Mutambara Mother and Child Survival Training and Program Development – Zimbabwe

Project Evaluation

Final Report,

May 27, 2007

Anne Mossige, Team Leader, Scanteam, Oslo

Simbirai Gwaze, Department of Nursing Sciences,
Faculty of Health Sciences, Africa University, Mutare

Scanteam
Analysts and Advisers

Oslo, May 2007

TABLE OF CONTENT

ACRONYMS AND ABREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BN	Bistandsnemnda (“Norwegian Mission in Development”)
CHBC	Community Home Based Care
HBCV	Home based Care Volunteer
HIV	Human Immunodeficiency Virus
DNO	District Nursing Officer
DS	District Superintendent
NGO	Non-Governmental Organization
NID	National Immunization Day(s)
NORAD	Norwegian Development Cooperation
PCN	Primary Care Nurse
PMTCT	Prevention of Mother to Child’s transmission of HIV/AIDS
TB	Tuberculosis
TBA	Traditional Birth Attendant
TM	Traditional Mid-wife
UMC	United Methodist Church
UNCN	United Methodist Church of Norway
UMCZ	United Methodist Church of Zimbabwe
VCT	Voluntary Counselling and Testing
WCBA	Women of Child Bearing Age

SUMMARY

This evaluation has assessed project achievements, relevance and sustainability of the Mutambara Mother Child Survival Training Project and has come up with recommendations for the project's future.

The Mutambara Mother Child Survival Training Project is implemented by the United Methodist Church in Zimbabwe (UMCZ) and is supported financially by UMC in Norway. The project was launched in January 2002. The first project period was five years until end 2007. The annual project budget is about 600.000 NOK.

The project's objectives are to improve: (i) the health situation of mothers and children and (ii) the living conditions of people affected by HIV/AIDS, in particular patients and orphans. The main project activities are immunization of children, health education training of village health volunteers (traditional mid-wives and home-based care workers) and peer educators. The project targets mainly 30 villages in the Mutambara area of the Chimanimani district in the Manicaland Province in Eastern Zimbabwe. The project is associated with UMC's Mutambara hospital.

The evaluation found that the project has performed well in carrying out many of its activities. The project activities are relevant. They respond to important needs of the Mutambara population and they complement the activities of other actors in the area and in the district.

The immunization and health education activities supplemented those of Mutambara hospital and the DNO of the Chimanimani district by reaching out to remote villages. The project also trained a substantive number of traditional mid-wives and home-based care volunteers. Currently, the Mutambara area seems to be well served with community based health workers who have been trained by the project and previously by other partners. It seems that this approach has improved the care given to terminally ill AIDS patients and that the communities are now accepting the home-based care concept and the supervision of the very ill by volunteers.

The project HIV/AIDS component is still not yet fully developed. The project team was small, had limited resources available and lacked previous experiences in running HIV/AIDS awareness campaigns and in assisting HIV/AIDS groups. Most of these activities were carried out as part of other activities and mothers and school children became the project's main targets. Several HIV/AIDS orphans have benefited from support from UMC members in Norway. Three staff of Mutambara hospital benefited from HIV/AIDS related training in Nairobi.

Concerning the future of the various project activities, it is believed that Mutambara hospital has the necessary human resources to carry out most of the activities apart from HIV/AIDS awareness activities and the assistance to HIV/AIDS which require a different set of skills and expertise.

Given the gloomy economic situation of the country, the hospital will not be able to run most of the project activities without continued financial assistance from UMC in Norway and NORAD through BN for some time.

General recommendations:

Based on the above findings and conclusions, the evaluation team recommends that UMC in Norway, with the assistance of BN and NORAD, continues to provide financial support to many of the ongoing activities, in particular immunization and health education, home visits and the supervision of the home-based care volunteers and traditional mid-wives.

The activities related to HIV/AIDS prevention and awareness, training of peer educators and assistance to HIV/AIDS support groups should be reexamined and revamped with the assistance of local/national partners who have the required skills and expertise in these areas.

In the future, project activities should continue to complement other actors' efforts in the Mutambara areas. A closer collaboration between the project and different partners is necessary.

Future support from UMC in Norway would also require a much greater ownership and involvement of the UMC's Mutambara hospital in the project activities, both in terms of planning and coordinating and in carrying out the various activities. The project should not function as a small independent unit of the Mutambara hospital but be an integral part of the hospital and of the UMC in Zimbabwe.

I. INTRODUCTION

1. BACKGROUND AND STRUCTURE OF THE REPORT

The Mutambara Mother Child Survival Training Project is implemented by the United Methodist Church in Zimbabwe (UMCZ) and is supported financially by UMC in Norway (UMCN - Metodistkirkens Misjonsselskap, which includes the church's development wing). Most of the project funds come from the Norwegian Development Cooperation (NORAD) via the Norwegian Mission in Development (BN)). The project was launched in 2002. The first project period was initially for five years until end 2007. The annual project budget is around 600.000 NOK.

The project has the two following main objectives: (i) to improve the health situation of mother and children and (ii) to improve the living conditions of people affected by HIV/AIDS, in particular patients and orphans. The main project activities are immunization of children, health information, training of village health volunteers (traditional mid-wives and home-based care workers) and peer educators.

The project targets mainly 30 villages in the Mutambara area of the Chimanimani district in the Manicaland Province in Eastern Zimbabwe. The project is associated with UMC's 120 bed Mutambara hospital. The total population of the catchment area is 17,000.

The evaluation was carried out between December 2006 and February 2007. The evaluation's main scope was to assess actual project achievements, document lessons learned and come up with future recommendations.

The document is divided into three parts. The first part includes the evaluation's TORs and a brief description of both Zimbabwe's health related challenges and of the Mutambara project (chapters 1-4). The second part comprises the evaluation's findings mainly related to the project's relevance, achievements and sustainability (chapters 5-7). The last part provides conclusions and recommendations for the future of the project (chapter 8).

2. EVALUATION'S SCOPE, TORS AND METHODOLOGY

The evaluation's main scope was to make an assessment of the project achievements in relation to initial project objectives, to document lessons learned in the project and to present recommendations for the future of the project. The evaluation addressed in particular the following issues and questions:

(i) *Project relevance:* Make an assessment of the project relevance in relation to the main challenges in the project area. Can the project be said to be highly relevant or less relevant in relation to the need of the people in the area; and

(ii) *Project targeting:* To what extent does the project successfully reach the stated target groups (children under five years old and women of child bearing age, school-children, youth, workers and the community at large and HIV-positive people and other patients and children orphaned by the HIV/AIDS pandemic

(iii) *Project efficiency* (an assessment about the efficiency of the resources used in the project in relation to the conducted activities): Should the activities have been carried out in another manner? Could the same activities been achieved with the use of less costly resources?

(iv) *Project effectiveness:* to which degree the project has achieved the project objective as stated in the project plan:

(v) *Project sustainability:* Make an assessment of the project sustainability. In particular give an opinion regarding the project possibilities to maintain its present work without external support.

(vi) *Future* development of the project.

For more details see the evaluation's TORs in Annex 1 of this report.

The evaluation team consisted of one international and one national consultant. One representative from UMC in Norway participated as an observer. The evaluation consisted of a desk review of relevant literature and a field evaluation which was divided into two periods, the first field work was carried out in December 2006 and the second and last in February 2007.

