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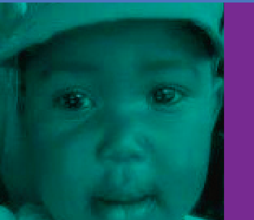
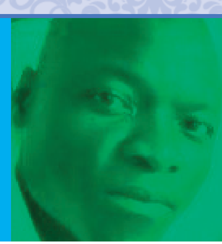
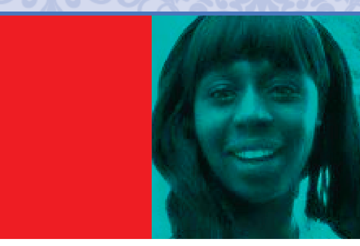
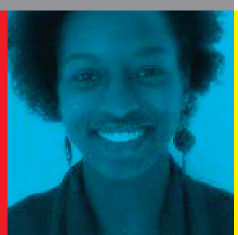
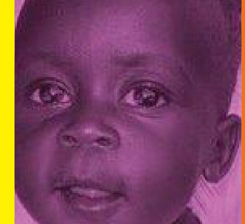


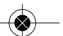



THE OPHID MBEREKO MODEL

Keeping Mothers and Babies Alive

Learning from the Field



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THE OPHID MBEREKO MODEL

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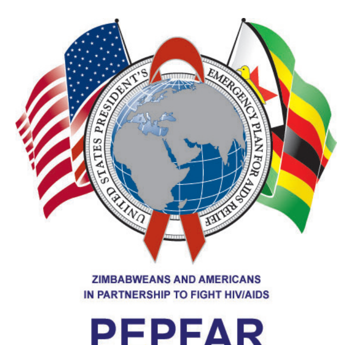
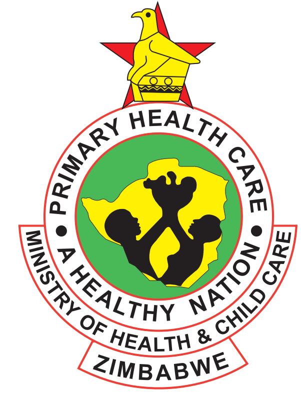
Learning from the Field

Acknowledgements

The Organization for Public Health Interventions and Development (OPHID) wishes to acknowledge and express their gratitude to the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) for their support to the Families and Communities for the Elimination of HIV in Zimbabwe (FACE-HIV) program, which enabled OPHID to carry out the majority of their work on the OPHID Mbereko model.

OPHID also wishes to thank the Ministry of Health and Child Care for providing the implementation guidelines for this model which enabled the integration of Maternal, Neonatal and Child, Sexual and Reproductive Health, Nutrition and HIV services at rural health facility and community level. Finally, we are grateful to UNICEF for providing additional funds to develop the model.





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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ARV	Anti-retroviral drugs
ART	Anti-retroviral therapy
CIDA	Canadian International Development Agency
DAC	District AIDS Council
DBS	Dried Blood Spot
DHE	District health Executive
DNO	District Nursing Officer
eMTCT	Elimination of Mother to Child Transmission of HIV
EID	Early Infant Diagnosis
EPI	Expanded Program of Immunization
HCW	Healthcare Worker
HIV	Human Immune Deficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
IMAI	Integrated Management of Adolescent and Adult Illnesses
IMCI	Integrated Management of Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IYCF	Infant and Young Child Feeding
L&D	Labour and Delivery
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
mHealth	Mobile (technology) Health
MNCH	Maternal, Neonatal and Child Health
MOHCW	Ministry of Health and Child Welfare
MTCT	Mother to Child Transmission (of HIV)
NGO	Non-Governmental Organization
OPHID	Organization for Public Health Interventions and Development
OVC	Orphans and Vulnerable Children
PCC	Primary Care Counsellor
PCN	Primary Care Nurse
PNC	Post natal care
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People living with HIV
PMD	Provincial Medical Director
PMTCT	Prevention of Mother to Child Transmission of HIV
PSS	Psychosocial Support
RHC	Rural Health Centre
TBA	Traditional Birth Attendant
VHW	Village Health Worker
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

The Organization for Public Health Interventions and Development (OPHID) has gathered experience in demand generation for health services through a number of community based models, with the socially inclusive Mbereko[1] model, a concept of peer to peer support groups for pregnant women and women with children under the age of two years, regardless of their HIV sero-status, proving to be the most successful one. In 2010, in an Orphans and Vulnerable Children (OVC) United Nations Children's Fund (UNICEF) funded project, OPHID demonstrated the important role of family social support groups for increasing access to family health services for HIV-affected children in rural Zimbabwe.[1] After learning from this intervention and complementing Ministry of Health and Child Care (MOHCC) and OPHID activities to strengthen Prevention of Mother to Child Transmission (PMTCT) and Maternal, Newborn and Child Health (MNCH) clinical services, OPHID designed the innovative Mbereko intervention to increase community access to integrated Prevention of Mother to Child Transmission of HIV (PMTCT) and Maternal Neonatal and Child Health (MNCH) services. This intervention was in line with the millennium development goals of improving maternal health, combating and mitigating the impact of HIV/AIDS and reducing child mortality by 2015 and now focuses on the Sustainability Development Goals 1, 3, and 5. With funding through the President's Emergency Plan For AIDS Relief (PEPFAR) and USAID for the Families and Communities for the Elimination of HIV (FACE - HIV) project OPHID was able to roll this Mbereko model out in three provinces of Zimbabwe.

Baby in a Mbereko cloth wrap produced by OPHID for the project

Background

Available data indicate that maternal, neonatal and child health in Zimbabwe is being compromised by low uptake of services along the continuum of care over the critical 1000 days, from the time when a woman learns she is pregnant to her child's second birthday, with more than 2/3 of all childhood deaths occurring within this critical time period.[2] With high HIV-related maternal and infant mortality, poor nutrition outcomes and a large numbers of deaths due to preventable infections and delays in care seeking, it is widely acknowledged that increasing uptake along an integrated continuum of essential maternal and child health services can significantly improve maternal and child survival in resource constrained settings.[3]

The most recent Zimbabwe Multiple Indicator Cluster Survey (MICS) 2014 demonstrates that 18% of women are delivering their babies outside of the healthcare system and Zimbabwe still has an unacceptably high maternal mortality ratio of 581 per 100,000 live births.[2] The leading direct causes of maternal mortality in Zimbabwe include post-partum haemorrhage, pregnancy induced hypertension and puerperal sepsis. The leading indirect causes include HIV and AIDS which account for about 26% of all maternal deaths.[3] This is associated with the high HIV prevalence rate in the country, estimated at 15.9%, among pregnant women attending antenatal care (ANC) in 2013.[4]

[1] Mbereko = Shona, the wrap that holds the baby close to its mother during the first two years of life

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Introduction

Additionally, Zimbabwe has an under five mortality ratio of 75 per 1000 live births with the rural areas in Zimbabwe experiencing higher mortality rates compared to their urban counterparts, specifically among the poorest households.[2] The leading causes of under-five mortality in the country are attributable to causes within the neonatal period including premature birth, birth asphyxia and neonatal sepsis.[2] Other main causes for under-five mortality are pneumonia, diarrhoea, measles and malnutrition. HIV and AIDS is said to be the underlying cause of deaths in under-fives dying from pneumonia and diarrhoea. Under-nutrition is also a leading contributor to child deaths. Additionally, according to the Lancet nutrition series of 2013, it was estimated that 45% of deaths among children in 2015 were due to under-nutrition (foetal growth restriction, stunting, wasting, micronutrient deficiencies and suboptimal breastfeeding). Most of these deaths, both maternal and child mortality, are preventable through uptake of health service interventions available at health facilities through the Ministry of Health and Child Care (MOHCC) including: ANC among pregnant women; skilled birth deliveries; prevention of mother to child transmission of HIV (PMTCT); and postnatal care (PNC) including immunization; Infant and Young Child Feeding (IYCF) and Community-based Management of Acute Malnutirion (CMAM).

The majority of initiatives to improve maternal, neonatal and child health are focused on the 'supply 'side', i.e., strengthening health systems and the services they provide to communities. The 'demand' side is receiving less attention despite communities playing an important role in promoting demand, sustaining uptake and creating an enabling environment for access to PMTCT and MNCH services. To achieve national goals and targets including eMTCT, there is an immediate need to strengthen the interface between the community and health service delivery, between the demand side and the supply side of PMTCT and MNCH services. Strengthening community participation is an important element in order to ensure transparency, accountability of health service management and community ownership of health programmes. A multitude of community based organisations, support groups and community networks and local level coordinating structures exist in Zimbabwe. Generally, community responses have not been sufficiently defined and prioritised, and have suffered from lack of cohesion and holistic vision to address the complexity of issues at community level, including individual contextual barriers to health service use. Additionally, service costs (direct and indirect), in a context of economic hardships, are a deterrent for mothers to access health services.

