or female considering that traditionally caregiving is perceived as a low-level female role. Gender-specific experience of caregivers, the Programme in its first ten years recruited only one man and after that man was recruited, it seemed as all cultural barriers had been broken and it managed to recruit more men. FGD sessions were facilitated using an FGD guide which focused on relevance and perceptions of the participants viz a viz the programme. The discussions being informal gave participants the chance to air their views and perceptions open and freely.

Key Informant Interviews

Interviews were held with key informant stakeholders. Those interviewed included the Mutambara Mission Medical Superintendent and the programme coordinator. The interviews were facilitated by a KII guide that focused on the following:

- a) Overview of the programme operations, its achievements and the lessons learned
- b) Programme efficiency and effectiveness
- c) Perceptions of sustainability

Reviewing Available Statistics

A desktop review of available statistics, evaluation and assessments reports was also conducted. Baseline Reconstruction Report for the period 2000, internal assessment, Mother and child survival programme, Mutambara Mission hospital report 2017 and Mutambara Mother and Child Survival Training, Zimbabwe, Programme Evaluation 2012 were reviewed for the purpose of gathering data for this report. The main objective of reviewing these documents was to have an overview background understanding of the programme noting its successes and failures over the years checking if recommendations from previous assessments were endorsed.

Sampling

The study used purposive sampling. The idea was to get a select group of people with varying experiences and relationship to the MCSP. The study covered programme caregivers, local leadership structures, programme, and Mutambara Mission Hospital staff and funding partners as well as the UMCZ district and local leadership. The study selected 5 out of the 13 main outreach points and at each outreach point focus group discussions were held with groups of caregivers, beneficiaries especially mothers and HBC clients, community leadership (both traditional and elected). The study then held KII with the programme staff, hospital medical superintendent, hospital administrator, the matron, the District Medical Officer, representative of UMCN and the station chairperson.

Literature review

The Assessment data gathering process started with the review of Programme literature. The assessment reviewed the Programme documents i.e Programme proposal, annual narrative reports for 2012 to 2017 and the Baseline Reconstruction Report for the period 2000. The literature review also looked into the national demography and health survey 2014 and other relevant public health literature in Zimbabwe

Findings

This section presents and discusses the findings of the evaluation in accordance with the expectations as spelt out in the terms of reference and guided by the Ethical guidelines for Digni, Criteria for evaluating development programmes as well as according to the Empowerment Assessment Tool. The results of the MCSP end of term evaluation were assessed in terms of their relevance, efficiency, effectiveness, impact, empowerment and sustainability in relation to the implementation of the project. Cross-cutting issues of gender and environmental sustainability were also considered during the evaluation while lessons learnt and recommendations are presented in the relevant section.

The context of the programme

The goal of the programme: “To improve the overall health status of the people in the Mutambara area of Zimbabwe” is highly relevant in a context where maternal and child mortality is among the country’s health needs. Firstly, it addressed priority HIV & AIDS needs of people as informed by empirical evidence gathered through extensive literature review and baseline survey whose results had indicated among other factors, limited knowledge pertaining to HIV and Aids, limited access to health services and health challenges being faced by communities especially women and their children. The programme was implemented at a time when Zimbabwe was battling with the economic meltdown that had seen a near collapse of health and social services. There was, therefore, an apparent need to scale up health-related, growth monitoring and AIDS prevention & support programmes targeting and placing children and women at the forefront. The MCSP is also aligned to government development agenda and national health priorities which include Zimbabwe HIV and Aids Strategic Plan 2006-2010 and the National Health Strategy for Zimbabwe 2016-2020 whose vision is to have the highest possible level of health and quality of life for all its citizens.

The programme fits well into these frameworks as its mandate is to bring health services, education, and awareness to the community deterring all barriers that might hinder rural women to have access to better quality maternal and child health care. Through the programme, women were encouraged to seek maternal and child health care to avoid maternal and child mortality. The programme aimed at educating women about the importance of delivering at health institutions. From the interviews conducted during data collection, participants noted that they have been a significant reduction in child and maternal mortality as well as home deliveries. The programme has managed to provide community-based health care.

Design of the programme

The end line findings further established that the MCSP activities were well aligned and in sync with the national priorities efforts in addressing health challenges and ensuring health services to for everyone especially women and their children. The interventions have also been consistent with country needs, especially the health sector priorities and addressed the HIV& AIDS-related challenges which the people of Chimanimani district were facing. More so the Programme aligned itself to the Ministry of Health (MoH) strategy of ensuring good health for mothers and their children. The Programme was designed to contribute to country-level efforts towards enhancement and attainment of Sustainable Development Goals (SDG) especially goals 3 and 6 which promotes good wellbeing and water and sanitation for everyone. This was largely addressed through the immunisation, growth monitoring, Ante-Natal Care (ANC) family planning outreach and WATSAN component of the project.

Programme Strategy

The approach and the strategies adopted by the Programme have been satisfactory and this made the Programme relevant from various angles. From the community perspective, the objectives of the Programme were extremely important in linking community and facilities to reduce maternal, neonatal and child health. From the perspective of the District Medical Officer (DMO) this Programme was also found relevant. At the national level, the design of the Maternal and Child Health was consistent with epidemiological evidence for achieving maximum impact.

The programme is in line with Maternal and Child Health Care (MCHC) -related programmes which the government through the Ministry of Health is spearheading. Prior to the project, some of the community members had limited access to health services, but the coming on board of the MCSP made access easy. According to the three delays model, barriers to utilizing maternal and child health services occur at three levels: (i) Seeking care, (ii) Reaching the health facility and (iii) Receiving appropriate care at the facility. The Programme addressed gaps and weaknesses within the Chimanimani at each of these levels. Furthermore, the Programme introduced outreach centres in hard to reach areas. Community members who were almost dying in their communities had easy access to services through the availability of a vehicle to carry them to the hospital to access medication and back home, this support was mainly extended towards pregnant women and home-based clients. The main strategy used to address barriers in reaching a health facility and receiving appropriate care at a facility, was capacity building of village health workers and caregivers to enhance their capacity to deliver when dealing with clients.

Programme Relevance

This was assessed in terms of the appropriateness of Programme objectives to the problems that the Programme was planned to address as identified in the reconstruction baseline study. The Programme has been in line with local beneficiaries' requirements, country needs, health sector priorities and policies. This also involved the quality of Programme preparation and design in terms of logic and completeness of the Programme planning process.

An assessment of relevance cannot be complete without contextualising the Programme– reviewing key issues that triggered the project. Of significance in the evaluation was to find out whether the participants could identify the problems they themselves faced, which the Programme was seeking to address. To address the key issues in relation to the relevance of the programme, the evaluation unpacked relevance in relation to,

- a) The needs at the community/ beneficiary levels
- b) The policies and priorities of the Government of Zimbabwe health-related initiatives
- c) The Programme design (Did we do the right things well?)

The evaluation established that the Programme is timely and relevant in various ways as indicated in sections below, as a summary of the information derived from the key informants and through FGDs.

Relevance of Interventions

MCSP interventions have been consistent with local beneficiaries' requirements. For example, the need to provide quality services to underserved Mothers and their children. During FGD, females and males respondents were asked their level of satisfaction regarding the various programme services they used which included ANC, delivery for women and Growth Monitoring during the Programme period. The main reason for satisfaction with delivery services mentioned by the women was competency and the quality

of care received at the facilities during outreach or hospital visits, which was exhibited by Programme staff. More so the ability of the Programme to respond positively to their health-related needs especially to the demands of HIV and AIDS. However, while analysing the sex-disaggregated data, it was observed that there are slight differences in the level of satisfaction between women and men. Men expressed dissatisfaction in the long queues they have to stand so that they access services at the mission hospital.

Table 1 Summary of findings

Activities	2012	2013	2014	2015	2016	2017
Immunisation	8308	7429	5102	2859	2852	2996
Home visits	71	71	97	183	152	32
Growth monitoring	10210	6871	5611	4061	3228	3118
Antenatal care visits	135	179	271	170	-	-

Intervention towards HIV/AIDS & other chronic diseases

The Programme responded to the HIV /AIDS that the communities were battling with. Baseline survey established that the prior to the Programme people were dying due to HIV/AIDS as the majority people did not have information, knowledge levels were very low and people in the community were in denial and did not easily accept that there was HIV/AIDS that was affecting people. Then, Mutambara Hospital did not offer any testing services for HIV. The MCSP came at the right time with critical services to ensure that lives are saved. During outreach services, the Programme availed a Voluntary Counselling and Testing facility where community members were encouraged to be tested. In 2017 alone 869 clients (59 males and 810 women) received VCT services at outreach points. Anecdotal evidence showed that there was a decrease in the death related to HIV and AIDS and this can be attributed to the MCSP. As value addition from UMCN, orphans and vulnerable children and children who had lost their parents due to HIV/AIDS were supported with a separate scholarship programme where they benefited through payment of school fees, uniforms and stationary. This enabled children to access their right to education.