The initial field evaluation was carried out from December 2 to 10. In Mutambara (in the December 3 – 9 period), the team met with different groups of project stakeholders including:

- Mutambara hospital staff and project staff
- Representatives from the UMC (Station chairman, district superintendent (DS) and the hospital chaplain)
- Representatives from Mutambara UMC primary and high schools
- Traditional midwives, traditional healers (N'angas) and home based care volunteers trained by the project
- Support groups of HIV infected community members; and
- Direct beneficiaries, including HIV positive people, orphans and women of child bearing age
- Mutambara center stakeholders workshop on December 8 to present and discuss preliminary findings

In Harare, the team met with Bishop Nhiwatiwa of UMC in Zimbabwe. The evaluation team's preliminary findings were presented and discussed both with some of the stakeholder groups during a workshop in Mutambara on December 8.

The evaluation period coincided with a busy period within the hospital, including the organization of the national immunization days (NIDs) and the graduation ceremony for primary care nurses. This limited the evaluation team's possibilities to visit and meet with different stakeholders (pregnant women, children, trained volunteers, orphans etc.) at village level. As a consequence, the national consultant carried out a supplementary field evaluation in Mutambara from February 1 to 12, 2007. The second field visit included home visits, focus group discussions with women of child bearing age (WCBA), attendance at immunization sessions and interviews with orphans, senior teachers, and the District Nursing Officer (DNO) for Chimanimani District.

3. ZIMBABWE

For some time, Zimbabwe and its population have faced accelerating economic and health challenges. A tremendous HIV/AIDS burden coexists with a disabling economic crisis, e.g. actual annual inflation was estimated in February 2007 to be around 1600 percent (!!) and increased poverty that seriously limit people's access to the already deteriorating public health services.

The situation is illustrated by gloomy health statistics: In Zimbabwe, life expectancy at birth was reduced from 39.8 to 37,2 years between 2003 and 2004. In the same period, the mortality rate for infants increased from 73 to 79, 4 and the mortality rate for under-fives increased from 117 to 129. In 2005, the HIV prevalence for the population between 15 and 49 was 20.1% (World Development Indicators database, April 2006). In 2003, the average antenatal HIV prevalence was 24, 6 percent (20,9% in urban areas and 28,1% in rural areas).

There are many reasons for the deteriorating health status of children and mothers. E.g. inadequate follow-up during pregnancies and deliveries can have negative consequences for both mothers and children. Insufficient knowledge about nutrition and hygiene among mothers and other caregivers make children more vulnerable to malnutrition and infections. Moreover, poverty often makes it difficult to translate knowledge into action.

At local level, the HIV/AIDS epidemic is manifested by a growing number of young orphans and a growing number of HIV patients that have to be taken care of by their families. Often more than 50 percent of patients admitted to hospital are due to HIV/AIDS and generally the hospitals do not have the capacity to take care of all these.

Women are most vulnerable to the HIV/AIDS infection. At the same time they are the most important caregivers of family members that are ill due to the virus. One third of infants born by HIV positive mothers become HIV positive. It is estimated that about 90 percent of HIV infected children are born to HIV infected women and acquired the virus during pregnancy, labour, delivery or through breast feeding. Moreover, many children lose one or both parents due to the HIV virus at an early age.

In the 1998-2000 period, population based surveys for the province of Manicaland reported an HIV prevalence of 22.3 percent for women aged 15 to 29 years. For Mutambara, more than 50 percent of the hospital admissions were due to HIV related conditions (Moreover, at the end of 2001, only four percent of Zimbabweans in need of services for prevention of mother to child transmission of HIV were receiving them[1]).

The Zimbabwe health care system is divided into eight provinces and 58 districts. It offers five levels of care: health post, health centre, and district, provincial and national hospitals.

[1] Perez, F. et al, 2004: Prevention of mother to child transmission of HIV: evaluation of a pilot programme in a district hospital in rural Zimbabwe

4. THE MUTAMBARA MOTHER AND CHILD SURVIVAL TRAINING PROJECT

4.1. Background

Mutambara is located within the Chimanimani district in the Manicaland Province in Eastern Zimbabwe. The UMC's Mutambara hospital has 120 beds and caters for a rural population of approximately 17 000 which is about 10 percent of the total population of the Chimanimani district. Mutambara hospital also functions as the designated district hospital for Chimanimani. The district has a total of 24 clinics and smaller hospitals. All are under the overall responsibility of Zimbabwe's Ministry of Health. Mutambara hospital has a wide range of departments which include male, female and children wards, out patients department, operating theatre, laboratory-x-ray department, mother and child department (labour ward, antenatal and postnatal wards) and the School of Nursing as well as three project teams . The hospital nurses are paid by the state. Mutambara hospital receives some state support for vaccines and part of recurrent expenditure. Due to the enormous inflation the last few years, the state provides little funds for medicines and other hospital expenditures. Some of these expenditures are currently funded by some of UMC's sister organizations in other countries.

The Mutambara Mission Centre has one primary school and one high school. Many of the schools' 2000 students live in dormitories. The teacher salaries are funded by the state. The primary school has classes for blind children and has a nursing school and a support program for poor and vulnerable families. The Mission Centre's Maintenance Department was established and built up by UMC in Norway and NORAD funds.

4.2. Health-related challenges

In 2000/2001, the UMC in Zimbabwe requested assistance from UMC in Norway to support activities that would assist in reducing the mother and child survival rates and the HIV/AIDS infection rates in the Mutambara hospital's catchment area. The UMC in Zimbabwe wanted the Norwegian assistance to address several important health-related challenges in the area, including:

(i) Low immunization levels of children living in relative remote villages in the Mutambara catchment area; partly due to poor road conditions and the hospital's inadequate means of transportation and consequent inability to reach out to villages located far from the hospital.

(ii) A very high HIV prevalence largely caused by interrelated factors such as a high and accelerating unemployment rate, high alcohol consumption, low family income and consequent increased use of prostitution as a survival strategy by women.

(iii) Need for adequately trained home-based care volunteers that can follow-up and supervise HIV positive and other patients in their homes. More than 50 percent of the admissions to the Mutambara hospital are due to HIV. The hospital has inadequate capacities to take care of all the HIV patients and consequently try to discharge many with the hope that they will be taken care of by their families and/or communities.

(iv) A growing number of orphans who have lost one or both parents due to AIDS. The orphans are often taken care of by other family or community members but are generally at risk of getting less care and food and to drop out of school due to the increasingly thinly stretched resources of their new caretakers.

(v) A general inadequate HIV/AIDS awareness of the Mutambara population, including men, women and elderly but also of at risk groups such as school and out-of school children, in particular adolescents.