Women in rural Zimbabwe have a heavy workload during pregnancy

Barriers to Accessing Health Services

OPHID investigated and interrogated the barriers faced by rural women in Zimbabwe to accessing quality health care which included a combination of socio-cultural, economic, environmental, pre-disposing, enabling and need factors. We understood that increasing demand and uptake for PMTCT and MNCH services necessarily requires a holistic community-based approach which needs to embrace the following issues:

- **Social support** has been seen as important for improved health outcomes among women and children [5] [1] and in the context of HIV, social support has also been demonstrated as a protective factor for depression among women.[6]

- **Economic resources** are required to access and pay for health services and transport is needed to reach health facilities. Furthermore, lost productivity at household level to access care has been noted to act as

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a major barrier to uptake of maternal health services among poor women.[7] Maternal mortality in Zimbabwe is therefore both attributable to and seriously undermines household wealth, livelihoods and national resources. UNDP and WHO have estimated that Zimbabwe is losing at least US$132 million (1.23% of the 2012 National GDP) as a result of maternal related conditions.[8]

- **Increased awareness** among rural women of key services and planning to overcome barriers to service uptake over the first 1000 days. OPHID's work on access to services in the PMTCT continuum of care has demonstrated that failure to set goals for service uptake and limited advanced planning impede service uptake.
- **Male involvement** is also particularly important for improving health coverage, infant outcomes in PMTCT programs,[9] and maternal health outcomes.[10] In Zimbabwe, male participation in the context of ANC and PMTCT interventions has been shown to positively influence the acceptability of HIV testing and counselling among pregnant women, adoption of behaviours that reduce sexual transmission of HIV during pregnancy and support of HIV positive women in adhering to ART and recommended infant feeding options for PMTCT.[11] Despite this, male participation in Zimbabwe's PMTCT program remains below target.
- **Limited social recognition** for achieving sustained MNCH service uptake in rural communities contributes to low demand for sustained uptake along a cascade of care.[12] Linked to this are issues of gender inequality and lack of female decision making. Gender inequalities and lack of empowerment have been shown to decrease maternal and child health service uptake and outcomes over the first 1000 days. Furthermore, a decline in both maternal mortality and morbidity and in child morbidity and mortality has been shown to be linked to women's empowerment.[13]

The abilities of women to access information, make decisions, and act effectively in their own interest, or in the interest of those who depend on them, are essential aspects of the empowerment of women. If women, the primary caretakers of children, are empowered, the health and survival of their infants will be enhanced as will their own health and survival. In fact, maternal empowerment fits into Mosley and Chen's framework on child survival as an individual-level variable that affects child survival through the proximate determinants.[14] Children of women in Zimbabwe who participate in one to two household decisions have an under-5 mortality rate (110 deaths per 1,000 live births) that is higher than those of children of mothers who participate in three decisions (64 deaths per 1,000 live births).[14] Women in Zimbabwe, who believe that wife beating is not justified for any reason, are more likely than other women to use any method of contraception, receive antenatal and delivery care from a skilled provider and postnatal check-ups within the first two days following delivery than women who agree wife beating is justified.

Additionally, vulnerable groups are less likely to access maternal health services in Zimbabwe. Existing evidence indicates that rural women, women with higher parity, women with limited education, women facing resource constraints and women belonging to the Apostolic faith, who have early and often polygamous marriages, have lower uptake of essential MNCH services in Zimbabwe [12]. Accordingly, creating an enabling environment to improve maternal and child health required OPHID to recognise the needs of vulnerable women for the design of feasible and acceptable interventions.

Creating Demand for and Access to Health Services

The principal objective of the Mbereko model was to reduce maternal and infant morbidity and mortality through creating informed demand for and access to appropriate integrated PMTCT, MNCH and nutrition services through the

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establishment of community-run and community based Mbereko groups. This OPHID initiative was intended to contribute to the overall objectives of the integration of National PMTCT, MNCH and Nutrition programmes and support the local communities, particularly the most vulnerable populations of HIV positive mothers and their infants in the rural communities and facilitate access to integrated health services through an effective, equitable and sustainable process.

Over the last few years the OPHID Mbereko model has been developed and fine-tuned with funding from various projects, e.g., Children First with funding from USAID through World Education, CIDA/UNICEF and more recently with USAID funding through the FACE-Paediatric HIV consortium. In fact, comparable women's groups, based on a similar concept, have been documented as a low cost intervention to successfully reduce maternal and neonatal mortality by up to 40%. [15] The Mbereko model importantly takes a comprehensive approach to the issue of community access to integrated health services, with an aim to empower women within the domestic and community arenas.

Our rights based approach focuses on patient rights by bringing to the fore the long neglected MOHCC Patients Charter (see Annex 1), which is interrogated both by the healthcare workers (HCWs) and the Health Centre Committees (HCCs) at the clinics and by the Village Health Workers (VHWs) and women within the Mbereko groups, ensuring that all know their rights and responsibilities. The model (see diagram Page 5) is based on the four axes of demand, empowerment, mobilisation and accountability to:

- **Facilitate the interface of clinical supply and community demand for PMTCT/MNCH services.** By working with the ‘supply’ side of health service delivery the Mbereko model aims to work with the health centre staff (HCWs), Health Centre Committees (HCCs) and the Village Health Workers (VHWs), a MOHCC community-based cadre, to increase the demand for services at the health facility through mobilising , informing and supporting the community.

- **Create a more accountable community environment through capacitating Clinic based HCWs, and community linked HCCs and VHWs to support the provision of appropriate quality services.** Working with the identified cadres the project aims to support and to encourage the role of each cadre in facilitating the uptake of quality PMTCT/MNCH services at the rural clinics through improving health service delivery at every point.

- **Mobilisation of community leadership to create awareness, understanding and appreciation of benefits of PMTCT/MNCH services.** Working with the community leadership to create a supportive community environment and encourage all pregnant and lactating women to access health services and realize the benefits of services such as PMTCT/MNCH, family planning services, IYCF services among other services offered at the health facility.

- **Empowerment of women through knowledge, increased confidence, skills and resources to demand and access their right to medical care and treatment.** Our focus was on bringing the clinic to the community so that the community gets adequate knowledge to make informed decisions about their health and additional resources to be able to access and demand services when they come to the clinic.

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The Mbereko Model

OPHID
Organization for Public Health Interventions & Development

Primary Health Care • A Healthy Nation • Ministry of Health & Child Care • Zimbabwe

Health Care Facility / Clinic

Accountability

Demand

Link to service

Health Centre Committee (HCC)

Represent

Village Health Workers

Skills

Knowledge

Mbereko Groups (Individuals)

Identify and Mobilise

Mobilisation

Empowerment

Hard-to-reach/ unidentified individuals

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The Mbereko Concept

Components of the Concept

Community-based activities require community ownership to make an impact and be sustainable. OPHID places emphasis on the importance of consulting the community and securing the support of community leaders and decision makers. [16] The chiefs and other traditional and religious leaders are sensitised on the implementation of the model. Particular attention is paid not only to community ownership, but also to ensuring sustainability of the Mbereko groups within the health system after donor support has been withdrawn. The Mbereko model initially involves sensitisation of the Ministry of Health and Child Care (MOHCC) staff in the PMTCT, Family Health Care and Nutrition Departments at national level and this is cascaded down through the provinces to the districts to the Rural Health Centres (RHCs). This ensures that the Mbereko model is embedded in and utilizes existing MOHCC and community structures on the ground and responds to local situations and local priorities.

Demand - The role of the VHWs

The bridge between the clinic and the community is strengthened by working with the village health workers (VHWs) whose role is to form and maintain community groups by facilitating participatory action meetings on integrated MNCH/PMTCT services with the pregnant women and mothers on a regular basis. Recruiting the right group facilitators is seen as crucial to the success of women's groups; there is need for people with the right attitudes and skills. [17] The VHWs are the fulcrum of the project. OPHID runs a four day course for the VHWs on current updated health information, how to conduct participant action meetings, project activities and objectives and keeping records. The VHW training is conducted using: the MOHCC VHW Community Flip-Chart produced by the OPHID FACE program focussing on MNCH and PMTCT (see Annex 2); IYCF Counselling cards; WHO/IATT (Expanding and Simplifying Treatment for Pregnant Women Living with HIV); the MOHCC Patients Charter; Milestone cards developed by OPHID; and Mbereko key messages (see Annex 3). Each of the trained VHWs is encouraged to recruit all pregnant women and those mothers with children below the age of 2 years in their villages into Mbereko groups. This inclusivity is fundamental to achieving results. Since meetings are based in the villages this allows for the inclusion of even the most marginalised women. Supporting the rights based approach of the project, VHWs also provide the women with information on the MOHCC Patients Charter, which aims to improve the relationship between patients and health care providers. It explains patients' rights, the kind of service that they can expect from the health care delivery system, the patients' responsibilities and obligations and how to effectively give feedback on the services provided. MOHCC and OPHID staff follow up with regular village based support visits to the community-based groups.

Accountability - The role of the HCCs

To embed the project further in community structures, OPHID also works with the Health Centre Committees. These committees, generally dominated by men and composed of community leaders, e.g. village heads, councillors, businessmen, teachers, religious leaders, etc., were resuscitated by the Results Based Financing of rural health clinics by the World Bank and are now supported nationally by the Health Development Fund. The aim is for the HCC members to understand and improve clinic service quality and performance data and by working with the health facility staff be able to cope with the demand for services

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Meeting with Health Centre Committee Members

that is anticipated to result from the Mbereko meetings. This is reinforced by the introduction of the principles of the MOHCC Patients Charter. It explains patients' rights, the kind of service that they can expect from the health care delivery system, the patients' responsibilities and obligations and how to effectively give feedback on the services provided. With this knowledge the HCCs can be more accountable to their communities and fully support the actions of the VHWs within the community while at the same time work with the rural health centre (RHC) staff to improve clinic service delivery and improve the clinic's chances of Results Based Financing.

Mobilisation - The role of the community leaders

Since political, social, cultural, religious and economic factors can be barriers to women's participation in group meetings and health service uptake, strategies are needed to secure the support of the gatekeepers, those who are influential in the family (e.g., husbands, mothers-in-law) and the community (e.g., religious and traditional leaders). Bearing this in mind the Mbereko model involves meetings with the traditional and religious leaders, followed by community mobilisation meetings to gain understanding and obtain "buy-in" to the Mbereko process. Then during regular review meetings with HCC members and other local leaders OPHID stresses the need for their continued support to demystify any negative perceptions of the Mbereko gatherings and to advocate for health service uptake. The major role of these leaders is to support VHWs' activities by mobilizing communities for meetings. Additionally, some of the leaders are keen to help the VHWs by disseminating information to the community during community meetings, this assists in ensuring that the project is sustainable.

Empowerment - Mbereko and ISAL Groups

It is frequently argued that there is no need for financial incentives to mobilise the target population if the meetings are addressing topics that are relevant to them. However, it has been OPHID's experience that although women may attend the meetings they are not able to access the relevant healthcare due to financial barriers. They listen politely, but do not internalise the information because they are unable to act on it. This led OPHID to introduce basic financial literacy and entrepreneurial skills. Women's empowerment is addressed through the addition of Internal Savings and Lending (ISAL) training followed by Income Generating Activity (IGA) training for Mbereko group members. This fosters engagement and commitment on an inclusive village basis. It also aims to tackle poverty and sustainability of the groups and substantially increases the health and life chances of all family members through not only increased healthcare knowledge, but also increased resources to access healthcare.

