



**Nelson Mandela Children's Fund**

**Child Survival, Development and Thriving Programme**

**Baseline Evaluation Report**

## **Executive Summary**

A baseline assessment conducted on the 6 new partners of the CSDT programme of the Nelson Mandela Children's Fund provided an insight into the readiness of the partners and the viability of the goals and activities towards achieving the CSDT outcomes. The study was conducted various district municipalities: two sites in Zululand, one site each in Mopani, Ehlanzeni, John Taolo Gaereke and OR Tambo districts. All the partners were visited and interviewed together with their identified stakeholders, and the results indicate a positive disposition towards attainment of the project goals and programme outcomes. This report presents the findings of the baseline study.

## **Data collection**

### *Participants*

A total of 103 participants were interviewed using mixed methods survey instruments, and 27 of the participants, namely CHWs, mothers and ECD teachers, were interviewed through focus group discussions.

### *Participants demographics*

Of the 103 participants, only 6 were mails and none of them was an active member of the projects, rather representing stakeholders.

## **Findings**

### *Positives*

- The quality of work is commendable and carried out with passion. The project staff in the respective areas are motivated and have belief in their work, and this comes out from the compliments given by beneficiaries, collaborators and observers. Stakeholder provide visible support as reported by 83% of the partners, and tangible assistance is provided to over 60% of the partners
- In the first 4 months since the start of the project, 4 out of 6 partners have achieved over 70% progress in implementation of planned activities, and 60% have met most of the targets they had set for themselves.
- There is evidence of support from NMCF project staff,

## *Challenges and concerns*

- The main concern raised was related to the delays in tranche payments and the subsequent effect it has on progress of projects. NMCF did communicate the delay, but it is hoped that this is addressed timeously in the future.
- The data collection tools are not standardised, and therefore indicators collected are not similar in all projects
- The project outcomes seem to be understood differently by the various partners, and this can also be observed on the interchangeability of the activities aimed at achieving the respective four outcomes. This needs to be addressed as some of the partners are funded for other activities related to the CSDT programme activities, and in the end, change achieved might end up not attributed to the NMCF.
- Data collected is not shared with the department of health and therefore, not seen to be contributing directly to the health interventions in the selected districts.
- The respective partners seem to understand nutrition monitoring differently, and they are using various methods that are not standardised for the CSDT projects. For example, some use MUAC, and some do not, and others carry scales and height measurements and others do not, and this needs to be addressed and made consistent.
- Training is not standardised or consistent across the projects, and not all training provided is accredited or at least based on SETA curriculum.
- Not all the CHWs / Fieldworkers have the tools of trade to carry out their work.
- NMCF branding was not visible during the fieldwork visits

## **Conclusions**

- The CSDT strategy is being implemented by the partners, however, only three legs of the strategy are visibly working, namely: Home visits by CHWs to educate families, and the use of CHWs to promote child and maternal health knowledge as well as strengthening links through family visits The remaining two, namely: *Training CHWs, needs standardised training and Training clinic committees-may not be achieved in this round of funding as clinic committees have not been appointed in all the areas.*
- The progress of five of the six projects is indicating a positive trajectory towards attainment of the goals of the respective projects, and that of the CSDT programme. Only one project was not satisfactorily measured as it was still in the process of MOU and community entry finalisation.

## **Recommendations**

### *Measurement of impact*

- The KPIs and agreements need to be addressed and made clear to all partners, and should be part of the reporting tool for the grant
- The duration of one year for the project is too short to measure impact, and is recommended that an extension be considered.

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# 1. BACKGROUND TO THE STUDY AND PROJECT DESCRIPTION

## 1.1. INTRODUCTION

A baseline study is an initial assessment conducted before the implementation of an intervention or project to gather data on the current situation, attitudes, and behaviours of the target population. The project baseline is typically established during the planning phase, once the project scope, schedule, and budget have been defined and approved by stakeholders. A baseline is a planned schedule or projected timetable for a specified project, and this baseline study is important for NMCF to evaluate and measure if the CSDT programme will be able to achieve its aim of strengthening the health care system to provide children under the age of five with efficient care that assures their survival, development and thriving.

### 1.1.1. Overview

The first year in the life of a child is a critical time in which the child develops foundations of their physical, cognitive, social and emotional skills and well-being. Both positive and negative early experiences have a very strong impact on young child development, learning, behaviour and health throughout the child's life-course. A holistic approach to child development means providing healthcare, proper nutrition, protection from violence and early learning and stimulation of children to ensure that children can thrive, develop and learn at their fullest potential.

These formative years, normally named "the first 1,000 days" refer to a child's life from the moment they are conceived until they reach 2 years of age (24 months)<sup>1</sup>. This is a time when their brain, body and immune system grow and develop significantly. During pregnancy, the mother's health, nutrition and stress levels can influence their baby's future, and child's health is most vulnerable. This period, from conception until a child's second birthday, offers a unique window of opportunity to shape healthier and more

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[www.researchgate.net/publication/344648224](https://www.researchgate.net/publication/344648224) 'Your baby's life depends on those first 1000 days' community health workers' perspectives of the first 1000 days of life

prosperous futures. In South Africa and most of the developing countries, the ability to take charge of the opportunities of these first years of life is mostly “lost” due inconsistent and sometimes inefficient health systems.

The Nelson Mandela Children’s Fund (NMCF) aimed to address and support efforts towards better services for a child from birth by developing programmes aimed at mitigating the impact of environmental factors and societal behaviours that can impact the health and safety of a child. Through the Child Survival, Development, and Thriving (CSDT) Programme, the NMCF aimed to ensure the safety and health of children through strengthening health systems and providing family outreach programmes mostly in underserved communities. Family outreach is carried out by Community Healthcare Workers (CHWs) who provide quality services to mothers and children while the CSDT programme works with clinic committees (CCs) to help improve the quality of services in these establishments. The CHWs visit the homes and provide families on issues of pre- and post-natal care, immunisation, nutrition, and early learning and child stimulation. Central to the work of the CSDT programme is the assertion that the levels of child malnutrition and mortality would decrease if a whole family empowerment approach was taken by all the role-players in the CSTD programme.

## **2. RATIONALE FOR THE BASELINE EVALUATION**

The data collected for a baseline is used as a reference point against which progress can be measured and evaluated throughout the life of the project. The baseline study provides a clear understanding of the current situation, identifies the gaps, and provides valuable insights that guide the development of appropriate interventions and the establishment of indicators to track progress towards achieving desired outcomes.

The baseline study is a critical component of monitoring and evaluation planning, and it is conducted to establish a baseline or starting point for monitoring and evaluating the potential of an intervention or project, based on a submitted plan. It provides data that is used to measure the effectiveness of the intervention, and it helps to identify

the changes that occur as a result of the intervention. Without a baseline study, it is difficult to measure the impact of an intervention accurately<sup>2</sup>.

The South African report on the state of the child indicates that statistics on South Africa's children is not very comforting, with 51% of children living in a household that is below the poverty line<sup>3</sup>. *The CSDT program seeks "to strengthen the care system to better care for children under the age of five and ensure their survival, development and thriving*, and this evaluation provides the CSDT an opportunity to determine if the work of the implementing partners will be able to help improve quality health services for children in the priority areas.

### **3. BASELINE EVALUATION OBJECTIVES**

The main aim of this evaluation was to collect, analyse and interpret data from the priority district where CSDT projects are implemented, with the objective of:

- i. Determining the statistics of child mortality and morbidity
- ii. Using the data collected to direct the CSDT programme indicators.
- iii. Determining the state of access to health care service by children and women
- iv. Evaluating the role of the CHWs in terms of child and maternal care provision by the health sector.
- v. Assessing if the clinic committees are effective and functional in the areas under evaluation.

### **4. SCOPE OF WORK**

The baseline review was conducted in the priority areas listed in Table through field visits to the respective organisations selected by NMCF as Implementing Partners. Although the objectives were already set, the review's approach was to also employ differing approaches to some of the questions set for individual partner organisations, as the implementing partners vary contextually and environmentally.

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<sup>2</sup> <https://www.evalcommunity.com/>.