Table 1: Population breakdown of the Mutambara area and Chimanimani District*

Category	Percentage	Mutambara	Chimanimani
Total Population		12577**	119979
Under 1year	3.2%	405	3462
Under 5 years	16.0%	2016	19197
Under 15 years	50.7%	6376	60829
WCBA	18.4%	2308	22016
Expected Pregnancy	4.0%	503	4799

*Population based on 2002 census with an annual growth rate of 3.2%
** The population of Mutambara catchment area is 10.4% of the total population of Chimanimani District

4.3. Project description

The project targets mainly 30 relatively remote villages in the Mutambara hospital catchment area. The project aims in particular to improve the health situation of mothers and children but also to improve the living conditions of people who are affected by HIV/AIDS, in particular patients and orphans. This would be achieved by implementing the following *project activities*:

(i) Immunization and growth monitoring of children below 5 years
(ii) Provision of health education to mothers (during the monthly visits)
(iii) Training of traditional mid-wives in hygiene, complications during pregnancy and delivery and about HIV/AIDS
(iv) Training of volunteers (both women and men) in home-based care with a particular focus on the growing number of HIV/AIDS patients
(v) Training of peer-educators at community level in HIV\AIDS awareness
(vi) Set up of HIV support groups
(vii) HIV/AIDS awareness activities at village level, in primary and secondary schools, during various gatherings for children and youths, in companies and in churches and
(viii) Assistance to orphans who have lost one or both parents to the HIV/AIDS pandemic. However, it is important to note that all of the activities targeting orphans, including school fees and distribution of different necessities such as clothes and food were funded by individual contributions to the UMC in Norway[2] and not funded by NORAD via BN.

The project's anticipated results (outputs) for the entire period, included:

- Improved mother/child's health situation in remote villages through health education, vaccination, growth monitoring, health care, and ante natal care (ANC)
- 10-15 volunteers trained yearly to work as TMs (traditional midwives).
- 20 volunteers trained yearly to work with Home Based Care (HBCVs).
- Improved living conditions for people affected by the HIV/AIDS pandemic, this includes patients, relatives, and orphaned children.
- Increased knowledge and awareness about HIV/AIDS in the whole population – children, youths, adults and elderly.

[2] In 2006, the individual contributions from Norway to orphans were more than US$ 2000.

- The establishment of support-groups for HIV-infected people in at least 10 villages. Moreover, the HBCVs were expected to establish a group and look into ways of making the HBC program independent of external funding in the future.

The *project team* is small with only three staff: the Norwegian project leader who is both a registered nurse and a registered mid-wife, and two local nurse aides. The project collaborates with the Mutambara hospital staff and the District Nursing Officer in Chimanimani. The project funded the purchase of one vehicle, and finances mainly project staff salaries, expenditures related to transportation costs and some supplies. Other operational expenditures are mainly related to training, organization of workshops and refresher courses etc.

4.4. Project time line

The project was prepared in 2001. The project start up was delayed from 2001 until early 2002 due to the long processes involved in both acquiring a vehicle and a work permit for the expatriate nurse/mid-wife. Some of the project activities related to HIV/AIDS awareness, including the training of peer educators were initiated and integrated into the project in 2003. Project execution experienced significant challenges when the work permit of the expatriate project leader was not renewed from July 2004. A situation of uncertainty prevailed until her work permit was finally renewed in December 2006. During the one and half year of absence of the expatriate nurse in Mutambara, most of the immunization and health education activities continued with the collaboration of nurses from the MCH department of the Mutambara hospital. Some of the scheduled activities such as training of the home based care volunteers and traditional mid-wives and the HIV/AIDS awareness campaigns were not carried out during that period. The project agreement was for an initial five year period until end 2007.

II. FINDINGS

5. PROJECT RELEVANCE AND ACHIEVEMENTS

5.1. Project relevance

The project objectives of improving the health situation of children under five years old, mothers and the lives of HIV affected people; in particular patients and orphans are very relevant in relation to the health needs of Mutambara's population.

The project's focus of targeting relatively remote villages in the Mutambara area complements and extends the Mutambara hospital's outreach capabilities to these communities. Currently around 60 percent of people in the district of Chimanimani live in hard to reach areas. Moreover, the DNO's office does not have transport for outreach activities in the most remote communities.

The training of home-based care volunteers to follow-up and supervise HIV positive and other patients and their primary caregivers in their homes is very relevant in a context where

hospitals do not have the capacities to take care of a growing number of HIV patients. Generally, the families and local communities end up being responsible for the care of their HIV positive members. However, families and communities have scarce resources and limited experience in providing for their HIV positive patients. Moreover, the stigma of HIV/AIDS makes home-based care difficult.

The Mutambara's population need for more HIV/AIDS awareness was also addressed by the project. However, mainly women and some school children ended up being the project's main target for its HIV/AIDS awareness activities and these project activities did not reach important groups such as out-of school adolescents, men and elderly.

5.2. Project targeting and achievements

5.2.1. Mother and child activities and training of traditional mid wives

The Mutambara project's main focus is on improving the health situation of children under five years old and women of child bearing age. The project activities targeting these two groups are mainly the following activities: (i) immunization and growth monitoring of "under fives", (ii) health education of mothers and (iii) training of traditional birth attendants (TBAs). The project carries out these activities well and they have positive effects on the health of children under five years of age and mothers. These activities also supplement the immunization activities of Mutambara hospital and Chimanimani district by reaching out to more remote villages.

Outreach activities. The project team carries out monthly visits to initially 10 and from 2005 and onwards[3], to 13 outreach points, covering a total of 30 relatively hard to reach villages, to vaccinate and weigh children under five years and to provide health education for mothers. The main bulk of the project's time is spent on these activities. On average, the project team spends 10 working days per month on these outreach activities. In the three most remote villages[4], the project also provides basic drugs[5] and sells family planning medication such as pills. Condoms are often distributed for free in the three villages.

The project provides growth monitoring and BCG, Polio (1, 2 and 3), DPT (1, 2 and 3), HBV (1, 2 and 3) and measles vaccination for children under five years. The project team provides health education to the mothers during the monthly visits to the outreach points and focuses on one specific theme every month. The following themes are covered at each outreach point: PMTCT and hygiene, breast feeding, immunization, HIV/AIDS prevention awareness and prevention of mother to child transmission of HIV (PMTCT). Other themes include growth monitoring, infant feeding, nutrition, family planning, common conditions like diarrhea and malaria.. .

Training of traditional mid-wives. In order to improve the follow up of women during pregnancy and delivery and to reduce perinatal mortality, the project upgraded the skills of traditional mid-wives (TMs) in the Mutambara catchment area. Community leader assisted in the identification and selection of the TMs. The project nurse/midwife and one to two nurses from the Mother and Child Health (MCH) department of Mutambara hospital are involved in

[3] The project added three outreach points as a request from the District Nursing Officer in Chimanimani
[4] The most remote outreach point is the village Ruwedza which is located 30 km from the Mutambara hospital
[5] The basic drugs comprise paracetamol, aspirin, multi-vitamins, indocid, or indomethocin, folic acid, erythromycin, cotrimoxazole, amoxycycline and betadine ointment

this training. Each training workshop lasts for two weeks (10 days). The training adopted the curriculum which had been developed by the Ministry of Health and Child Welfare The course topics are comprehensive and comprised of the following issues:

(i) simple anatomy of the reproductive organs, signs and symptoms, minor discomfort and complications of pregnancy, and importance of antenatal care;
(ii) birth processes and preparation for delivery, labour process, delivery of baby and the placenta, immediate care of mother and baby, record keeping, and reporting to the rural health centre;
(iii) at risk patients during the antenatal period, during labour, and during the puerperium, and babies at risk
(iv) post natal care, immunization and growth monitoring, and family planning
(v) traditional practices related to pregnancy, labour and the puerperium as well as care of the baby
(vi) HIV/AIDS related issues such as basic facts as well as the prevention of mother to child transmission (PMTCT), including the use of Nevirapine and infant feeding, the importance of knowing ones HIV status, and
(vii) Infection control and inter-personal relationship issues

The project has also provided annual refresher courses to the TMs. Moreover, the project or other partners such as the PACT project (which supports the Voluntary Counseling and Testing Department of Mutambara hospital) have during the last two-three years provided uniforms and a kit to all the trained HBCVs. The traditional midwives receive delivery kits depending on the number of deliveries carried out per month.