Strategizing during a Mbereko meeting in Marondera rural district

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Mbereko Meetings

Using the MOHCC Village Health Worker Community Flip Chart on MNCH and PMTCT (see Annex 2) the trained VHWs facilitate regular dissemination of health information sessions with their groups. To compliment these sessions OPHID staff and members of the District Health Executive (DHE), usually the Community Nurse, also assist during monitoring meetings in placing emphasis on childhood developmental milestones (so that mothers recognize and appreciate changes related to specific physical and cognitive abilities such as walking and understanding language); information on early warning signs of neonatal/child illnesses (e.g. rapid breathing, laboured breathing, signs of dehydration); feeding of the sick child; simple measures to help sick babies (e.g. use of the kangaroo concept); the importance of testing and retesting for HIV, stigma, discrimination and disclosure; benefits of Option B+, benefits of ART adherence and compliance, early identification of HIV-infected children and appropriate management (including initiation of Paediatric ART), and care of an HIV exposed infant; and challenges faced by pregnant and lactating mothers, effects of maternal workloads, as well as the role of men in family and child care and information on gender based violence (GBV).

Each Mbereko member receives a Maternal and Neonatal Child Health Milestone card, an 8 page booklet in English or Shona, which provides the women with guidance on accessing health services and child development. During monthly meetings held by the groups in the implementing catchment areas, VHWs disseminate information to equip mothers with knowledge using a participatory action approach, enabling them to problem solve on barriers to accessing health services and adopting healthy behaviour. These health education sessions aim to help women to determine their own priorities in dealing with the various problems that they face in bringing about change and improvements within their families and communities; and to equip mothers to make informed choices regarding their health care and their ability to access healthcare at their local clinics.

The women are given Zambias (lengths of cloth that they can use for themselves or as mbereko). This is a token for the enthusiasm with which they embrace the project, to improve the visibility of the project, and to provide IEC material on the importance of demanding and receiving integrated MNCH/PMTCT service delivery.

ISAL and IGA Training

Women are trained in basic financial literacy and assisted to become economically empowered through the Internal Savings and Lending (ISAL) methodology, a four day training, followed by a further four day training on basic entrepreneurial knowledge on managing Income Generating Activities (IGAs). These trainings aim to improve women's income, education and health in an effort to strengthen their financial capabilities to access health services and improve family health practices. In the implementing districts adolescent girls are particularly vulnerable to early pregnancy, sexual abuse and child marriage mainly due to lack of education for the girl child. The low levels of literacy make training for ISALs more challenging and are seen as a major obstacle preventing these young women from identifying health problems early, impacting on their own and their families' health.

Mbereko women selling the wares from their IGAs after meetings

Gender equality and empowerment of women are acknowledged as catalysts for multiplying development efforts within the districts. Investments in gender

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equality yields have been shown to give the highest returns of all development outlays [18]. Women usually invest a higher proportion of their time and earnings in their families and communities as opposed to men. Through ISALs and IGAs the economic empowerment of women aims to increase the capacity of women to participate in community development issues, so that together with their greater knowledge of Patients' rights, their voices can be heard by policy makers and programmers as they contribute towards family welfare and benefit from the growth processes with their family and community status elevated.

Each ISAL group formulates its own constitution with the assistance of a template. These constitutions contain the fundamental principles which outline the purpose, structure, and limits of an ISAL group. In essence, these constitutions provide a foundation upon which established groups operate. The documents are very basic, governing the rights and responsibilities of the individual members and committees of different groups. ISAL groups complete their draft constitutions which are then reviewed and authenticated by the local councillor, Chief, Headman or a Zimbabwe Republic Police senior officer.

The Majority of ISAL members are women between the ages of 16 to 40, with a few male members some of whom are village health workers

- **Individual community members self-select themselves, and form Internal Savings and Lending (ISAL) groups (between 5 and 15 members a group)**
    - Usually on the basis of how much they can save, in some groups all members save $1 another maybe $5
- **OPHID provides training and coaching to the groups before they form and once they are operational**
    - Includes training on skills, knowledge, finance profitability; and household needs/ budgeting
    - Once a group has started saving regularly (2-3 months) OPHID trains them for another 4 days on how to select, plan and manage their income generating activities (IGAs).
- **Each group adopts its own constitutions, with some standardized structures from a given template, including:**
    - Designating a Secretary to keeps records and a Treasurer to keep the funds
    - Deciding on the contributions by members and the interest to be charged on loans.
- **Members meet regularly; borrowers repay loans within a stipulated time frame with an agreed interest rate, usually 10%**
    - All funds should be loaned out to group members
- **At the end of an agreed time period, usually a year, the group shares out their funds and then starts another savings round**
- **Groups may also set up a social fund which is a certain percentage of the group savings that can be borrowed by any member interest free in case of an emergency or health need e.g. clinic delivery, funeral etc.**

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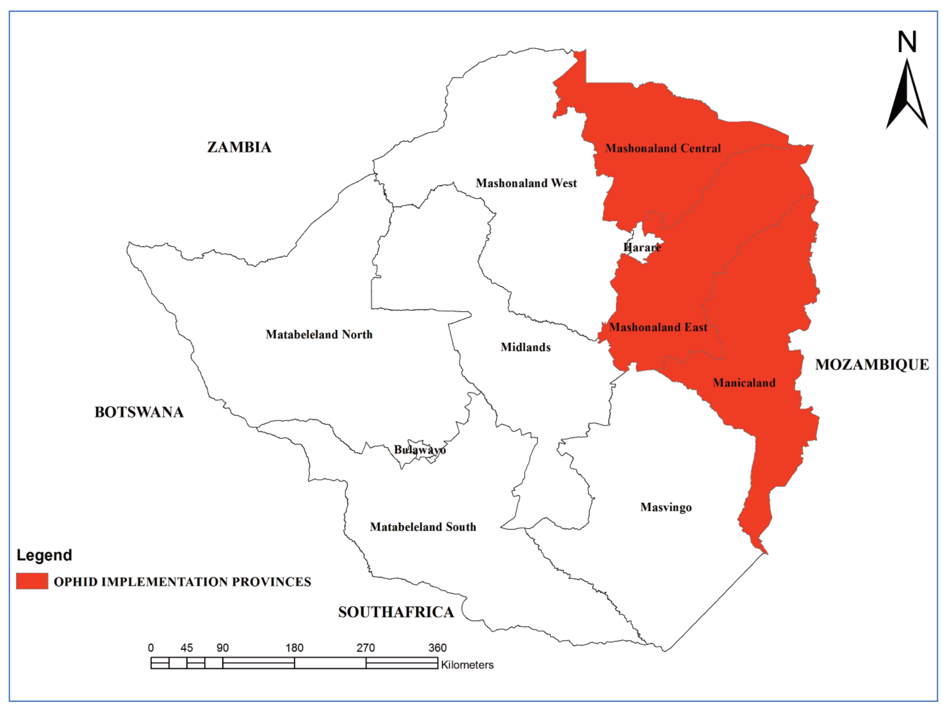
Mbereko Project Locations

Initially two clinics in Marondera district in Mashonaland East, Border Church clinic and Chihota rural hospital were the pilot sites where Mbereko groups were established in 2012. Later in 2013 Mbereko groups were established in the catchment area of Zindi clinic in Mutasa district in Manicaland province. With further funding from the USAID funded OPHID FACE program more Mbereko groups were initiated in the three provinces of Mashonaland Central, Mashonaland East and Manicaland. By October 2015 OPHID, had established 828 Mbereko groups in the catchment areas of 38 clinics with 13 682 members.



The Story of the Mbereko group for mothers living with HIV

The Village Health Worker for part of Skimpton Clinic Catchment area, Beater Chigayo, established a Mbereko group in her area. After a couple of meetings the women who were HIV positive in this group decided to form their own group because they perceived that their health needs differed from the negative women. However in forming the ISAL groups within the Mbereko groups they mixed together with their neighbours who were HIV negative. The HIV positive group in Skimpton catchment area now has a membership of 28 women, these are the stories of four of them.

Chipo Gwegwe is 44 years old, she is the mother of 6 children. The first born child is now 28 years old and her youngest is a year old. Her husband died of HIV in 2015 after her son was born, he was in denial and never accepted his HIV status.

Chipo became aware of her HIV status once she became pregnant with her youngest and was put on Option B+. She states that she learnt a lot from joining the Mbereko group and it gave her strength to stand in front of people and disclose her HIV status. Living positively was a challenge for her, but after joining the group she had help with adhering to her treatment and she realised she was not alone, so together a few HIV+ women approached the VHW to ask if they could start an Mbereko group for mothers living with HIV.

They have a lot of challenges, but they help each other. She explains that they need healthy food to fight of Opportunistic Infections (OIs); the turnaround time for DBS samples for EID is slow; generally disclosure, adherence and retention in the ART system remain their greatest challenges.

Yeukai Cheu is a 38 year old mother of three children; her eldest is 18 years old and her second born 12 years old. She discovered that she was HIV positive during her third pregnancy and followed the steps for PMTCT with Option B+. Her daughter who is HIV

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negative is now a year old. Her husband initially refused to accept that he was HIV + then after he had TB he accepted his status, but it was too late he died. She learnt so much from joining the Mbereko group, in particular about the effects of stress on her body, which she was not aware of, especially the stress from not disclosing her HIV status. She also acknowledged that stigma and discrimination also caused her stress. Now she found a group where she was accepted.

Yeukai stated that the Mbereko project alerts her to the dates and times of the mobile OI clinic which frequently change becase of the unavailability of fuel to conduct outreach programmes.

Evelyn Muchabarwa is a 36 year old, married woman. She has four children the youngest is 7 months old the others are 17, 13 and 9 years old. Both husband and wife are now on ART and their last child was born after they knew their HIV status through the PMTCT programme. Through joining the Mbereko group she states she had courage to disclose her status and became one of the founding members of the HIV+ Mbereko group. She now feels empowered and has had Norplant inserted for family planning. "The group also supported me in getting access for HIV testing for my baby". She explains that she had been reluctant to get her baby tested because of her own status.

She is now supported by her husband and through the ISAL savings groups she explains, several groups have banded together to set up a grinding mill in their area to generate income for the women and their families and meet a felt need in the community.

Tariro Kutambura, 25 years old, and her husband Fungai Gwegwe, 28 years old, are both HIV positive, but to their delight their son who is nearly two years old son is negative. She had lost two previous children, the first when he was 3 years old and the second one at 8 months of age. The husband knew he was HIV+ but hid his status from his wife, who discovered it when she found his clinic card. Meanwhile they had blamed the deaths of their two previous children on witchcraft. He thinks he got HIV when he was working as an illegal gold miner at Hwedza mountain. When they found a little gold they would sell it and go drinking at Hwedza growth point. Once Tariro had discovered his status he apologized for deceiving her. Then when she was pregnant for the third time their VHW persuaded her to go to the clinic for testing, both husband and wife went to the clinic for her first ANC visit. Membership in the Mbereko group has given them a lot of support, knowledge and information about living positively and the importance of supporting each other to adhere to their medicine. Fungai realized that he needed to help his wife more in looking after their son when he was a baby and that while she was breast-feeding she needed support in the household chores.

