

2015

## **MIDTERM ASSESSMENT REPORT**

Implementation of Mother Support  
Groups in Mutare and Makoni  
Districts of Manicaland Province



## **EXECUTIVE SUMMARY**

### **Background**

In July 2014, the EPAZ team embarked on enrolment for a study entitled, “Effects of Mother Support Groups on PMTCT Outcomes in Mutare & Makoni Districts, Zimbabwe: A Cluster Randomized Controlled Trial”. The investigators hypothesized that a strategy of establishing facility-based MSGs for HIV-positive mothers will result in increased retention rates of HIV-exposed infants in clinic-based PMTCT follow-up systems twelve months post-delivery compared to clinics that lack MSGs. The study is being conducted in health facilities in rural Mutare and Makoni districts of Manicaland Province in Zimbabwe. A two-arm cluster controlled study design is in place in 30 rural clinics randomly assigned to either arm to compare the effectiveness of MSGs. Arm 1 of the study consists of standard of care whilst Arm 2 consists of standard of care together with the facility-based MSGs intervention.

### **Methodology**

A descriptive cross sectional study design was employed using a predominantly qualitative approach in the carrying out of this midterm assessment. The assessment activities were carried out in all of the 15 sites making up the EPAZ study MSG intervention Arm 2 in Makoni and Mutare districts of Manicaland Province, Zimbabwe. Pre-testing of instruments used in the MTA was conducted at Gwindingwi clinic and actual data collection was carried out in the remaining 14 MSG sites. A census approach was used in the selection of the HFs as sites for data collection. 14 of 15 facility-based MSGs with members enrolled into the EPAZ study were targeted for the MSG midterm assessment. 6 members from each of the 10 high volume sites were targeted for random selection using the random number generator software installed on mobile phones used during data collection. 51 of the 60 targeted MSG members were actually interviewed. All of the key informant individuals were purposively selected and requested to take part in the interviews because of the significance of their positions to the execution of the MSG project. One FGD was conducted at each of the four health facilities with the lowest enrolment levels out of the total sample size of 14. These facilities were Chipfatsura, Matsika, Mayo 2 and Chinyadza. The ‘thematic content analysis’ framework was used in the analysis of qualitative data obtained from interviews and FGDs. This consisted of reading and re-reading the field notes and transcribed texts, manual coding in the margins and synthesizing and grouping data into relatively exhaustive categories.

### **Summary of Findings**

Individual characteristics such as age and level of education did not seem to be of great significance as we seek to understand behaviour of MSG members at individual and community level and in outlining the entry point in informing current MSG programming. The findings show an even distribution of interviewed participants across the age and education continuum which suggests that the group is accessible and acceptable to women across the demographic divide. Some of the MSG coordinators and nurses noted some unwillingness among the elite members of the community (those considering themselves as ‘better off’) to participate in the MSG initiative, which could imply the need for more personalized approaches in targeting this minority group. Stigma in communities remains a real threat to delivery of HIV programs such as PMTCT or engagements of beneficiaries into interventions such as MSGs. However, even within this context, the MSG project has fostered positive efforts of emphasizing the importance of disclosure and seems to have facilitated disclosure of HIV status of the participants to their male partners and immediate family. Efforts at roping in male partners early on aimed at providing similar support in terms of information, counselling and fellowship may help to mitigate strain in relationships that may lead to family breakdowns following disclosure.

It was reported that a few male partners across the visited health facilities currently escort their female partners to the MSG meetings without themselves actually participating. In an environment where getting male partners to accompany their partners even for core ANC and PNC activities has proved a mammoth task, these could be realized as first positive steps towards gaining male partner support for the MSG members and ultimately roping them in to participate on a wider scale in the general RMNCH continuum of care. Literature reveals that men generally feel excluded from most RMNCH programs and most aspects of the health system are not designed with the objective of reaching out to men. This includes IEC material which is biased towards female readers, service infrastructure which does not support privacy between the sexes or even health worker attitudes and practices in which they do not make an effort to relate to male partners who do accompany their female partners for services. The latter is consistent with the findings of this MTA in which the majority of MSGCs as well as the nurse practitioners interviewed admitted to the fact that they have not made any effort to reach out to male partners of MSG members in any way.

Health facility nurses have been very supportive of the MSG program to some extent and their involvement is an integral part of the functioning of the MSG. This support is felt all the way to the DNO's offices who have expressed their appreciation of the MSG program. Members not only appreciate this involvement because of the clarification that nurses bring to the content of the lectures but also the impression of importance that the grouping gains due to the association with the formal health sector. MSG engagement with the community based health sector links has not been as pronounced with both the VHWs and the HCC members expressing limited knowledge of the program.

### **Recommendations**

- **Male Participation & Involvement:** It would be best not to directly include male partners in the MSG meetings since this might make other members uncomfortable during the sessions and make those members whose partners are not available feel unwelcome to the group and this might have negative effects on participation, attendance and retention in the MSG program.
- **MSG Coordinator Functioning and Retention Activities:** To increase MSG retention up until graduation period and beyond, the project would do well to encourage all of the health facilities to synchronize the dates for the MSG meetings with the dates for ART re-supply and/or ANC and PNC visits. This would aid the MSG members by reducing the frequency of visits to the health facility considering that some of the members have to walk long distances as far as 17km or more.
- **Data Monitoring:** It is recommended that the EPAZ staff continue to support data entry activities in the MSG sites to ensure quality documentation of proceedings. Said cadres should however refrain from joining in the actual MSG meeting proceedings as this does interfere with the purity of the intervention delivered and has a bearing on how replicable the project is in the future.
- **MSG and Health Sector:** The project is encouraged to explore the option to engage with HF HCCs with the aim of providing them with information to increase their understanding, appreciation and support for MSGs. This may aid in garnering long term local support for the MSG strategy even beyond the life of the EPAZ intervention.
- **MSG Sustainability:** The EPAZ study should have an exit strategy that will see the MSGCs, nurses and VHWs (if involved) with the capacity to carry on with the project. In essence, the MSG Assistant Officers should start withdrawing from regularly attending MSG meetings in order to assess whether the members can hold meetings on their own and leave the quality assessment to be done by the health facility staff. Limited visits will provide an opportunity for evaluation and to address concerns were required.

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## **LIST OF ACRONYMS**

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Anti-Natal Care
<b>ART</b>	Anti-Retroviral Treatment
<b>DNO</b>	District Nursing Officer
<b>EPAZ</b>	Elimination of Paediatric Aids in Zimbabwe
<b>FGD</b>	Focus Group Discussion
<b>HCC</b>	Health Centre Committee
<b>HF</b>	Health Facility
<b>HIV</b>	Human Immune Virus
<b>KII</b>	Key Informant Interviews
<b>PMTCT</b>	Prevention of Mother To Child Transmission
<b>MTA</b>	Midterm Assessment
<b>MSG</b>	Mother Support Group
<b>MSGC</b>	Mother Support Group Coordinator
<b>RNG</b>	Random Number Generator
<b>SMS</b>	Short Message Service
<b>STIs</b>	Sexually Transmitted Infections
<b>VHW</b>	Village Health Worker

# 1. INTRODUCTION

## 1.1. Background

### Facility Based Mother Support Groups

Although biomedical breakthroughs now make it possible to prevent vertical HIV transmission of HIV, poor retention along the Prevention of Mother To Child Transmission (PMTCT) cascade limits the impact of programmes. Research suggests that a significant proportion of the contribution to this phenomenon lies within the socio-cultural context within which these PMTCT programs operate. This clearly leaves room and opportunity for community based interventions such as Mother Support Groups (MSGs), which if crafted and implemented strategically, are well placed to influence social norms, values, perceptions, knowledge and practice. MSGs have been used as a low cost evidence based public health intervention to drive various Maternal, Newborn and Child Health programs with demonstrable success in many parts of the world<sup>1,2, 3</sup>. Some pioneer health facility-based MSGs were initially established in some settings targeting expecting women living with HIV with the objective of improving ART adherence, providing psychosocial support and increase facility deliveries. Review of recent literature reveals an array of studies demonstrating that community-based and community-oriented interventions significantly influence retention and related outcomes along the PMTCT cascade<sup>2</sup>.

Housing MSG programs at the local health centres means that they become closely integrated with the PMTCT services offered at the health facility. Another advantage to basing MSGs at the health facility (HF) include the observation that women who may otherwise not seek health services are drawn into the formal health system because of a felt need to participate in the MSG. It has also been observed that while women may feel distanced and fail to relate openly with clinical providers, the peer to peer approach utilized by MSGs makes it easier for members to relate with and interact more freely with their peers responsible for coordinating the groups. In some programs where mentor mothers or group coordinators have been empowered with counselling skills, it has also been observed that institution of MSG programs helps with task shifting/sharing of some basic counselling from HF staff who are

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<sup>1</sup>Tirmizi N. et al, Women's empowerment, participation in mother-to-mother support groups and nutritional outcomes for children under age two. Conference abstract. 141st APHA Annual Meeting and Exposition 2013 Available from: [https://www.researchgate.net/publication/266813277\\_Women%27s\\_empowerment\\_participation\\_in\\_mother-to-mother\\_support\\_groups\\_and\\_nutritional\\_outcomes\\_for\\_children\\_under\\_age\\_two](https://www.researchgate.net/publication/266813277_Women%27s_empowerment_participation_in_mother-to-mother_support_groups_and_nutritional_outcomes_for_children_under_age_two) [accessed Jun 3, 2015].

<sup>2</sup>Marcos Y, Phelps BR, Bachman G. Community strategies that improve care and retention along the prevention of mother-to-child transmission of HIV cascade: a review. *J Int AIDS Soc.* 2012 Jul 11;15 Suppl 2:17394. doi: 10.7448/IAS.15.4.17394.

generally overwhelmed with counselling duties among other expected outputs in resource limited settings<sup>3</sup>.

## The EPAZ Project's MSG Intervention

In July 2014, the EPAZ team embarked on enrolment for a study entitled, "Effects of Mother Support Groups on PMTCT Outcomes in Mutare & Makoni Districts, Zimbabwe: A Cluster Randomized Controlled Trial". The investigators hypothesized that a strategy of establishing facility-based MSGs for HIV-positive mothers will result in increased retention rates of HIV-exposed infants in clinic-based PMTCT follow-up systems twelve months post-delivery compared to clinics that lack MSGs. The study is being conducted in health facilities in rural Mutare and Makoni districts of Manicaland Province in Zimbabwe. A two-arm cluster controlled study design is in place in 30 rural clinics randomly assigned to either arm to compare the effectiveness of MSGs. Arm 1 of the study consists of standard of care whilst Arm 2 consists of standard of care together with the facility-based MSGs intervention.

### **1.2. Purpose of the Mid Term Assessment**

This assessment was carried out in order to systematically and independently measure the progress so far made in the implementation of facility-based MSGs. This progress was assessed in terms of the inherent functionality of the MSGs as well as the extent to which the MSGs are thriving and relating with relevant entities within the wider context of the health delivery system and their surrounding communities.