Project achievements related to its mother and child activities are significant. In fact, the District Nursing Officer stated that the project's immunization activities have been a major contribution to the important reduction of measles outbreaks in Chimanimani district although the measles coverage of 84% is very low, compared with 190% for BCG and 118% for Polio 1, the coverage is high enough to control outbreaks. The project's very high vaccination coverage (see figures in Table 2 below) results from the project's consistent outreach services which contribute to 22% of the District figures. The measles coverage however is very low suggesting that many children are not reached by the project at 9 months.

The project expected to train 15 traditional mid-wives (TMs) per year however a total of 50 TMs were trained between 2002 and 2004 which is a lower number than expected. The project did not train new TMs as scheduled during the project leader's absence from Zimbabwe from mid-2004 to end 2006. However, the Mutambara catchment area has a total of 99 trained TMs. The other 49 were trained by the hospital and its other partners before 2001. The project however provided refresher courses for a total of 86 TMs during the expatriate nurse's absence. The current number of 99 TMs trained in the Mutambara area seems to be adequate. The training of these volunteers by the project and previously by other partners seems to have contributed to improved care of infants and their mothers during pregnancy and delivery. The current low number of home deliveries of only nine percent of total deliveries in the Mutambara area demonstrates this. During the field evaluation, the team met with about 40 trained TMs[6] who confirmed that an important outcome of the training was their improved ability to identify risk factors and refer early which contributes to reduction of mother and infant mortality.

[6] Some of these TMs had been trained by other partners than this project.

Table 2 comprises indicators related to *specific achievements or results of the* project's mother and child activities from January to December 2006.

Table 2: Results and achievements of the project's mother and child activities and training of TMs (Annual Report: January to December 2006)

Indicators	**Figures/results:**		**Comments**
ANC bookings	673		- This figure is higher than the expected pregnancy within the Mutambara area but the figure is expected for a referral centre - 10 to 15 ANC attendances are also recorded monthly at two outreach points which are 18 and 35 kms from the hospital
Hospital deliveries:	853 (91% of all deliveries)		The number of hospital deliveries is over double the expected for children under one year for Mutambara area, of these a total of 58 (6%) were caesarean sections and 71 (7.5%) of the babies had birth weight of below 2.5 kg
Home Deliveries:	87 (9% of all deliveries)		87 (9% of total deliveries) An encouraging low figure. However, the % of home deliveries rises to 21% when compared with the expected birth rate.
Outreach Points	13 actual	10 expected	Originally 10, 3 points were added as a request from the DNO: The outreach points cover a total of 30 villages
Outreach register	1549		The number of children who are under 5 years are1293 and the remaining children need follow up for various reasons
Vaccination coverage:			
BCG	190 %		These figures demonstrate a very high coverage and contribute to 22% of the District figures as result of the consistent outreach services provided by the project. The measles coverage however is very low compared with BCG and POLIO indicating that many 9 months old babies are not being reached
Polio 1	118 %		
Polio 2	112 %		
Polio 3	110 %		
HBV 1	120 %		
HBV 2	120 %		
HBV 3	115 %		
Measles	84 %		
Growth monitoring	Boys	Girls	
Total weighed	2810	3440	
Under weight	206	369	It is of concern to note that the girl child appears disadvantaged from a very early age
% underweight	7.3%	11%	
Childhood illnesses	ARI Malaria Skin diseases Diarrhoea Injuries		Top 5 conditions for children under five years of age
Training of traditional midwives			
Number of TMs trained by project	50 from 2002 to 2004	10-15 per year expected	There is a total of 99 TMs trained in the Mutambara area. 49 were trained by the hospital and other partners before 2001.
Number of TMs receiving refresher courses	86	Figure not available	

5.2.2. Training of home based care volunteers (HBCV) and home visits by project team

The training of home based care volunteers (both women and men) is another project activity which has been carried out well. The project's focus was to train HBCVs to follow-up and supervise families and other community members' care of home-based patients, in particular the growing number of AIDS patients that the hospital is not able to take care of. The main objective of the training of the HBCVs (and also the TMs) is to build capacities of families and local communities to be responsible for their own health and take care of its sick family and community members. The approach has been adopted by Zimbabwe's Ministry of Health and its National AIDS Council but had not been fully implemented in the Mutambara area because of inadequate funding for training of community based volunteers.

All the HBCVs attend a 5 day initial training as well as annual refresher courses. The project team and Mutambara hospital's VCT coordinator provide the training. For the last two years, there has also been close collaboration with the PACT/Ruvheneko project which is also based at Mutambara hospital in the training of volunteers. The five day workshop for the HBCV covers the following topics:

(i) handling of and interaction with the patient, family members and other care givers, including the need for due respect to all individuals and the confidentiality aspect
(ii) how to provide physical, psychosocial and spiritual care to the patient,
(iii) hygiene of care giver(s) and patient, including the promotion of latrines
(iv) health and health care of patient, including the importance and promotion of HIV testing, the importance of referral, proper care of drugs, prevention of sores, etc.
(v) nutrition and proper diet of patient
(vi) health care and protective measures for care giver, including disposal of gloves
(vii) infection control practices and
(viii) management of common conditions like diarrhea and malaria

Most HBCVs have received a uniform and a kit containing soap, small Vaseline, sodium hypochloride, gloves, draw sheets, draw mackingtosh and linen savers if available from the project or from other partners such as the relatively new PACT project.

The project team also carries out home visits to patients. The project planned to use about two weeks per month for home visits which would be an estimated two visits for each patient per year. However, the actual frequency of visits to each patient would depend on the patient's need and also the availability of project vehicle, fuel and staff. The home visits would often be carried out jointly with the HBCVs to encourage and supervise them. Staff from Mutambara hospital's VCT (PACT) would sometimes participate. During these visits, the project often distributed different items in kind support such as tablets of soap, small packets of beans, rice and dried fish, analgesics and items of clothing as and when available. This in-kind support is not financed directly by project (NORAD) funds but as gifts from individuals in Norway that are shipped to Mutambara by the UMCN.

Project achievements related to the training of HBCVs and home visits by project team are important. To date the project has trained a total of 85 home based care volunteers. The project expected to train 20 HBCVs per year. The project has also organized refresher courses for a total of 114 volunteers, including 18 previously trained by the hospital and nine trained by the Red Cross

.
The training of HBCVs was carried out from 2002 to 2005. There was no training of home based care-volunteers in 2006 despite the scheduling of this activity. This seems to be partly due to the absence of the expatriate nurse in Mutambara in 2006, and partly because currently the project area appears to be relatively "saturated" with volunteers. This was also confirmed by hospital staff and during the evaluation team's meeting with 78 of the HBCVs. Currently most villages in the catchment area have two volunteers each; some have up to five while four villages have only one volunteer each. Only five of the HBCVs trained by the project are men. During the HBCV meeting, it was stated that although it would be more difficult for men to provide home based care for female patients there was a need to have more male volunteers in the future.