Primrose Madzinga and her husband Joshua Kamedza have 3 children, aged 19, 13 and 9 months. She found out that she was HIV positive when she was pregnant with her third child. When she discovered her HIV status she encouraged her husband to visit the clinic to be tested. Now they are both on ART and being treated from the local clinic. With advice from the Mbereko group we had our baby tested with DBS when the baby was 6 weeks old, the baby is negative. She is carefully following the advice of Mbereko group and hopes to keep her baby negative. Her husband was away from home a lot working on farms and mines and he thinks that is when he got infected with HIV.

Mbereko Participatory Field Evaluation

Without funding for an implementation science approach to evaluating the project, OPHID recognised the importance of documenting and sharing programmatic evidence and lessons learned from the Mbereko project in order to build on and share our knowledge. Mirroring the Mbereko model's participatory design, OPHID wanted to employ a reflective and action-oriented evaluation approach to documenting key lessons that recorded the perspectives of all participants in the project. This field evaluation approach principally emphasised documenting the perception of community-based stakeholders, so as to capture the voices from the field and allow us to responsively incorporate lessons learned from community perspectives into improving the model.

Objectives of the Field Evaluation

The primary goal of the evaluation was to document and describe the perceptions and experiences of the clinic service providers (VHWs and HCWs) and the community members supporting the model (HCCs and male partners of Mbereko women), as well as Mbereko mothers who participated in the groups in the catchment area of 6 out of the 38 participating health facilities in Manicaland, Mashonaland East and Mashonaland Central provinces of Zimbabwe.

Specific objectives of the evaluation were to:

1. Describe the uptake of MNCH and PMTCT health services by women who were in the Mbereko groups during their last pregnancy.
2. Document the community level support for mother-baby pairs who were in the Mbereko groups.
3. Describe the perceived benefits of participation in the Mbereko groups for increasing uptake of PMTCT and MNCH services and family health.

Methodology

A mixed-method participatory evaluation approach was employed to achieve the evaluation's stated objectives. The methods employed two complementary qualitative evaluation approaches:

1. **A Quantitative Mbereko Mothers survey –** which conveniently sampled women who were in Mbereko groups during their last pregnancy at six health sites namely: Nharira rural health centre (RHC) and Chinyika RHC, in Mashonaland East province; Nyawa RHC and Katanya RHC in Mashonaland Central province and Zindi RHC and Nyanyadzi RHC in Manicaland province. The intention of surveying Mbereko Mothers was to document the characteristics of women participating in the groups together with self-reported service uptake and outcomes.

   The group of interest for the evaluation survey was 'Mbereko mothers', women who reside in the catchment area of 6 rural health facilities where Mbereko groups have been established and have participated in these community groups during their last pregnancy. The individual interviews were with women with children below 6 months at the time of the interviews and who were coming consistently to the meetings.

2. **Qualitative Focus group discussions (FGDs)** were held with 3 key community-based stakeholders of the Mbereko project: 1) Mbereko mothers who participated in the Mbereko groups during their last

pregnancy; 2) Health Centre Committee (HCC) members and male partners of women in the Mbereko groups; and 3) VHWs at the health facilities where Mbereko groups were established, who acted as group leaders. The intention of the FGDs was to discover the various stakeholders' perspectives on the effectiveness of the Mbereko model.

The criteria for selection of the women for the FGDs were women with children above 6 months who were consistently coming to the Mbereko group meetings. Other groups of interest were gatekeepers to MNCH services at community level (i.e., HCCs and male partners), health care workers (HCWs) and village health workers (VHWs) providing services at participating health sites. The FGDs for the men and HCCs were made up of male HCC members as well as partners of the women who were coming to the meetings. Evaluation procedures were co-facilitated by OPHID staff who had been involved in Mbereko Group Training and Formation, individuals known to the stakeholders of interest.

Participatory Evaluation Strengths

Evaluation process that is a learning experience for participants.

Emphasis is on identifying lessons learned that will help participants improve program implementation, as well as on assessing whether targets were achieved.

USAID. Performance Monitoring and Evaluation TIPS – Participatory Evaluation: http://pdf.usaid.gov/pdf_docs/Pnadw101.pdf

The methods were chosen to emphasise a participant-centred interpretation of the effectiveness of the Mbereko model for increasing uptake of maternal and PMTCT health services, while capturing contextual information on perceived benefits and limitations of the model. The evaluation was embedded within routine program activities and project exit procedures, with findings informing sustainability measures.

Mbereko Mothers Survey

Women who participated in Mbereko groups during their current and last pregnancy were conveniently sampled, with current and previous Mbereko mothers asked to gather at their normal Mbereko Group meeting place. Mothers were interviewed by project personnel to explore service uptake and behaviours among women using a standardized questionnaire. With facility level data on MNCH service use recorded in multiple facility registers making reporting of individual outcomes difficult, the Mbereko Mothers Survey was intended to provide an indication of the outcomes and effectiveness of project activities for the Mbereko mothers. Specifically, we compared service utilisation in the current pregnancy after the implementation of the Mbereko model against the previous pregnancy without the Mbereko model. This analysis was used as a proxy measure of individual outcomes of female beneficiaries in the absence of a large-scale community based survey with an intervention and control group. We used service uptake along the same indicators in the previous pregnancy to conduct pairwise before and after (i.e., service uptake in previous pregnancy with no Mbereko group vs. service uptake recent pregnancy with Mbereko group) comparisons to give an indication of the effectiveness of the Mbereko group model on uptake and utilisation of PMTCT/MNCH services.

Key Issues addressed during the FGDs

- Maternal Neonatal and Child Health Priorities in each community
- Stakeholder knowledge of and perceptions of PMTCT
- Experiences of Mbereko groups
- Barriers and facilitators to maternal health service uptake.
- Key lessons from Mbereko Group experiences that could be applied to improve sustainability and/or further roll out of the Mbereko model.

Table 1: Sampled sites

Clinic	District
Nharira	Chikomba
Chinyika	Goromonzi
Nyawa	Bindura
Katanya	Bindura
St Peters	Mutasa
Nyanyadzi	Chimanimani

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Mbereko Community Stakeholder FGDs

The purpose of holding focus group discussions was to describe the perceived benefits and limitations of Mbereko groups for increasing uptake of PMTCT/MNCH in each community. The focus group discussions also provided information on community level support for the uptake of PMTCT/MNCH services and barriers to health service uptake and perceptions of how these could be addressed. Three groups of FGDs were conducted at each health facility and described below.

Table 2: Target groups of FGDs for Mbereko Groups Community Evaluation

Target Group	Definitions	# FGDs to be held/ Place to be held	FGD characteristics	Purpose of FGD
Rural Women	Women who were in the Mbereko groups.	Total of 6 FGDs; 1 FGD per target site with a sample of women surveyed and female elders caring for young children.	Rural women who were in the Mbereko groups during their last pregnancy living in the catchment area of the targeted health facility.	To assess perceptions regarding the benefits and limitations of the Mbereko groups for supporting health service uptake in their community. Document experiences and key lessons of implementing the Mbereko model.
MNCH Gatekeepers	Decision-makers, community level supporters and resource controllers for health care access of women and infants.	Total of 6 FGDs; 1 FGDs per target site with a sample of community gatekeepers.	Male partners, HCC and other community leaders in the community.	
Village Health Workers	VHWs that participated in Mbereko Group Training (ISALs, IGAs and maternal and child health) and acted as Mbereko Group leaders – recruiting women into groups and organising group meetings.	Total of 6 FGDs; 1 FGDs per target site with a sample of village health workers.	VHWs serving the catchment area of a health facility that was participating in the evaluation.	

Evaluation Findings

The evaluation findings aim to provide a summary of key perceptions regarding the influence of Mbereko Group membership upon health service uptake among Mbereko Mothers, and the perceived benefits and limitations of the Mbereko model for community stakeholders for supporting the uptake of MNCH and PMTCT services in rural communities. Lessons learned provide a synthesis of the project's achievement of its overall goal of increasing health seeking behaviour and facilitating access to MNCH and PMTCT services at local clinics and providing an important opportunity to document and share the voices of community-based participants. Additionally, some key lessons are recommended for application to refine the Mbereko model further.

What We Learnt

Objective 1: Describe the uptake of MNCH and PMTCT health services by women who were in the Mbereko groups during their last pregnancy.

Improved MNCH Service Uptake

A total of 299 Mbereko Mothers were interviewed at the 6 targeted health facilities. The average age of Mbereko Mothers was 27 years (range 15-44yrs). The average number of pregnancies was 2.5. The majority of the women lived in the communal lands (86%) and were married in monogamous unions (88%). More than half of the women interviewed belonged to the Apostolic Faith (59%). A summary of the characteristics of female respondents can be found in the table 3.