### **1.3. Specific Objectives**

Specific objectives of the midterm assessment as outlined by the Project Scope of Work were:

1. To describe the relationship between HIV status disclosure and MSG participation.
2. To describe the nature of male involvement in MSGs and effects of male involvement on MSG functionality.
3. To describe the relationship between MSGs and the health sector.
4. To assess the effectiveness of data monitoring of MSG activities.
5. To make recommendations specifically on the following areas of MSG functioning:
  - Male participation
  - MSG Coordinator functioning (including retention activities (cell phone communications; liaison with nurse)
  - Data monitoring
  - Graduation of mothers from MSGs
  - MSG functioning when groups grow in size and divide into two or more groups

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<sup>3</sup> Intrahealth International (2008) Mothers Support groups in Ethiopia: A peer support model to address the needs of women living with HIV

In addition, the CSR team also sought to provide the following information on the MSG project:

6. To establish the observed trend and perceived reasons for MSG attendance by members
7. To assess the sustainability of the MSG intervention beyond the EPAZ project intervention

## **2. METHODOLOGY**

### **2.1. Study Design**

A descriptive cross sectional study design was employed using a predominantly qualitative approach in the carrying out of this midterm assessment. Qualitative methods were used to understand complex social processes around MSGs, to capture essential aspects of MSGs from the study participants and to uncover beliefs, values and motivations that underlie HIV positive mothers in attending MSG meetings. Quantitative methods were used mainly to establish frequency and range of occurrences or phenomena and that the questionnaire for the MSG members was one such that it had pre-determined response categories.<sup>4</sup> Thus, a mixed methods approach was used to capitalize on the respective strengths of each approach. In essence, mixed methods approach achieved corroborating findings, generated more complete data and more importantly used results from one method to enhance insights attained with the complementary method.

### **2.2. Study Site**

The assessment activities were carried out in all of the 15 sites making up the EPAZ study MSG intervention Arm 2 in Makoni and Mutare districts of Manicaland Province, Zimbabwe. Pre-testing of instruments used in the MTA was conducted at Gwindingwi clinic and actual data collection was carried out in the remaining 14 MSG sites.

### **2.3. Study Population**

This MTA elicited information about the MSG intervention from the following stakeholder populations:

- Mothers enrolled in the MSGs from the intervention sites in Makoni and Mutare districts
- Mother Support Group Coordinators (MSGCs)
- Health Facility (HF) nurses supporting the implementation of MSGs (EPAZ Focal persons)
- Village Health Workers (VHWs) from the MSG sites in Makoni and Mutare districts
- Health Centre Committees (HCC ) Representatives from the MSG sites

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<sup>4</sup> L. A. Curry; I. M. Nembhard; E. H. Bradley (2009) Qualitative and Mixed Methods Provide Unique Contributions to Outcomes Research

- District Nursing Officers (DNOs) from Makoni and Mutare districts
- Facility-based MSG and FCH ANC records

## 2.4. Sample Size and Sampling Techniques

A census approach was used in the selection of the HFs as sites for data collection. Fourteen (14) of the fifteen (15) facility-based MSGs with members enrolled into the EPAZ study were targeted for the MSG midterm assessment. This approach provided an opportunity to get the complete representation from the established facility-based MSGs hence affording the assessment with comprehensive information that will inform the project programming for second phase implementation. Pre-testing was carried out in the fifteenth site in the Intervention Arm 2, Gwindingwi. Simple random sampling method was used for the selection of one site that would provide the complete picture of what we were to expect during the full scale data collection process. All the 15 sites were assigned numbers (1-15), and Random Number Generator (RNG) software on mobile phone was commanded to select one number which would represent the site for the pilot survey. The pilot survey was conducted in order to assess the relevance of the data collection tools, adjust the data collection tools where necessary for the collection of appropriate data for the assessment. Table 1 below summarises the different sampling techniques and details on the sample sizes for the different population groups.

**Table 1:** Summary of sampling methods employed in the MTA

Population	Sampling technique	Population size	Sample size aimed for	Sample size achieved
MSG members	Convenience	188	60	51
MSGCs	Census	14	14	14
HF Focal persons	Census	14	14	14
VHWs	Convenience	10	14	10
HCC Representative	Census	14	14	14
DNOs	Census	2	2	2
MSG Records	Census	14	14	14

### 2.4.1. Recruitment Methods

All of the key informant individuals were purposively selected and requested to take part in the interviews because of the significance of their positions to the execution of the MSG project. This included the MSGCs, the HF nurses (EPAZ Focal persons), the HCC Representatives and the DNOs. Convenience sampling of mothers attending the MSG meeting on the day of data collection was done in order to select MSG members to participate in the questionnaire administration in the 10 HFs with the top 10 enrolment out of the total sample size of 14. This was mainly done to take advantage of members attending meetings since it would have been difficult to follow the members to their

respective villages of residence during the data collection exercise. One FGD was conducted at each of the four health facilities with the lowest enrolment levels out of the total sample size of 14. These facilities were Chipfatsura, Matsika, Mayo 2 and Chinyadza. All of the members who had attended the MSG meeting on the day of data collection at these 4 sites participated in the FGD proceedings. The VHWs were selected based on their availability on the MSG meeting which was also the day for data collection. A VHW at the site on the day of the MSG meeting was selected by the nurse and in the event that there was no one at the site, the nurse would call a VHW residing close to the HF. At each HF, data collectors requested for the following facility based records for desk review: Records from August 2014 to July/August 2015 from the MSG books (summary of session, MSG meeting form) and ANC registers.

## 2.5. Data Collection

Data collection efforts were carried out in order to find out information on the following study variables of interest:

- i. the relationship between HIV status disclosure and MSG participation
- ii. the nature of male involvement in MSGs
- iii. the effects of male involvement on MSG functionality
- iv. the relationship between MSGs and the health sector
- v. the effectiveness of data monitoring of MSG activities\*
- vi. the effectiveness of MSG Coordinator functioning (with main reference to retention activities)
- vii. the process of graduation of mothers from MSGs
- viii. the effect of growth in recruitment numbers on MSG functioning
- ix. the trend of attendance

Table 2 shows the range of qualitative data collection methods and tools that were used on the samples described in the preceding section. The different data collection approaches and samples were used in order to provide a balanced view-point of the perceived concerns around MSG function.

**Table 2: Summary of Data Collection Methodology Employed in the MTA**

Sample	Data Collection Method	Data collection tool	Study variables of focus
MSG Members	Questionnaire	Interviewer Administered Qnre	i, ii, iii, vi, vii
	FGD	FGD Guide	ii, iii, vi
MSGCs	KII	Key Informant Qnre	i, ii, iii, iv, v, vi, vii, viii
HF Focal Persons	KII	Key Informant Qnre	i, ii, iii, iv, v, vi, vii, viii
VHWs	KII	Key Informant Qnre	i, ii, iii, iv
HCC Rep	KII	Key informant Qnre	iv
DNOs	KII	Key Informant Qnre	i, ii, iii, iv, v, vi, vii, viii, ix
MSG records	Desk Review	Data extraction schedule	v, vii, ix

- Appropriate translation of the tools from the English language to Shona was carried out followed by back translation exercises in order to maximise validity and reliability of the instruments.
- The investigators facilitated a training exercise for the data collectors on administering the in-depth interview questionnaires and facilitating FGDs. Training received was specific to the instruments to be utilised in this particular study as well as a general overview of the MSG intervention.
- Data collection for the MSG members and all of the facility based key informants was carried out over a period of 5 weeks with the investigators travelling to the study sites on the dates coinciding with the scheduled MSG meeting dates. Appointments were secured with the DNOs from both districts over the same period of time.

## **2.6.Data Analysis**

The 'thematic content analysis' framework was used in the analysis of qualitative data obtained from interviews and FGDs. The interviews were recorded on voice recorders and were transcribed and translated from Shona to English. This consisted of reading and re-reading the field notes and transcribed texts, manual coding in the margins and synthesizing and grouping data into relatively exhaustive categories. The quantitative data collected through the MSG questionnaire were coded and entered into SPSS Version 20 from which data was analysed through frequencies and cross-tabulations.

### 3. ASSESSMENT FINDINGS

A socio-demographic breakdown of the MSG members who took part in the questionnaire administration is presented in Table 3.

**Table 3: Frequency Distribution of MSG Member Demographic Characteristics (n=51)**

Variable	Frequency	(%)
<b>Age</b>		
18 - 24	11	22
25 - 29	8	16
30 - 34	17	33
≥35	15	29
<b>Education</b>		
N/Enrolled	2	4
Primary	14	28
Secondary	35	69
<b>Religion</b>		
Traditional mainline churches	16	32
Pentecostal	6	12
Apostolic/Zionist sects	27	54
Non-Religion	1	2
<b>Distance from health facility</b>		
1 - 3 km	22	43
4 - 6 km	13	26
7 - 9 km	10	20
≥10 km	6	12

#### 3.1.HIV Status Disclosure and MSG Participation

A question was asked of the various population samples which aimed at eliciting **whether participating in MSGs had any perceived bearing on disclosure of HIV status**. The majority of the MSG members interviewed felt that participation in the MSGs helped them to disclose their HIV positive status only to their partners and immediate family members. In essence, participants in FGDs in all the four sites confirmed that the MSG meetings have actually played a major in helping them to disclose their status to their spouses and immediate families. This effect has not been the same for disclosure to the wider community as most of the members have not disclosed their HIV status beyond their family. All of the 14 MSGCs interviewed expressed the perception that disclosure was a key expected outcome of the MSG

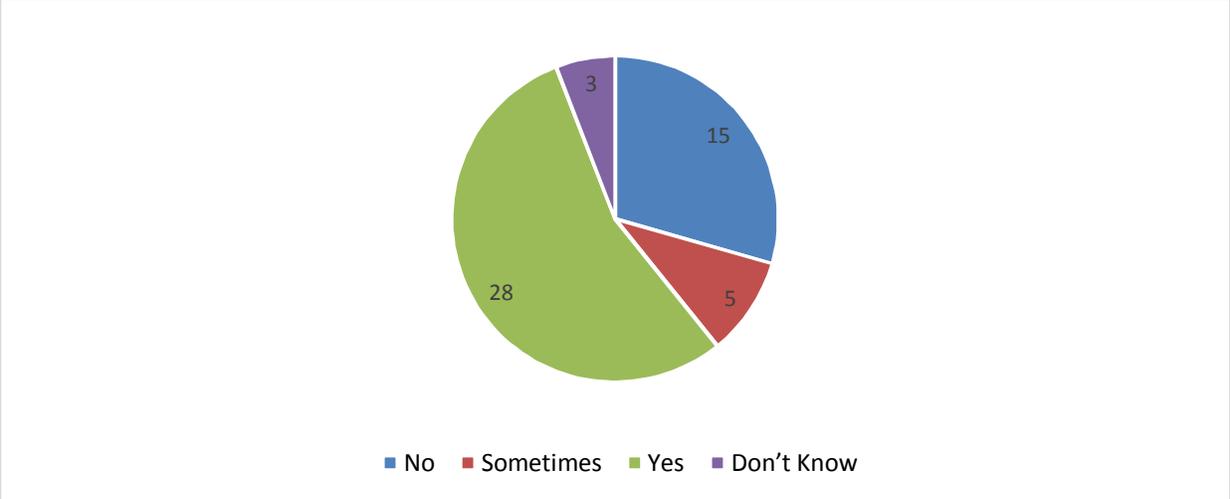
intervention. *“I was taught and trained a lot. I used to be scared but MSG’s have given me the strength to go on and shown me the importance of disclosure. We went for several training courses in Rusape.”*

On being asked to **describe the role played by MSGCs in facilitating disclosure among their members**, most MSGC mentioned the use of personal illustrative experiences and testimonies with a lot of them referring to their own life experiences. The coordinators generally look at encouraging disclosure as one of their major roles as coordinators. *“Mothers are grasping very well. They totally understand disclosure, family planning and PMTCT. All the members have disclosed to their partners. I tell them if they don’t disclose their statuses then it would be hard to adhere to the programs and medications”*. One MSGC however indicated that she had not yet disclosed her status to her immediate family. *“I left my husband and I stay with my parents. I have failed to gain the strength to tell my parents about my status. The nurses have told me to tell them but my mother suffers from BP and I can’t tell her. My parents want to feed my baby porridge but I can’t let them. Therefore I have to always carry my baby with me every time and make sure that I lie about our MSG meetings here”*.