The trained HBCVs follow-up and supervise different kind of caregivers and their patients who include elderly who are not very ill to very chronically ill AIDS patients. This is done on a regular basis. The frequency of the visits depends on the needs of the care takers and patients. The HBCVs also register the orphans in their area and provides this information to the project team.

The evaluation team visited, accompanied by the project team or by HBCVs, with eleven clients and their care givers. The ages of the clients visited ranged from 10 years to around 80 years. Three clients were on anti Tuberculosis (TB) drugs. Two were on Anti Retroviral drugs, the 10 year old was physically (blind) and mentally disabled, three were older adults with varying chronic conditions, one elderly was quite senile and one was elderly but with no visible conditions except for old age. The clients met often mentioned their appreciation for support given in kind by the project (tablets of soap, small packets of beans, rice and dried fish, analgesics and items of clothing) as and when available. An account of each individual client visited can be found in Annex 2.

The catchment area seems now to be well served with community based health workers which is an important achievement; in particular as this is a relatively new approach. Concerning the particular outcomes of the home visits by volunteers and by project team, the two following results were mentioned by different stakeholders: (i) the communities' acceptance of the home-based care concept and supervision of the very ill by volunteers; and (ii) improvement of the care given to the terminally ill AIDS patients.

It is important to note that the introduction of ARVs at Mutambara Hospital through the PACT project and other partners has resulted in an important reduction in the number of HIV/AIDS patients on home based care. E.g. in one village only two out of ten clients were still bedridden or house bound. On the other hand, a clients' inability to walk to the hospital for review would often lead to defaulting treatment. The reduction of terminally ill AIDS patients appears to have resulted in an increased focus by the project to care for elderly people who are often already taken care of by their families.

So far ways of funding the HBC program by the local communities' own resources have not been identified as initially planned. This might be difficult and too optimistic in the current economic dire situation of Zimbabwe in general and in the Mutambara area in particular.

5.2.3. Promotion of HIV/AIDS prevention and awareness at community level, including schools and support to HIV/AIDS support groups and HIV/AIDS orphans

The project planned to carry out the following activities related to HIV/AIDS awareness and support to HIV/AIDS affected people:

(i) Training of peer-educators at community level in HIV\AIDS awareness;
(ii) Setting up of HIV support groups;
(iii) Carrying out HIV/AIDS awareness activities at village level, in primary and secondary schools, during various gatherings for children and youths, in companies and in churches,
(iv) Assisting orphans who have lost one or both parents to the HIV/AIDS pandemic. Most of the activities targeting orphans, including school fees and distribution of different necessities such as clothes and food were not funded by NORAD via BN but by individual contributions to the UMC in Norway.

HIV/AIDS prevention and awareness: In general, awareness activities were carried out as part of other activities. Local women, through health education, and some school children, through sporadic HIV/AIDS awareness campaigns, ended up being the project's main target for the HIV/AIDS awareness activities.

The project integrated HIV/AIDS awareness as a theme in the health education provided to women during the project's outreach activities. However, neither women's groups nor other community groups were targeted separately for HIV/AIDS awareness.

The project carried out visits to 11 primary schools and five secondary schools in the Mutambara area related to HIV/AIDS awareness. The project visited a total of eleven primary schools and five secondary schools. Peer educators were not trained as planned. Youth and out of school children were not specifically targeted. There were some attempts to provide HIV/AIDS awareness to adult men, e.g. early on in the project period the project team would try to meet and discuss with men around plantation areas where men gather while searching for work.

When invited, the project team presented health related topics during church gatherings. The project also organized a one day workshop on harmful practices in relation to HIV/AIDS for 10 of the 30 traditional healers (Naangas) operating in the Mutambara area.

Assistance to HIV/AIDS orphans and support groups. Orphans who have lost one or two parents to HIV/AIDS have been identified by the home-based care volunteers and referred to various projects and funds, including the Mutambara project. In the Mutambara area, there are many actors supporting the school attendance of orphans. E.g. at the Nhedziwa High School, a community school run by the local authority, there are eight players, including this project and one government sponsored program. Each school supporting orphans has a register of orphans and vulnerable children indicating the child's status, the current guardian and or home environment and the organization supporting the child. This enabled the identification of children not yet supported and those needing urgent support. The teachers also often carry out interviews with children as necessary to identify changes in the children's circumstances.

UMC Members in Norway provided funds to support the orphans assisted by the project with school fees, full uniform, satchel, exercise books, pens and pencils.

Training of hospital staff: Three of Mutambara's health staff benefited from HIV/AIDS related training in Nairobi which was financed by the project.

Project achievements related to *HIV/AIDS awareness activities.* It was difficult during this evaluation to assess project achievements in terms of increased knowledge of and awareness about HIV/AIDS in the Mutambara population – children, youth, impact of its HIV/AIDS prevention awareness activities compared to the impact of other similar projects in the area (PACT, PMTCT (Prevention of Mother to Child's transmission of HIV/AIDS, Zvitambo (NGO) project). E.g. some schools have had sporadic IEC HIV/AIDS activities funded by different organizations. The mixed results of the project's HIV/AIDS awareness activities can partly be explained by the very small project team, its scarce resources, including time and also the staff's lack of previous experiences in HIV/AIDS awareness activities and lack of finding other partners to carry out this activity.

At local community level, it appears that the *health education* provided by the volunteers (TMs and HBCVs) and the project team has improved the knowledge and awareness of HIV/AIDS. However, most of the health education activities have targeted pregnant and breast feeding mothers during the immunization sessions. Men, adolescents, out-of school children and the elderly have been targeted to a much lesser extent (the project has targeted men and adolescents but this seems to be very sporadic). Men, in terms of their decision making role in the home, adolescents and out-of school children in terms of their age and vulnerability, and the elderly given their important role in caring for orphans and advising the young are very important targets.

Between the groups of beneficiary women we met, there were noticeable differences in the responses concerning the level of knowledge of basic HIV/AIDS facts and the level of empowerment. One group of 16 women, living in the newly resettled area about 18 km from the hospital needed to be given accurate information on transmission of HIV. Only one woman knew about mother to child transmission. Similar levels of knowledge we found in women at an outreach point 35 km from the hospital. Another group of 40 women living along the Mutare/Chimanimani highway, about 13 kilometers from the hospital knew about PMTCT. In fact it was encouraging to note that more than 60% of them had been tested and knew their status. It was disappointing however that these women were afraid to talk to their partners about the benefits of being tested. They then suggested some approaches to talk to the men including going to beerhalls, churches or inviting the spouses to accompany their wives to immunization sessions.

A discussion with 50 women of child bearing age (WCBA), at a centre 10 km away from the hospital, revealed that the women had adequate information about HIV transmission and a number of them had been tested through the PMTCT program. Five mothers had brought their babies for BCG following deliveries at home. This indicated a high level of awareness about the importance of prevention of childhood diseases.

One member of the evaluation team also met with a large group of a total of 386 women and 12 men, including members of the Apostolic Faith who do not use modern medicines for religious reasons. The people's level of knowledge about HIV/AIDS prevention was high. Topics addressed included PMTCT, Voluntary Counseling and Testing, Anti Retroviral drugs and how to access these drugs and the Home Based Care program. During the meeting, one young man spoke openly about his positive status.