<sup>3</sup> <https://www.nelsonmandelachildrensfund.com/wp-content/uploads/2023/12/nelson-mandela-children-deloitte-report-1.pdf>

<b>Partner Name</b>	<b>Province</b>	<b>Municipality</b>	<b>Implementation Site</b>
Kopano Ke Matla	Northern Cape	JT Gaetsewe	Heuningvlei
Humana People to People	KwaZulu Natal	Zululand	Pongola
Lulamaphiko	KwaZulu Natal	Zululand	eDumbe
Hoedspruit Training Trust	Limpopo	Mopani	Hoedspruit
Wellbeing Africa	Mpumalanga	Ehlanzeni	Bushbuckridge
One to One Africa Children's Fund	Eastern Cape	OR Tambo	eNyandeni

Table 1: Implementing Partners

## **5. BASELINE STUDY METHODOLOGY**

### **5.1. Study method**

This baseline review adopted both qualitative and quantitative approaches, with units of analysis being organisations selected by the client. Data was collected through desktop review of NMCF documents, structured interview sheets for various respondents, focus group discussions and telephonic interviews in some instances.

### **5.2. Data collection and data collection methods**

Data collection started with a desktop review which involved the identification of intervention per partner in the respective areas as well as contact persons and their contact details for each organisation. It also involved perusal of various reports, policies and publications to address some of the questions accompanying the objectives.

The Consulting team travelled to all the selected sites, holding interviews with the selected participants and collected other forms of information from the reports of the NMCF partner. Secondary data was collected through perusal of programme files supplied by NMCF and or the respective NMCF partners.

### 5.3. Data collection tools

Eight data collection tools were developed for use in collecting primary data in the conduct of the baseline evaluation. The *first structured-interview sheet was used to collect information from the Management of the project; the second structured-interview sheet was used to collect data from the participants and supporters of the project; the third structured interview sheet was used to collect data from stakeholders other than those directly working in the project, and focus group discussion interviews sheets were used to collect data from selected participants.*

The study made use of interview sheets for each of the categories of respondents, and covered the areas outlined in Table 2.

<b>Stakeholder/ Participant</b>	<b>Areas of questions / Sources of data</b>
<b>NPO Management</b>	Project background information (any report on the project) Statistics on children and mothers being taken care of Data collected to direct the CSDT programme indicators Information about status quo of children in the priority areas Available services for children Detailed information about the projects Data collection models
<b>NPO Staff</b>	Role CHWs/ECD Practitioner / Mentor in child and maternal care provision The state of access to health care services by children and women
<b>CHWs / ECD / Mentor</b>	Role of the CHWs in terms of child and maternal care provision The state of access to health care services by children and women Child mortality and morbidity; Conditions of places where children grow up
<b>Mother / Primary Caregiver</b>	Gaps, strengths, and weaknesses that affect or impact on access to quality health care services for children and pregnant mothers
<b>Local leadership</b>	Child mortality and morbidity Environmental context
<b>Relevant Municipality representative</b>	Child mortality and morbidity Environmental context Services available for health care services for children and women
<b>Community member-(not part of programme)</b>	Available services for children Access to health care services by children and women
<b>Hospital / Clinic representative/ Hospital board</b>	Functionality of Clinic Committees / Hospital Boards

Table 2: Content of data collection tools

#### **5.4. Ethical considerations**

The baseline review followed all tenets of ethical considerations as expected of any scientific study including human participants.

All respondents signed an informed consent form, agreeing to participate after being given an overview of the process of the evaluation, and they were informed that they would be allowed to withdraw with no prejudice. Privacy and confidentiality were assured by the researchers, and they at all times respected and acknowledged environmental contexts, values and culture of the participants. The participants' identity was kept anonymous, and no collection of their names was recorded and no will ID copies were required. All pictures taken of the participants were done so with expressed consent, and where children were present, care was taken that their faces were not shown.

#### **5.5. Limitations**

The review relied on implementing partners and beneficiaries to share details and focus not only on present issues, but also to highlight core issues outside the CSTD programme. Some had difficulty relating to the CSTD programme as they were used to the organisation but not yet versed with the new CSTD programme.

It was also difficult to evaluate the IPs that were not at the same level of financial or period of prior programme / project implementation. For some IPs, the delays in receipt of the grant had a direct implication for implementation of the programme, while others had some cushion from their reserves. These delays limited implementing partners in terms of achieving intended outputs according to the intended plans, which varied from 3–6 months. Consequently, organisations were at different stages regarding their implementation timeline, and some had made adjustments to accommodate the delays. The evaluation process was limited to programmatic interventions and did not explore organisational aspects such as the size of the programme for all the IPs.

## 5.6. Sampling

The initial sampling method that was employed in this study was non-probability, purposive sampling. A purposive sample is one that is selected based on characteristics of a population and the objectives of the study and focusses on characteristics of a population that are of interest to the study<sup>4</sup>. This was used to collect information from selected participants with the aim of determining the main variables that were measured and the suitable participants from the study population that may be able to provide that information.

## 5.7. Sample size and selection

The review conducted interviews and focus group discussions in the communities within the six priority areas. Table 4 shows preliminary selections based on the parameters provided proposal, but was slightly altered when the list of possible participants was provided by the respective implementing partners.

Stakeholder	Data collection method	Number to be selected (per area)
Implementing Partner	Interview	1
NPO Management	Interviews + FGD	1
CHWs	Interviews + FGD	2 for interview, 4 for FGD
ECD/ Creche Teacher*	Interview + FGD	2 for interview, 4 for FGD
Mother / Primary Caregiver	Interview	4 per area
Local leadership	Interview	1
Hospital / Clinic representative	Interview	1 per clinic / hospital in area
Hospital board / Clinic Committee member	Interview	1 per clinic / hospital in area

Table 3: Categories of participants

In the end, a total of 103 participants was selected, and the categories are depicted in diagram, and the number per area are shown in Table 3.

<sup>4</sup> <https://pmc.ncbi.nlm.nih.gov/articles/PMC4012002/>

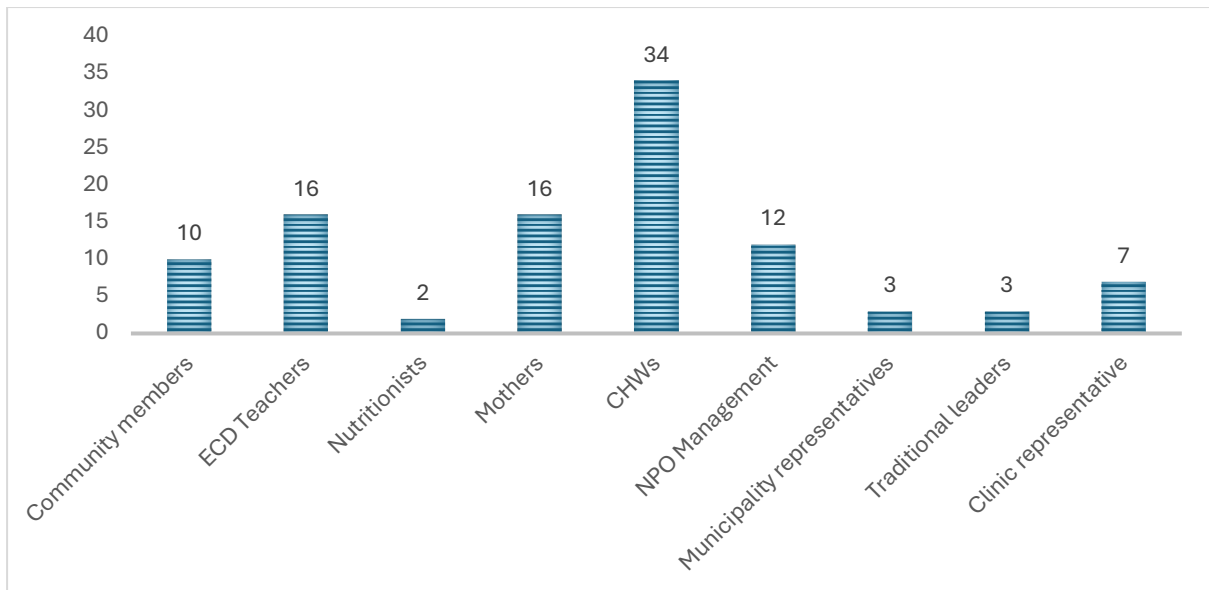


Figure 1: Categories of respondents

### 5.8. Respondents per area

	Kopano KM	HPPSA	Lulamaphiko	Hoedspruit	Wellbeing	One to One	Total
<b>Community members</b>	2	0	2	2	0	4	10
<b>ECD Teachers</b>	4	2	4	4	0	2	16
<b>Nutritionists</b>	0	0	2	0	0	0	2
<b>Mothers</b>	2	3	3	4	0	4	16
<b>CHWs</b>	8	5	4	10	4	3	34
<b>NPO Management</b>	2	1	1	3	1	4	12
<b>Municipality representatives</b>	1	1	0	1	0	0	3
<b>Traditional leaders</b>	1	1	0	0	0	1	3
<b>Clinic representative</b>	1	1	1	3	0	1	7
<b>TOTAL</b>	<b>21</b>	<b>14</b>	<b>17</b>	<b>27</b>	<b>5</b>	<b>19</b>	<b>103</b>