Another question was asked on the **community perception on HIV positive mothers and fathers and specifically on MSGs and whether it prevents other mothers from joining or attending the MSG meetings**. Most of the MSGCs (12 of 14) responded that the community was aware and supportive. *“The community is aware. We received hats and bags from EPAZ and people asked about that in the community. I explained what my role is and they respect my position and value it. The group is my social system as they have become my friends”*. In essence the majority of the MSGCs reiterated that there have been an increase on awareness of HIV issues recently and this has somewhat helped to reduce stigma issues to reasonable levels. Thus, the communities had begun accepting HIV positive community members as part them. The key issue raised was that of family members failing to accept the HIV status of the mother and this would be having negative effects particularly non-attendance to MSG meetings.

The review of clinic records revealed that a significant number of HIV positive ANC attendees were mothers who were actually eligible but not enrolled into the MSG (n=101). Discussions with the nurses cited several reasons such as refusing to participate in the study or having their husbands deny them to join the MSG. Further KIIs findings revealed that at sites like Burma Valley and Weya where significant numbers of mothers were not in the study, the issue of stigma in these communities was still playing a major role in discouraging eligible mothers to join the study.

A question was asked on the MSG members and the nurses to determine some of the **issues perceived to negatively affect initial uptake and enrolment into the MSG**. The lengthy consenting process; stigma, religion and higher socio-economic stratum were highlighted as some of the perceived factors negatively affecting enrolment. A presentation of each of these findings proceeds below. Chart 1 illustrates the distribution of respondents’ views on whether the consenting process at recruitment is perceived to be a barrier for those interested in participating in the MSGs that are part of the EPAZ study.



**Figure 1: Frequency Distribution on whether ‘Requirement to consent negatively affects enrolment among interviewed MSG members (n=51)**

The majority (28 of 51) of the respondents felt that the requirement to sign a consent form had a negative influence on the decision to take up the intervention. Specifically, reservations were expressed especially on the need for spouses to sign the consent forms. Some MSG members interviewed indicated that it might take some time to navigate disclosure and obtain consent from their spouses and the process reduces their chances of enrolling into the MSG as there is a cut off period of 35 weeks and above of gestation. The views drawn from nurses during this assessment is that the required enrolment procedure might be too long and sometimes deter some mothers from joining the group but it is part of the study requirement and therefore must be followed. It was indicated that by the time some of the women returned with the signed consent forms, they had already surpassed the gestation period required for enrolling into the study, although they could still attend MSG meetings as non-enrolled participants. The interview with one nurses revealed that “... *the process of enrolment is not very difficult and we only have a small proportion that refuse to be part of the group. We have to be patient enough to allow the mother’s time to willingly join the MSG. Stigma still plays a part in some mothers’ lives. We know some of them are unwilling to disclose their status, and as such will not participate in the MSG*”.

Membership of certain apostolic sects that object to formal health seeking practices was reported to have an effect on mothers’ willingness to participate in the initiative. Another nurse held that “... *sometimes we face problems with the “elite” ones who pose a class struggle challenge. Such mothers don’t want to associate with other mothers perceived to be of inferior social standing. Apostolic members also refuse to join the group...*”.

**3.2.Nature of Male Involvement in MSGs**

This section of the report explores the **extent to which the male partners of women in the MSG members have been involved directly or indirectly in the MSG**. Of the interviewed 51 MSG members, 7

reported to have had their husbands escort them to the health facility for MSG meetings against 44 who cited they never had their husbands escort them to the health facility. The MSGCs reiterated that the MSG was not directly focusing on male partners on board, however they the only support they were providing their spouses was escort to the meeting and this was mainly when the children were still infants. In fact, 8 MSGCs cited that they had some of their members being escorted to the health facility while 6 MSGCs clearly stated none of the members had received such support. However, the 8 MSGCs who indicated MSGs being escorted also spelt that this was not a regular practice but at some point during their membership they had received such support from their male partners. The overall observation from the MSGCs was that the male partners were giving limited support as they had cited that males were difficult to deal with especially with HIV issues.

A number of the MSG members interviewed voiced the concern that there should be a way in which their male partners could gain the knowledge they are getting through MSG meetings so that they are on the same page in terms of HIV positive living. The MSG members were of the view that the more the knowledge the male partners gain the easier it is for them to understand the importance of MSGs for PMTCT, general adherence to ART and family planning issues especially for HIV positive couples. Emphasis was raised on issues such as knowledge on STIs and family planning methods especially considering that most of the male partners were reported to be refusing to use protection during sexual intercourse. The different sample groups were asked **whether in their opinion, men would want to participate in MSG meetings** and 14 of the 14 MSGCs answered yes to this question. One of the coordinators who answered positively had this to say, *“They would love to attend the meetings. They actually remind and send their wives to attend meetings and some even approach to tell us why their wives failed to attend meetings.”* Only one MSGC indicated that she was approached once by male partners of some MSG members inquiring as to whether there was a possibility of joining the MSG. One of the interviewed DNOs clearly stated that having men even to attend ANC was a challenge and having men to support MSG members in any way was even a much difficult task.

### **3.3. Effects of Male Involvement on MSG Functionality**

MSGCs, VHWs and EPAZ nurse focal persons were asked if they had **ever reached out to male partners of MSG members to invite their participation** and almost all of them responded in the negative. Both DNOs further indicated that the MSGs were not really targeting male partners hence the limited efforts in involving them. They were also asked if **they thought male partners should be involved in MSG activities**. 6 of the 14 MSGCs, 5 of the 14 nurse focal persons and all of the DNOs who responded to this question expressed the opinion that men should indeed be involved. Even for the KIIs who expressed that male partners should be involved in MSGs, they clearly cited there would be a complication in terms of combining both males and females in the same group. Further, they were mainly interested in having men have knowledge on family planning methods as it was cited that men do not want to use condoms. Of the 51 mothers in the in-depth interviews, 16 indicated that men should be definitely involved. **Reasons why men should not be included in the MSG activities** emerged from the FGDs, the in-depth interviews as well as the KIIs according to the following major themes:

- It would be difficult for women to discuss some women issues in the presence of men
- Those members whose partners are absent might not be comfortable with the setup and might view it as an exclusive group for members with partners available to attend the meetings

These opinions were also associated with the impression that involving men would ultimately result in lower attendance of MSG meetings than currently experienced. Another issue that came through during the discussion are the **reasons why it would be difficult to involve men in MSG activities** and the two major themes cited are:

- These MSGs are at health facilities based in rural areas, where the male partners for the MSG members are not usually residing together. Most male partners are mainly involved in economic activities to support their household in urban areas. This complicates and makes it even difficult to engage male partners into MSGs in any way since they are not usually there to attend even if they are willingly to.
- A number of nurse EPAZ focal persons indicated that it would be extremely difficult to involve male partners in MSGs considering that it was already difficult to involve them in accompanying their spouses for ANC and PNC visits which are also core support activities for pregnant mothers and those that have just given birth.

Respondents who indicated that they were comfortable with having male partners in the MSG came up with the following **reasons why men should be included in the MSG activities**:

- As partners they are both aware of their HIV status so there is nothing to hide
- It would be good for male counterparts to receive the same messages that the women learn so the couples can be on the same page in terms of positive and healthy living.
- Both males and females would be seen to be receiving the same service when they come for ART resupply. Currently there seems to be some segregation when clients come for ART services then only women proceed to get an additional supportive intervention.

Some opinions expressed by some of the key informants interviewed on the matter of male involvement in MSG activities include: “... *It is difficult because other women are single so having male participants involved will be awkward. But it would be great if males create their own group. There is a need as most men are hard headed so if they manage to discuss issues it will be better. Otherwise people who want to form their own group are welcome to do so*”. An MSGC at one of the HFs shared the same sentiments and cited that, “... *It has been brought up especially in cases where maybe the mother is away, it would make sense to have the father attend in her stead. This is complicated because not everyone will be comfortable with that arrangement due to the nature of the discussions that take place in meetings. The mothers may not be comfortable having a man listen*”. When asked the question **whether they had ever had a male partner attend an MSG meeting before**, she responded, “... *we did have a male attend on behalf of his spouse once and it was very uncomfortable*”. All 14 MSGCs were asked this question and only one said they had had the experience of a man attending their meetings at least once. All of these pointed out that it had been an uncomfortable experience with participants not expressing themselves as openly as they would usually do.

### 3.4. Relationship between MSGs and the Health Sector

This section focuses on the presentation of findings on the linkage of the MSG and the mainstream health sector. This is with specific reference to the roles that nurse and village health workers play in the functionality of the MSGs. Most of the MSG members (94%) acknowledged that they get assistance (48 of 51) in different forms as an MSG from the nursing staff at the health facilities. Emerging themes for the nature of assistance received were as follows:

- Nurses assist in clarifying issues under discussion when they attend MSG meetings or when they are called to make those clarifications.
- Nurses uphold their privacy and confidentiality concerning their status which is important to them
- Nurses remind members of the MSG meetings especially those who might skipped attending MSG meetings.