In the absence of a control group, service uptake of key PMTCT/MNCH services during the recent pregnancy after the implementation of the Mbereko groups (After Mbereko) and previous pregnancy before the Mbereko group (Before Mbereko) showed the proportion of women who made use of services in

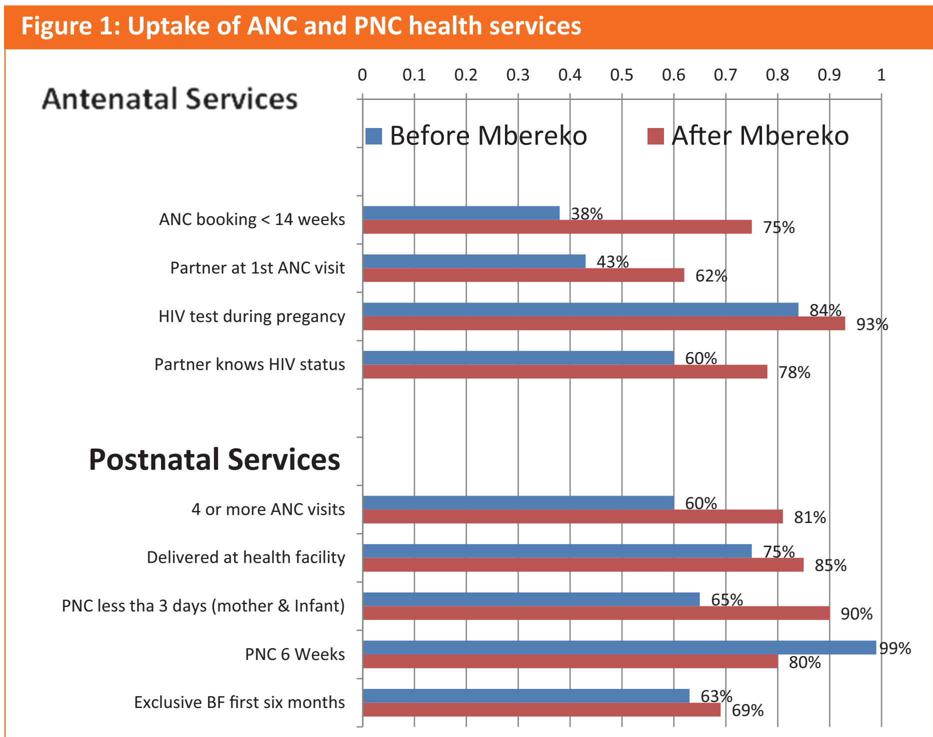
pregnancies before and after the Mbereko groups. Mbereko mothers reported higher levels of service utilisation and adherence to the MOHCC recommended guidance on services for both PMTCT and MNCH services following involvement in Mbereko Groups.

Table 3. Characteristics of Mbereko Mothers Survey participants (N=299)

	Frequency	Percent
Age group		
15-24	117	39%
25-34	149	50%
35-44	33	11%
Place of residence		
New resettlements	8	3%
Communal Lands	257	86%
Large commercial farms	34	11%
Educational level		
Primary or none	78	26%
Secondary -Form 1-2	69	23%
Secondary - Forn 3-4	151	51%
Form 5 and above	1	0.3%
Current marital status		
Never Married	6	2%
Married-monogamous union	263	88%
Married-polygamous union	24	8%
Divorced/separated	6	2%
Religion		
Apostolic	175	59%
Catholic	28	9%
Protestant	14	5%
Pentecostal	57	19%
Traditional and other	25	8%
Distance of homestead from the nearest health facility		
Less than 1KM	21	7%
1-5 Km	143	48%
5-10 Km	81	27%
10+Km	26	9%
Do not know/No response	27	9%

Figure 1 below indicates service utilisation during pregnancy to ensure safer pregnancy through early booking and PMTCT through the HIV testing and counselling services. Health service utilisation and breastfeeding practice among women during delivery and postnatal care is also indicated. Among the women who resided in catchment areas with waiting mothers homes at the health facility, more women utilised the facility in the most recent pregnancy after implementation of the Mbereko project compared to the previous pregnancy, 33% and 28% respectively. There was also a marked increase in the proportion of mothers living with HIV who had their children tested for HIV at the 6 weeks postnatal visit in the most recent pregnancy 63% compare to the previous pregnancy of 43% before the implementation of the Mbereko project.

Figure 1: Uptake of ANC and PNC health services



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Strengthened Community-Facility Linkages

The Mbereko project focused on strengthening the relationship between the community workers, the VHWs, and the clinic to enable service access. The National PMTCT programme has been successful at increasing the proportion of women who access antenatal care and receive HIV testing, care and treatment. However, vulnerable women who fail to present to care and failure of many women to uptake all essential services across the PMTCT cascade had not been addressed. The inclusive nature of the Mbereko model enabled these women to be reached and linked to facilities.

A common theme reported among all stakeholder groups during FGDs was the role of Mbereko Groups in empowering communities to appreciate and plan for improved maternal and child health in their communities, using existing resources. A summary of key feedback by stakeholder group is provided.

Apostolic Women holding Mbereko meetings

Health Centre Committees

- An increase in knowledge and improvement in service access was seen at clinic level with an increase in early booking and clinic deliveries.
- HCC committee members articulated that because of their participation in the program they have become more responsive and aware of health issues in their community.
- HCCs perceived Mbereko groups as having brought social cohesion to women within the community. As a specific example, HCC members indicated that the inclusive village-based approach meant that Apostolic Faith members were now able to participate in health matters.

> *'Mbereko yakasvika pagere vanhu'*
>
> *Mbereko came to where the people are'*
>
> -HCC Member, Nyawa Clinic

One safe delivery: HCC intervention in clinic deliveries

Background

As part of the Mbereko project, data review meetings with the Health Centre Committee (HCC) and the clinic staff were held on a quarterly basis. The objective was to get the support of the HCC in the mobilisation of the community to take up health services at the clinic. The HCC who are the link between the clinic and the community is a committee made up of local leadership as well as other influential community members and the nurse in charge is the secretariat to the committee. Because the committee is made up of non-clinic staff members it is sometimes difficult for them to understand their role and support the clinic in health education within the community hence the need to have regular meetings with them to get them to appreciate the work done at the clinic and map ways for their participation in improving health service uptake.

Mbereko collaboration

In Bindura district the HCC and VHW review meetings were led by the district personnel with the support of OPHID. It was during one of these meetings that the issue of the continued increase in home deliveries was mentioned. The nurses at the clinics bemoaned the lack of a

waiting mother's shelter at the clinic a strategy that has been proven to be effective in reducing home deliveries and improving a safe and clean delivery for the mother and baby. It was not all committees that appreciate the importance of the shelter, but a few of the committees took it upon themselves to find a solution to the problem.

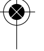
Three clinics of Takunda, Manga and Katanya have so far made an effort towards resolving this problem. The clinics are located in the new resettlements with the main area of livelihood being farming. The population surrounding the clinic is made up of people who used to work on the commercial farms, they are of different origins (Mozambigue, Zambia, Malawi) and the majority attained grade 7. With this low level of education the culture in the communities surrounding these clinics is for home deliveries. It is against this background that the HCC with the help of the clinic staff after the August review meeting managed to identify old farm houses that could be converted to become waiting mother's shelters. It was not enough to just identify the shelter; the committee with the help of the VHW started mobilising the community to make use of the shelter for deliveries. It takes time to change the mind set of people and it will be a long time before the whole community accepts the idea of waiting for delivery.

Immediate results

To date Manga and Takunda clinic have opened their temporary waiting shelters while Katanya clinic is in the process of renovating the identified shelter. So far within just one month since the idea was planted there has been an increase in the women coming for delivery. Takunda clinic used to have an average of 3 deliveries, but in September 2015 they recorded 5; while Manga clinic used to have an average of 8 deliveries a month they recorded an impressive 13 deliveries. Katanya clinic has maintained its normal deliveries with 7 deliveries in August and 6 in September 2015 but they anticipate an increase when they open their shelter later in the month.

Conclusion

Use of the farmhouses as temporary waiting mother's homes has been beneficial since pregnant mothers are now coming to wait for delivery at the clinic. HCCs and VHWs are continuing to utilise village meetings to sensitise communities on the use of waiting mother's homes. The next steps will be to make further improvements to the shelter with the addition of beds, food packs and entertainment for the women. While the figures are still low one safe delivery is worth it say the clinic staff and they will strive to increase the numbers of women who deliver at the clinic.



Village Health Workers

- VHWs described witnessing changes in access to some underutilised maternal health services through the course of the project, including:
  - Women becoming more open about revealing their pregnancy in the early weeks;
  - More women attending the clinic with their partners for ANC booking.
- VHWs described their relationships with the community as having improved as they had increased direct interaction. In the words of one VHW: *'takabatanidzwa tikaita hushamwari hwakasimba'* 'We have been united and it has brought us a closer friendship'- VHW from Zindi Clinic.
- VHWs attributed Mbereko groups with creating a supportive community culture for service uptake, noting mothers in communities with Mbereko groups now encourage each other to go to the clinic.

Mbereko Mothers

- The Mbereko women also mentioned that because of their Mbereko groups they have started using the clinic services more.
  - *"Mambereko groups' aita kuti tive tinotambira pedyo nechiptara tichinyoresa pamuviri nekuuya kusikero pamazuva anenge akatarwa nana mukoti zvinova zvataisakoshesa kare."* We are now in a good working relationship with our local health workers and visiting the clinic for ANC visits on all the scheduled review dates.
  - *"Nekuda kwemambereko groups tinofara kuti tava kukoshesa kuenda nevana kusikero pamwedzi wega wega tichibayisa vana majekiseni avo."* The Mbereko groups have made us value immunisation dates per month for our babies.
  - *"Hatichatye kuongororwa ropa maererano neutachiona we HIV pa kiriniki pedu, zvinova zvataitya kuita munguva yapfuura tisina ruzivo*

rwakakwana kubva kunana mukoti" We are now confident to go for HTS at the clinic, prior to the Mbereko program we hesitated going for HIV testing because of lack of knowledge.

- *"Tange tiri murima maringe nekuronga mhuri, tichifunga kuti mapiritsi ndiwo chete nzira yekuronga mhuri asi nemambereko groups tasununguka kusvika pakiriniki tichikurukura nanamukoti maererano nenzira dzekuronga mhuri dzinosanganisira depo nema condom."* We were unaware of the various methods of family planning with little knowledge of the family planning pill, but now we frequently visit the clinic to access family planning from the nurses.

Objective 2: Document the community level support for mother-baby pairs who were in the Mbereko groups.

Mbereko Mothers' Perspective on who assists in uptake of health services

During the interviews women were asked who they thought supported them most in accessing health services. Women used a 5-point Likert scale (1=strongly agree to 5=strongly disagree) to rate the extent to which individuals "helped you to overcome barriers to service uptake" during pregnancy. Women indicated husbands/male partners (n=196, 66%) were the individuals in their community of greatest help in overcoming barriers to service uptake and utilisation, followed by VHWs (n= 178; 59%).

This was echoed during the FGDs where women reported that immediate family members and VHWs are the most important people providing support to women. Some women mentioned that husbands are important because they urge women to go to the clinic, while others said the opposite claiming that men do not support women because they do not place importance on health issues. The VHWs were cited as the most consistent persons in supporting women's uptake of health services because they conduct home visits in the community. VHWs were seen as the information hub where one could get health related information and were seen as being influential in convincing husbands to prioritise health issues.