Table 4: Respondents per area

## 6. FINDINGS AND RESULTS

This section provides the results derived from analysis of the data collected from the participants and from additional references used. The evaluation was guided by six objectives and all data collected as geared towards attainment of the objectives.

Table 6 lists the objectives of the baseline study, and also provides a snapshot of the findings, and a guide of where the detailed results are in the section.

	<b>Objective</b>	<b>Abridged Findings</b>
i.	Determining the statistics of child mortality and morbidity	The statistics are still high, in both the District and the Province:
ii.	Using the data collected to direct the CSDT programme indicators.	Data collection is not standardised, and the CHWs do not have the same kind and level of training to collect the data
iii.	Determining the state of access to health care service by children and women	Challenges still exist, with distance and lack of resources in the establishment being the main issues
iv.	Evaluating the role of the CHWs in terms of child and maternal care provision by the health sector.	The CHWs are an interface between the department of health and mothers and children
v.	Assessing if the clinic committees are effective and functional in the areas under evaluation.	Clinic committees are reported as non functional in the priority areas
vi.	Determining the statistics of child mortality and morbidity	Statistics are not readily available, DHIS has not released them in detail.

Table 5: Objectives and Guide to Findings

In addition to the objectives, the baseline terms of reference required further desktop information to back up the findings. The information relates primarily to the status quo and environmental context in the priority areas, and covered the areas in Table 6. The data was collected primarily from available literature comprising of reports, government documents and research findings from related interventions.

<b>Additional information to back up findings</b>	<b>Source</b>	
	<b>Literature</b>	<b>Stakeholder</b>
Extent, scope and causes of under-5 child mortality	X	
Mortality and morbidity rates in the identified priority districts	X	
Status of access and quality of child and maternal health services	X	
Role of CHWs in the child and maternal health care system in CSDT priority areas	X	X
Functionality of Clinic Committees in areas where the CSDT programme is implemented		X

Table 6: Sources of additional information to back up findings

## 6.1. Desktop findings

### 6.1.1. Overview and context of literature

According to the South African Early Childhood Review (SAECR), South Africa has nearly 7 million children under 6 years of age, and over a quarter of households in the country have one or more children in this age group<sup>5</sup>. It is reported that 70% of these young children are in households defined as poor, being below the official “upper-bound” poverty line, and nearly 40% live in households that do not have enough income to provide for their basic nutritional needs<sup>6</sup>. The WHO reports that about 9 million infants die from infectious diseases each year, and breastfeeding prevents an additional 6 million deaths<sup>7</sup>. Breast milk has the right amounts of necessary nutrients that are easy for the baby to digest, and helps to develop and support the immune system of the baby and provides the baby with antibodies from the mother, that can help the baby fight infection<sup>8</sup>. The American Academy of Paediatrics recommends that babies should be breastfed for at least 6 months before the introduction of complementary foods, and continuation of breastfeeding to one year or more<sup>9</sup>. The World Health Organisation (WHO) on the other hand, recommends that breastfeeding should start as early as one hour after birth and last until the child is two (2) years old<sup>10</sup>.

To provide context to the project, over and above data collected through interviews, information was collected on the extent, scope and causes of under-5 child mortality by province for all nine provinces, including worst affected districts and their profiles as well as under-five mortality rates per province.

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<sup>6</sup> [https://ci.uct.ac.za/sites/default/files/media/documents/ci\\_uct\\_ac\\_za/533/sa-early-childhood-review-2024.pdf](https://ci.uct.ac.za/sites/default/files/media/documents/ci_uct_ac_za/533/sa-early-childhood-review-2024.pdf)

<sup>7</sup> "WHO | Child mortality". *www.who.int*. Archived from [the original](#) on March 14, 2011.

<sup>8</sup> Breastfeeding Benefits Your Baby's Immune System: *Claire McCarthy, MD, FAA*. 2020

<https://www.healthline.com/health/breastfeeding/11-benefits-of-breastfeeding>

<sup>9</sup> Breastfeeding and the Use of Human Milk. 2012. <https://pediatrics.aappublications.org/content>

<sup>10</sup> Promoting proper feeding for infants and young children. 2018. WHO.

<https://www.who.int/nutrition/topics/infantfeeding/en/>

### 6.1.2. The extent, scope and causes of under-5 child mortality by Province for all nine Provinces, including worst affected districts and their profiles.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life, and refers to the number of babies under 12 months who die in a year, per 1,000 live births during the same year<sup>11</sup>. Similarly, the under-five mortality rate (U5MR) is defined as the probability of a child dying between birth and the fifth birthday, in a year, per 1000 live births in the same year.<sup>12</sup>

Table 7 shows the provincial breakdown of deaths reported through DHIS for 2019, and the CSDT priority Provinces are highlighted, indicating Kwazulu-Natal as the province with the highest mortality, followed by Limpopo and Eastern Cape, while Northern Cape had the lowest child mortality.

PROVINCE	0 - 7 DAYS		8 - 28 DAYS		29 DAYS – 11 MONTHS		12 - 59 MONTHS		TOTAL
	N <sup>o</sup>	%	N <sup>o</sup>	%	N <sup>o</sup>	%	N <sup>o</sup>	%	N <sup>o</sup>
EC	1 061	49.3	267	12.4	590	27.4	236	11.0	2 154
FS	637	58.4	187	17.1	162	14.8	105	9.6	1 091
GP	2 082	56.4	693	18.8	592	16.0	327	8.9	3 694
KZN	1 888	54.0	510	14.6	730	20.9	369	10.6	3 497
LP	1 580	64.4	233	9.5	371	15.1	268	10.9	2 452
MP	797	63.8	118	9.4	210	16.8	125	10.0	1 250
NC	240	55.9	55	12.8	89	20.7	45	10.5	429
NW	552	52.2	111	10.5	219	20.7	175	16.6	1 057
WC	650	57.9	180	16.0	205	18.3	87	7.8	1 122
<b>RSA</b>	<b>9 487</b>	<b>56.7</b>	<b>2 354</b>	<b>14.1</b>	<b>3 168</b>	<b>18.9</b>	<b>1 737</b>	<b>10.4</b>	<b>16 746</b>

Table 7: Provincial child mortality statistics, 2019 (Source: DHIS)

A close focus on the districts where the CSDT operates, provides a different picture where the figures change around, with OR Tambo showing a much higher child mortality rate, followed by Ehlanzeni.

<sup>11</sup> <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/1>

<sup>12</sup> South African Medical Research Council. 2012-2014 and 2021-2022 mortality rates derived from the same Medical Research Council Rapid Mortality Surveillance project published by the UN Inter-agency Group for Child Mortality Estimation and available at <https://childmortality.org/all-cause-mortality/data?refArea=ZAF&indicator=MRY0T4>.