All the MSGCs further supported these sentiments on how helpful the nurses are to the running of the MSGs. Below are a few quotes from the coordinators:

*"...the nurses help in communicating with the mothers who fail to attend meetings regularly. Nurses then send VHWs to locate mothers. Nurses also help in clarifying certain points which I cannot understand and when they are free they attend meetings".* And;

*" ....nurses are really helpful in the recruitment process and when they are free they do attend the meetings. We usually work with the nurses and VHWs to talk to members who fail to attend meetings. Nurses also attend meetings but due to their busy schedules they sometimes fail to attend. Nurses also help in making sure our meeting days coincide with re supply days as some mothers have to walk distances of up to 20km. We do not work with VHW's directly".*

On being asked about the kind of support that the MSG members get from the nurses one MSGC said, *"They help, like once when my child had a cold, the grandparents suggested boiling water and putting a lemon in for the child but I ran to the clinic and the nurses helped by contacting my parents saying the child would be fine".* In reminding the members for the MSG meetings, the MSGCs indicated that the nurses mainly remind the members whose names would have been submitted after not turning up for the meetings for a long time. In the event that a member of the group does not attend meetings twice or more times, the MSGC notes the individuals and submits the names to the nurse for tracking through calling per phone or making use of the VHW. From the standpoint of the MSG members, even though the assistance provided by the nurses is very helpful, these individuals are overwhelmed by patients (voiced by 40 of 51 mothers) and have little time to attend their meetings. The findings from both the MSGmembers, MSGCs and the nurses themselves clearly shows that the nurses are understaffed and have a busy schedule that might not allow them to regularly attend the proceedings of the meetings.

It was therefore revealed during the assessment that there is no clear linkage between the MSGs and the conventional health system at the grassroots level. This was prominent throughout the visited sites where the VHWs and representatives of the Health Centre Committee (HCC) only cited that they were

aware of the group but had nothing to do with the group. This little knowledge about MSGs at their health facilities is adequate evidence of very insignificant or no linkage at all.

### **3.5. Effectiveness of Data Monitoring of MSG Activities**

Document review through the MSG Files at the 14 HFs revealed that most of the facilities were up to date in terms of the availability of updated attendance registers and record of meeting minutes and other information in the MSG books which include the MSG meeting forms, enrolment and graduation, and the summary of session forms. Between July and October 2014 data entry on MSG issues was done on pieces of paper. MSGCs could get their hands on since the MSG book had not yet been introduced. When the MSG books were introduced later in October 2014 MSGCs transferred the information they had on the papers onto the books. At this time some of the papers had been lost and some of the transcription was not adequately carried out hence some blank spaces in the MSG books. Most of the MSGCs revealed that there was initially a lot of confusion when they started using the MSG books since at that time they had not yet received any training on how to use them. However, following their participation in workshops held since December 2014, they indicate it was very helpful and improved their knowledge and skills in the accurate completion of the MSG books and operationalisation of MSGs.

The physical review of the MSG books revealed findings that were synchronous to the interview findings stated above. During the assessment it was shown that the completion of the MSG books from August – December 2014 had a lot of gaps especially in accuracy and type of information to be filled in. Discrepancies were revealed between attendance register information and information provided by the EPAZ staff. Some of the information that needs to be filled in like notifications through SMSs and calls, home visits and informing the nurses of members not attending meetings was not filled in at all on the MSG meeting form. In the summary of session, even in cases where there was very low turn up by the members it was very rare to find it indicated on the meeting assessment options while in most cases MSGCs indicated that *“the topic was easy to teach”* and *“members asking questions”*.

Some of the files for MSG members were missing some crucial forms that are expected to be available at the time of recruitment in order to verify that the recruitment processes was carried out ethically and in a manner within the confines of the study protocol (Table 4). Of note is the finding for Burma valley and Marange clinics where MSG Files were missing 10 and 14 Inclusion/Exclusion criteria forms respectively.

**Table 4: Data quality and availability in MSG Files**

Health Facility	No. of Consent forms missing in MSG Files	No. of Inclusion/Exclusion Criteria forms missing in MSG Files
Chitakatira	0	0
Zvipiripiri	0	1
Nyazura	2	0
Rukweza	2	0
Mayo 2	2	1
Burma Valley	2	10
Chipfatsura	0	3
Chinyadza	0	1
Tandi	1	1
Matsika	0	1
Marange	1	14
St Theresa	4	1
Weya	0	1
Mayo 1	0	0
<b>Total</b>	<b>14</b>	<b>34</b>

The MSG books must at some point be verified by the health facility MSG focal person for accuracy; however the latter cadres expressed that sometimes they have limited time to carry out the task. One of the nurses stated that, “... Yes we do verify at times. So depending on the workload, we check accuracy. Sometimes you are alone and it is difficult to do the verification. So unless we have a specific person just working with MSGs it would be better”.

What seems to make the MSGCs content with their work in terms of the MSG books is that they have generally not received any complaints or negative feedback from the EPAZ staff who carry out data extraction and verification activities. The MSGCs revealed that they do not know the frequency and scheduling of the data extractors’ visits. MSGCs also commented that they get a lot of assistance in filling MSG books from the EPAZ MSG Assistant officers who also sit in during the meetings. Comments also came out that the MSG Assistant officers sometimes help to clarify issues that come out during discussions in the MSG meetings. The MSGCs were asked a question of their opinion on the security of the data collected in terms of the storage and non-sharing of the information concerning individuals. All of the MSGCs indicated that the records were kept at the HF in locked cabinets. One concern that came up related to this is the point that MSGCs conduct their retention activities (SMS/call reminders) from home so some MSGCs may forget to make appropriate entries on these retention activities since their books are kept at a different setting (HF).

### 3.6. Effectiveness of MSG Coordinator Functioning

There is consistency in the coordination of the MSG activities with 12 of the 14 MSGCs interviewed stated that they have been in the positions since the inception of the intervention in the sites. All of the MSGCs interviewed indicated that they found the trainings that they had received through the EPAZ project very useful and relevant to the implementation and discharge of their duties.

#### 3.6.1. Meeting Procedures

Questions were asked from the MSG members on the conduct of the MSGs with specific reference to individuals responsible for engaging members, the methods used for engaging these members and the satisfaction of the members on the frequency of the meetings and surrounding issues. The assessment checked if the current conduct satisfied the set out procedures as per established MSG manual. There are key aspects in the proceedings of the MSG meetings that must be continuously done for a successful meeting as per MSG module. In that respect, all 51 of the questionnaire respondents stated that the objective of each session was clearly outlined to their satisfaction. Further to that, the members also indicated that the issue of confidentiality about the MSG members was actually emphasized at the beginning of each session. Thus, all 51 of the respondents indicated that they were constantly reminded on the importance of upholding confidentiality of the status on other MSG members.

Interaction between the facilitator (MSGC) and the members during the session is of great importance if participants are to understand the fundamentals of the MSG module. In fact, they must have the opportunity to share their experiences and ask questions during proceedings to enhance their understanding. Most of the respondents indicated that the MSG meetings actually did encourage the sharing of experiences (43 of 51). These shared personal experiences bring depth into discussions and realistic perspectives allowing for the members to better relate to each other through experiences. Also, 49 of the 51 respondents pointed out that they *always* have the opportunity to ask questions to MSGCs or the nurses when they attend while only 2 indicated 'sometimes'.

#### 3.6.2. Meeting Venue

The venue for the MSG meetings also plays an important role in encouraging members to participate freely without fear or segregation, privacy of their discussions during the session and continuously attend the meetings. In that regard, 42 of the respondents cited that they were satisfied or fairly satisfied with the venues while those not satisfied were 9. The respondents who indicated that they were satisfied mainly conducted their sessions in an extra room or the mothers waiting homes at the health facility. This to a greater extent

Figure 2: MSG members holding their meeting indoors



provided the privacy they needed. Those who indicated dissatisfaction conducted their meetings in open spaces at the health facility (e.g. under tree shades, back of nurses' houses). This to some extent might discourage attendance especially for those members who do not want their HIV status to be known to the general public. In essence, the unsatisfied mothers indicated that their venues were not friendly to their cause.

### **3.6.3. Meeting Frequency**

On the aspect of frequency of the meetings, it was shown that most of the members were satisfied (45 of 51). The members who were fairly satisfied and not satisfied proposed that meetings be held once every month as opposed to twice. Of the 14 Nurse EPAZ focal persons, 10 felt that the frequency was appropriate while 12 of the 14 MSGCs thought the same. One of the nurses stated, "*..... the frequency is high. It is hard for the women to get away from home twice a month. We have tried to get the MSG meeting to coincide with the day for ART re-supply to minimise days away from home. Even the mothers themselves have expressed the desire to only have one meeting per month. The length of meetings is fine. They usually last for about an hour or so. It would be good to try out having one meeting per month to see if the rate of non-attendance would decline. Personally I think once a month would be more effective. It is something we should look at trying out to see if it is effective...*". On the other hand, another nurse pointed out that "*... the frequency for the meetings is fine as it gives the mother's adequate time to carry out other duties in between meeting dates. The MSG members are fine with the frequency. They expressed that weekly meetings would be more challenging to attend...*". This was also supported by many of the other interviewed nurses including one who specified that "*.... I see the meetings are spaced well and the timing is fine as people can go for a meeting one week and rest the following week. So they can manage. The timing is fine depending on if they want the programme. So the duration is up to the participants as they are discussing issues*". Overall intervals for the MSGs meetings were acceptable to the majority of the FGD participants, key informants and respondents during the questionnaire administration as it gives them time to rest and focus on other household and livelihood activities.

### **3.6.4. Retention Activities**

The MSGC respondents during the assessment ascertained that the MSGs have managed to retain most of their members in both districts. Some of the reasons given by the coordinators for non-retention of some members include:

- Stigma issues within the family
- The MSG member being denied to attend by the husband

Most of the questionnaire respondents consider the groups important to their new way of living. Asked to comment on the main reason why they have remained active in the groups, the following themes emerged from MSG members:

- the teachings at the MSG meetings (17 of 51)
- information shared during meetings is helpful in raising their children (14 of 51)

- encourages positive and healthy living (9 of 51)
- phone call and SMS reminders (6 of 51).

Notifying the MSG members for the next meetings is an integral part of the functionality of the group. It is of great importance to keep on reminding members since it plays a role in retaining them until their graduation and hopefully after that. To that end, 45 of the 51 MSG members interviewed indicated that they always get notifications against 6 who cited that it is not always but sometimes. It was also discovered through FGDs that those who indicated that they do not receive notifications for the next meeting were the individuals who did not possess mobile phones on which they could be contacted through calls or SMSs. However, those who do not get notifications pointed out that they relied on remembering the dates of the next scheduled meetings.

The notifications for the meetings are received through different means. In essence, three methods of notification were identified by the MSG members questionnaire respondents. The majority of the respondents indicated that they receive notifications through SMS (24), MSGC phone call (22) and during the MSG meetings (5). It was also related that the date for the next meeting was told to the attendants at the end of every meeting and those who attended the MSG meeting would be aware of the date for the next meeting. Despite receiving notifications through different methods, members had their own preferences. Of the 51 MSG members interviewed, 24 preferred phone calls from the MSGC, 23 preferred SMS reminder and 4 actually preferred announcement at the MSG meeting. The individuals who preferred SMS reminder considered problems with network availability in the sense that one might not be able to get through but if one sends an SMS, the message will get through when network is good and still delivering the notification. Overall, the preferences indicated by the respondents was mainly centred on the resources and knowledge of their area they had at an individual level opening up for the preferred method in getting hold of them.