Male involment: father with a baby consulting HCW

Other groups mentioned included neighbours and relatives who provide support with either transport or encouragement, while OPHID was mentioned as helping by reinforcing the messages given by the VHWs. Nurses were similarly said to encourage women when they come to the clinic, but were believed to not have enough time for the women, unlike the other community members mentioned.

> *'Patanga tiri tega vana amai vanga vane ruzivo rushoma asi neMbereko tava kutoremeredzwawo'*
>
> Before Mbereko mothers had limited knowledge and now we have dignity
>
> **VHW FGD**

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VHWs' narrations of how the Mbereko model capacitated them showed that there was an improvement in their skills and knowledge related not only to maternal and child health, but other topics ranging from data management to income generation. Training received before establishing the groups had a variety of relevant topics that related to women and children's health issues, (see Annex 2 and 3). From the training and through conducting Mbereko sessions, VHWs mentioned that they have become more confident of their facilitation skills; gained respect from the community; improved their data management skills; and generally upgraded their knowledge. The project also increased VHW motivation, as remarked by one VHW, *'before tanga tine nungo but now tavakutofambira vana mucommunity'* meaning 'before Mbereko we were reluctant to conduct home visits but now we are willing to do them' another said *'ndava necare nevana vari pasi pe 2 years nevanhu vane nhumbu ndavakukwanisa kusvika ndakasununguka kuvanhu ava'* meaning 'I now care for the children under 2 years and pregnant women and interact with them freely.'

Objective 3: Describe the perceived benefits of participation in the Mbereko groups for increasing uptake of PMTCT and MNCH services and family health.

Benefits of being an Mbereko Mother

The women's comments on the impact that Mbereko had on their lives addressed the topics discussed and activities conducted during Mbereko group sessions. Some major themes arising from focus group discussions regarding how involvement with Mbereko groups had impacted women's lives can be summarised as:

- **Awareness of health rights:** Women now understood their rights and the channels they could follow if their health rights were violated.

MATERNAL AND NEONATAL CHILD HEALTH

MILESTONE CARD

This Milestone Card will help you to make key decisions and take action to access health services and practices for yours and your baby's happiness and health in the early years of its life. The main areas covered are:

- Pre-pregnancy- Steps for planning your pregnancy
- Pregnancy to delivery - Early antenatal care helps to ensure a healthy pregnancy for you and your baby.
- Knowing your HIV status - If you are HIV positive and are started on ARVs it is important to continue taking the medication as prescribed by your health practitioner.
- Childbirth and early days - Early postnatal care for mothers and babies to help prevent most conditions and infections that affect mothers and babies after birth.
- Early childhood- Regular growth monitoring helps to ensure a healthy and happy child to go through the expected development stages.

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- **Improved knowledge and access to services:** Women commented that through the meetings they learned valuable information and improved relationships within the home. To them Mbereko *'inobatanidza mhuri mai, baba nevamwe vari pamba'* meaning that it created unity of purpose in families. Women appreciated the community HIV testing as it was an opportunity for couples to get tested. While others commented that because of their greater knowledge communication had improved within the home.

- **Improved planning for sustained health service uptake over the first 1000 days:** The benefits of the milestone card used by Mbereko Mothers as a reminder and prompt for them to go to the clinic at the appointed time for selected services were emphasised. Some women emphasised that it did not only help plan their service uptake, but also that of their male partners and planning for couples HIV testing.

- **Greater willingness to adopt recommended practices:** VHWs commented that the women are now more open to disclosing their HIV status and are now more comfortable adopting some practices, such as, exclusive breastfeeding regardless of cultural pressures not to do so. Women from the Apostolic Faith are even willing to adopt new practices, such as immunizing their children, as a result of attending the Mbereko sessions.

- **Greater support for women, by women:** Some of the women have formed HIV treatment buddies from within members of the groups as they have developed trusting relationships within the groups to the extent of disclosing their HIV status. Also women are even disclosing their children's EID results and getting support from group members on how to raise their children.

> *'rinondipa chenjedzo neruzivo kubvira ndisati ndaita pamuviri, ndaita pamuviri uye ndazobereka mwana wangu'*
>
> 'it reminds me what I have to do each step of the way from before pregnancy, during pregnancy and when I have my baby'.

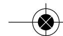
Economic empowerment through ISALs and IGAs

Comments on the ISAL/IGA trainings showed that women appreciated being economically empowered as they had started saving and are now able to meet the basic needs of their families, including being able to pay for medical related bills. Among the women interviewed, 51% (n=149) per cent were members of the ISAL groups. Eighty seven per cent of these women contributed to the ISALs on a monthly basis while 13% were making weekly contributions. The amounts saved ranged from $1-$8 for weekly contributions and $1-$60 for women for monthly contributions. The main objective for participating in the ISAL groups among women included:

- to purchase household assets and payment of school fees for the children, 66%;
- to start or improve IGA such as poultry projects and horticulture, 30%;
- to purchase farming equipment and consumables such as fertiliser, 4%

Points that were brought out by all FGD participants showed that the ISAL methodology is a good initiative and has been embraced by the community. The HCCs said it has not only brought social cohesion among groups, but it is a great and practical way for the community to access health by saving from what they have. They also reiterated the need for the community to take up the methodology in order to be able to meet any health related needs that may require money. The women likewise said the methodology not only helped women to be financially independent by having their own projects, but also helped them to raise money to take sick children to the clinic through the social fund, a fund specifically for emergencies.

Healthy Happy Baby



The Story of Border Church, Marondera district, Hamamaoko ISAL group

In 2013-2014, village-based Mbereko groups in Marondera were established by OPHID, with the groups getting training in ISALs, they were then further supported and monitored by the Mbereko project. ISAL group members are members of an Mbereko group, i.e. an Mbereko group of around 10-20 members may have several self-selecting ISAL groups.

The Hamamaoko group at Border Church Clinic in Marondera district is made up of 11 members comprising 10 women and 1 man. They reside within the catchment of Boarder Church clinic. There are four women with children under 2 years and 6 caregivers of children under 5 years. Ages of the group members vary from 29 to 69 years with the majority having attended some secondary education.

The group started saving in October 2013 and agreed to contribute $20 a month at 10% interest on all money loaned out. The group's credit record from the time it started has been good with all members managing to pay their monthly contributions and repay their loans on time every time. Asked about the secret of this impressive record, the group members said it was key that every member understood the objective of saving, followed the agreed constitution and encouraged each other to work so that it was easier to repay the loans. As the group continued to save, the husband of one of the women in the group decided to join the group. He was keen to learn from the women before he started a male group.

The achievements of the group transcend health issues as their social status within their community is the talk of their relatives and the wider community. The women in the group claim that now that there is visible improvement in their lives, their husbands are now boasting to other men in the area that their wives are now "educated". In the words of some of the members *"ini hapana kwandichaenda ndamira nemakumbo maviri ndavakutoziva kuti murume wangu haachabudi mumba nekuti ndinoshandira mhuri yangu"* translated "I am now secure in my home I now know that my husband will not go and look for other women because I am a hardworking woman" another woman said "Harare yauya muruzevha" translated "the life in Harare is now here in the rural area". A pregnant woman who has since delivered said she now had an option of delivering her baby at any clinic as she could now afford it, meaning she is no longer limited to her local rural health centre as before. One woman noted that in the Mbereko group she had learnt the importance of understanding the need for good nutrition, "I now know that my children need vegetables of all colours in their meals for a healthy diet, so if I have extra carrots I trade them with my neighbour for cabbage".

Savings to date:

Month	Savings	Interest	Total savings plus interest
October – December 2013	$540	$56	$596
January – March 2014	$1 080	$204	$1 284
April – June 2014	$1 620	$720	$2 340
July – September 2014	$2 160	$1 070	$3 230
Start of new cycle			
October – December 2014	$990	$136	$1 126

The group members have managed to improve their lives and between the members they have bought new sofas from Harare, a water tank, a bull, built a better cottage, renovated their toilet to become more modern and added a bathroom, secured a contract to supply OK with vegetables, bought an irrigation pump and managed to send a child for driving lessons. The children who are in school have their school fees paid on time every school term and the family diet has greatly improved. One woman has managed to start a thriving cross border trading business, while another has a poultry project, which is the envy of their community. The greatest achievement is their empowerment as women and the recognition they have gained from their partners and families. The women expressed their gratitude for the ISAL methodology.

Recommendations from the Field

Echoing the Mbereko model's participatory design, OPHID employed a reflective and action-oriented evaluation approach to documenting key lessons that recorded the perspectives of all participants in the project. The focus group discussion participants made suggestions to improve the model's implementation. Apart from the overwhelming responses from all discussants on the need to continue with the process, the participants said the Mbereko model was unique in that it not only came to where the people lived, but also helped the community to understand health issues better by giving them an opportunity for discussion in a conducive environment within their community. The suggestions for improvement revolved around greater male involvement and health service improvements.

Male involvement

The participants all agreed that while the target group was the right group, if meaningful change was to take place it was suggested that men should be more involved. OPHID understood that a more inclusive program that incorporates men was likely to be more effective in changing community behaviour related to health issues. One male participant acknowledged that men are the head of the family and they are the ones who are best able to bring about any change within the home but the problem is that *'vana baba tinofanirwa kupiwa knowledge but we are getting it at district and ward level and not village level. Dai taiwana munhu anouya pavillage level during mameetings nasabhuku we would get more men participating'* translated 'as men we are getting information at district and ward level and not at village level, if only we could get people who would come to our meetings with the village head we would get more men participating in health issues'. Men wanted meetings as men only at village level and some even went on to suggest having a milestone card for men that they can complete as the woman goes through pregnancy and the baby's early years of life.

Happy father with baby in a Mbereko

Health Service improvements

All FGDs put forward recommendations on how to continue to improve the relationship between the clinic and the community. The suggestions touched on improvements at both the health facility and community level. For the health facility, groups were unanimous in advocating for a feedback mechanism at clinic level for better communication between the community and clinic. After understanding the Patients Charter, respondents suggested that clinics should have a suggestion box, with the HCC members further proposing that the district and provincial health teams should be more proactive in taking up suggestion coming from the community.