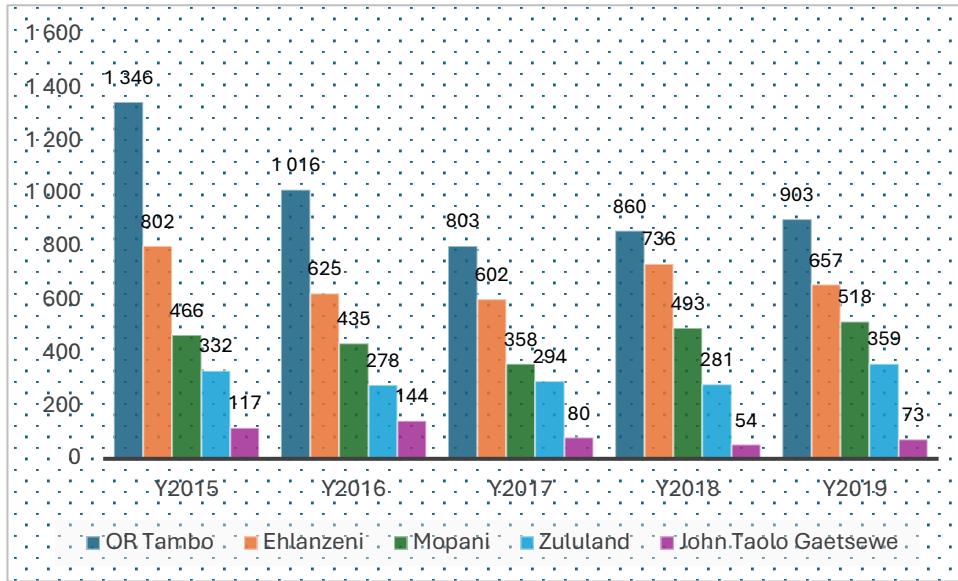


Figure 2: Child mortality statistics per priority area (2015-2019)

In the most recent data on under 5 mortality, it was reported that the under-5 mortality rate declined to 28,6 per 1000 live births in 2024. This data provides a good benchmark from which the Implementing partners can measure their contribution towards the decline during the years of support by NMCF.

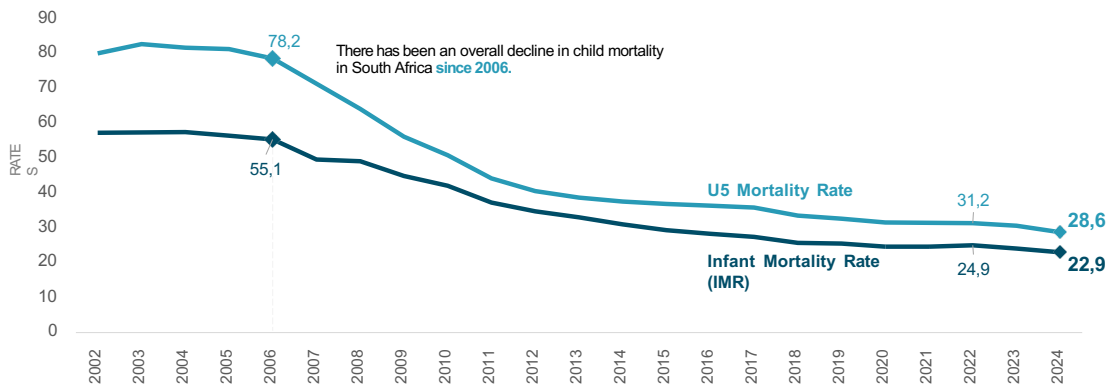


Figure 3: Under-5 child mortality: 2002-2024

### 6.1.3. Challenges faced by children in different priority districts in relation to child mortality and morbidity.

Since COVID-19 lockdown, there have been delays in the release of the “Causes of Death data by StatsSA, but estimates of the leading causes of under-five mortality (other than neonatal causes) have generally been those in Figure 4.

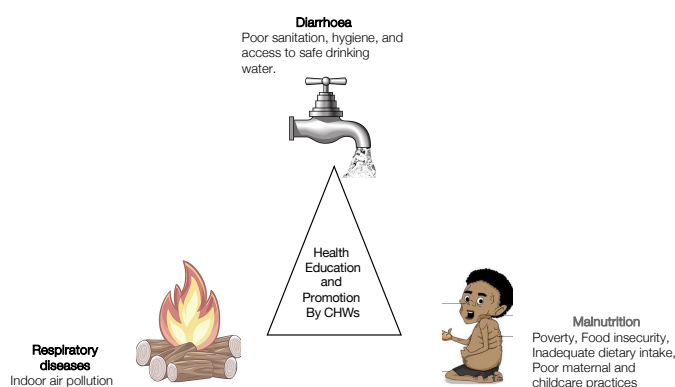


Figure 4: Main courses of child deaths

Diarrhoea, pneumonia and other respiratory infections as well as malnutrition are often underlying causes of death in young children<sup>13</sup>. While air and water pollution are factors that lead to child morbidity and mortality through diarrhoea and respiratory diseases, they need intervention through provision of resources. For malnutrition on the other hand, breastfeeding is identified as one of the main interventions, and it requires the CHWs to be involved for it to be successful. According to the United Nations Children’s Fund (UNICEF), less than half (44%) of infants were exclusively breastfed at 14 weeks in 2021/22, which showed a decrease from 49% in 2019/20<sup>14</sup>. In the South African Demographic and Health Survey of 2016 (SADHS), it was reported that only 32% of babies up to the age of 6 months were exclusively breastfed, and the results from the HSRC Food Security and Nutrition Survey of 2024 suggest that this rate has dropped further, to 22%<sup>15</sup>. It is advised, through the report, that if South Africa is to meet the WHO target of increasing breastfeeding rates for at least the first 6 months, to 50% by 2025, there will need to be increased investments in breastfeeding promotion. These findings and the final statement provide concrete

<sup>13</sup> <http://childrencount.uct.ac.za/indicator.php>

<sup>14</sup> <https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-024-00695-0>

<sup>15</sup> <https://ilifalabantwana.co.za/wp-content/uploads/2024/07/SA-early-childhood-review-2024-FINAL.pdf>

support for the work that NMCF is doing with the young kids and mothers, and may need an additional indicator or target for each of the programmes.

### 6.1.3. Role of CHWs in the child and maternal health care system in CSDT priority areas

The baseline was able to establish the roles played by CHWs in communities and in the health care system in the CSDT priority areas, as per diagram number 5.

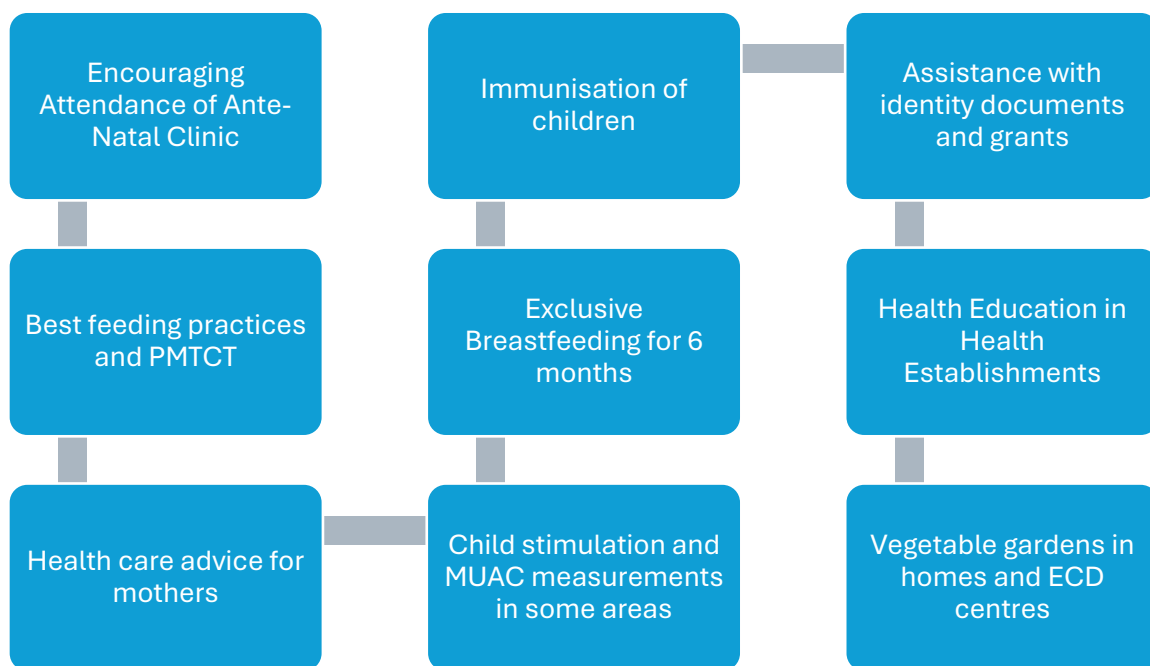


Figure 5: Role of CHWs in the child and maternal health care system

The findings are further supported by Le Roux et al (2020)<sup>16</sup>, in a study conducted in per-urban Cape Town, whose results mirror the findings of this baseline study. The baseline did however, find out that the CHWs are not adequately trained for the work that they do, even within the same organisation the CHWs do not possess the same qualifications or level of training.