Other channels of engaging the members would involve the nurses at the health facilities initiating a tracking mechanism of non-attending mothers through VHWs. This strategy is reported to be dependent on the efficiency (if they actually make the effort) of the individual nurses to contact these mothers through the VHWs. While nurses generally report that they follow up non-attending mothers in this way, most of the MSGCs expressed doubt on whether the nurses actually initiate this process due to forgetfulness or their overwhelming work responsibilities. Thus, this assessment identified the weaknesses of the current retention activities as perceived by the members. The majority of the respondents in fact did not perceive the retention activities as having any weaknesses at all (32 of 51). However, a few (19 of 51) pointed out the following as loopholes in the current strategy employed to retain participants:

- Inadequate funds for airtime
- Telephone network connectivity problems for those with cellphones
- Limited effort from the nurse
- MSG members lying to the nurse/MSGC over the phone

According to one of the MSGC: *".... I think the issue of low airtime is a major weak point. We only get \$5 a month to contact members, if I could manage to get at least \$15-20 a month for airtime then it would*

*be easier to contact them*". Currently, the amount of airtime given to the MSGCs through the EPAZ project is not aligned in accordance to the number of the members in the group. The MSGCs are given a uniform amount of \$5 per month throughout the MSGs without regard to the number of members in the group or the number of times the MSGCs would have to call or send SMSs to the members. To that end, those MSGCs with larger members, like Marange and Weya, end up not being able to contact all members to remind them about the forthcoming meetings.

Another key observation under this discussion is that not all the MSG members are in possession of mobile phones through which they can be contacted or reminded about meetings. Findings from the document review revealed that approximately 67 of the 188 MSG members currently enrolled in the 14 sites (36%) do not have mobile phones (Table 5). Some of the members' homesteads are located in areas further from the main communication network facilities where there is no reception. This makes it difficult for the nurse/MSGC to communicate with them reminding and encouraging them to attend the regular meetings. As a result such members come to the MSG meetings because they are self-motivated to come since they are limited ways to remind them of the meetings (see result in Table 5).

**Table 5: Mobile phone ownership among MSG members**

Health Facility	No. of Mothers enrolled in MSGs	Members without phones	
		Freq	(%)
Chitakatira	18	No data	-
Zvipiripiri	22	9	41
Nyazura	14	4	29
Rukweza	12	5	42
Mayo 2	14	3	21
Burma Valley	12	7	58
Chipfatsura	7	2	29
Chinyadza	8	3	38
Tandi	11	6	55
Matsika	7	3	43
Marange	20	0	0
St Theresa	11	3	27
Weya	16	10	63
Mayo 1	16	12	75
<b>Total</b>	<b>188</b>	<b>67</b>	<b>36%</b>

### 3.7. Process of Graduation of MSGs Members

Findings from the MSGCs and MSG Assistant Officers indicate that based on the criteria set for graduation, 52 of the 188 enrolled MSG members were deemed to qualify for graduation at the time of

data collection (28%). The assessment findings revealed that the graduation criteria<sup>5</sup> used in the MSG was rated as either good or fair by 43 of the 51 MSG members interviewed. Eight of respondents were not aware of the graduation criteria. The majority of the respondents who were not aware of the graduation criteria were from one site. Even some of those who could spell out the graduation criteria were not absolutely certain since those they knew to have satisfied the graduation requirements had not yet graduated and nothing had been mentioned to that regard. One of nurses emphasized that *"...more knowledge is needed about graduation criteria as well as enforcing the importance and benefits of graduation"*. It was further revealed that approximately 52 MSG members were due for graduation at the time of the assessment and during the assessment nothing had been mentioned as to when these mothers were going to graduate. This is despite the fact that the MSG Module that is used by the MSGC actually indicates the graduation criteria for the MSG members. Having said this however, some of the mothers indicated that they do not really care about graduation as long as they get vital information from their meetings.

### **3.8. Effect of Growth in Recruitment Numbers on MSG Functioning**

The EPAZ study set a target enrollment of 300 for the entire study, implying a total of 150 for the MSG intervention arm, with the intention of recruiting at average 10 members at each of the 15 sites. During this assessment data was collected from 14 of the 15 intervention HFs which were visited during the process of data collection. These 14 MSGs had recruited a total of 188 members at the time of the assessment. The project had therefore managed to recruit 134% against the targeted total 140 members (for 14 sites). As can be seen in Table 2, only three facilities out of the fourteen, i.e. Chipfatsura (n=7), Chinyadza (n=8) and Matsika (n=7) are yet to achieve enrolment of 10 MSG members each, at the time of data collection. Some of the high volume HFs have even managed to double the initial expected MSG sizes, for example Zvipiripiri (n=22), Marange (n=20) and Chitakatira (n=18). The MSG Coordinators with big groups did not express any particular difficulties in managing bigger groups. They indicated that the bigger the group the better it is to teach and discuss. It was further revealed that bigger groups are rich in discussions and experiences shared during the proceedings. Further to that, coordinators expressed that they prefer only to have one MSG at each site as compared to splitting it because of size. According to the coordinators, having two groups at the health facility might result in divided approaches, and in the process losing track of the main objective of the MSG.

### **3.9. Attendance**

A desk review of all attendance registers for more than 20 meetings held since the inception of MSGs in July 2014 was carried out at each of the 14 HFs included in this assessment. The average site attendance percentage for MSGs is fluctuating around 50% indicating in many cases less than half of the members

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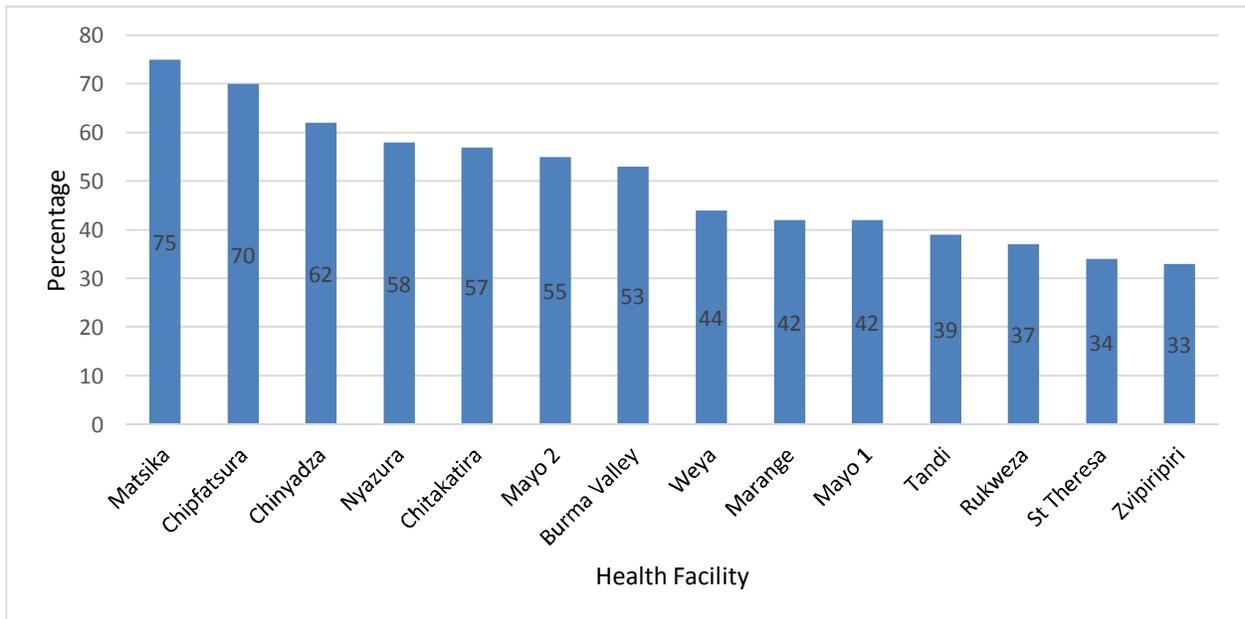
<sup>5</sup> The graduation criteria for the MSG is as follows: mothers who are 6 months postnatal and about to leave the group should be recognized. Those who have completed 8 sessions receive a graduation certificate. Those who have completed less than 8 sessions receive an attendance certificate. When mothers graduate, reinforce the ~~to~~ mothers graduate at 6 months postnatal ~~message~~ as stipulated in the MSGC Manual.

show up for the meeting. Records revealed that there was never a scheduled meeting during which all the members turned out even for those groups that have synchronized their meeting dates with ART re-supply, ANC and PNC visits. Average Site Attendance (ASA) was calculated for the 14 HF's as follows: First find the

$$\text{Percentage Site Attendance (PSA)} = \frac{\text{Total attendance}}{\text{Total members in MSG}} \times 100 \text{ then find:}$$

$$\text{ASA} = \frac{\text{Sum of PSA}}{\text{Total number of meetings held (with available information)}}$$

Groups that have managed to achieve relatively high average site attendance percentages are Chipfatsura (70%) and Matsika (75%). The HF's with the lowest average attendance percentages are Zvipiripiri (33%) and St Theresa (34%) (Figure 3).



**Figure 3: Percentage Distribution of Health Facility Average Attendance**

This is also similar to the individual average attendance which is 47% showing that less than half of the members are managing to attend the meetings. This is further shown in (Table 5) as only 9 members in the 14 surveyed groups have managed to attend all the sessions (1 to 8) even in haphazard manner. The majority (n=105) are members that have managed to attend more than 4 meetings since joining the group. Some of these members might have attended more than 8 meetings but they did not attend all the prescribed sessions 1 to 8, indicating that there is still need to acquire more knowledge based on the session/s yet to be attended. A significant number (n=62) of the members have only attended less than 4 meetings since some of them take a long time to finally decide to start attending meeting while others skip more meetings in between their attendances. The records further revealed that they are MSG members that were not attending meetings for more than two months and then attend one or two

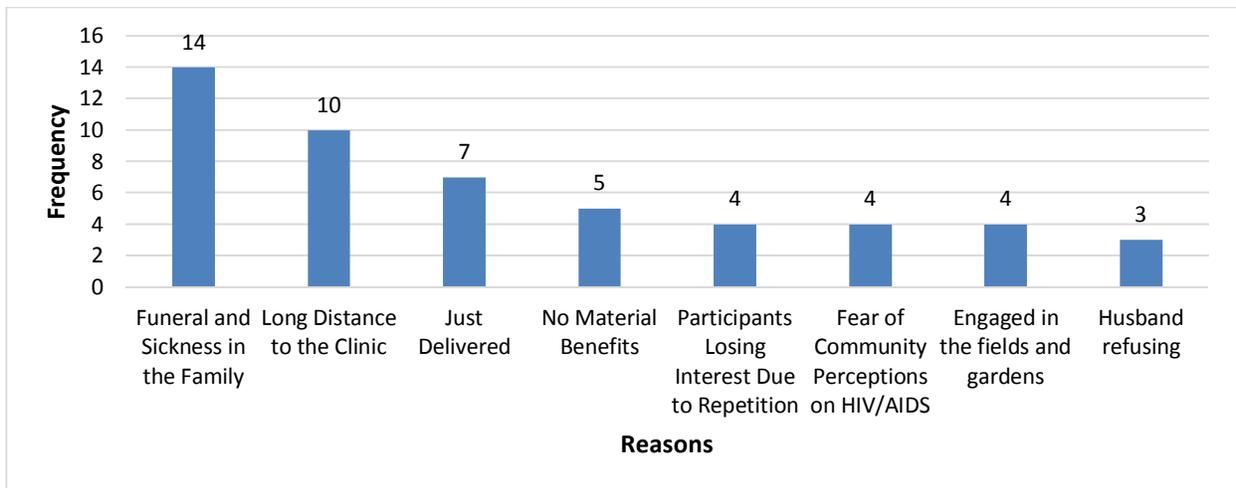
meetings indicating inconsistent participation. These would lower the cumulative average attendance percentage for individual groups.