> **Community Response**
>
> *'Chirongwa chakagashirwa zvakanyaya kupfuura mamwe maprojects'*
>
> The Mbereko project has been well received compared to other projects.
>
> **VHW FGD**

General feedback

The strongest suggestion from the discussion was for more women to join ISAL groups for them to become self-reliant and be able to save money for health related emergencies. Women acknowledged that the methodology was a good way for women to be able to address identified barriers. Continued health education was recognized as important in changing the mind-set of the

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community regarding health issues, while others suggested that women should start prioritising their own health despite all the challenges surrounding them. Through community collaboration the women are able to reduce the user costs in accessing health services, provide transport for those referred to the next levels of health care and strengthen the accountability of service providers.

The groups welcomed the IEC materials that were provided and recognized that the 'Zambias' (wrapping cloths: see picture of happy, healthy baby above) with the messages made a huge difference within the community and gave the Mbereko members a sense of identity.

Strengths and Limitations of the Evaluation

The mixed method approach used to conduct the Mbereko evaluation enabled different groups to provide an in-depth understanding and evaluation of the benefits and challenges of the Mbereko group model. The perspectives from both the direct (pregnant and breastfeeding women) and indirect (male partners, the HCC members and the VHWs) beneficiaries of the project facilitated a more comprehensive assessment of the outcomes of the project and also offered OPHID recommendations to improve the model.

The women who participated in the Mbereko group evaluation were conveniently sampled and were group members who responded to the call for a meeting at the cluster meeting places for the groups mobilised by the Village Health Workers.

Lessons Learned

The field evaluation approach principally emphasised documenting the perception of community-based stakeholders, so as to capture the voices from the field and allow us to responsively incorporate lessons learned from community perspectives into improving the model.

1. ***Women in Mbereko Groups Report Improved Uptake of Essential MNCH/PMTCT Services.***

   Women in the Mbereko Groups did report an increase in uptake of services and encouraged others in the family and community to do the same. They also became more discerning about where they would go for services after understanding patients' rights from the interrogation of the MOHCC Patients' Charter, not always taking up services at their nearest health facility. While OPHID's Mbereko model has been successful in fostering demand generation, OPHID's work in supporting the supply side of services needs to be responsive to this. Indeed the incorporation of the HCC members in the model is a step towards greater community involvement in quality service provision at local health facilities. This is being complemented by the MOHCC Quality Improvement initiative.

2. ***Mbereko groups improved family and community-level support for mothers to make use of health services.***

   The model has evoked very encouraging responses in local communities to support MNCH and PMTCT service uptake and some communities have collaborated to raise funds to build Waiting Mothers' Homes at their local clinics and organise transport to clinics. Feedback from the community indicated that the men in the community felt left out of the Mbereko model and realised they lacked knowledge on matters of family health, which had until now been considered women's business. The FGDs indicated a great demand from men in the community to receive similar health information. In response, OPHID has now modified the Mbereko model to include the dissemination of health information to men in the communities to promote greater involvement of men in safe and responsible parenthood. It was also encouraging to have positive feedback from the VHWs, who considered themselves more empowered to give advice to mother's on PMTCT/MNCH issues and also felt themselves to be more accountable to their communities.

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3. ***Community stakeholders described multiple health and non-health related benefits to Mbereko Groups.***

As well as the Mbereko women acquiring greater knowledge and more confidence on family health matters the women participating voluntarily in the ISAL and IGA trainings considered that they had benefitted greatly through their concomitant elevated status within the family and the community. This empowerment translated itself into improved quality of life for all family members and an enhanced relationship with their male partners. Along with this new found confidence came a realisation of the local resources that were available to the community to improve their health and other aspects of community development through community collaboration. The socially inclusive nature of the groups was also commended by the community, together with the mainstreaming of HIV care and treatment. OPHID sees the Mbereko group model as important in empowering all pregnant women in low resourced communities. Additionally, the reluctance of women to leave the groups after they have completed the first 1000 days is a good indication of the sustainability of the model and augers well for the health knowledge base that is being built within the communities.

Conclusions

Although it is difficult to measure impact and sustainability over a short period of time, voices from the field demonstrated that the Mbereko model has been very well received by the communities involved. The survey demonstrated that participation in the Mbereko groups has led to greater uptake of MNCH/PMTCT services. The model benefits from sufficient flexibility to respond to the context on the ground and adaptations were able to be made for the variable demand, with emphasis placed on particular health issues according to local needs. The focus on integration of health services was greatly appreciated by the HCWs, VHWs and the community, who acknowledged that it was a change from the vertical programs frequently implemented. There was also appreciation of the greater understanding of patients' rights through the interrogation of the Patients Charter on the part of the community and the health facility staff.

Capacitating the HCCs on health issues has helped them to support the work of the health staff and increase community demand. The HCCs, as community members and working with the health facilities, have added benefits in that they now have a greater understanding of health issues and patients' rights and are working towards the improvement of the programme from logistical, service provision and community relationships points of view. The VHWs as members, who are already working in the community have been given additional facilitation skills with their ability to utilise the participatory action framework and access to more health information which they can use in their day to day work. Additionally, the VHWs have appreciated the opportunities that the Mbereko model has offered them to give greater support to mothers and babies in their communities.

Social inclusion was an important driving factor for the model, with all pregnant women and mothers with children under two years of age being eligible for recruitment into the groups, and separate groups, as requested, being set up for PLHIV and for the conservative members of the Apostolic Faith. With the support of traditional leaders and HCC members, inroads were made into challenging the deep rooted gender role stereotypes and gender discrimination of the patriarchal culture. With the improvement in women's income and health education came increased confidence; this enabled them to better communicate with their partners, access health services and improve family health practices. There are still significant obstacles to equitable access to MNCH services and HIV prevention, care and treatment, but opening the discussion at village level, informing women of their health rights and promoting understanding and accessibility of MNCH and HIV services has achieved much in enabling community dissemination of knowledge on MNCH and HIV prevention, care and treatment and promoting health greater service uptake.

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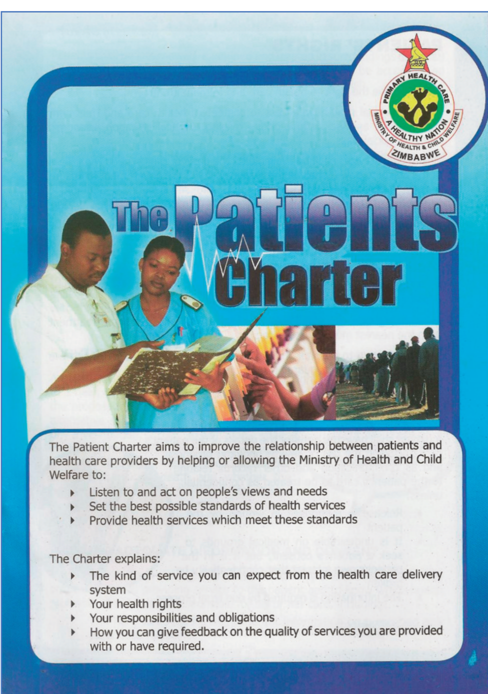
Annexes

Annex 1:

The Ministry of Health and Child Care's Patients Charter



The Patients Charter aims to improve the relationship between patients and health care providers by helping or allowing the Ministry of Health and Child Care to:

- **Listen to and act on people's views and needs.**
- **Set the best possible standards of health services.**
- **Provide health services which meet these standards.**

The charter explains about:

- **The kind of service patients can expect from the health care delivery system**
- **Patients' rights**
- **Patients' responsibilities and obligations.**

If patients have any feedback on the quality of services provided at this clinic, they can contact the nurse-in charge.

THE PATIENTS' CHARTER

PATIENTS' RIGHTS

- Patients have the right to health care and humane treatment.
- Every individual shall have access to competent health care and treatment regardless of age, sex, ethnic origin, religion, political affiliation, economic status or social class.
- Health care services shall be available on the basis of clinical need regardless of the ability to pay. It shall be the responsibility of the government to ensure that every person has access to essential health services.
- Every patient shall be treated with care, consideration, respect and dignity without discrimination Of any kind, including vulnerable groups such as children, women, people with physicalchallenges, and rural dwellers, taking into consideration issues of accessibility to both physical structures and information.
- All drugs and vaccines shall be of acceptable standards in terms of quality, efficacy and safety.
- In an emergency, every individual shall have the right to prompt treatment from the nearest medical/health facility.
- A child admitted to hospital shall, whenever possible, have the right to the company of a parent or guardian.

CONFIDENTIALITY

A patient shall have the right for the details of the patient's care (including the use of new technology) prognosis and all communication and other records relating to the patient's care to be treated as confidential, unless:

- Release is authorised in writing by the patient
- It is undesirable on medical grounds to seek a patient's consent, but it is in the patient's own interest that confidentiality be broken
- The information is required by due legal process.

PRIVACY

Patients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if they so wish.

RIGHT TO CHOICE OF CARE

- A patient shall have the right to a second opinion at any time while consulting the same medical or health care delivery system.
- A patient or next of kin shall have the right to an explanation about their case history and medical records, and to have them explained. The patient or next of kin shall also have the right to authorize in writing for another health professional to obtain a copy of the medical records and to inform him or her of what they contain.
- If a patient's health professional refuses to allow another health professional to be called in, or breaches any other provisions of this charter, the patient shall have the right to seek alternative service/care or to take the issue up with the Health Professions Council.

RIGHT TO SAFETY

- A patient, if not incapacitated, shall have the right to a clear, concise explanation - in lay terms - of the proposed procedure and of any available alternative procedure, before any treatment or investigation. The explanation shall incorporate information on risks, side-effects, problems relating to recuperation, likelihood of success, risk of death and whether the proposed procedure to be administered is an investigation.
- It is a legal requirement that clients or patients accept treatment or other intervention where the condition may affect the wider public.

RIGHT TO ADEQUATE INFORMATION AND CONSENT

A patient shall have the right to know the identity and professional status of the individuals providing service to the patient and to know which health professional is primarily responsible for his or her care, including:

- The right to adequate and coherent information on prescribed and purchased medicines.
- The right to choose among competitive products based on unbiased information.
- The right to know his or her prognosis and everything about their medical problem.

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- A patient's written consent shall be required for the inclusions of a patient in any research or teaching programme. The patients shall be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and any discomfort it may entail. The patient shall be informed that he or she is free not to participate in the study and that he or she is free to withdraw his or her consent to participate at any time
- To ensure that informed consent is not obtained under duress or from a patient in a dependent relationship to a health professional, the informed consent shall be obtained by a health professional who is not engaged in the investigation and who is completely independent of the official relationship between the patient and the health professional responsible for the research. In the case of a child, informed consent shall be obtained from the parent or guardian.