Interview with a Key Informant who is a nurse's aide echoed the sentiments shared by others pertaining to the relevance of the Programme and revealed that prior to the project, children were dying as a result of communicable diseases. 'Within the project, we have a WASH component which started in 2014 as a result of communicable disease outbreak that were recorded. I can say that the WASH component of the Programme was adaptive and responsive to issues that our communities were facing.

Overall, the evaluators concluded that the Programme was highly relevant to the needs of the target groups and was aligned with national policies and Ministry of Health mandate of ensuring health to all. The table below shows the number of HBC clients over the years with some improvements from those who progress from being bedridden.

Table 2 HBC Clients 2012 - 2017

	Bedridden	home bound	mobile
2012	14		10
2013			
2014	8	71	34
2015	53	54	50
2016	3	13	20
2017	7	9	6

Decentralization of Health Services

As the Programme marks its 18th year of operation this year, it has successfully managed to decentralize maternal and child health care. From the Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS), we know that about three quarters (73%) of all maternal deaths are attributable to the three delays namely: (1) the delay in deciding to seek health care services (56%); (2) the delay to reach a health care facility once a decision to seek care has been made (5%), and (3) the delay to access care at the health facility (11%).⁴

Further, the findings indicate that the risk of maternal death increased significantly by delivering outside institutions, operative delivery, delivery by non-skilled persons and belonging to the Apostolic faith religious groups. Affiliation to the apostolic faith (which constitutes about 33% of the population) has been linked to the limited use of modern health care facilities as a result of the teaching, doctrine, and regulations of the ultra-conservative apostolic groups in Zimbabwe.

The Mutambara rural community is not immune to the above-mentioned disadvantages. According to the data collected during FGD's the caregivers noted that prior to the programme they were high rates of home deliveries due to lack of financial resources and the three delays mentioned earlier on. While a baseline figure was not available corroborated evidence revealed that the last recorded home delivery was in 2012. By decentralizing health care services, the Programme has managed to combat maternal mortality. According to the MSCP staff and the Hospital there has not been any recorded unattended births or home deliveries in the last 5 years. Decentralization of health services also comes with education and awareness which have contributed to empower and enlighten rural women to understand and appreciate the importance of seeing health care during pregnancy and even after pregnancy. One caregiver noted that due to lack of knowledge some pregnant women hesitated to visit the hospital in fear of accumulating hospital bills. After being asked how the programme has benefited the community here is what one caregiver had to say;

“Most women now understand the importance of giving birth in a hospital. Before the programme people wouldn't go to the hospital because of lack of financial resources. But now women go to the hospital because they have been educated and made aware that maternal health is free.

⁴ Zimbabwe Demographic Health Survey 2010/11

Decentralization of health services has helped in encouraging women to attend antenatal classes at an early stage because we would tell them that if you register early you will not pay for your maternal health."

Decentralization of health services has not only brought health care to the community but it has also brought health education and awareness. Decentralization has also ensured that children under five complete the full course of immunizations. Prior to the programme, due to the long distance between Mutambara Mission hospital and the villages, most children would not attend all recommended baby clinic visits as their mothers would hesitate to walk the long distances

The evaluation team also sought to assess the extent to which the Programme approach, objectives, expected results and strategies adopted by the Programme have been achieved and satisfactory over the 18 year Programme implementation period. The assessment team established that interventions and the strategies that have been employed by the Programme are not only relevant as mentioned in the sections above but also effective in delivering the desired results as per Programme targets. The Programme has generally performed well in terms of providing outreach services (immunization, growth monitoring and health education) to hard-to-reach areas among other components.

Antenatal Clinic Attendance by Pregnant Mothers

The Focused Antenatal Care (FANC) strategy which seeks to promote the health of mothers and their babies through targeted assessments of pregnant women, recommends a minimum of 4 visits during every pregnancy during which a pregnant woman undergoes a comprehensive physical examination to determine her physical state and that of the unborn baby. During the evaluation, the mothers were asked to report whether they attended the antenatal clinic (ANC) during their last pregnancy. FGD with pregnant women at Mutsiyabako outreach point established that the majority of women attended ANC as per requirement. This they attributed to the outreach services that were provided by the project. Mutsiyabako outreach centre is one of the furthest centres where people walk 18 kilometres or a 5 hours journey on foot to access the health services at Mutambara Hospital on foot and if they have to use alternative transport they have to hire a car at the cost of \$60. The women further revealed that though they stayed far from the hospital, the Programme made deliberate efforts to ensure access to ANC service during the outreaches that are done in the communities. Only a few women who were reported not accessing ANC services. While reasons for not receiving ANC service vary, the end line aimed to identify common reasons for not receiving scheduled ANC and these were due to lack of financial resources to pay for either transportation to access the services itself (in cases where clients preferred the hospital as compared to the outreach). This was followed by limited knowledge regarding the importance of ANC as well as ignorance which was said to be common amongst the apostolic sects prompted by their religious beliefs which do not encourage utilisation of health facilities.

Child Immunization

Child immunization is one of the key strategies for reducing infant morbidity especially in relation to immunizable diseases namely: tuberculosis, influenza and polio. The evaluation established that a lot of children received some immunization as compared to the years 2000 and beyond where immunization was very low and mothers only concentrated on getting BCG. Interview with the DMO revealed that the immunisation programme covered 100% and this he attributed to the outreach programme spearheaded by the Programme team and the importance that the mothers were now attaching to immunisation. While immunization statistics from 2001-2011 could not be established, the desk review showed that a total of 29 546 immunisations took place between 2012 to 2017 as shown in the table below

Table 3 Immunisation 2012 - 2017

	2012	2013	2014	2015	2016	2017
BCG	473	83	26	11		5
POLIO1	510	234	97	45	58	48
POLIO2	579	388	197	107	112	94
POLIO3	494	452	257	119	133	124
PENTA1	575	234	97	45	58	48
PENTA2	574	388	197	107	112	94
PENTA3	503	452	257	119	133	124
PCV1	655	234	97	45	58	48
PCV2		388	197	107	112	94
PCV3		452	257	119	133	124
MEASLES	561	500	275	203	474	381
DPT	588	457	340	241		201
OPV BOOSTER	877	510	340	241	246	201
DT	449	324	340	72		
VITA 1IU	1028	437	335	178	177	197
VITA2IU	442	1896	1674	948	876	1071
ROTA1			41	45	58	48
ROTA2			78	107	112	94
total	8308	7429	5102	2859	2852	2996

Children were immunised respectively. Children were mainly immunized against Polio, BCG, PVC1 & 2, Measles and Rota 1 & 2 to mention a few.

Child Delivery Practices

Skilled attendance at birth is one of the most effective ways of reducing maternal deaths. Skilled attendance refers to the presence of a clinician or a midwife all of whom are capable of handling complications. The baseline survey noted that prior to the Programme there were more home deliveries than hospital deliveries where the community relied more on traditional midwives than the trained hospital staff. The practice of giving birth at home was described as being common prior to the intervention. The long distances to the hospital hampered most mothers from attending the prenatal clinics. Lack of knowledge on the importance of delivering in medical facilities was also a facilitating factor to the high rates of home delivery. However, with MCSP made deliberate efforts to encourage women to use the hospital for safe delivery. The Programme further trained VHWs and caregivers on how to educate the mothers on the importance of health facility delivery among other requirements. This encouraged mothers to register their pregnancies and access safe health services for delivery. However, the same findings also established that a few mothers still made use of the Traditional Birth Attendance (TBA) and these are largely women from the apostolic sect who do not believe in accessing health services from the clinic/ hospital.

One of the areas that the Programme has had a significant impact is in reducing the number of unattended births.

The practice of using traditional untrained midwives for birth was prevalent in Mutambara community like most rural communities in the country. From the evaluation, 5 people including 4 caregivers, confessed that they had given birth using traditional midwives. The practice persisted up to 2010. The caregivers mentioned that in the last 5 to 6 years if anyone gave birth at home that would have been unavoidable mistakes caused by some extreme circumstances because the outreach programme provides regular monitoring and follow-up of all registered pregnancy. In addition, the traditional leaders have also taken a position of zero tolerance to unattended birth in the communities, due to programme intervention. The participation of traditional leaders gives moral authority and guarantees the sustainability of the drive towards zero unattended births.