**Table 5: MSG Attendance Statistics**

Health Facility	Never attended an MSG meeting	Attended 1-3 MSG meetings	Attended 4-7 MSG meetings	Attended Sessions 1-8	Attended 8 or more meetings	Individual average % attendance <sup>#</sup>
Chitakatira	1	7	10	0	4	60
Zvipiripiri	2	7	11	0	3	33
Nyazura	0	5	8	1	5	54
Rukweza	2	3	6	1	3	38
Mayo 2	0	4	8	2	4	51
Burma Valley	2	4	6	0	2	38
Chipfatsura	1	1	3	1	0	60
Chinyadza	1	2	3	1	0	51
Tandi	0	4	5	1	1	42
Matsika	0	2	4	1	2	64
Marange	1	5	11	0	6	44
St Theresa	0	4	10	0	5	36
Weya	1	6	12	0	3	38
Mayo 1	1	8	8	1	1	49
<b>Total</b>	<b>12</b>	<b>62</b>	<b>105</b>	<b>9</b>	<b>39</b>	<b>47</b>

\* Individual average attendance (IAA) is a product of the total meetings attended divided by the total number of meetings held since joining the groups multiplied by 100 to get the IAA as percentage.

MSG members were asked the major cited reason for failing to attend MSG meetings regularly. Several issues were brought up by the respondents as possible reasons for not attending the MSG meetings regularly or factors that would discourage members to attend meetings. Graph 2 presents the perceived most important reason why MSG members do not attend MSG meetings regularly. The graph also outlines the frequency with which the factors were mentioned across all the visited health facilities.



**Figure 3: Frequency Distribution on Perceived Reason for Not Regularly Attending Meetings (n=51)**

The assessment findings indicate that the majority of the (14 of 51) MSG member respondents cited funerals and sickness in the family as the major factor for not attending meetings. The FGD participants in both districts also indicated that even if one is aware of the meeting dates, the occurrence of funerals and sickness in the family or community tend to supersede MSG meetings in terms of priorities. The second most commonly cited reason for non-attendance by the MSG members was the issue of perceived long distance (10 of 51) to the clinic from place of residence. At one site, the interviewed nurse stated that, “... one of the mothers in the MSG has to travel almost 17km whilst pregnant; making it difficult to make attendance in all meetings especially when close to giving birth...”. In another site, the nurse further supported the above view when she pointed out that, “we have had no complete dropouts from the MSG to date, which is a good thing. Attendance is tricky mainly because of the distance or proximity to the clinic. This is why we set about dates coinciding the MSG meeting with resupply days. It’s difficult for the mothers to get away from home often. We have to remember that some of these are expecting mothers and they have to walk long distances in this condition, which is not healthy”. The sites in which distance was mentioned as the major limitation for attendance to MSG meetings include: Zvipiripiri, Rukweza, Weya, Mayo 1 and Mayo 2.

The FGD participants also further highlighted that it is difficult to attend meetings soon after giving birth (7 of 51) since mothers will not be strong enough to walk long distances and also that they have infants to walk with making it difficult for the members. According to feedback from the FGDs, there are some MSGs which have not yet aligned their meeting dates with the community holiday “chisi” making it hard for other members to attend since they will be engaged in the fields especially during the cropping season. Another factor identified by the members themselves even in FGDs was that issue that some of the members had already attended all the 8 sessions in the MSG module, and recycling the same modules with the same person (4 of 51) – made some of the members not to attend with the impression that they are already aware of the issues to be discussed in the selected forthcoming session. This was further reinforced by views from one of the MSGCs who specified that “...I think there is a repetition of the topics so some members will not attend the meetings citing that they know the work that we shall be discussing”. She went on to state that, “...sometimes when you call the members reminding them about

*the meetings, they even ask which module will be discussed and the response will tell you whether or not that individual is particularly interested in the upcoming meeting..”.*

In some of the clinics, religion was pointed out as having an effect on the decision by some mothers to participate in MSGs or their ability to attend all meetings. A case in point was Zvipiripiri clinic (Mutare district) where it was reported by the key informants that the predominant apostolic sect religion negatively affects the functionality of the MSG since the church doctrine objects to their membership seeking formal health care at health facilities. However, some key informants expressed that some members of these religious sects were still actively participating in the MSGs in significant numbers in spite of the church doctrine. In the opinion of one MSGC, *“I don’t think religion plays a part because we can all make excuses and lie about where we are going. We have four apostolic members who attend. So if a person really wants to attend I don’t see a reason why they can’t attend.”*

MSG members during questionnaire administration as well as the FGD were asked to make **suggestions on how to improve MSG attendance** levels. Findings revealed the following major themes:

i. The availability of material benefits

A significant proportion of MSG member (21) of the 51 indicated that the availability of material benefits could realize an improvement in the attendance of the MSG members. The material benefits indicated by the members included: food for the members during meetings since all the members are on ART and also they have to walk long distances to the health facility, umbrellas for all members during the rainy season, hats and T-shirts for all members to associate themselves with the group like many other groups. In fact, it came out during FGD that the members were not pleased with the fact that only MSGC were the ones provided with hats and umbrellas to use during sunny days or rainy season. In these FGDs, it was indicated that in rural communities people are used to attending meetings where they realize material benefits and in this case they give total disregard to knowledge benefits associated with attending MSG meetings. According to one MSGC, *“EPAZ provided all members including the non-enrolled with exercise books and this seems to have motivated them.”*

ii. Constant reminding before the dates when a meeting is due

Some members expressed that just being reached out to once before the meeting date was not adequate as a lot of other competing priorities came up and it was easy to forget about the meetings.

iii. Creation of a friendlier environment at the MSG meetings.

The MSG members were more concerned with the venue for their meetings especially at the sites where they conducted their meetings in open spaces. They indicated that even though they disclosed their status but it was only to their families and not the entire community. Therefore they preferred to hold their meetings in venues that would offer them privacy to openly and privately hold the meetings without fear to be seen or identified by community members.

iv. Synchronizing resupply dates with MSG meeting dates

Members felt that this strategy would ensure that all members would attend meetings as scheduled because they have no choice but to come to the clinic for resupply. It was also felt that this strategy would limit the number of clinic visits necessary for mothers.

- v. Carrying out home visits to remind members when the next meeting is due  
Of the 51 respondents, 2 came up with the strategy of utilizing home visits as a potential intervention to increase attendance rates.

## 4. DISCUSSION & CONCLUSIONS

This chapter discusses the pertinent findings revealed in the previous chapter, drawing parallels with current trends and programs findings documented in other similar resource limited contexts and aligning with conclusions made on the issues of concern as described by the Scope of work and objectives for this Mid-term assessment.

### 4.1.HIV Status Disclosure & MSG Participation

The findings from this MTA suggest that the issue of disclosure of HIV status to close family members is emphasized and prioritized by the MSGCs in their discussions with the members of the MSG. The majority of respondents report that they have disclosed their HIV status to family and also acknowledge the role played by their MSG involvement in facilitating this disclosure. Disclosure to partners and family members is not without its cost in some instances. As revealed in this assessment where the KIIs highlight that one of the contributing factors for a small fraction of women who are not retained in the MSG program is that they move out of the catchment area following break up of relationships after disclosing HIV status to the spouse/male partner. It is not surprising that MSG members have generally not taken the decision to open up about their HIV status to the community beyond their close family. One of the greatest barriers to HIV programming since its inception has been stigma. HIV disclosure patterns are well documented to be related to existence of stigma<sup>6,7</sup>.

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<sup>6</sup>Emlert CA. A comparison of HIV stigma and disclosure patterns between older and younger adults living with HIV/AIDS. *AIDS Patient Care STDS*. 2006 May;20(5):350-8.

<sup>7</sup>Wolitski RJ<sup>1</sup>, Pals SL, Kidder DP, Courtenay-Quirk C, Holtgrave DR. The effects of HIV stigma on health, disclosure of HIV status, and risk behavior of homeless and unstably housed persons living with HIV. *AIDS Behav*. 2009 Dec;13(6):1222-32. doi: 10.1007/s10461-008-9455-4. Epub 2008 Sep 4.

Although definitive conclusions may not be drawn from the analysis of demographic findings of the interviewed sample due to the study methodology, individual characteristics such as age and level of education did not seem to be of great significance as we seek to understand behaviour of MSG members at individual and community level and in outlining the entry point in informing current MSG programming. The findings show an even distribution of interviewed participants across the age and education continuum which suggests that the group is accessible and acceptable to women across the demographic divide. Some of the MSG coordinators and nurses noted some unwillingness among the elite members of the community (those considered 'better off') to participate in the MSG initiative, which could imply the need for more personalized approaches in targeting this minority group.

Stigma associated with HIV disclosure may also play a role in less than optimum MSG enrolment patterns in some sites under discussion. The ease and speed with which the EPAZ study has generally succeeded in achieving set enrolment targets for the MSGs lays testament to the high burden of HIV prevalence in the study context and the real need, appreciation and acceptability for community interventions such as the one under assessment. However very low enrolment rates noted in some individual clinic records reveal a cause for concern that seems to be context specific and hence requiring of even further investigation and possible targeted action since they do not seem to be in keeping with the norm. The three sites to note in this case are Weya, Chitakatira and Burma Valley each reporting MSG enrollment among HIV positive ANC attendees of 27%, 35% and 35% respectively. Discussion during the assessment pointed towards issues of stigma being rife in the communities making up the catchment areas for these HFs as well as the prominence of religious groupings that object to the use of formal healthcare services.

Stigma in communities remains a real threat to delivery of HIV programs such as PMTCT or engagements of beneficiaries into interventions such as MSGs. However, even within this context, the MSG project has done a good job of emphasizing the importance of disclosure and seems to have facilitated disclosure of HIV status of the participants to their male partners and immediate family. Efforts at roping in male partners early on aimed at providing similar support in terms of information, counselling and fellowship may help to mitigate strain in relationships that may lead to family breakdowns following disclosure.