<sup>16</sup> [https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09468-w#:~:text=The%20Community%20Health%20Workers%20\(CHWs,issues%2C%20antenatal%20care%2C%20optimal%20infant](https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09468-w#:~:text=The%20Community%20Health%20Workers%20(CHWs,issues%2C%20antenatal%20care%2C%20optimal%20infant): Community Health Workers impact on maternal and child health outcomes in rural South Africa-a non-randomised two-group comparison study.

#### **6.1.4. Data collection models best suited to collection of data by NGOs implementing child and maternal health interventions.**

According to Choudhury et al, (2022), data collected by CHWs from routinely tracking pregnancies, births, and deaths are promising for timely program monitoring and evaluation. Despite some limitations, programmatic data may be more sensitive in detecting vital events than cross-sectional census surveys asking women to recall these events<sup>17</sup>.

To be successful, Community health worker (CHW) programmes need to be adequately integrated into mainstream health systems. In this manner, they can provide a viable, affordable and sustainable path to strengthened health systems that best meets demands for improved child health, especially in resource-constrained situations<sup>18</sup>. The CHWs need to *be salaried, trained, and supervised properly* so that they can help address gaps in routine data collection while delivering care in low-resource settings. Data routinely collected by CHWs can provide timely program monitoring and evaluation at a small scale, but needs to have standardised and consistent data collection, storage and sharing tools and systems.

#### **6.1.5. Gaps, strengths, and weaknesses that affect or impact on access to quality health care services for children and pregnant mothers**

##### *6.1.5.1. Strengths*

The CHW, by virtue of being part of the community and an interface between the mothers and the clinical staff, already comes with a strength to the equation. They are easily positively received by the health facilities and are recognised when they make referrals to the health establishments.

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<sup>17</sup> <https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-022-00293-4>

<sup>18</sup> Mupara LM, Mogaka JJO, Brieger WR, Tsoka-Gwegweni JM. Community Health Worker programmes' integration into national health systems: Scoping review. Afr J Prim Health Care Fam Med. 2023 Mar <https://pmc.ncbi.nlm.nih.gov/articles/PMC10091149/>

#### 6.1.5.2. Weaknesses

Weaknesses affecting access to quality healthcare for children and pregnant mothers include the following challenges<sup>19</sup>:

- i. *Geographic barriers like distance to facilities*
- ii. *Poor transportation to the clinic or the hospital*
- iii. *Inadequate infrastructure*
- iv. *Limited availability of skilled healthcare providers in the health facility*
- v. *Poor quality of care within facilities has also been reported,*
- vi. *Long waiting times as well as stigma associated with certain health conditions,*
- vii. *Inadequate awareness about essential health services*

One of the improvements that need to be made to the work of the CHWs, is the formalisation of the relationship between the partner organisations and the health care facilities.

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<sup>19</sup> <https://www.ncbi.nlm.nih.gov/books/NBK568218>

## 6.2. GENERAL FINDINGS FROM FIELDWORK

### 6.2.1. Project synopses

This section provides overall feedback on progress on the project synopses provided by the Implementing Partners.

#### 6.2.1.1. Project goal

100% of the IPs were found to be in line with the CSDT outcomes, with focus on health, nutrition, decrease in infant and child mortality, decrease of stunting and increase in development of children.

#### 6.2.1.2. Proposed project outputs

Each of the projects had outlined outputs in line with the project goal. The outputs were evaluated through interviews and perusal of reports and documents to determine if they are feasible within the scope of work and resources at the disposal of the organisations. The percentage depicting progress or possibility of achievement are reflected in the respective tables under the Individual Report Section.

#### 6.2.1.3. Progress against project targets

Project targets were found to be inconsistent and not in line with project activities and stakeholder engagements. Some of the IPs did not have targets aligned to the CSDT outcomes. Targets for activities related to *involvement of men, ECDs and clinic committees were not included in all the projects, and gardening was only included by one of the IPs*. The targets are not set, but activities are carried out by the IPs, and this will pose a challenge when the final impact evaluation of the programme is carried out.

	Children <5 years	Pregnant women	Farms / Communities	Men	ECD	Mothers / Caregivers	Families / Households	Clinics	ECD Children	Household gardening
Kopano Ke Maatla	250	250	0	0	0	0	350	0	100	50
Humana People to People	2000	1000	31	210	0	2000	1400	0	0	0
Lulamaphiko	100	0	0	0	4	100	0	4	200	0
Hoedspruit Training Trust	2000	290	50	100	50	0	0	0	0	0
Wellbeing Africa	500	40	0	20	8	240	240	0	0	0
One to One Africa Children's Fund	2000	400	16	200	0	400	0	0	0	0
<b>Totals</b>	<b>6850</b>	<b>1980</b>	<b>97</b>	<b>530</b>	<b>62</b>	<b>2740</b>	<b>1990</b>	<b>4</b>	<b>300</b>	<b>50</b>

Table 8: Partner progress against project targets

The evaluation also looked at the stakeholder relations between the implementing partner and the community-based stakeholders they had listed as a collaborators. Table indicates the level of support, collaboration and acceptance that each of the organisations receive. This is important as it helps cement the organisation in the community where it operates, and can contribute to its sustainability.

	Observation of collaboration with stakeholder / Support for NPO								
	1=Strongly disagree	2=Disagree	3=Neutral	4=Agree	5=Strongly Agree				
	STAKEHOLDER								
IMPLEMENTING PARTNER	Community Members	ECD Teachers	Nutritionist	Mothers	ECD Gardening	NPO Manager	Clinic	Traditional Leader	Municipality
<b>Kopano Ke Maatla</b>	5	4	NA	5	2	5	5	4	3
<b>Humana People to People</b>	5	5	NA	5	2	5	4	5	5
<b>Lulamaphiko</b>	5	5	5	5	5	5	5	NA	1
<b>Hoedspruit Training Trust</b>	5	5	NA	5	5	5	5	3	4
<b>Wellbeing Africa</b>	NA	NA	NA	NA	NA	5	NA	NA	NA
<b>One to One Africa</b>	5	5	NA	5	2	5	5	5	2

Table 9 : Observed collaboration with stakeholders

### 6.3. RESULTS FROM RESPECTIVE IMPLEMENTING PARTNERS

This section of the report provides insight on the individual Implementing Partners, with particular focus on the main findings that came from the respective areas. The evaluating team visited all the projects in the priority areas highlighted in the map. The results that follow for each IP are based on the interviews, focus group discussions, observations and perusal of relevant reports and documents.