Figure 1 Unattended Births

Growth Monitoring

Growth monitoring among under-fives is important in detecting nutritional disorders that predispose children to other ailments. Growth faltering is a major indicator of the abnormal growth of a child and a pointer to imminent nutrition-related disorders. The execution of screening exercises which assessed children for growth monitoring was an effective strategy of identifying children who would immediately benefit from the program through various outreach services. The evaluation established that mothers tend to adhere to growth monitoring requirements. This evaluation investigated trends and patterns in child growth monitoring and a majority of the mothers interviewed through FGDs reported that the children had been weighed during either clinic visits or outreach visits. The few mothers who were reported to have stopped taking their children for growth monitoring or never took their children for growth monitoring cited many domestic chores of women as the main hindrance and religious beliefs which did not encourage utilisation of health facilities. A desk review of office records revealed that statistics for growth monitoring indicates that there has been a remarkable reduction of the children underweight as compared to the previous years.

Table 4 Growth Monitoring

Year	Children seen	Children underweight	% underweight
2012	10210	721	7%
2013	6871	305	4%
2014	5611	162	2.90%
2015	4061	200	4.90%
2016	3228	257	12.60%
2017	3118	47	1.51%

The peak in 2016 is explained by World Food programme: An estimated 1.5 mill. people in Zimbabwe, 16% of the population, faced food insecurity in the 2015-2016 lean season.

Access to Outreach Services

While baseline survey established that in 2001 the programme served on 3 outreach points, the end line survey established that after 18 years of Programme implementation the outreach points had increased

to 13 (with 7 outside the catchment area) During FGD with female caregivers at Marayisi outreach centre, they praised outreach work highlighting that people are now in a position to access services like ANC, Growth monitoring and Extended Programme on immunisation (EPI). They further shared that without the outreach they had to walk about 14 km to access health services at the mission hospital. In relation to this, anecdotal evidence revealed that the Programme has been highly effective in reducing morbidity and mortality among women and children which usually occurred due to distances that were travelled to access the hospital services, improper feeding practices, lack of knowledge about pregnancy-related diseases, etc. The outreach enabled vulnerable beneficiaries to access services closer to home. Before the establishment of Ruwedza outreach, people walked 34kms to access services at the mission hospital.

Capacity Enhancement of VHWs and Caregivers

According to the Programme proposal, the Programme targeted training of village health workers and caregivers. The evaluation established that 109 VHWs and caregivers charged with the overall responsibility of coordinating the health interventions at community/ village level were trained. During the 1st years of the project, the Programme facilitated the training of 60 village workers. However, the demand for the services was high and more VHWs were trained to offer the services. The Programme roped in Ministry of Health to collaborate the trainings of village health workers. Focus Group Discussions with the VHWs revealed that they were capacitated to provide basic curative health services which included, diagnosis of uncomplicated malaria, treatment of diarrhoea through oral Rehydration and improved feeding practices, and ensuring adherence to TB treatment, handling HBC clients, counselling, the importance of testing and adherence to treatment, cleanliness, nutritional value and how to treat OI patients and prevention of mother to child illness. This strategy was effective as it enabled the community to access service whilst at home. Where complications were noted, they further revealed that they were also trained to make appropriate referrals to health facilities. Though the Programme enhanced the capacity of VHWs and caregivers with ad hoc refresher trainings, the Programme failed to support the capacity enhancement of its staff to enable them to perform better, resultantly they leveraged on the refresher trainings meant for caregivers and VHWs. However, the evaluation noted some gaps in terms of refresher trainings which were meant for the VHWs and caregivers which were not conducted as per plan due to limited resources.

Perceptions and Attitudes of Males towards Utilization of Services

It came out that men's attitudes towards women accessing health services during their pregnancy and after delivery of the child and if they provided any support to the women varied across household though more skewed towards being unsupportive. Discussions revealed that the number of women receiving support from the men was far from encouraging. More to this the women also shared that men also do shy away from even getting tested for HIV though however, the few that get tested prefer to use the hospital rather than access the service at the outreach centre.

Access and utilisation of family planning

The end line survey desk review indicated that a lot of women had access to family planning services (see table below). The data which was recorded over a period of 11 years shows that on average a quantity of 4532.455 progestogen is issued per year with a minimum number of 1770 and a maximum of 10692 over the same period. Also, an average of 5464.818 combined oral pills are issued per year with a minimum of 2022 and the maximum ever recorded was 9303. On injectable, the minimum quantity issued was 264 with a maximum of 1214 and an average mean of 826.9 issued per year.

Table 5 Family Planning Statistics

QUANTITY ISSUED						
METHODS	2012	2013	2014	2015	2016	2017
CONTROL PILLS		2486		2579	2875	2237
SECURE PILLS		1612		1217	1449	1647
PETOGEN				18	38	47
JADEL				0	0	31
LOOP				0	0	0
DEPO PROVERA		27		0	0	0

The graph below further shows the distribution trend of the three family planning controls stated above as issued from 2001 to 2016. The highest recorded for all the controls was in 2007 but there was a decrease in 2012. From there onwards, there has been a gradual increase in all the controls. The table below is also showing the frequencies of another method of control that was issued during the same period.

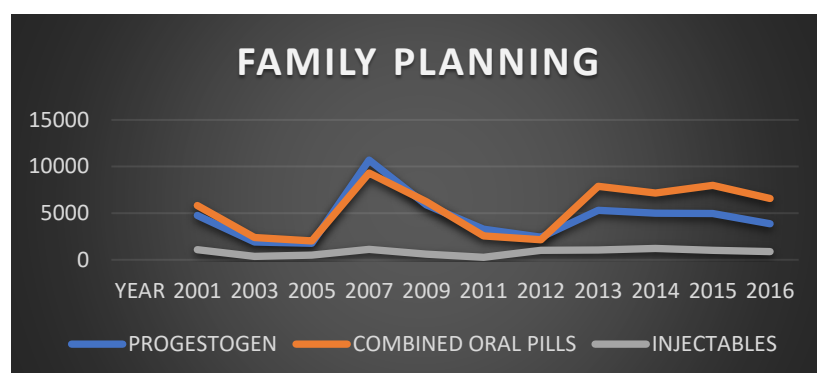


Figure 2 Family Planning trends

Combating HIV/AIDS, TB, Malaria and other diseases

The increasing number of people with HIV points to the need to intensify health education on HIV Aids, TB, Malaria and other endemic diseases. Treatment of minor diseases is also done on outreach hard to reach areas; antenatal services are also offered. Zimbabwe has a very high HIV Aids infection and they finally see themselves home on home-based care as hospitals are not able to cope with the ever increased number of patients with a long hospital stay. The relatives and significant others will find themselves as caregivers hence the importance of trained volunteer home-based care who are members of the community and always available to assist with care. Advice and counselling hence the relevance of this Programme to community needs could not be overemphasized.

The baseline survey states that during the years 2000 and beyond, Mutambara mission hospital did not offer any testing services for HIV. A lot of people died due to HIV /AIDS. On average it was estimated that

there were at least 5 deaths per week per village. The programme through its education and awareness activities has managed to encourage members of the community to get tested early and seek medication. According to the 2017 report, out of 869 tested for HIV, only 1 tested positive.

Through these campaigns in the programme, there has been a significant reduction in stigma and discrimination. Voluntary health caregivers who initially started with the programme pointed out that back then stigma and discrimination were very high, and most people did not get tested or seek medication early as they feared discrimination. They also noted that it was difficult for them at first to penetrate in the HIV/AIDS area but with the training, they have managed to convince many people to get tested and understand that one can live longer with HIV for as long as they follow instructions and take their medication.

Staying uninfected is the only curative treatment to HIV Aids hence this program has an emphasis on health education to the youth and children in school. This is very appropriate and lifesaving as the majority of school children have not started to indulge in sex hence it is hoped that the knowledge they gain from health education will assist them to abstain or practice safer sex thereby reducing chances of getting infected.

Voluntary caregivers played a vital role in providing community-based health care, education, and counselling, usually through household visits. They also attended local health facilities, obtain and dispense supplies of drugs and other essential products used in curing and preventing diseases, this helped in combating diseases within villages thus improving the health of the local community in Mutambara. The health caregivers also encouraged the community to practice better hygiene practices, particularly hand washing with soap (or ashes), the safe disposal of excreta, and boiling water before drinking it and water purification by water guard to reduce the incidence of diarrhoea occurrence

Water Sanitation and Hygiene

The WATSAN intervention is one clear demonstration of how the programme has been responsive and adaptive to the needs of the communities that it was serving. The evaluation exercise noted that in the conceptualisation and the first decade of the programme WATSAN was not part of the key activities serve in cases of public awareness campaigns. In 2012 after a cholera outbreak the programme made a decision to incorporate WATSAN as part of its activities thereby moving towards providing comprehensive health services to the community and dealing with primary health care concerns. 22 villages have benefited from the WATSAN services. To date 11 boreholes have been drilled and 24 standard blair toilets (26 holes) have been constructed.