## **4.2. Male Involvement**

It is not difficult to see how a concerted effort at involving male partners at some level could yield positive effects towards retention of the mothers in the MSG. Male partners play a role in influencing their female partners' ability and willingness to adhere to diverse product use<sup>8</sup>. In sub-Saharan Africa reproductive health decisions, including whether or not a woman may participate in MSG activities, are

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<sup>8</sup>Montgomery E, Van der Straten A, Torjesen K. Male Involvement in women and children's HIV prevention: challenges in definition and interpretation. *J Acquir Immune Defic Syndr.* 2011;57(5):e1146e115. doi: 10.1097/QAI.0b013e31821d33d6.

greatly influenced by male partners<sup>9,10</sup>. Combined efforts from both the female members and their male partners might result in increased regular attendance of the MSG meetings and adherence to all the prescribed PMTCT practices.

It was reported that a few male partners across the visited health facilities currently escort their female partners to the MSG meetings without themselves actually participating. In an environment where getting male partners to accompany their partners even for core ANC and PNC activities has proved a mammoth task, these could be realized as first positive steps towards gaining male partner support for the MSG members and ultimately roping them in to participate on a wider scale in the general RMNCH continuum of care. Literature reveals that men generally feel excluded from most RMNCH programs and most aspects of the health system are not designed with the objective of reaching out to men. This includes IEC material which is biased towards female readers, service infrastructure which does not support privacy between the sexes or even Health worker attitudes and practices in which they do not make an effort to relate to male partners who do accompany their female partners for services. The latter is consistent with the findings of this MTA in which the majority of MSGCs as well as the nurse practitioners interviewed admitted to the fact that they have not made any effort to reach out to male partners of MSG members in any way.

Different views were expressed concerning male participation in MSG meetings by members, MSGCs and VHWs. Just about everyone would like men to benefit from an opportunity to receive messages similar to what the mothers have been receiving through the MSGs. Emphasis was raised on issues such as knowledge on STIs and Family planning methods especially considering that most of the male partners were reported to be refusing to use protection during sexual intercourse. But including the men during the same session with the women on a regular basis would possibly not be the best way to go, as the majority of participants did not seem to be for the idea. The one instant quoted by the respondents during which a man sat through an MSG meeting, was described as “uncomfortable”. Because of existing socio-cultural norms women and men are not free to discuss sensitive issues around sexuality and childbirth in a communal forum. In addition, those women whose partners would not be able to participate or those women without a male partner would then feel excluded. In these rural settings, male partners still migrate to urban areas in search of employment to support the families, so quite a number of the women would then fall into this group of ‘women without partners present’. It was also interesting to note that among reasons quoted for not attending MSG meetings, “Husbands refusing” was only brought up by 3 of the 51 respondents, keeping in mind of course that this is among

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<sup>9</sup>Pool R, Nyanzi S, Whitworth JA. Breastfeeding practices and attitudes relevant to the vertical transmission of HIV in rural south-west Uganda. *Ann Trop Paediatr*. 2001;21(2):119-25.

<sup>10</sup>Tirmizi N. et al, Women's empowerment, participation in mother-to-mother support groups and nutritional outcomes for children under age two. Conference abstract. 141st APHA Annual Meeting and Exposition 2013 Available

from: [https://www.researchgate.net/publication/266813277\\_Women%27s\\_empowerment\\_participation\\_in\\_mother-to-mother\\_support\\_groups\\_and\\_nutritional\\_outcomes\\_for\\_children\\_under\\_age\\_two](https://www.researchgate.net/publication/266813277_Women%27s_empowerment_participation_in_mother-to-mother_support_groups_and_nutritional_outcomes_for_children_under_age_two) [accessed Jun 3, 2015].

women whose partners have already consented to their initial enrolment into the MSG in the first place. It was not possible to ascertain the contribution of male lack of support for those women who decline to participate in the intervention.

Men's involvement in the MSG program to date has been limited to accompanying their partners to the MSG meeting and this only happened in a small fraction of the couples concerned. The nurses and group coordinators have generally not made an effort to reach out to the male partners with any extra support. Most of the male partners have not voiced a desire to participate in MSG meetings. Most participants in this MTA would not want men to be co-opted as members of these MSG in their current form. MSG members and KIs generally want the male partners to be able to receive the same information and opportunity for social support that the mothers have been receiving.

### **4.3. MSGs & Health Sector Linkages**

The assistance by the health facility staff especially the Nurse-In-Charge is an integral part of the whole MSG project. Their capacity to provide adequate assistance to the MSGs has a bearing on the ability of the MSG to realize their full potential in terms of impact to the HIV positive mothers and their children. Hence it is key for MSG programming efforts to find ways to keep this cadre motivated to keep doing what they do and think through (from a sustainability perspective) how this cadre can be made to remain motivated even outside of a stricter study context such as EPAZ where there is more monitoring and rewarding activity. Evidence remains limited for complex interventions combining strategies across different ecological levels for trying to improve retention in PMTCT<sup>11</sup> where for example a community oriented grouping like an MSG then goes on to meet at facility level with the guidance of the facility based HW so this example should provide exciting results. However, facility based MSGs have been established to be closely integrated with the PMTCT program and can certainly impact on retention of mother baby pairs in the latter<sup>12</sup>.

The presence of the nurse in the MSG meeting boosts the morale of the members and makes members see theirs as an important cause at the health facility. Thus an improvement in attendance by the nurses to the MSG meetings would see more appreciation from the members and consequently improving on the general attendance by the members. It was further understood in this assessment that some members of religious sects may be less likely to participate in modern health care and this might influence them consenting to joining the MSG or to attend group meetings consistently once enrolled. The assessment revealed that 54% of the respondents in the two districts belong to either the apostolic

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<sup>11</sup> Busza J, Walker D, Hairston A, Gable A, Pitter C, Lee S, Katirayi L, Simiyu R and Mpofu D. Community-based approaches for prevention of mother to child transmission in resource-poor settings: a social ecological review. *Journal of the International AIDS Society*, Vol 15 Supplement 2 (2012)

<sup>12</sup> Intrahealth international (2008) Mothers Support groups in Ethiopia: A peer support model to address the needs of women living with HIV

or to the Zionist sect both of which sometimes fall into the category of religious objectors. It would be interesting and possibly worthwhile to investigate the feasibility and effectiveness of setting up a non health facility based variation of the MSG in these religious objector strongholds, probably outside the current EPAZ study context as that would dilute the intervention. But from a non-study related and more programming oriented viewpoint, this level of engagement would possibly impact positively on a significant segment of the needy population.

The assessment revealed that there is no clear linkage between the MSGs and the conventional health system at the grassroots level. This was prominent throughout the visited sites where the VHWs and representatives of the Health Centre Committee (HCC) only cited that they were aware of the group but had nothing to do with the group. HCCs are administrative bodies that oversee and make decisions on the general day to day running of onsite health facility business as well as health related community activities such as outreach EPI rounds. Engagement with these government established HCCs presents an ultimate opportunity for stimulating their understanding, appreciation and support for MSGs and maybe in the long run pave way for sustainability of the groups. For example, this body would have the authority to allocate funds from the facilities income to purchase airtime for the nurse at the HF to initiate tracking for non attending mothers. Similarly, VHWs are an invaluable resource to the health system and a more targeted approach at involving them could greatly impact on attendance and retention of MSG members. Acknowledging the fact that a lot of programs have been 'task-shared' with this cadre, there is a gradual trend towards integration in Zimbabwe. Currently, a Community child health integrated tracking tool has been successfully piloted by MOHCC and partners in Mutasa and Buhera districts in which VHWs have been involved in tracking children under 5 looking at EPI, Vitamin A and PMTCT follow up. There may well be room in this type of integrated activity to accommodate MSG meeting attendance.

Health facility nurses have been very supportive of the MSG program and their involvement is an integral part of the functioning of the MSG. This support is felt all the way to the DNO's offices who have expressed their appreciation of the MSG program. Members not only appreciate this involvement because of the clarification that nurses bring to the content of the lectures but also the impression of importance that the grouping gains due to the association with the formal health sector. MSG engagement with the community based health sector links has not been as pronounced with both the VHWs and the HCC members expressing limited knowledge of the program. Exploration of further avenues and implications of engagement at these levels is encouraged, especially with the view of facilitating continued long term program implementation.

#### **4.4.Effectiveness of Data Monitoring of MSG Activities**

Effective program monitoring involves assessing the process of implementing an intervention so that questions about the program can be answered in a systematic manner. The MTA sought to assess the tools (Management Information system) used to monitor the performance of the MSG intervention in terms of the comprehensiveness of the tools in capturing all the essential data. The MSG books that are

currently being utilised by the MSGCs were seen to adequately capture all the relevant information about the processes involved in running the program including the staff providing the service, the number of MSG sessions conducted, summary of activities, matters arising during each meeting, and coverage to targeted beneficiaries. The MTA also sought to find out the perception on user friendliness of the tools among the MSGCs. The experiences noted in the Findings section indicate the initial challenges faced by the MSGCs as the expectation to capture data using the tools preceded the conduction of appropriate training. However, following this training effort, MSGCs report themselves to be well capable of capturing required data in the MIS and review of the records confirms this.

In addition, the MTA reviewed the supportive supervision processes in place for the MSGCs data collection and capturing processes. The project has a data verification process in place whereby EPAZ staff visit all the intervention sites reviewing entries and providing appropriate feedback. Also the project has employed MSG Assistant officers who assist MSGCs in capturing data following MSG proceedings and this process is appreciated by the MSGCs and clinic nurses as ensuring good quality data. A concern to note is the report that these officers will sometimes contribute to MSG meeting proceedings usually being requested and offering clarification on some issues under discussion. From the EPAZ study perspective, this practice is not to be encouraged as this contaminates the intervention and has the potential to influence outcomes.

Another aspect of data monitoring assessed was the completeness/availability of records that are component to the MIS at the sites. All the requisite paperwork was found to be available in the files of all the MSG sites except for the two sites indicated in the findings section where consent forms and exclusion/inclusion criteria forms were found to be missing for a significant number of MSG participants. These sites will require further support and follow up in order to ensure improved completeness of record keeping. MSG data security and confidentiality issues were well taken care of with MSG files in all 14 intervention sites being kept under lock and key and enforcement of limited access.

Effective data monitoring strategies are being employed by the project. EPAZ data quality staff must desist from interfering with actual proceedings of MSG meetings.

#### **4.5. MSG Coordination & Functionality (Attendance and Retention)**

The participants speak highly of their MSGCs and express that they feel encouraged to participate and share experiences during meetings. The assessment also revealed that coordinators stick to the guidance provided in the protocols on how to conduct these meetings. The coordinators themselves did not express any untoward comments on the project. They did however raise the issue that those dealing with bigger groups would desire that their airtime allowance be reviewed accordingly. The experience of this level of commitment in a program driven by volunteerism is similar to experiences in other places such as the Intra-Health International MSG intervention in Ethiopia or the M2M program in South Africa.