Achievements related to the project support to HIV/AIDS orphans. The project supported a total of 130 orphans, including 77 in primary schools, 52 in secondary schools, and one some at college with fees, full uniform, satchel, exercise books, pens and pencils. This support comes from individual UMC members in Norway and is not financed by NORAD via BN. Some attempts have been made to introduce some income generating activities for orphans at different villages covered by the project, but these efforts were scattered and apparently not viable

.

A focus group discussion was held with 17 pupils supported by the project at Nhedziwa High School. Their knowledge of HIV / AIDS was up to date including the importance of abstinence. They had aspirations to reach college or university level and become professionals and they all greatly appreciated the support given by the project. One Form 4 pupil who aspires to be a poet summed up their thoughts and feelings when he said "The project had given them all Peace of mind" Peace of mind to the child, peace of mind to the caregiver /guardian and peace of mind to the school.

One of the students supported by the project has successfully completed his 'A' level studies and has been accepted into the Zimbabwe College of Forestry. Peter Mukonya is 21 years old and has been supported by the project from May 2005. His father died and his mother who is the breadwinner is now not well. He has one stepsister in Form 2 who is also supported by the project. The support came as a great relief to both him and his mother. He was aware that he used to put a lot of pressure on his mother to find money for him to continue with his education. He thinks that the pressure must have contributed to the deterioration in her condition but now she is improving. He hopes one day to be a holder of a Doctorate in his chosen field. This he says will require him to have a 'good character, commitment and to be a role model' to his peers especially those being supported by the project.

Interview with a grateful relative

One morning a 29 year old woman was waiting at the project vehicle. She burst into tears when she saw members of the project team. She went on to explain that hers were tears of joy and that she had come to express her gratitude for the support given to her brother's children. This is her story:

> "My brother's first wife died leaving 5 children. My brother then married a second and third wife who both had two children each. When my brother also died it was my old mother's responsibility to look after the first wife's 5 children which became a burden for her. I could not look after the children because I had just got married with two young children. The program is now providing for the 5 children, two in secondary school and three in primary school. When schools open I met the children on their way from school looking smart and very happy in their new uniforms and I had to come and say Thank You". Heartfelt gratitude from a thankful and relieved aunt ----Peace of mind

The project did not assist the establishment of village level support groups as planned. One HIV/AIDS support group within the Mission centre was formed in 2006. The establishment

was supported by the church and not specifically by the project. The support group *Vimbainashe* (Trust in the Lord) aims to give physical, psychosocial, financial, material and spiritual support to its members. Currently the group tries to raise funds to start income generating activities. The project incorporated some members of the umbrella support group in their health education activities targeting mainly mothers.

6. PROJECT EFFICIENCY AND EFFECTIVENESS

The Mutambara project has a small budget of around NOK 600 000 annually and was run by a very small team of only one expatriate nurse/midwife and two local nurse aides. The project budget funds mainly one vehicle, other transportation costs, some supplies and expenditures related to training and workshops and salaries of project staff.

The project has generally performed well in terms of providing outreach services (immunization, growth monitoring and health education) to relative hard to reach areas, training traditional mid-wives and home based care volunteers and providing some support to orphans. The lack of meeting several of the project's objectives related to its HIV/AIDS awareness activities and assistance to HIV/AIDS support groups can to a great extent be explained by the project's small staff and scarce resources, including time, and lack of previous experiences in e.g. HIV/AIDS awareness.

The project team was too small to cover all the planned activities. Some of the staff of Mutambara hospital were involved in some project activities. This included the involvement of one nurse from VCT in the training of the HBCVs and during some home visits and one or two nurses from MCH in training the TMs. The rest of the activities were almost exclusively carried out by the project staff. The project did not try to identify other partners outside Mutambara who could have provided know-how and assistance in carrying out HIV/AIDS awareness activities.

The project vehicle was very important and would on average be used 10 days every month for the outreach activities. The focus on immunization, growth monitoring and health education resulted in less time available for other activities, such as some of the home visits and HIV/AIDS awareness campaigns. Sometimes periods of fuel shortage would make it difficult for the project to carry out the project activities as planned.

The 18 months period when the project leader, the project's only registered nurse was absent from Zimbabwe (due to lack of a work permit) demonstrated that the project's trained manpower was inadequate, and that it was necessary to increase the involvement of more of Mutambara's staff and other potential partners outside the Mutambara area. During this one and half year period some of the scheduled activities such as training of new HBCVs and TMs and HIV/AIDS awareness campaigns were not carried out. However, most of the immunization and health education activities continued as the project started to involve nurses from the MCH department of Mutambara hospital. The MCH nurses who participated in the outreach activities received a small daily allowance if they were off-duty. It was stated that this remuneration was motivational and encouraged the nurses to be involved and work in remote communities. The absence of the expatriate nurse also demonstrated the need to upgrade the skills of the nurse aides, e.g. to assist them to under go the PCN course.

7. PROJECT SUSTAINABILITY

With regard to the crucial issue of sustainability, it was expected that Mutambara hospital would take over the different project activities after the external assistance from UMC Norway was phased out by the end of 2007. Currently the Mutambara hospital has the necessary human resources, in particular with regard to registered nurses, to plan, coordinate and carry out most of the project activities apart from most of the HIV/AIDS awareness activities which need skills and know-how from partners outside the hospital. However, the economic situation of Zimbabwe is not enabling. Consequently, it is unlikely that Mutambara hospital will be able to run the project activities without external funds for some time. The decline of government funds for vaccines, medicines and other hospital expenditures is an indicator of the hospital's need for significant assistance from abroad at least in the medium term.

The DNO's office of Chimanimani district is in the same difficult economic situation as Mutambara hospital and stated that it was still very dependent on continued project funds to reach remote areas of Chimanimani for immunization and health information activities.

The project and other partners have trained an important number of HBCVs and TMs to supervise and assist home-based caregivers of infants and mothers and HIV/AIDS patients and other patient. The area seems now to be adequately covered with volunteers, also given the reduction of bedridden clients due to the increased use of ART. It is believed that the HBCVs' continued work would require regular supervision and quality control. Mutambara hospital, in particular its VCT department, has the necessary human resources but is short of transportation means to supervise the volunteers who work in the remote areas of Mutambara. The project's tendency to distribute in kind support during home visits should be carefully reviewed. This kind of assistance can create dependency and question the sustainability of the home based care. The project's increased focus on elderly clients who often are taken care of by their own families and are at times not in urgent need for outside assistance should also be carefully examined.

The project's HIV/AIDS awareness activities are still at an infant stage. The focus and approach of these activities have to be revised if such a component should continue in the future. There should be a much stronger focus on training peer educators in secondary schools, and also focusing on men, elderly, and out of school adolescents. The UMC in Mutambara should also be strongly involved in the HIV/AIDS awareness activities. Currently, Mutambara hospital has limited know-how and previous experiences in HIV/AIDS awareness activities. Consequently, any follow-up of this component should be done with the assistance and involvement of partners with the necessary competencies and experience. During the last decade, many international and national NGOs and other local civil society organizations have been involved in HIV/AIDS awareness activities in Zimbabwe and some of these would have the necessary expertise that a future project could use.