Table 6 Number of Boreholes drilled, and Toilets constructed

Year	2014	2015	2016	2017	2018
# of Boreholes drilled	3	2	2	2	2
# of Toilets (holes)	4	0	4	12	10

Both toilets and boreholes were constructed using a strong partnership model which involved the community leadership in siting for the boreholes and offering manual labour and locally available resources. With regards to toilet constructions the programme took a two pronged approach. At one level the programme and the community constructed community toilets (two toilets with two holes each)

at community meeting points. The second level was the identification of most vulnerable households especially the elderly and were there are chronically ill patients. The identification was done by the community members themselves and the manual labour and locally available resources for the construction was provided by the community.

The strength of the processes lies in the community engagement from planning through to construction/drilling. There is evidence that communities have taken ownership of the facilities. In areas where boreholes have been drilled the Village Development Committees have elected Water Point Committee to oversee the maintenance and improvements of the facilities.

WATSAN Challenges

While the programme has made commendable efforts given its budget, there is still a huge gap in terms of coverage. The current efforts are not sufficient to ease the threat of waterborne and sanitation related diseases. According to its 2017 annual report, total of 10 villages reported that 1 212 households have no access to safe water. Out of these villages 2 benefited in 2017 (Murare and Mukundu) which have 410 households, and 2 villages (Mhandarume and Chiramba) in 2018, with 127 households (44,3%). 675 households (55,7%) are still in need of safe water supplies.

With regards to sanitation coverage, 18 villages reported in 2017 that a total of 292 households are still using the bush system and 21 are using substandard pit latrines. The program then managed to build 12 individual households toilets in 2017 and 10 toilets in 2018 (7,5%) meaning that 270 (92,5%) households are still in need of toilets.

Programme Effectiveness

The Programme has managed to instil interest and knowledge in the community about health issues. Prior to the programme, issues to do with antenatal health care, immunisation and even HIV/AIDS were considered mainly to be women's affairs but now even men are concerned about such issues showing interest and wanting to know more. This has been possible through the education and awareness campaigns that the programme runs every now and again. For instance, it is the village "sabhuku" who is mainly a man who mobilises his community and make sure everyone attends health education and awareness campaigns. One caregiver noted that there was once a family who did not take care of their sick mother and they locked her in the house but the caregiver, with the help of the village head managed to approach the family about the whereabouts and health status of their mother.

Another example is of one woman who says that her husband shows much interest in the health of their child so much that if she goes for immunisation with their child her husband makes it a point to ask for the baby card to verify and make sure that she has attended immunisation and their child has received proper and adequate health care. Such was not the case before the initiation of the programme.

One caregiver also noted that when she attends their meetings her husband always enthusiastically asks her about what they were discussing at the meetings if there are any new initiatives the programme is bringing and any progress on pending issues. In her own words, she said, *"When I was coming to this meeting, my husband emphasized that I ask about the progress on borehole drilling even though we did not know what the meeting was about and that's how he is always like when we called for meetings. He really is keen and interested in issues surrounding the programme."*

Such enthusiasm and interest that is being shown by the community have resulted in many changes. For instance, more men now participate in health-related issues supporting their wives especially during pregnancy. There is a significant change in behaviour toward HIV/AIDS testing because initially men did not want to get tested, but through education and awareness campaigns they now understand the importance of getting tested, early intake of ARV's and not defaulting the medication.

This shows the efficiency of the programme and how it has managed to immerse into the community. The programme has managed to plan for the year ahead of every December. In December of every year, a plan and schedule are laid out, outlining the dates of outreach visits to every point and this is communicated through the caregivers and community traditional leaders. There are dates for every point which are 13 points per month for 12 months. This has resulted in maximum outreach day attendance because of the investment for building relations and networks in planning and pre-planning which makes the Programme efficient without wasting. There is never a day that the outreach vehicle goes out and comes back without conducting outreach work. There is also a collapsing of roles into few individuals, for example, the nurse aides are also drivers and they participate in training. This has resulted in maximum utilisation of the available few resources thus reducing spreading the few resources thin consolidating the resource in few people and enhancing their capacity to deliver.

Strengthening of social ties is another component that proves the effectiveness of the programme. The Programme improved the social cohesion of the community in various ways. The selection of caregivers

was left to the community through village meetings which brought people together in selecting the people to be trained as caregivers. One caregiver narrated how she was selected stating that, *“I was selected by the people of this community to be a caregiver at a meeting that was attended by the people of this community chaired by the village head.”* Improved social cohesion was also witnessed on how the people came together in construction and maintenance of community assets. Upon being asked how the community managed to build a toilet at their satellite health facility one caregiver responded that, *“We had to come together as a community in moulding bricks, digging the pit and providing the builder to construct the toilet. We also put a mechanism within the community to keep the toilet clean.”* This shows how the program managed to bring the people of the community together for a common health cause.

There was also a reduction of deaths within the community which was mainly due to ignorance and fear of victimisation. Prior to the introduction of the program people living with HIV defaulted on medication mainly due to the fear of disclosing their status to community members. *“People used to die in numbers in this community..., many people didn’t want their status is known by community members”* responded one caregiver when she was asked on how the community had benefitted from the program. Due to the awareness campaigns by the caregivers, people started to shift from discrimination to acceptance and from secrecy to disclosure, a situation that reduced defaulting on medication leading to the recovery of people and reduced deaths. *“I was once called by a certain man whose wife didn’t want to take her medication so that I could counsel her and encourage her to take her medication since he had failed to convince her. After counselling the wife, she later started taking her medication and she recovered,”* noted one caregiver.

Programme Efficiency

Programme efficiency was assessed based on its outputs and how the entire MCSP programme was managed. Particular focus was placed on how productively the resources were used to realize the results, paying particular attention to programme management and the management of funds.

Programme Management

The general management of the programme was noted to be efficient as it was characterized by specifically dedicated personnel with a clear reporting line and structures. The programme is run by a competent, qualified and dedicated programme coordinator who oversees the entire management of the programme with technical support from the mission hospital staff. The evaluation also established that there was a good coordination among the Programme staff, the hospital and district office where these key people complemented each other.

This was noted to be key in terms of achieving the projects. The Programme team shared monthly reports and gave constant feedback of programme implementation to the DMO who represented the Ministry of health in Chimanimani. Regular meetings with these people were conducted throughout the life of this programme. In addition, child and maternal health interventions were planned together with hospital staff. This ensured tactical coordination, supervision and leadership of the health-related interventions by MoH which is critical for sustainability. Synergies were observed in several cases were player leveraged on each other so as to manage and not waste resources

Interview discussions with the programme coordinator indicated that the Programme was efficiently managed and most of the Programme activities were implemented as per plan, though he indicated that there was some instance that the Programme team had to delay implementation of activities because they money would have arrived late.

“We have a roaster which runs from January to December, so our work as a Programme team is guided by that roaster. This has enabled us to perform our duties well and makes use of the resources efficiently. There was never a time that we mobilised people and failed to turn up. However, there was an instance where we would anticipate a change in the programme we would then call to demobilise the communities well before the actual day of the meeting” said the Programme coordinator.

Further findings revealed the efficient use of the programme resources in relation to the finances of the programme. The Programme employed nurse aides who also double up as drivers. More so the Programme leveraged on the expertise of the other health staff who do not have a direct link to the MCSP but they managed to support some of the Programme key interventions which had a contribution to the projects intended outcomes.

Programme’s Fund Management

The evaluation established that there is evidence of sound Programme fund management. The programme had in place mechanisms to reduce possibilities of fiduciary risks which included having a well-defined authorization and approvals terms for any funds disbursements, which were also dependent on programme activities and timelines. Though the Programme did not have a finance person, it made use of the hospital finance person who is competent and reliable with the sound financial background. During the period under review, annual audits were done to account for the donor's funds. Purchase of any goods was done following stipulated procurement procedures.

The foundation of any approach to value for money are systems for organisational and programme management. Whilst the Programme established effective Programme management systems, i.e. financial monitoring was generally effective, the main weakness was its failure to establish a functional M&E system to allow for the measurement of intended outcomes and closely monitor whether the Programme was delivering what it was intended to deliver.