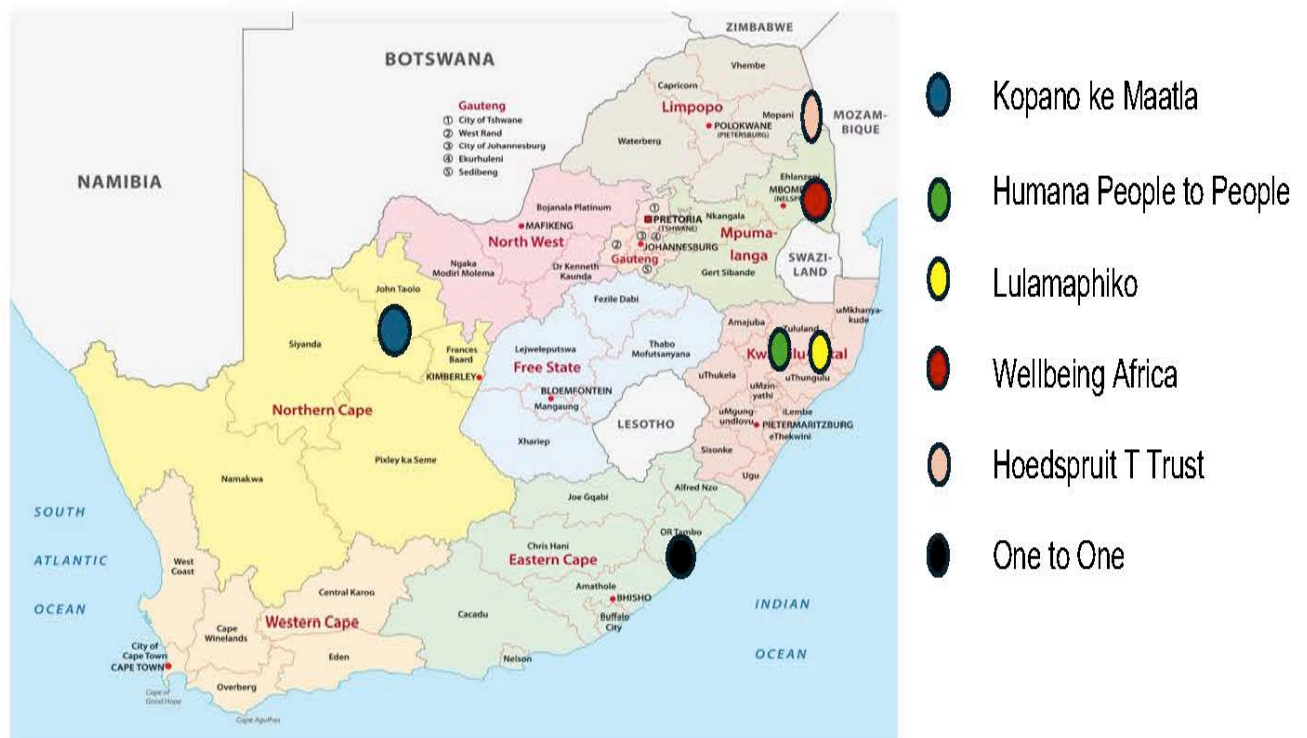


Figure 6: Geographic location of the Implementing Partners

Each of the projects had outlined outputs in line with the project goal. The outputs were evaluated through interviews and perusal of reports and documents to determine if they are feasible within the scope of work and resources at the disposal of the organisations. The results that follow provide an indication of the IPs to successfully implement the projects in line with the plans they submitted.

Each individual report is guided by the sub-sections described in Table 10:

Heading	Description
<b>Background information on the areas</b>	Provides a context of the project and area
<b>Project Goal against Project outputs</b>	A table that outlines the partner's stated goal, and the progress observed during the fieldwork
<b>Project targets</b>	Performance progress on targets and feasibility of achievement
<b>Participants / Respondents</b>	Provides a list of respondents who participated
<b>Human resources and skills</b>	Training received in light of the work to be done
<b>Needs and challenges</b>	Tool of the trade requirements and availability
<b>Stakeholder responses</b>	Comments from traditional leaders, municipality, local clinic, ECD, mothers, community members
<b>Impact and Sustainability</b>	Feasibility of successful implementation of project
<b>Challenges faced by the IP</b>	Needs that might hinder the project
<b>Concluding remarks</b>	Overall view of the project

Table 10: Content of individual Implementing Partner reports

### 6.3.1. KOPANO KE MAATLA

#### 6.3.1.1. Background information on the area

Kopano Ke Maatla is a non-governmental organisation based in Heuningvlei in Joe Morolong local municipality, which falls within the John Taolo Gaetsewe District municipality, in the Northern Cape Province. The John Taolo Gaetsewe District Municipality, previously Kgalagadi, is situated in the Northern Cape Province and is bordered by the ZF Mgcawu and Frances Baard District Municipalities to the west and south; the North West Province (Dr. Ruth Segomotsi Mompati District Municipality) to the east and northeast; and Botswana to the North West. It comprises of 186 towns and settlements, of which the majority (80%) are villages. It is characterised by a mixture of land uses, of which agriculture and mining are dominant, and it covers an area of 27 323km<sup>2</sup>. John Taolo Gaetsewe District was identified as one of the worst affected areas in child mortality. It is an under-resourced deep rural area with only one clinic that provides services to community members within the five-targeted villages of Shaleng, Makhubung, Gammokwane, Gamagau and Gatsejane.

To address this challenge, Kopano Ke Maatla aims to implement family outreach activity, which is one of the three components of Child Survival, Development and Thriving (CSDT) programme. Activities are designed to respond to all the CSDT programme outcomes. This will be done through family visits.

Secondly, Kopano Ke Maatla works closely with relevant stakeholders and the clinic to ensure that all the beneficiaries within the targeted areas have access to health care services, are knowledgeable on good nutrition, maternal and child health and in

ensuring that children are well developed and stimulated accordingly. The work will be implemented through its Community Healthcare Workers (CHWs) who will facilitate and provide various services and support to pregnant women and mothers.

The area is arid and less populated, and is far from the urban area of Gasegonyana which is the administrative area of the district, and it is where most facilities and service points are based. The hospital is a two-hour drive from Heuningvlei in the area of Batlharos.

The population of the district shows an increase from 2016 to 2022, with the target group for the programme (children) (0-14 years) age category amounting to 31.4% of the total population<sup>20</sup>.

There is only one clinic in the area, and the nearest hospital is Batlharos, a two-hour drive away from Heuningvlei where the babies are delivered. The local clinic does not have facilities for delivering babies, and so the women have to be transported to the hospital by ambulance, which has to be requested from the hospital as there is no ambulance locally.

### 6.3.1.2. Project outputs against Project goal

The partner's goal is to improve children's health and nutrition through family support, health awareness and providing access to health care service, and this was evaluated through the contents of the project synopsis document outlining planned activities. The evaluation established that there was evidence indicating that work had already.

IP	Proposed Outputs	Observed Progress		Description / Source of Information
		YES	NO	
<b>KOPANO KE MAATLA</b>				
	Pregnant mothers and mothers with babies attending Ante-Natal Care (ANC) and Post-Natal Care (PNC).	X		Documents, and interview with clinic representatives and mothers
	Pregnant women, women and caregivers of children 0 – five years are well informed about maternal and children's health, good nutrition and access to health services.	X		Documents, and interview with clinic representatives and mothers
	Community members equipped with information on maternal and child health	X		Interviews with project non-beneficiaries
	Functional partnerships between Kopano Ke Maatla, local clinic and stakeholders are formed and maintained for effective and efficient coordination of services for children.	X		Meeting with the clinic and local traditional leadership.
		100%		

Table 11: Progress of project outputs against Project goal

<sup>20</sup> <https://municipalities.co.za/demographic/135/john-taolo-gaetsewe-district-municipality>

### 6.3.1.3. Project targets

In the first few months of implementing the project, the partner was able to reach the number of beneficiaries indicated in Figure 7.