Initially the project was very much run like a small but efficient NGO where the project team would carry out most activities. This included a separate project account which was not integrated into the hospital accounts. Mutambara hospital's ownership of the project seems to have been rather weak until around 2006. Although some of the hospital staff, in particular from the VCT department, were involved in some of the training activities, the project team

coordinated and executed most of the activities. This fact was also demonstrated by many of the beneficiaries who would often praise the expatriate nurse and would associate the project with her and her two assistants and not with the hospital or the Church.

It was only after the project leader had to leave Zimbabwe in mid 2006 that the hospital started to plan and coordinate some of the project activities and then some of the hospital nurses got involved in the project's important outreach activities. The project accounts were also managed by the hospital from 2006 as recommended after a visit by the Norwegian Mission in Development (BN). During this period, a close collaboration with the project PACT/Ruvheneko (also based at Mutambara hospital) started in following- up of clients who had been commenced on ARVs. There are now plans for closer networking in the follow up of defaulters.

III. RECOMMENDATIONS

8. FUTURE DEVELOPMENT OF THE PROJECT – CONCLUSIONS AND RECOMMANDATIONS

The Mutambara mother child survival training project is a small project with a limited budget and a very small project team that has performed well in carrying out many of its activities. The project activities are relevant. They respond to important needs of the Mutambara population and they complement the activities of other actors in the area and in the district.

The immunization and health education activities supplemented those of Mutambara hospital and the DNO of Chimanimani district by reaching out to remote villages. The project also trained an important number of traditional mid-wives and home-based care volunteers. The Mutambara area seems now to be well served with community based health workers who have been trained by the project and previously by other partners. It seems that this approach has improved the care given to terminally ill AIDS patients and that the communities are now accepting the home-based care concept and the supervision of the very ill by volunteers.

The project's HIV/AIDS component is still not yet fully developed. The project team was small, had limited resources available and lacked previous experiences in running HIV/AIDS awareness campaigns and in assisting HIV/AIDS groups. Most of these activities were carried out as part of other activities and mothers and school children became the project's main targets. Several HIV/AIDS orphans have benefited from support from UMC members in Norway.

Concerning the future of the various project activities, it is believed that the Mutambara hospital has the necessary human resources to carry out most of the activities apart from HIV/AIDS awareness activities and the assistance to HIV/AIDS which require a different set of skills and experiences. Given the gloomy economic situation of the country, the hospital will not be able to run most of the project activities without continued financial assistance from UMC in Norway and NORAD through BN for some time.

Prioritization of themes for a new project period

The evaluation team organized working sessions with the project team and with hospital and UMC staff at Mutambara to find out their prioritization of themes for a possible future phase of the project. HIV/AIDS prevention and awareness was overall the most important theme. The five most important themes included also training of HIV/AIDS counselors, support to HIV/AIDS affected people, immunization and health education, and home based care.

At the DNO's office in Chimanimani, immunization and health education was the first priority, HIV/AIDS prevention and awareness number two, home based care program number came third, while support to HIV affected people was the fourth priority. Geographical expansion was not perceived as important as this was viewed as not practical considering the distances involved. It was also felt that the project's current impact could be diluted by the expansion. The DNO's priorities were based on two important considerations: (i) The district is one of 12 districts in Zimbabwe chosen to benefit from the Global fund where training of HIV /AIDS counselors is one major component and (ii) Mutambara hospital is also one of 5 centers in Manicaland Province chosen to pilot Anti Retroviral Therapy. There are therefore some funds available to support specific HIV /AIDS activities.

General recommendations:

Based on the above findings and conclusions, the evaluation team recommends that UMC in Norway, with the assistance of BN and NORAD, continues to provide financial support to many of the ongoing activities, in particular immunization and health education, home visits and the supervision of the home-based care volunteers and traditional mid-wives.

The activities related to HIV/AIDS prevention and awareness, training of peer educators and assistance to HIV/AIDS support groups should be reexamined and revamped with the assistance of a local/national partner who has the required skills and experiences in these areas.

Future project activities should continue to complement and not compete with other actors' efforts in the Mutambara area. Networking and a close collaboration between the different partners and projects is necessary.

Future support from UMC in Norway would also require a much greater ownership and involvement of the UMC's Mutambara hospital in the project activities, both in terms of planning and coordinating and in carrying out the various activities. The project should not function as a small independent unit of the Mutambara hospital but be an integral part of the hospital and of the UMC in Zimbabwe.

Specific recommendations:

Organizational aspects:

1. Mutambara hospital's ownership of the project should be strengthened by either: (i) identifying a local registered nurse as the project coordinator or (ii) having the Matron of Mutambara hospital coordinate the project activities (iii) allowing nurses to earn extra money as they take turns to join the outreach program (iv) running the project as an integrated program of the hospital

2. In the future, an expatriate nurse/health worker could have an important advisory role but not as the project coordinator

3. The preparation of a future project should examine: (i) the need for strengthening the capacities of the project team, including staff at Mutambara hospital to enable them to carry out the project activities, in particular with regard to the implementation of HIV/AIDS related activities.

4. The project vehicle is more than 5 years old. It has been used intensively during all the outreach activities and home visits. The vehicle needs to be replaced during a new project phase. Concerning the management and the control of the car, it is recommended that Mutambara Hospital be in control but that the vehicle will be used as a project vehicle ONLY

5. The project is very hospital based. In future activities, the project and Mutambara hospital should try to build more linkages with other actors actively involved in the same or complementing areas and try to network and collaborate closely with these, including: The Girl Child Network, New Life and Memory Book under Family Aids Trust.

6. The UMC in Mutambara should become visible and be more involved in the project activities. The Church should be in the forefront in advocating for equity, fairness and social justice as well as sourcing for funding to run different projects. The project vehicle and volunteers' uniforms and bags etc. should have the UMC logo/emblem.

Aspects related to project activities/themes:

Mother and child activities:

7. The villages and outreach points that are relatively close to Mutambara hospital or other health centers should be reexamined to find out their real needs for immunization by the mobile project team or if possible find ways to encourage mothers to walk to the static health facilities. At the same time, these needs should be compared with the hospital's actual capacities to take care of these women and children at the hospital centre.

8. Mothers in hard to reach areas should be provided on a more regular basis with information and opportunities to access PMTCT services during the ANC sessions.

Home based care volunteers, including traditional mid-wives

9. Prior to a new project phase, a mapping of the number of HBCVs and TMs and the actual need for their assistance in each village, in particular with regard to the number of bedridden and housebound clients, should be made to find out the potential need for training more volunteers in the future

10. A future project should try to train more men as HBCVs

11. The distribution of in-kind support during home-visits should be reviewed carefully to avoid dependency. Such support can hamper the development of a sustainable home based care system

12. The project should reduce the provision of care to elderly who already have family members or others who take care of them.

13. The project should examine how to also target some of the training to the many volunteer women in the Mutambara area who take care of child orphans.

14. An important part of a future project would be to examine ways for making the home based care system more sustainable.

HIV/AIDS awareness, training of peer educators and support to HIV/AIDS groups

15. The project/Mutambara hospital should work in close collaboration with a national/local partner in developing and revamping this important project component. Several national NGOs in Zimbabwe have already acquired many years of experience in the fields of comprehensive HIV/AIDS awareness campaigns, training and supervising peer educators for different target groups and providing assistance to HIV/AIDS groups including identifying, launching and monitoring income generating activities for such groups.