Empowerment

Empowerment concerns itself with transforming power relations and decision making roles. It also concerns itself with imparting certain capabilities that would be instrumental in improving wellbeing and increasing life chances. Though significant strides have been made in Zimbabwe to redress gender imbalances and empower women the structural impediments still persist and gendered differentiation of roles and chances in life is prevalent. The evaluation revealed that in its own way the MCSP has been instrumental in empowering women and changing their status within their communities. The evaluation sought to establish the extent to which women in the programme have been capacitated and how their interaction with the programme has had a knock-on effect on their lives. The evaluation looked at empowerment as, “... a multi-dimensional social process that helps people gain control over their own lives” (Page and Czuba, 1999 in DIGNI empowerment assessment tool). Focus groups and KII interviews

allowed for the in-depth revelation of multifaceted transformation the participants had experience and how in their view they think the programme contributed.

Using the empowerment assessment table (table 7 below) the MCSP scores high with regards to strengthening of Civil Society. In this report Civil Society is taken to mean the capacity of the community to self-organise and mobilise themselves, plan and engage in activities that enhance their wellbeing. For instances in the areas where boreholes have been drilled the communities have organised themselves through a water point committee. The communities have been able to design security rosters, cleaning rosters and further make improvements on the waterpoint like erecting a parameter fence. This capacity to influence, mobilise and get results has been attributed to a significant extent to how the programme staff has capacitated the communities and accompanied them in their processes.

Table 7 Empowerment Assessment Table

DEGREE AND LEVEL OF EMPOWERMENT						
THEMATIC AREAS OF RESULT		Level Output 1:	Level 2: Output	Level Outcome 3:	Level Outcome 4:	Level Impact 5:
		Individual or community	Individual or community	Individual or Community	Community and/or Society	Community/ Society/ Structural
	Strengthening Civil Society (mandatory)			X		
	Health				X	
	Gender Equality (mandatory)				X	
Total assessment of project				X		

Empowerment scale

The finding from the evaluation with regards to empowerment can be placed at level 3 and 4 outcome levels. In this section, two examples will be used to give evidence for the ranking.

Level 3 Outcome

- Resource: The key resource of the programme has been knowledge acquired through training. Empowerment has happened at multiple levels. From Programme staff to volunteer caregivers and to women in the communities.
- Agency: the Digni Empowerment Assessment Tools states that agency at outcome 3 level entails that the individual has gained ‘power within’ as well as power with. The following story illustrates this point.

The Programme employees 2 nurse aides to support the outreach. The nurse aides also double as Programme drivers. The previous programme evaluation reports for 2007 and 2012 as well as the 2017 Internal Assessment Report details how the programme has empowered the nurse aides with key skills, opportunities to engage in programmes design planning and delivery as well as exposure. The reports also detail why this important given that nurse aides are at the end of the health service delivery hierarchy and at times are stuck in menial roles. Nota one of the nurse aides who has been with the programme since inception described how being part of the Programme has been empowering at an individual level and how she has acquired agency to negotiate and influence within her household.

Nota is married, with 3 children, two of school going age. As the interview progressed she mentioned how her concern has always been how she will be able to fund her children's education to university. She mentions that because of her exposure to ideas and skills like planning and thinking ahead she brought the idea of buying assets as investments that can be liquidated 10 years later towards paying education expenses for her children. Being female, she didn't want it to seem like she is getting ahead of her husband in planning, so she had to negotiate and be persuasive so that her husband buys into the idea and they can implement it together. The process included developing a culture of saving and prioritising. She mentions that the discipline required to save was motivated by her desire to ensure that her children get to university level education. To date, they have accumulated assets in the form of cattle as a future investment for the family.

Level 4 Outcome

The MCSP has had an enduring impact and the primary health care givers will form a resilient bulwark against major outbreaks. The story of Mrs. Muningirwa is illustrative of the depth of the work that the MCSP does towards supporting primary health care as a first line of defence for vulnerable communities in Zimbabwe, and how the caregivers have been empowered to canvass support and influence decisions and processes in their community, based on the information acquired. The story also reveals other important nuances with regards to the levels of appreciation by the community of the fecundity of caregivers. This story is one case of how a female caregiver immensely contributed to averting a cholera disaster in her village.

Zimbabwe continues to be vulnerable to water borne diseases like cholera and dysentery. As recent as August 2018 cholera outbreak claimed lives across the country with Harare being the epicenter. In 2008 cholera claimed more than 4000 lives. In 2012 there was a cholera outbreak in Mutambara. What follows is an amazing case of alertness, proactiveness and community appreciation.

Mrs Muningirwa is a village health worker, she started off as a volunteer caregiver with the MCSP and progressed to become a government trained village health worker. One day in 2012 she received information of death in her village. Mrs Muningirwa says by the time she arrived at the funeral, people had already gather and the funeral wake was underway. She inquired as to the cause of death but since the deceased had not received medical attention no one knew what caused the death. She further inquired about the symptoms leading to the death. Upon being informed of the symptoms she

immediately suspected cholera. She asked if she could be shown where the deceased last defecated and she collected sample of the stool. She then asked one of the villagers to take the sample to the hospital.

“Once I suspected that the cause of death was cholera I wrote a report to Mutambara Mission hospital as we had been trained to do. I realized I had to take charge of the situation and put into practice the training I had received [on what to do with cholera related death funeral]. By this time neighbours and community member had already prepared the evening meal. I realized that I had to convince the village head first and then get his support to disperse the neighbours. I asked for water and ashes. I mixed the water and ashes and spread the area where the deceased had defecated. I then engaged with the village head and began to educate him on the procedures of handling a cholera related death. I explained the danger of spreading the diseases and asked that the deceased be buried on the same day. The community could not accept this easily as this was against our traditional custom of how we pay respects to our deceased. However, I am glad that the village head understood the gravity and supported me. I then took charge of all the proceedings with regards to precautionary measures. I also used the opportunity to educate the community on the cholera epidemic it causes, precautionary measures and what each person can do to stop the spread of cholera. I also warned the death meant that the community was now at high risk.”

Mrs Muningirwa celebrates that from this intervention she managed to mobilise the community to arrest the spread of cholera and galvanize community vigilance and collective response to cholera. She notes that of the 380 reported cases of cholera from her community there was only that one death. She attributes this success to the community response to her call and the village head’s leadership.

Women empowerment and gender mainstreaming

The evaluation collected data on decision making and empowerment of women in areas related to MCHC. It was found that the majority of women feel empowered and revealed that they now have the skills and ability to make decisions at home and in the community. All women were asked about their own perceived ability and skills to participate in community-level decision making, particularly in community groups. Overall the majority of women esp. caregivers and VHWs in the Programme mentioned that they feel they have the ability and capacity to make decisions at the household and community level. The programme through its outreach points passed public health education and awareness programme improved the levels of knowledge amongst women about their sexual and reproductive health.

Interview with one of the programmes nurse aides indicated how the Programme has also empowered her, *LI believe that the programme managed to contribute to the empowerment of women starting with me. look at me, I now have a licence and I can stand up in front of many people and deliver on any health-related topic, something I could not do prior to joining the Programme team. More so, many female caregivers and VHW that we work with now have knowledge and ability to support their communities even in the absence of hospital registered of health personnel/nurses.”* The number of care givers currently stands at 106 (92 females and 14 males).

The Programme made a conscious effort towards promoting gender in all its initiatives. Women, especially VHWs caregivers, are active participants and agents of their own development. The other important step that the Programme took was to involve men in interventions that are labelled as dominated such as

health promotion. The Programme managed to mobilize males as VHWs and caregivers and these have been providing health education in their communities. The evaluation team established that this has helped reduce gender barriers which in turn contributed to the successes of the program

Confidence

The programme has managed to instil the sense of self-esteem and confidence in caregivers especially female caregivers. When the programme started in 2001 the role of a caregiver was diminished to be the lowly role and according to the data gathered during the survey, most women had a very low self-esteem upon joining the programme. Through the programme's training and the knowledge they have gained these same women are now very confident to address the community during their awareness campaigns and even during community meetings that have nothing to do with the programme.

Decision making

The program managed to empower female caregivers in the community. One female caregiver noted that, *"...these days my husband consults me on decisions concerning our family, and he acknowledges that I am now helping in a way he didn't realise before I became a care giver. I joined the programme after I admired how the other female caregivers were improving on the way they made decisions pertaining to the upkeep of their families"*, said another caregiver who joined the program midway. This shows how women have been empowered by the program to an extent that they are now role models to younger women in the community.

Problem-solving

Through trainings and knowledge that has been imparted on them, the caregivers revealed cases where they have been able to provide solutions both in their work and in their households. One caregiver pointed that nowadays she is able to solve her household problems without asking for advice, she said, *"because of the knowledge that has been given to me, I now understand some things better and I now know how to tackle my problems head on without consulting my neighbours and friends."* She went on to say that this programme has taught her how to present her cases and petitions better to her husband and how to choose her words correctly when talking with her husband, something that has led to an improved healthy marital life.