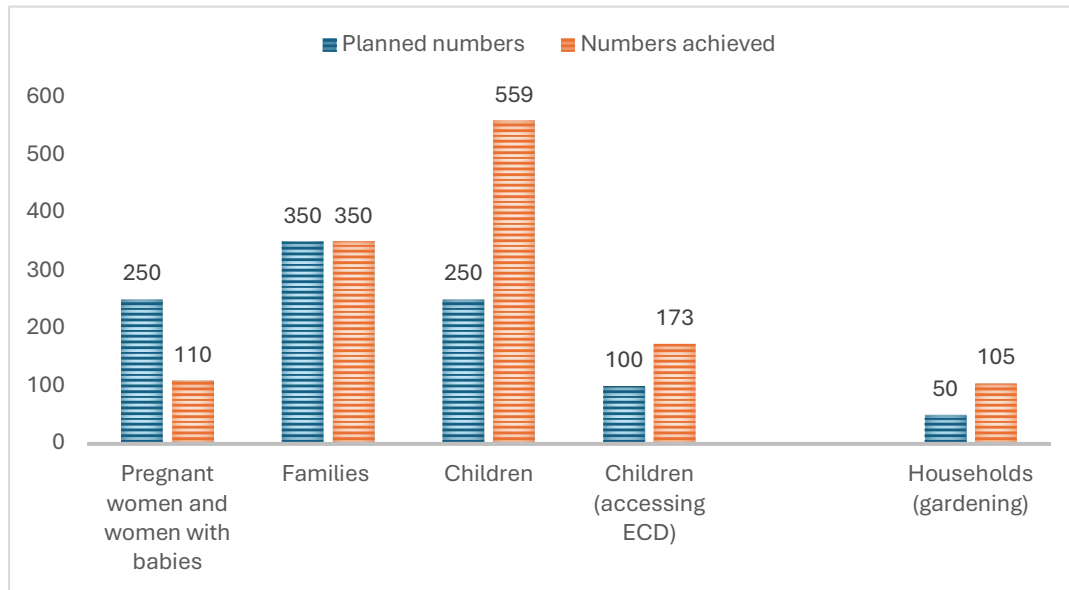


Figure 7: Project Targets

### 6.3.1.4. Participants / Respondents

The partner was able to organise all the participants that were required for the baseline evaluation and account of their responses will be given in 6.3.1.7.

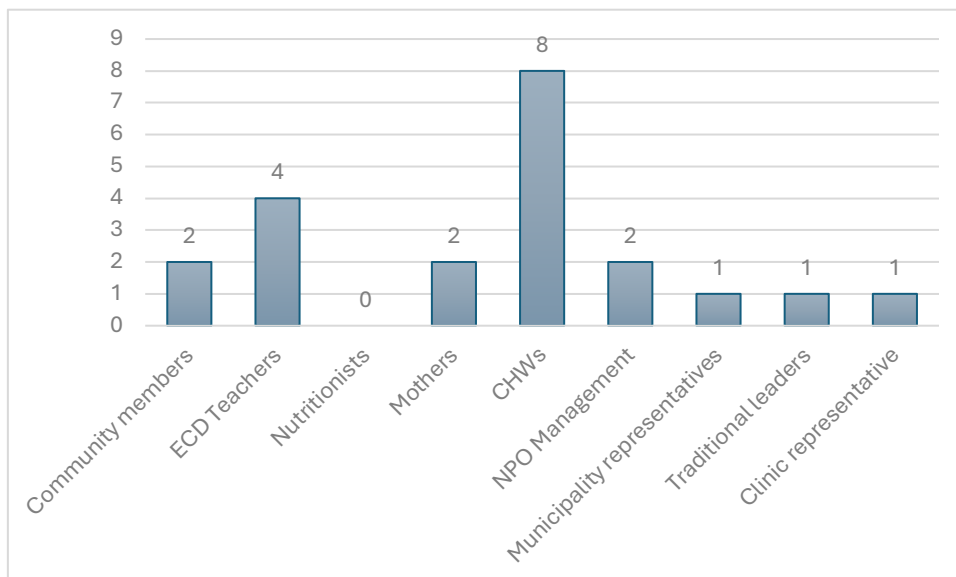


Figure 8: Participants

### **6.3.1.5. Human resources and skills**

The partner organisation comprises of a total of 10 CHWs of which 2 are part of management. This number is not enough for the amount of work that they do as each has to visit a minimum of 12 households per week and they travel long distances.

The CHWs listed short training programmes in Immunisation, Mother and baby, Adolescent, monitoring and evaluation and computer literacy as some of the trainings they attended.

### **6.3.1.6. Needs and challenges**

The CHWs indicated that they need tools of the trade like branded uniform, bags, shoes, phones and data to be able to be reachable and to report emergencies while in the field. They also indicated that community leaders do not come to meetings and they are not receiving support from them.

### **6.3.1.7. Stakeholder responses**

#### *6.3.1.7.1. Community members*

Community members who were interviewed were two mothers who are not part of the programme but are aware of the work carried out by the project. The questions posed were related to (i) *knowledge of the organisation and the work that they do;* (ii) *services available for children and* (iii) *access to health care services by children and women.*

#### *6.3.1.7.2. Municipality representative*

The representative was asked questions on their knowledge of the partner, support available to the partner, issues of child mortality and morbidity in the areas and services available for health care services for children and women.

She responded that she was worked in the Councillor's office and was aware of the NPO and the work that they do, namely "*working with pregnant women and children; they make sure that the women attend the ante-natal clinic and that children attend the clinic for immunisation*". She was not aware of the issues of mortality and morbidity in the area, and that health care for children was provided by the clinic and the NPO.

She added that the office of the Councillor was always available for assisting the NPO, but this statement was not supported by the partner.

#### *6.3.1.7.3. Traditional leadership*

The office of the traditional leader was represented by an Admin Officer as the Chief was not around. She had a commendable knowledge of the NPO and the work that

they do. She also indicated that the CHWs were very valuable to the community as the Department of Health CHWs were not enough to carry out the work in the vast area. It also emerged from the interview that the local Chief owned the house that was used as a work base by the NPO, and was provided to them to use as long as they are offering services to the community.

The main concern and request from the traditional office, was for the KKM to be able to provide services to the women who live in cattle ranches with no access to health services.

The partner confirmed that they were supported by the traditional office, and that the representative of the traditional office attend their events and also advocate for them.

#### *6.3.1.7.4. Clinic representative*

The clinic representative reported that there are only four CHWs working for the Department of Health, and that they are understaffed for the work that they need to do. The CHWs from the DOH are not equipped to properly carry out the work on maternal and child health as they have to cover the whole spectrum of community based work for adults and children. *“The Kopano ke Maatla team is really useful to us as they help us a lot with what our CHWs cannot do. They have assisted a lot in improving our numbers of ante-natal clinic and road to health. We work very closely with them in the clinic and in outreach activities”*. The partner confirmed that they were supported by the Clinic, and that the clinic sometimes gave them supplies that they need.

#### **6.3.1.8. Conclusive response on participants**

The stakeholders portrayed a close relationship with the NPO, and all of them pledged their support for the project and the work of the CHWs. The one important stakeholder whose support is required by the NPO is the municipality. Despite the assertion that the office was supportive and available, the partner reported that the municipality does not support them as much as they need them.

#### **6.3.1.9. Impact and Sustainability of the project**

The partner is visible and active in the community, enjoying relatively strong ties with the local clinic and traditional leadership, but the relationship with the local government is not well-established. Interviews with the local partners indicated strong ties and collaboration. The local clinic reported that they are more dependent on the IP than they are on the CHWs that are appointed by the department of health. The traditional office commended them for reaching outlying and underserved areas, but that they face challenges of reaching cattle ranches where there is no access to any form of health care.

### **6.3.1.10. Challenges and recommendations**

- i. The IP has no other sources of support to augment the NMCF support, and with the good work that they do, lack of continued financial support, the gains that they have seen will be to waste. They have a potential to be flagship (diamond in the rough) in the most arid area, and since they are in an area with several mines, there is a potential that NMCF can advocate for the mines to support them. This could be as a replacement funding, or collaborative support.
- ii. The team has to cover vast areas to be able to reach some of the clients. The roads are not in a good condition, there is no public transport there are deserted, vast areas and is not safe for the CHWs to be walking alone or on foot.

## **6.3.2. HOEDSPRUIT TRAINING TRUST**

### **6.3.2.1. Background information**

Hoedspruit Training Trust (HTT) is a registered non-profit organisation implementing the Hlokomela programme which aims to reduce HIV vulnerability through peer education, raising of awareness, prevention and treatment. The organisation has been implementing its programme for the past 18 years in 72 sub-project sites. The Hlokomela women's clinic and baby clinic ensures that maternal and child healthcare services are provided in farming communities. In 2005 the organisation started creches to keep children out of the farm orchards and ensuring that they are safe and stimulated.