16. The training and supervision of peer educators should become a priority

17. Future HIV/AIDS prevention and awareness activities should focus more on targeting important groups such as men, out-of school adolescents, elderly and other important community groups such as local influential leaders and church leaders.

18. Currently there is only one HIV/AIDS support group for the affected people in the project area. The establishment and support to more groups should be a priority, also in order to complement the success of Anti Retroviral Therapy

19. Education for life skills is one important area to be addressed so as to support and improve the quality of life for the orphans

20. The Church (UMC) should become more involved in the project's HIV/AIDS awareness activities

ANNEXE 1: TERMS OF REFERENCE

1. Introduction

United Methodist Church in Norway hereafter called UMCN has engaged Ms. Anne Mossige and Ms. Simbirai Gwaze to undertake an integrated evaluation and feasibility study of the **Mutambara Mother & Child Survival Training and Program Development** in Zimbabwe.

The work should be carried out in close cooperation with the representative of the UMCN and together with the United Methodist Church in Zimbawe as well as with the project staff.

2. Purpose of the evaluation

- To make an assessments of the project achievements in relation to the objectives stated in the corresponding project plan, annual plans etc.
- To document lessons learned in the project.
- To present recommendations for the future of the project.

3. Specific assessments to be carried out.

The evaluation shall be carried out based on the evaluator's best professional judgement and according to accepted best international evaluation practices. In particular the following items shall be included in the evaluation.

3.1 Target group

To which extent has the project successfully reached the stated target group

- Children under 5 years old
- School-children, youths, workers and the community at large (HIV prevention campaigns)
- Women of child-bearing age
- HIV-positive people and other patients
- Children orphaned by the HIV/AIDS pandemic

3.2 Project efficiency

Make an assessment about the efficiency of the resources used in the project in relation to the conducted activities. Should the activities have been carried out in another manner? Could the same activities been achieved with the use of less costly resources?

3.3 Project effectiveness

Make an assessment to which degree the project has achieved the project objective as stated in the project plan:

- 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.

- Purpose / immediate objective of the project/ programme for the entire period:

- The goal of this project is to improve the health situation for mother and child, and to improve the living conditions of people who are affected by HIV/AIDS (both patients and orphans) in Mutambara area, Chimanimani district of Zimbabwe. This will be achieved by training the women in the community who are conducting home deliveries in order to improve their knowledge about hygiene, complications during pregnancy and delivery and about HIV/AIDS. Monthly visits with growth monitoring and immunisation of children below 5 years will be carried out in 13 remote villages in Mutambara Hospital's catchment area. The community is encouraged to select volunteers (both women and men) to be trained to assist with caring for the patient on home based care in the villages. The proect also aims to train peer educators to inform the community about HIV/AIDS and to mobilise them to take action against AIDS. Information about HIV/AIDS will be carried out in the community, in primary and secondary schools, during various gatherings for children and youths, in companies and in churches.
-

- Anticipated results (outputs) for the entire period:
  - Increased knowledge and awareness about HIV/AIDS in the whole population – children, youths, adults and elderly.
  - 10-15 volunteers trained yearly to work as TMs (traditional midwives).
  - 20 volunteers trained yearly to work with clients on Home Based Care (HBCVs).
  - Improved Mother/Child's health situation in remote villages through health education, vaccination, growth monitoring, health care, ANC (ante natal care)
  - Improve the living conditions for people affected by the HIV/AIDS pandemic, this includes patients, relatives, orphaned children.
  - Have support-groups for HIV-infected people in at least 10 villages.
  - The HBCVs will form a group and look into ways of making the HBC programme independent of external funding in the future.

4. Project relevance

Make an assessment of the project relevance in relation to the main challenges in the project area. Can the project be said to be highly relevant or less relevant in relation to the need of the people in the area.

5. Project sustainability

Make an assessment of the project sustainability. In particular give an opinion regarding the project's possibilities to maintain its present work without external support. Preferably the sustainability model developed by Norwegian Missions in development should be applied in evaluating the project sustainability in relation to the following three factors:

- Activity profile
- Organisational capacity
- Context

6. Future development of the project.

Make a specific recommendation in relation to the future of the project. The recommendation should preferably be based on the same sustainability model developed by Norwegian Missions in Development.

7. Reporting

The evaluator shall present her/his findings in a workshop to be held at the project site attended by the project staff, members from target group as relevant, as well as representatives from UMC in Zimbabwe and Norway.

A written report in English shall be prepared based on this Term of Reference. Before the final report is presented, a draft report shall be presented to the project management, UMC in Zimbabwe and in Norway who shall be given reasonable time to present their comments regarding the draft report.

Oslo

Tove Odland
United Methodist Church in Norway

Anne Mossige
Evaluator

ANNEX 2: BRIEF ACCOUNT OF THE HOME BASED CARE CLIENTS VISITED BY EVALUATION TEAM

- Forty-two year old man living with his wife, 3 children, his sister and mother; on anti TB drugs and taking them as prescribed but still coughing; wife still breastfeeding; sister shows signs of pellagra; client is the only one who knows his HIV status.
- Thirty-five year old man living with his maternal uncle and his 4 children; on anti TB drugs and Cotrimoxazole prophylaxis; not able to walk to the hospital and has therefore defaulted treatment; three year old child has signs of malnutrition; client and careers aware of his HIV status; wife died some months ago.
- Fifty-one year old man living with wife and 3 children; on Anti Retroviral Therapy (ART) but not able to walk therefore has defaulted treatment for a month; wife not feeling well but is now the breadwinner; no food to eat in the house; son just completed primary education but not going to secondary school because there is no money.
- Twenty-four year old woman living with her parents and grandmother; on ART and coping well except for a rash and sores on both legs; divorced due to ill health and only child died 6 months ago at age 2; careers very supportive.
- Sixty-seven year old woman living with her husband and caregiver; is diabetic and hypertensive and now has dementia.
- Ten year old girl who is blind and dumb; both parents died and now being cared for by her father's 88year old brother and his 82 year old wife; careers able to provide basics but are not able to give Ruvarashe (God's flower) the constant supervision she needs.
- Seventy-four year old man living with his wife and grandchildren; on anti hypertensive drugs; has had a cerebro vascular accident.
- Eighty year old woman living with adult grand children; children take turns to be primary careers; defaulting treatment when she feels better.
- Ninety year old woman living with grand children supported by married daughter who lives nearby
- A77 year old man living with wife and children. Had a stroke some ten or so years ago and has developed left sided paralysis and has difficulty in talking
- A 24 year old mother of two children living with her parents. Responding positively to ART. Parents very supportive

Issues Raised

- Great appreciation for support given in kind by the project (tablets of soap, small packets of beans, rice and dried fish, analgesics and items of clothing) as and when available
- Appreciation for the introduction of ARVs at Mutambara Hospital which has resulted in a massive reduction in the number of clients on Home Based Care. An example is of one village where only 2 out of 10 clients were still bedridden or house bound
- Inability to walk to the hospital for review leading to defaulting treatment
- Inability to work (client and primary caregivers) leading to lack of food leading to slow recovery and or relapse