Improved status

The programme has also empowered the caregivers by improving their social status. *"We are now being invited to take part, and address village and table on community meetings because of our role as health workers,"* said one female caregiver. Another caregiver stated that, *"... at most community meetings we are now being given the opportunity to address people as health personnel, our opinion is now being sought after by community leadership."* What the caregivers said shows that the community now respects them, because such an honour is not easy to come by if you are not of a better social standing.

Literacy

Picking up from the internal assessment (2017) is an element of improved literacy and how that has been transformational for women without a formal education but who feel confident to write and read. One example from the internal assessment is regarding an elderly lady who is very proud of her capacity to read and interpret medical cards for her HBC clients. She mentions that before joining the caregivers she

could barely read and write but with the MCSP continued training and capacity reinforcement she is proud of her acquired skills.

Transformed mindset

The programme did not only empower females but also males. Involvement of male caregivers in the program has been transformational to the extent that it has impacted on the perceptions of caregiving as well as gender roles in the rural community. Mutambara Mission is located in the rural areas where patriarchy still holds sway significantly. There are strong beliefs around gender differentiation which extends to roles and place of women in the society. From literature, caregiving has been considered to be a domain of women. The same was true for the MCSP. Prior to the inception of the Programme, the role of caregiving was perceived to be the preserve of women. It was viewed as insignificant and something that men shouldn't be bothered with. Initially, when the programme started there was only one male caregiver out of the 80 women who were there. It took 10 years to recruit males into the programme. Though still very small compared to women (14 males to 92 females) the number of males.

The first male caregivers gave testimony of the transformation at an individual level narrating his experience he stated that at first it was not easy for him to get used to the idea but he quickly adjusted and settled in well. The involvement of men has improved their understanding of health issues. *“Initially in this community, we had a belief that health issues mainly on pregnancy and HIV/AIDS were meant for women and some women thought it was beneath the males to engage in caregiving. I benefitted much from the program and my understanding that we are really all equal and a man can do the same roles that women do and that doesn't mean he is no longer a man. I have some of my male friends coming to me saying I am brave working with women. I don't think I am brave I think this is an important role in our community and the health of our community is more important.”*

Sustainability of the Programme

The trained caregivers have the passion and have demonstrated that they can work with minimum resources and they understand their volunteer role. Besides them being passionate about their work these caregivers have a strong support system from within their households and the community at large. Most female caregivers have highlighted how their husbands have been very supportive of their work and how they have been given the blessings to do their work even as at times it includes working odd hours or leaving household chores to attend to the HBC clients in the community. One female caregiver noted that sometimes it is her husband who gives her information about meetings and health status of the community. In her own words, she said, *“Sometimes it is my husband who brings information about upcoming care giving meetings at Mutambara mission hospital and emphasizes that I spread information”*.

To add on, the programme coordinator also noted that the traditional leaders fully support the programme so much that even when they have their own community meetings they call him to come and address people, not only does he get to be called during community meetings but even on political rallies. The MP or councillor calls him to address people, especially on voluntary counselling and testing. Such initiatives have seen most men participating in voluntary HIV/AIDS testing something that was not so common before. Infiltration of the programme through traditional and political leaders guarantees its sustainability and viability.

People in rural areas turn to listen and respect word from their leaders and this programme have managed to make the traditional leaders their mouthpieces and tools for community mobilisation. In some cases, even in the absence of the programme’s coordinator, the village heads acknowledge the presence of the community caregivers is it male or female and they give them platforms to address people. This does not only guarantee the sustainability of the programme, but it has also boosted confidence and self-esteem within the caregivers especially female caregivers.

Sustainability Pillars

The Programme assessed the extent to which programme activities may continue without the support of MCSP as well as the extent to which community stakeholders will continue providing prerequisite support to the communities. The programme made efforts to ensure sustainability of the programme in many ways as highlighted below.

The evaluation established that there is some evidence that the approach MCSP adopted in the delivery of the Programme provides pillars for longer-term sustainability due to the high-levels of buy-in and engagement it encouraged from the outset, particularly in terms of its capacity to mobilise other key hospital staff and other key stakeholders in the implementation of the programme. Another important dimension of the Programme was related to community training and capacity building which, in the long run, is the best prerequisite to ensuring the sustainability of any project.

“If an organisation is taking up something and it doesn’t involve other people, sustainability becomes a problem, buy-in becomes a problem. But once you get other people to be involved from the outset, they can make the issue their own. We had a lot to learn from working with other players in the Health sector if they take your message for you then you have a whole host of people

on board and they can sing the anthem for you where you are no available”, said one of the Programme staff members

An Empowered Community

When infants and children become sick, it is their families, especially parents and other primary caregivers, who form the first line of care. Household members, particularly mothers, undertake the primary diagnosis of illness, assess the severity and probable outcomes, select treatment and care options including home treatment and procure and administer drugs and other remedies. Families and caregivers make the decisions to seek formal health care for pregnant women or children who have fallen ill, and they decide whether to adopt diverse feeding and hygiene practices. The training and deployment of voluntary caregivers by the programme have managed to educate families; mothers in particular on how to undertake primary diagnosis and administer appropriate treatment before taking their sick children to the hospital. One caregiver noted that before the programme as caregivers they can administer first-line treatment to a patient depending on the illness, it could be painkillers for pain, salt, and sugar solution for diarrhoea in transit to a health care facility. According to her as caregivers, they have also passed on this information to the locals thus empowering them to take charge of their health. In her own words she said;

“The programme has sprouted a seed in us that no one can ever uproot. The knowledge and education that we have gained through this programme will be in us and it shall be imparted to other generations”.

The programme has managed to give the community and the voluntary health caregivers appropriate support to undertake first line healthcare. The programmed has also empowered the community to protect children from injury, accident, abuse, and neglect.

However, some respondents during FGD felt that as long as there are no resources availed to support the programme, continuity of the programme hangs in the balance. One of the FGD respondents who is also a village head indicated that without MCSP, the activities would die a natural death, *“in our community, we have numerous health problems that we still need to deal with and the exit of the MCSP will pose a gap. In the absence of MCSP, it would be difficult to sustain the Programme activities”.* He further revealed that in his community there were not many partners working in the health-related interventions.

Community participation

Community participation is viewed as a mechanism to reduce and eventually eliminate profound disconnections between knowledge, practice and attitudes that impede efforts to address both the supply and demand sides of care. The importance of community participation in health care, hygiene practices, nutrition, and water and sanitation services go beyond the direct benefits to community members as they engage in activities that can impact positively on their health. It forms the heart of a rights-based approach to human progress. Participation is critical to enable people to achieve their full capabilities, exercise their rights to engage in public and community affairs, and foster equity, equality and empowerment characteristics that are fundamental to sustainable human development and to the objectives of such compacts as the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the

Convention on the Elimination of All Forms of Discrimination against Women and the Millennium Declaration, among many others.⁵

Organization alone is not sufficient to bring lasting change in communities. For a community-based programme to be truly effective and universal in scope, community participation must be socially inclusive. The MCSP mother and survival program has managed to penetrate into the community by engaging the locals in its activities. According to the acting Programme coordinator, community engagement has been their number one priority ever since the initiation of the programme. The programme has managed to include everyone from the community starting with the traditional leaders going down to everyone. This has resulted in the Programme gaining momentum and support among the locals. Community participation has also made it easy for the programme to carry out health education and awareness campaigns.

The direct involvement of the community in the Mother and Child Survival Programme has fully helped the programme to implement its goals and objectives without facing much resistance. The programme has managed to engage the community from the onset through stakeholder consultation of traditional leaders and allowing the community to pick and select individuals whom they see fit to be their caregivers. This has given the community a strong sense of ownership to the programme and they positively rally behind. Community involvement has been relevant and appropriate for easy management, flow, and sustainability of the programme making it easy for caregivers to conduct their daily duties and activities.

Further findings through the FGDs showed that the local leaders and their communities have totally embraced the programme. The evaluation also established a high degree of community satisfaction with the programme. In the WATSAN component, the beneficiaries came up with the water point committees, which are responsible for the maintenance of the boreholes during and post the project implementation period. Further discussions at Mutsewari water point committee revealed that the WATSAN component of the Programme will be sustainable as they have already started to implement their plans for the sustainability. It was revealed that all water users within their catchment area contribute 10c per month per household which they will use for the maintenance for the borehole if at any point in time it becomes mal-functional. At the time of the evaluation, they had \$10 in their coffers.