Some participants pointed out that they were not satisfied by the sites where MSG meetings are conducted because of the apparent lack of privacy which has the potential to lead to inadvertent disclosure of their HIV status to the broader community accessing services at the Health facilities. Literature confirms that privacy issues can be a significant setback for enrolment into various HIV related interventions. This status quo may well contribute to the less than desirable attendance figures observed in some facilities. It may also have a bearing on initial enrolment of eligible women as members of MSGs. In addition, this would also raise ethical questions on the achievement of protection of the confidentiality of EPAZ study participants. The project is encouraged to the extent possible to facilitate processes that support maintenance of privacy and confidentiality for the MSG members which are friendlier to their cause.

The average attendance for all the assessed sites is approximately 50% which is less than desirable and suggests the need to improve efforts at improving attendance and participation. Several reasons have been cited by the members as to why they are not regular in terms of attendance to meetings. The most prominent factors cited include: funerals and sickness in the family, distance to the health facility and working in the fields. These cited factors present the complexity of the rural communities in terms of regular attendance of meetings which will also present a challenge in terms of addressing the attendance issue for MSGs. Matters such as attending funerals carry a lot of socio-cultural weight especially in rural communities with a strong social fabric especially when it comes to helping communities during death and this in most cases overrides any other activities including MSG meetings. Attending MSG meetings is viewed as an extra curricula activity which must not become a barrier to their daily life activities that form their livelihoods. However, this is a concept that can be changed over time through continuous emphasis on the importance of the group, positive and healthy living and sharing of experiences through group meetings.

It is encouraging to note that the major reasons cited for non-attendance are not directly linked to the intrinsic design and/or conduct of the MSG intervention which speaks well to how the MSG is currently structured. However, the project would do well to assess how best to operate within the context of these negative external environment factors so that what can be turned around effectively is applied in order to maximize the benefit of the MSG intervention to the community. The issue of distance as an example, to what extent is the opportunity available to bring the MSG intervention closer to the households in those contexts noted such as the Mayo clinics? Can full advantage be taken of pre-existing community based structures and entities such as VHWs, churches, etc? Granted, these options may not be applicable within the strict protocol of the EPAZ study context, but considerations have to be made going forward and thinking beyond the life of the EPAZ study with focus on the perpetuation of the MSG strategy.

Another suggestion that was expressed overwhelmingly by the members and the MSGCs as a strategy for improving attendance was the attachment of material gain to the MSG intervention. It was felt that mothers would be more motivated to enroll and participate fully in the MSG program if they could benefit from small items of grocery, provision with meals when they attend or receipt of project associated freebies such as t-shirts or umbrellas as is the apparent trend when community members

participate in other partner-led programs. Related to this was the suggestion of attaching income generating projects to the MSG. Because of the ultimate hope to scale up the MSG intervention in the event that it is proved to improve retention in the PMTCT program, any attachment to material benefits becomes undesirable at this stage since in that format the intervention is less replicable from a public health point of view.

The activities for retaining group members were shown to have been instituted well to a greater extent but there is still room for improvement. The three main activities used for retention include SMSs, phone calls and home visits through the VHWs and all have their limitations especially in the rural areas. A significant number of members do not possess mobile phones therefore it does become difficult to communicate with them, current disbursement for airtime has been noted to be inadequate in some sites with bigger groups and there is no certainty as to whether the nurses actually do the follow up for the members whose names are submitted to them by the MSGCs. The nurses are few at their stations and in many times fail to attend the MSG meeting which could have been a boost to the members and retention itself. Thus, finding adequate time to make follow ups on MSG members not attending meetings might not be a priority in their daily activities at their health facilities. In the end, although the members may not completely dropout, they do become erratic in attending the MSG meetings.

A successful MSG initiative of a similar nature was rolled out by Intrahealth International in Ethiopia where the coordinators received a monthly stipend of approximately US\$22, which covered travel for home visits and mobile phone costs to track lost to follow up participants<sup>13</sup>. The MSGC (mentor mother) in this particular case had the additional role of carrying out follow up herself. This differs from the current EPAZ model that requires the nurse to initiate follow up through the VHW which may be unacceptable to some mothers because of issues of confidentiality. The familiarity that comes from engaging with the coordinator rather than the VHW may also be more welcome. Having noted this however, it is also important to point out that when asked to come up with suggestions for improving attendance, only 2 of the 51 respondents suggested conduction of home visits. This could well be interpreted in the light of the stigma issues in these communities as already highlighted in the discussion and the role that home visits may play in causing inadvertent disclosure of the members' HIV status.

The MSGCs in this assessment voiced a preference for the groups to be left intact in spite of their expansion in size beyond the envisaged membership of 10 even doubling in some instances. The request by the coordinators can possibly be read into the expectations on their time and level of effort should the number of groups increase. Further analysis into the group attendance suggests that these 'bigger' groups do not actually congregate in the large numbers suggested by the attendance statistics which average 50%. So in effect, the MGSCs have not actually had a feel of what it would be like to sit through a meeting with 20 odd participants. Most of the literature reviewed on MSGs is silent on ideal size. A

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<sup>13</sup> Viadro C, et al. Mother Support Groups in Ethiopia: A peer support model to address the needs of women living with HIV. Intrahealth International. June 2008

publication on IYCN MSGs from USAID and Path spells out guidelines on setting up MSGs and advocates for up to 15 members per group.

The issue of graduation was not properly understood by some members especially in a few specific sites which may reflect negatively on the MSGCs in the specific areas. None of the members who had qualified for graduation at the time of data collection had been graduated officially. This may cause discontent among the MSG members since some of them might be looking forward to graduation which could be the drive behind attending the meeting. It demoralises the mothers that are due for graduation and in the end might lose the interest of being in the group even beyond the graduation point which could have a bearing towards the sustainability of the project.

## **5. RECOMMENDATIONS**

The suggested recommendations for the MSG project presented below are guided by the MTAScope of work which required that recommendations be delivered on the following specific areas of MSG functioning:

- Male participation
- MSG Coordinator functioning (including retention activities (cell phone communications; liaison with nurse)
- Data monitoring
- Graduation of mothers from MSGs
- MSG functioning when groups grow in size and divide into two or more groups

In addition, recommendations were added on the area of sustainability.

### **5.1. Male Participation & Involvement**

- 5.1.1.** It would be best not to directly include male partners in the MSG meetings since this might make other members uncomfortable during the sessions and make those members whose partners are not available feel unwelcome to the group and this might have negative effects on participation, attendance and retention in the MSG program.

**5.1.2.** Indirect involvement of male partners in supporting the MSGs is encouraged where possible as this would likely have a positive bearing on attendance and retention and most of the respondents have acknowledged that they would like their partners to be involved. This type of engagement may take the form of update letters and brochures sent directly to the male partners or invitation to participate in discussion forums for male partners, etc. The project could take advantage of the approaching advent of Option B+M within the Zimbabwean PMTCT program, to support the establishment of Father Support Groups as a stand-alone entity that would however complement the MSG initiative, providing the family centred approach that respondents expressed a desire for, without diluting the impact of the MSG in itself.

## **5.2. MSG Coordinator Functioning and Retention Activities**

**5.2.1.** To increase MSG retention up until graduation period and beyond, the project would do well to encourage all of the health facilities to synchronize the dates for the MSG meetings with the dates for ART re-supply and/or ANC and PNC visits. This would aid the MSG members by reducing the frequency of visits to the health facility considering that some of the members have to walk long distances as far as 10km or more.

**5.2.2.** To increase retention there is need to ensure that all HFs have a private and confidential room/building that will be used for holding MSG meetings. The promotion of MSG member's privacy and confidentiality at the HFs makes the members feel that their issues are valued and it will be within the parameters of medical research.

**5.2.3.** Further studies exploring the feasibility of need driven non facility based MSGs in communities where access is diminished due to either distance or religious doctrine.

## **5.3. Data Monitoring**

**5.3.1.** It is recommended that the EPAZ staff continue to support data entry activities in the MSG sites to ensure quality documentation of proceedings. Said cadres should however refrain from joining in the actual MSG meeting proceedings as this does interfere with the purity of the intervention delivered and has a bearing on how replicable the project is in the future.

## **5.4. Graduation of MSGs Mothers**

**5.4.1.** The MSGs members that have satisfied the graduation criteria must be seen to be graduating on time in order to motivate the remaining members to want to reach the required levels.

**5.4.2.** Because of the stigma that could otherwise be attached to it, we further suggest that the graduation be a low key (cost effective and high impact) event during which the graduates are presented with certificates of completion

## **5.5. MSG Growth**

**5.5.1.** MSGs may continue to function in their current state without splitting. Clinic and EPAZ staff monitoring efforts should pay particular attention to those sites where there are bigger numbers to assess the impact on functionality of the group. The decision to split the groups may be made on a case by case basis depending on what the monitoring efforts reveal.

## **5.6. MSG and Health Sector**

**5.6.1.** The project is encouraged to explore the option to engage with HF HCCs with the aim of providing them with information to increase their understanding, appreciation and support for MSGs. This may aid in garnering long term local support (logistic, financial, community mobilization, etc) for the MSG strategy even beyond the life of the EPAZ intervention.

**5.6.2.** Consider establishing direct linkages between MSGCs and VHWs so that they can discuss and find ways to deal with members that are not attending meetings regularly. The bureaucracy of having to submit names to the nurse might not be working effectively hence reducing all those stops might prove a more efficient and faster way of following up on non-attending members.

**5.6.3.** Strengthening the application of home visits where necessary through the VHWs would play an important role in informing and reminding those members without mobile phones and also those that are difficult to reach mainly because of the network problems in the rural setting. An opportunity presents itself for further investigation and pilot where the project could take advantage of the current roll out of Community Integrated child health tracking tools for VHWs in which the aspect of MSG attendance could be further added into the integrated tool as a means to stimulate attendance and retention.

## **5.7. MSG Sustainability**

**5.7.1.** The project to consider co-opting VHWs into all stages of the MSGs including facilitating meetings and training of the MSGCs to ensure that at all health facilities there are more than one individual who will be able to facilitate the MSG meetings. The VHWs are already in the health system and their local knowledge on community health behaviour might be important in running of the MSGs.

**5.7.2.** The EPAZ study should have an exit strategy that will see the MSGCs, nurses and VHWs (if involved) with the capacity to carry on with the project. In essence, the MSG Assistant Officers should start withdrawing from regularly attending MSG meetings in order to assess whether the members can hold meetings on their own and leave the quality assessment to be done by the health facility staff. Limited visits will provide an opportunity for evaluation and to address concerns were required.

**5.7.3.** The project is recommended to implement efforts at advocacy and/or support for facilitating privacy during the conduction of MSG meetings for those centres conducting meetings in open spaces.