RIGHT TO REDRESS OF GRIEVANCES

- A patient shall have access to appropriate grievance handling procedures, bearing in mind that health care delivery professionals are not superhuman.
- A patient shall have the right to claim damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her, while treating the patient.
- A patient shall have the right to legal advice regarding any malpractice by a health care professional.

RIGHT TO PARTICIPATION AND REPRESENTATION

A patient shall have the right to participate in decision making affecting his or her health:

- With the health professionals and other support staff involved in direct health care
- Through consumer representation, in planning and evaluating the system of health services, the types and qualities of services, and the conditions of service under which health services are or were delivered
- To give an assessment of the quality of services offered to him or her.

RIGHT TO HEALTH EDUCATION

Every individual shall have the right to seek and obtain comprehensive information advice regarding preventive and curative medicine, aftercare and good health.

THE RIGHT TO A HEALTHY ENVIRONMENT

Every individual shall have the right to an environment that is conducive to good health. This includes and extends to health professional's office, health centre, hospital room and any other facilities.

PATIENTS' AND FAMILY'S RESPONSIBILITIES/ OBLIGATIONS

- Whilst you have the right to be heard, you also have an obligation to listen to medical instruction concerning your treatment.
- The patient and family shall provide accurate and complete information to assist the health professional to plan for your stay and treatment adequately.
- The patient and family shall produce proof of inability to pay for health care services, except in emergency cases as determined by the health care professionals.
- To avoid inconvenience to yourself and to others, follow the referral chain and ensure you have the necessary documents for easy access into hospital.
- Keep your hospital notes safe and clean, you will need them during your next visit or contact with the health services.
- The patient and family shall ensure that the patient understands the purpose and cost of anyproposed investigations or treatment before deciding to accept it.
- The patient shall insist upon explanations until he or she is adequately informed and shall consult with all relevant persons before reaching a decision.
- The patient and family shall accept the consequences of the patient's own informed decisions.
- The patient and family shall establish a good relationship with the health care provider and follow the treatment determined by the health professional primarily responsible for the patients care.
- The patient and family shall inform the health professional if the patient is currently consultingwith or under the care of another health professional - including traditional medical practitioners in connection with the same complaint or any other complaint.
- The patient and family shall keep appointments and shall inform the health professional if unable to keep an appointment.
- Every individual has a responsibility to maintain his or her own health and that of society by refraining from indulging in:-
  - Consumption of unhealthy food
  - Substance abuse
  - Life styles that have an adverse impact on health, such as sexual promiscuity, reckless activities and physical inactivity.

Every individual has a responsibility to accept all preventive measures sanctioned by law.

The patient and family must be aware of the limits of health care providers.

- Patients should not expect a prescription at every visit. Many illnesses are short term and do not require medication. You do not need a pill for every sickness.
- Take your medicines exactly as instructed and complete any course of treatment.
- Take interest in your condition and read more information to get the best out of healthpromotions.
- Do not share prescribed medicines.
- The patient shall conduct himself or herself so as not to interfere with the well-being or rights of other patients or providers of health care.

SERVICES

ADMISSION AND YOUR STAY IN HOSPITAL

In the event of an accident, illness or emergency, you will be attended to by competent health workers. You will be assessed and dealt with appropriately and immediately upon arrival.

Whether you are admitted as an emergency case or not, hospital staff shall:

- Inform your relatives/next of kin or whoever you wish, where practicable
- Keep your clothes and valuables in a safe and clean place
- Give clear information about your illness and condition and the treatment plan for your recovery
- Give clear information about domestic arrangements and any other information relevant to your stay in hospital.

OUTPATIENTS SERVICES

Provided you have followed the referral chain and you do not require complex diagnostic procedures, you will receive treatment promptly.

You have the right to clear information about your full treatment. Health workers will be happy to answer your concerns.

You have the right to request for assistance or help when you require it.

INTER-HOSPITAL TRANSFERS

In some cases, it will be necessary for you or your child to be transferred to another hospital for continuation of treatment. If this is so, staff will:

- Give you information concerning the reason for the transfer and the arrangements to effect it
- Inform your relatives, or whomever you wish, of the transfer, where such communication is possible
- Upon discharge, if need be, your relatives will be advised to take you home.

COMMUNITY SERVICES

Health services are based on the referral chain. This means that you are required to visit your local health centre or general practitioner in the first instance when you are not feeling well. However, if you are involved in an accident or emergency, you can go to the nearest hospital without referral.

In addition, the following Community Health Workers are available in your locality for your assistance.

- Village Health Workers (formerly known as village community workers-VCW)
- Environmental Health Technicians (EHTS)
- Community Based Distributors (CBDS) (Family Planning)
- Community Nurses
- T.B. Co-ordinators
- Health Centre Nurses
- Home based care providers.

In the community, you have a right to:

- Communicate with health workers on matters which concern your health. You do not have to wait till you are ill
- Continuing care at home, where there is need (e.g. invalidity, old age, recuperation, etc). When you are discharged, the hospital will arrange for continuing care with your nearest health facility if there is need. In the event that you request an ambulance, it will be dispatched to you as soon as possible. However, arrival timewill depend on distance, condition of the roads and availability of ambulances.

FREE SERVICES IN ZIMBABWE

- Immunisation for children
- Immunisation for pregnant women
- Treatment for mental illness
- Treatment for epilepsy
- Rehabilitation for children under five years old
- Treatment for survivors of sexual abuse
- HIV/AIDS clients, including prevention of parent-to-child transmission services
- Treatment for tuberculosis
- Treatment of leprosy and its related complications
- Treatment for those aged 65 and above.

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Annex 2:

Content of Village Health Worker Flip Chart

The Village Health Worker Community Flip-Chart on Mother, Newborn and Child Health and Prevention of Mother to Child Transmission of HIV

Section 1: HIV Prevention

What are the Benefits of HIV Testing and Counselling?
Preventing HIV: Using a Male Condom
Preventing HIV: Using a Female Condom
What is the Importance of Disclosing One's HIV Status

Section 2: Family Planning

Prevention of Unintended Pregnancy
Methods of Family Planning

Section 3: PMTCT of HIV

What is PMTCT?
How can HIV Transmission be prevented during ANC?
Lifelong ART for HIV Positive Pregnant Women
Malaria and HIV in Pregnancy
TB and HIV in Pregnancy
How to prevent MTCT during labour and delivery

Section 4: Continuum of Care for Mother and Baby

How to prevent HIV Transmission during Breastfeeding
Early PNC
How to care for a newborn in the era of HIV
Early Infant Diagnosis
What is Exclusive Breastfeeding?
What Foods should a Breastfeeding Mother Eat?
Adherence to ART
What is the importance of Growth Monitoring?
When do Babies go for Immunisation?
Understanding the PMTCT Roadmap

Annex 3:

Mbereko Group Key Messages for VHWs

Late booking and male involvement

Book early for ANC and get tested for HIV *(Kana wakazvitakura kurumidza kunyoresa pachipatara chiri pedyo nemi)*

Men accompany your partner to at least 1 ANC visit *(Vana baba perekedzai mudzimai wenyu kuchipatara panguva yaanenge akazvitakura)*

When you test HIV positive get started on ARVS on the same day *(Uchinge wanzi une hutachiona hweHIV zvakakosha kuti ubve watanga kumwa mushonga pazuva racho iroro)*

Option B+, adherence and retention

Lifelong ART for positive women helps to improve the health of the mother and helps reduce HIV transmission to the baby *(MaARV anobatsira kuwedzera hutano kuna amai uye anoderedza mukana wekutapudzira hutachiona kumwana)*

Option B+ means healthy babies and healthy families *(Option B+ inopa hutano kune mwana nekune mhuri yese)*

Always take your medication as instructed by your health care worker *(Torai mushonga wenyu sekurairwa kwamakaitwa nevehutano)*

If you are HIV positive continue to take your medication as prescribed by the nurse on time every time *(Kana muchirarama nehutachiona ramambai muchitora mushonga wenyu mazuva ose nguva dzose sekuudzwa kwamakaita namukoti wenyu)*

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Family planning

Use family planning to prevent unintended pregnancy *(Shandisai nzira yekuronga mhuri kudzivirira pamuviri pasina kurongwa)*

Dual protection means using condoms and another method of contraception *(Shandisai macondom pamwechete neimwe nzira yekuronga nayo mhuri)*

Leaving at least two years between one baby and the next is better for the health of both mothers and babies *(Kusiyanisa pamuviri nemakore maviri zvinopa hutano kuna amai nemwana)*

Infant and Young Child Feeding

Exclusive breastfeeding for the first 6 months is best regardless of your HIV status, introduce other foods from 6 months *(Ipai mwana mukaka chete kwemwedzi mitanhatu yekutanga yehupenyu zvisinei nekuti mune hutachiona here kana kwete. Ipai kumwe kudya kubva pamwedzi mitanhatatu yehupenyu hwemwana)*

Continue breastfeeding till 2 years and beyond *(Yamwisai kusvikira pamakore maviri kana kupfuura)*

Take your baby for growth monitoring every month till 5 years of age *(Mwedzi woga woga kusvikira pamakore mashanu, yeresai mwana wenyu pachipatara chiri pedyo nemi kana kuna mbuya kana sekuru utano)*

Pediatric HIV testing, HIV testing and retesting

Everyone should know their HIV status. Get tested together with your partner today *(Ziva paumire ongororwa ropa nemudiwa wako nhasi)*

Your partner's HIV status is not your own. Get tested for HIV *(Mamiriro emudiwa wako haasi ako ongororwa ropa kuti uzive paumire)*
If you tested negative during pregnancy, retest at 32 weeks of pregnancy and again at 6 weeks after delivery *(Zvakakosha kuti urambe uchiongororwa ropa kana wakazvitakura uchinyoresa wava nemwedzi minomwe uye kwapera mavhiki matanhatu wabva mukusununguka)*

At 6 weeks or as soon as possible thereafter all babies born to HIV positive mothers should be tested for HIV using dried blood spot (DBS) and be given Cotrimoxazole *(Pamasvondo manomwe ekuzvarwa vana vose vakabarwa namai vanehutachiona vanofanirwa kutorwa ropa rekutarisa kuti vanehutachiona here. Vanofanirwa kutanga kupihwa mushonga weCotrimoxazole)*

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