Collaboration with Mission Health Systems

The Programme worked to strengthen the existing health system, rather than create a parallel system. This in itself enhances sustainability as the health services, as well as requisite funding, will continue to be available after the Programme ends. The regular updates and networking meetings conducted with other health officials i.e. mission and government officials were important for sustainability. Ensuring that the government officials were aware of the activities and achievements of the programme, and were part of the decision making, instilled a sense of ownership and contributed to the integration of the Programme developments into the District Health Plan.

Strengthening of VHW and caregivers

Village health workers and caregivers play a pivotal role in sustaining the achievements of the health project. These cadres are and form the key component of the decentralization of health planning and are

⁵ The state of the world's children, (2008), UNICEF

responsible for taking leadership on health initiatives at the village level. They are responsible for acting as a pressure group to bring accountability to the government health system at the village level, and for improving health awareness and access to services amongst their community members. Strengthening the capacity of the VHW to fulfil their role through continuous refresher training courses has proved to be a key pillar as this has resulted in them internalising the content and improved capacity to apply knowledge in the community with minimum supervision.

The DMO was of the view that the program will be sustainable considering that it still remains the ministry of health's baby to ensure the delivery of health services to the people. The ministry will have to refocus to ensure that the monthly outreaches continue. However, he was quick to say that there are some areas which they might not be able to assist because they fall out of the district, like Mutsiyabako outreach centres which fall under Mutare district.

Financial limitations

The sustainability of the programme usually depends on the availability of resources and the linkages within the government and its commitment to the issue at hand. Realising the above the Programme made a deliberate move to work with strategic partners to ensure Programme sustainability. The Programme made collaborations with the Ministries of Health and other stakeholders such as the District Development Fund (DDF) for the Water and Sanitation and other non-governmental organizations. It was therefore certain that when the Programme ends, the activities initiated by the Programme would be propelled by other collaborators.

Recommendations

The first recommendation is to say the programme needs to take seriously all recommendations from the last 2 evaluation and the internal assessment exercises (2007, 2012 and 2017). There is a need to have a clear programme of how they will address the recommendations with timelines milestone.

The evaluation acknowledges that some recommendations have been addressed but this is not done in a programmatic fashion and as such it makes it difficult to track which recommendations have been adopted and to what extent have they been implemented, and which ones have not been adopted and what are the reasons.

The programme going forward would require a designated coordinator who is charged with the day to day programme management. In addition, the coordinator should have the responsibility of designing a solid monitoring framework that allows for the programme to track its activities viz-a-viz mandate, budget and annual work plans. One major weakness of the programme is data for its beneficiaries over the 18 years is difficult to find with some grey areas and years without information. A designated coordinator should be able to plug into this loophole.

The programme needs to have a robust Monitoring and Evaluation framework which is designed deliberately to capture and keep track of programme activities outputs and outcomes. In addition to this a proper documentation system would be most advantageous. The current state of affairs makes it difficult to tell the story of progress and impact as data is not readily available.

References

Muzondo P; (2012), Rural women's right to maternal healthcare before, during and after delivery: A focus on women in Romsley resettlement area, Rusape district, Manicaland, Zimbabwe.

UN in Zimbabwe Issue Paper Series - Paper I; Maternal Mortality in Zimbabwe Evidence, Costs and Implications, (2013)

UNICEF; (2008), The state of the world's children

Zimbabwe Demographic Health Survey 2010/11

Annex A: Terms of Reference

Terms of Reference, Final evaluation 2018,

Mother and Child Survival Program, Mutambara Mission Hospital

1. Evaluation purpose

This is the third and final period with support from Digni for the Mother and Child Survival program in Chimanimani district in Manicaland province in Zimbabwe. The main purpose of this evaluation will therefore be to sum up the experiences, lessons learnt and results, both quantitative and qualitative, achieved throughout the duration of the program. The evaluation will also present recommendations for the sustainability of the program in the future, without support from the United Methodist Church in Norway and Digni.

2. Background information

The United Methodist Church in Norway and UMC in Zimbabwe has cooperated in different mission activities since 1938. Among other things, The United Methodist Church in Norway has sent several missionaries to Zimbabwe and has supported various mission and social activities carried out by The United Methodist Church in Zimbabwe.

In 2001, UMC in Zimbabwe started a Mother and Child Survival training program in Mutambara, with help from Norad/Digni and UMC in Norway. The program focused on improving the health of people, especially women and children in the Mutambara area of Zimbabwe.

Zimbabwe was reeling under the AIDS pandemic and the affected population had scarce access to treatment. Many patients were too sick or too poor to go to hospitals and the program developed a home - based care program by training volunteers from the local communities. Many children became orphans when their parents died with AIDS and the program ensured that the children could continue education. The local government health authorities supported the program and allocated the outreach sites for the project staff to work in. The government provided supplies, vaccines and staff to supplement the project activities.

The UMCN and Digni have provided full financial support for the program, including staff, vehicle, training for Home based Care givers and village health workers. From 2014, a WASH program was added; including boreholes and toilets in needed communities.

2.1 Program goal

Improving the health situation of children under five years old, mothers and the lives of HIV affected people; patients and orphans.

2.2 Target groups

- women of childbearing age
- children under 5 years of age

- school children
- people living with HIV/AIDS
- orphans and widowers/widows
- workers
- church-leaders and congregations
- community at large

2.3 Program summary

The projects will through education, awareness and training in good health practices try to improve living conditions and survival rate of the target group, women and children. The fight against Malaria, Diarrheal Diseases and HIV/AIDS is also a component in this program.

3. Scope of the evaluation

The evaluation shall be carried out based on the evaluators' best professional judgement and according to accepted best international evaluation practices and Digni's governing document "Policy for evaluation" and "Empowerment Assessment tool".

The scope of the final evaluation spans 16 years of implementation of program activities in the Mutambara area, in which the Mother and Child Survival program has been engaged implementing, health, water and sanitation projects. The evaluation will assess the achievements from the start of the program to date, according to set objectives described in the Terms of Reference, documenting best practices and lessons learnt in the program during the time of support from Digni.

In particular, the following items shall be included in the evaluation; Program effectiveness with focus on empowerment of women, the community and the local institutions, Program efficiency, Program relevance and Program sustainability.

A baseline study at the start of a new program was not a requirement until recently and therefore not found in the program documents. Baselines for the relevant objectives will be developed by the evaluators, tracing available data, in order for changes to be described as concretely and precisely as possible.

4. Objectives of the Evaluation

The evaluation will specifically seek to answer the questions below, under 4.1-4.4.

4.1 Program effectiveness

How has the program increased empowerment of women, the community, and the local institutions?

Has the program achieved the project objective as stated in the program plan?

Assess the effectiveness of the program according to the development goals.

Long-term overarching development goals:

- Improving the overall health status of the people in Mutambara area of Zimbabwe.

- Empowering communities to take charge of their health as well as their lives through economic development, better nutrition, sanitation and general education and awareness.

The specific program objective is:

- Improving the health situation of children under five years old, mothers and the lives of HIV affected people; in particular patients and orphans.

Program outputs

- Improved health situation for mothers and children under the age of 5 years.
- Increased knowledge and awareness about HIV/AIDS in the whole population – children, youths, adults and elderly.
- People affected by HIV/AIDS are able to cope with the situation.
- Trained volunteers work with Home Based Care (HBCVs). At least 2 in each area
- Improved Mother/Child’s health situation in remote villages through health education, vaccination, growth monitoring, health care, ANC.
- Improved life condition for People Living with HIV/AIDS (PLWHA).
- Have support-groups for HIV-infected peoples
- The HBCVs will form a group and look into ways of making the HBC programme independent of external funding in the future.
- VHVs have adequate kits to manage Malaria at Community Level
- Improved community-based management of Malaria
- Improved safe water and sanitation

Programme activities

The project is based on a comprehensive approach and has therefore identified a long and detailed list of planned activities:

- Train HBCVs on HIV/AIDS and communicable diseases; organise refresher courses for HBCVs 4 times per year; strengthen home visits at least twice a month; Provide needed and appropriate nursing care, improve mother and child’s health education in remote villages.
- Establish a monthly schedule for immunizations and inform the VHVs and the community; Immunisation and growth-monitoring of the under-5 at monthly outreaches and examine pregnant mothers in remote areas.
- Improve the Waiting Mothers Home by constructing cubicles so that 4 women can share a cubicle; procure beds for the mothers and provide a living room with sofas and television;
- Provide 4 training and refresher courses per year (once per quarter) for Village Health Workers on Community Based Management of uncomplicated Malaria.
- Conduct 4 support and supervision visits for Village Health Workers implementing the Community Based Management of Malaria.
- Supply replenishment to Village Health Workers once per quarter i.e. Gloves, Soap, Vaseline.
- Supply 18 bicycles to Village Health Workers.

- Construct 20 Blair Toilets per year for high risk communities in Mutambara Catchment area (Provide 6 bags of cement and asbestos sheets to a household, the community will then do the rest)
- Drill 4 boreholes per year for high risk communities within Mutambara Catchment area.
- Hold quarterly meetings with Water and Sanitation Committees
- Information to schools, churches and the entire community about HIV/AIDS.

4.2 Program efficiency

Should the activities have been carried out in another manner?

Could the same activities have been achieved with the use of less costly resources?

Make an assessment about the efficiency of the resources used in the programme in relation to the conducted activities.

4.3 Program relevance

Can the program be said to be highly relevant or less relevant in relation to the need of the people in the area? Assess the program relevance in relation to the main challenges in the project area. Make a special assessment of the project relevance in relation to the public health plan and activities in the area.

4.4 Program sustainability

What are the possibilities for the program to maintain its present work without external support?

Make an assessment of the program sustainability. Preferably, the sustainability model developed by Digni should be applied evaluating the project sustainability in relation to the following three factors:

- Activity profile
- Organisational capacity
- Context

Make specific recommendations in relation to the future of the program.

5. Methodology of Evaluation

The methodology used by the evaluation team shall be participatory and beneficial to creating a “sharing, learning, and competence building” environment for UMCN, UMCZ, including the administration and program staff at Mutambara Mission Hospital, and members of the project communities. At time of project visits, in addition to partners and program staff, the voice of rights holders will be heard, as well as interviewing relevant stakeholders in the context.

Data collection will be done through reading of all project information and other relevant documents, by conducting interviews with UMCN, UMCZ and the administration and program staff at Mutambara Mission Hospital. The evaluation team will visit projects in different communities and organize interviews with program staff, focus group meetings with relevant beneficiaries and interviews with other relevant stakeholders in the communities and region.

The preliminary findings from the evaluation team shall be shared and discussed in a meeting with UMCN, UMCZ, the administration and program staff at Mutambara Mission Hospital, members of the project communities and other relevant stakeholders after the field visits. This is to secure the dialogue and the participatory process of the evaluation and strengthen the learning process for all parties.

5.1 Field work

The team will develop the field work methodology based on the evaluation objectives and questions.

It is expected that the team will interview selected people from core stakeholders. Such people may include community members within the programme catchment area and direct beneficiaries of the project, home based care givers, traditional leadership, community health workers, local government authorities and relevant people from the UMCZ and UMCN, in addition to the program staff and administration at the Mutambara Mission Hospital.

5.2 Work plan and Schedule

Task	Task Description	Days	Man-days team leader	Man-days team member
1	Document Review- recreating baseline	6	6	1
2	Design of Data collection tools, Pretesting	2	2	1
4	Field work and Data collection	5	5	4
5	Reflection workshop	1	1	1
6	Meeting with UMC Health Board in Harare	1	1	-
7	Data entry and analysis	5	5	2
8	Report production	3	3	1
	Total time input	23	23	10

An individual contract will be prepared for each evaluator establishing distribution of days and responsibilities.

6. Document review:

6.1 The main reference program documents:

2018 10387 Mother and Child Survival Program Annual plan
 2017 10387 Internal assessment, Mutambara mother and child survival program
 2017 10387 Mother and Child Survival Program Annual report
 2017 10387 Mother and Child Survival Program Annual plan
 2016 10387 Mother and Child Survival program, annual plan

2015-10387-Annual report-Mutambara mother and child survival project-Zimbabwe
2015-10387 Mutambara Mother Child Survival, annual plan
2014-10387-Annual report-Mutambara mother and child survival project-Zimbabwe
Midterm report 2014
Mutambara Mother Child Survival 2014-2018, programme plan
2013 Mutambara Mother Child report
Evaluation Report 2012, Mutambara Mother and Child Survival
Mutambara final evaluation report May 2007
Attachment to partnership agreement Mutambara draft
MUTAMBARA MOTHER CHILD application 2002

6.2 Documents from Digni:

- Empowerment assessment tool
- Digni's ethical guidelines
- Guide to monitoring and evaluation
- Policy for evaluation
- Sustainability and Risk analysis

7. Reporting

A written report in English shall be prepared based on the Terms of Reference and Digni's Empowerment Assessment tool. The final report, maximum 40 pages, must include an executive summary, introduction, a presentation of methodology, findings, conclusions and recommendations.

Before the final report is completed, a draft report shall be presented to the program management at Mutambara Mission, UMC in Zimbabwe and in Norway who shall be given reasonable time to give their feedback regarding the draft report. The evaluation team shall jointly prepare and write the evaluation report, but the team leader shall be responsible for finalizing and sending the report within due time.

The final report is expected to be completed by the 1st of November 2018.

8. Evaluation team

The team will consist of two consultants with a suitable professional background, experience and independence. A balanced gender composition in the team will be ensured. The consultants must have sufficient cultural competence, and follow Digni's ethical guidelines, and be accepted by both parties.

Annex B: Interview questions

1. Project Coordinator

1. What is your role in the MCSP?
2. Given all this you have shared what's your role or what does your role entail and how you fit in the programme?
3. Can you share a bit more about the programme and what it does?
4. How do you organise your day to day work? I.e. do you have work plans?
5. Which activities were in the programme and were they implemented according to work plans/schedule?
6. Do you think the activities implemented add value to the programme?
7. How many people do what you do?
8. What capacity do you think you now have as a result of the programme?
9. What do you think you have achieved and how? What do you attribute to your achievement?
10. In terms of palliative and home visits, what are the services or package you have provided?
11. Who are the other people who are working with you in the programme and how do you create synergies?
12. What training have you received?
13. Is there any time that you mobilised communities and you did not turn up for the meeting or venue you arrive at the venue they were all gone?
14. Do you think that activities implemented added any value?

2. Project Beneficiaries

1. We need to gather information about knowledge of the programme and how it has helped them?
2. How much time do you take to get to the hospital, how many kilometres, if you use transport how much does it cost?
3. Let's say if a woman is pregnant, what are the child services you receive for your unborn child under 5 years?
4. Before the project, what was your source of water and how far was it, what was changed as a result of the project?
5. Gather more information about the key components which were addressed by the project like WASH components, find out about the water points committees, whether they have pump minders how many boreholes were drilled in the area, are they still functioning, what have they done to maintain their community's contribution.
6. How did women participate in the project?
7. Ask to see the homesteads which have benefited from the toilets constructed in the area as result of the project.

8. Find out more about those who accessed EPI and the distance they have to walk in order to access the EPI.
9. What have been your experience with the team at office, are you happy with their job?
10. How have been male involved in this project?
11. Are there any kind of public awareness you have undertaken? Share more about the awareness'.

3. Community leaders

1. How have you been involved in the day to day running of the project?
2. What has been your role in the programme?
3. How have been the man in general involved in the project?
4. Tell me about the project, what has been your role?
5. As traditional leaders do you take ownership of the project?
6. What value does the project brings add to the community?

4. Care givers

1. Tell me about the project and your role in the programme?
2. Has /is your family been supportive about your role in the programme
3. How many years have you been working as a caregiver?
4. In your own view, what do you think has changed in your life as a result of the programme or you being a caregiver. e.g. your social statues etc.?
5. What are your most success stories?
6. How much distance do you travel to the hospital?
7. What kind of support have you received from the programme staff?
8. Have you suffered any backlash in your role as a caregiver?

5. FGD with Women

1. How do you feel about the project?
2. What services have you received as a result of the project?
3. Do you think that the project has made your life any better than before?
4. What capacity do you think you now have as a result of the programme?
5. How do you feel the project has helped and empowerment other women please explain
6. In your view do you think that the programme will be able to continue post its life span, consider sustainability in relation to the factors like access to resources, community participation, and capacity?
7. What do you think the project staff could have done better?

6. Other Staff

1. What is your role in the MCSP?
2. Given all this you have shared what's your role or what does your role entail and how you fit in the programme?
3. Can you share a bit more about the programme and what it does?
4. What services do you provide to the people?
5. Which ones are the ones you started with when the programme when it officially started?
6. What support do you get from hospital ignored for you to execute your duties effectively?
7. How do you organise your day to day work? I.e. do you have work plans?
8. Which activities were in the programme and were they implemented according to work plans/ schedule
9. Do you think the activities implemented add value to the programme?

7. Responsible Authorities

1. How does your role relate to the programme? What success can be attributed to you?
2. Could the project have suffered any challenges, what were they and how did you resolve them?
3. Is the church prepared to take ownership of the project life?
4. In your own view what could be done better?