HTT is located in the Maruleng Local Municipality which is part of the Mopani District Municipality, a Category C municipality located within the north-eastern quadrant of the Limpopo Province. It is bordered in the north by Zimbabwe and Vhembe District Municipality and it covers an area of 3 563km. The Maruleng Local Municipality is a Category B bordered by Ba-Phalaborwa and Tzaneen to the north, Tubatse and Bushbuckridge to the south, the Kruger National Park to the east, and Lepelle-Nkumpi to the west. It is one of the five municipalities in the district, with the majority of the area rural. The town of Hoedspruit can be considered the administrative and economic centre of the area.

The population of the local municipality shows an increase from 2016 to 2022, with the target group for the programme (children) (0-14 years) age category increasing from 1% from 31,7% to 32,7% of the total population in the last count<sup>21</sup>.

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<sup>21</sup> <https://municipalities.co.za/overview/128/mopani-district-municipality>

### 6.3.2.2. Project outputs against Project goal

The partner's stated goal is to reduce child mortality in Mopani District in the Limpopo Province and this was evaluated through the contents of the project synopsis document outlining planned activities. The evaluation established that there was evidence indicating that work had already begun, Based on interviews with selected stakeholders, as well as perusal of documentation, the partner is on course to achieve the activities as only two of the activities were not observed or sufficiently covered during the fieldwork.

IP	Proposed Outputs	Observed Progress		Description / Source of Information	
		YES	NO		
HOEDSPRUIT	Improved child immunisation	X		IP Management, Clinic Representatives, CHWs and Nurse	
	Capacitated Health care workers who are able to provide maternal and child health support	X		CHWS, training plans perusal	
	Empowered men on paternal, maternal and child health		X	Men dialogues in progress	
	Mothers capacitated with knowledge on healthy diets and how to start a food garden		X	Not observed, but gardens noted in ECDs	
	ECD centres will be capacitated with the knowledge of healthy diets and gardening	X		Gardens observed in ECDs	
	Established gardens that will provide healthy diet for children	X		Feasible, but not observed	
	Mothers who are exclusively breastfeeding	X		Interviews with Mothers and perusal of CHW reports	
	Access to social services for community members	X		Interview with mothers	
	Strong developed relationships with various stakeholders that will result in informed and accessible policies in place.	X			
	Children access ECD centre	X		Interviews with ECD centres and IP Management	
	Improved child stimulation	X		Reported by Mothers, ECD and CHWs	
	Caregivers who stimulate their children at home	X		Reported by Mothers	
			<b>83%</b>	<b>17%</b>	

Table 12: Project outputs against project goal

### 6.3.2.3. Project targets

The target group include under five year olds, pregnant women, mothers/caregivers, males, families and communities.

In the first few months of implementing the project, the partner was able to reach the number of beneficiaries indicated in Table 13

Category	Planned numbers	Numbers achieved
Under five year olds	2000	1200
Pregnant women and mothers	290	Information not received
Farms	50	50
Men	100	100
ECD Centres and gardens	10	10

Table 13: Project Targets

### 6.3.2.4. Participants

The partner was able to organise all the participants that were required for the baseline evaluation and account of their responses will be given in subsection 6.3.2.7.

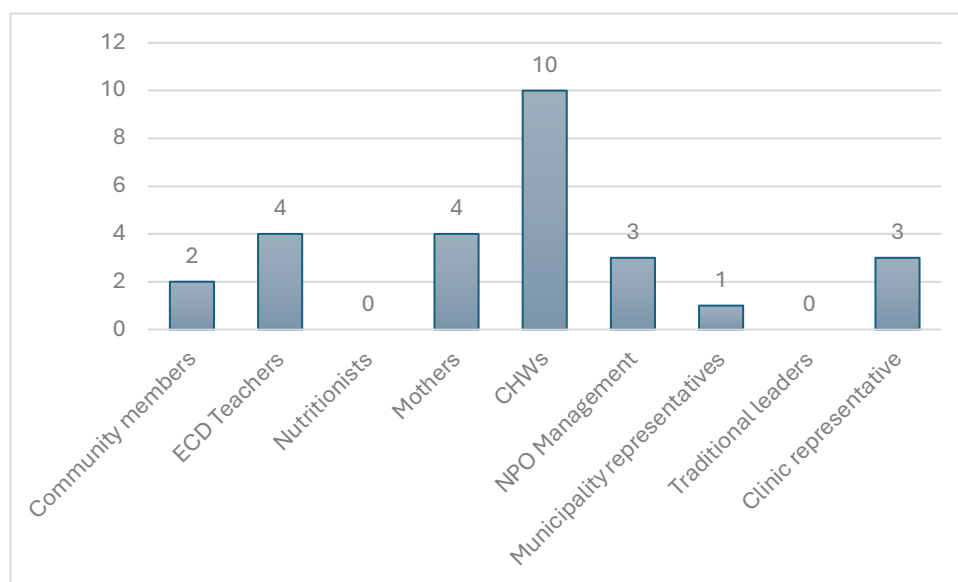


Figure 9: Respondents

### **6.3.2.5. Human resources and skills**

The partner organisation comprises of a total of 81 CHWs, of which 41 are on the Hoedspruit Training Trust payroll and others are CHWs from the Department of Health. They receive regular training from the organisation, as well as from specialists that collaborate with HTT.

### **6.3.2.6. Needs and challenges**

The main concern from the CHWs who work for the Department of Health is the overlap in the work of the Trust, and that of the Department. It does happen that HTT requires the CHWs to be involved in activities at the same time that the Department is expecting them to do carry out other duties. This is a challenge that they need sorted out.

### **6.3.2.7. Stakeholder responses**

#### *6.3.2.7.1. Community members*

Community members who were interviewed were four mothers who are beneficiaries of the programme. The mothers were appreciative of the work done by HTT and Hlokomela, and relayed the benefits they receive and how the project changed their lives.

#### *6.3.2.7.2. Municipality representative*

A representative from the local municipality vouched for the organisation, and pledged support from the office.

#### *6.3.2.7.3. Clinic representative*

The clinic representatives, both at Management level reported that they had a good relationship with the organisation, and that the work done by the Trust provided them with relief of being able to reach places they would be able to get to. They reported that the clinic does not have a Dietician, and that they rely on the Hoedspruit Training Trust for education of communities in nutrition and interventions on identification of children with malnutrition. The also reported that they do not have an MOU, and there is no active Clinic Committee.

### **6.3.2.8. Impact and sustainability**

CHWs have been appointed, with some getting paid by the Trust, and some paid by the Department of Health. The programme is part of a Trust, so most work is done

within an already existing ecosystem, and they have strong ties with the Provincial and local government and the clinics. They assist with social development and welfare issues and assist migrant labourers as well.

#### **6.3.2.9. Challenges and recommendations**

- No formal training of project staff on the NMCF related interventions, but the CHWs have received training from Dieticians on MUAC (2-3 days). More training needed on nutrition and child and maternal health
- There have been long delays in tranche payment, leading to a delay in achieving some of the set targets.
- There was a long delay from conception to inception of project, with a lot of changes to the original submission
- Duration of funding is too short to be able to determine impact. Funding for at least two years can lead to measurement of impact.

### **6.3.3. LULAMAPHUKO**

#### **6.3.3.1. Background information on the area**

Lulamaphiko is a non-profit organisation established in 2021. It is based in uPhongolo, within the Zululand district municipality in KwaZulu-Natal province. The uPhongolo Local Municipality is a Category B municipality located in the north of the Zululand District in KwaZulu-Natal. It lies adjacent to the Swaziland Border and the Mpumalanga Province Border. It is one of five municipalities in the district. The municipality contains very low settlement densities, with the main economic sectors being Agriculture and Tourism. The municipality covers an area of 3 110km<sup>222</sup>.

For this contract, Lulamaphiko will be implementing a project called FUKAMELA, which aims to ensure malnourished babies and young children up to the age of five years are supported to get back on track in respect of their health, growth, development and learning. The organisation aimed to work closely with different stakeholders like Departments of Health, Basic Education, Social Development, and Agriculture and Rural Development to improve access to services and learning opportunities for these children. Other activities will include support and equipping parents and caregivers with information on the importance of good nutrition. This will include encouraging and teaching parents on how to start food gardens to enable them to provide healthy, fresh vegetables for their children and families. Resources such as tools and seedlings will be provided. On the other hand, children will be supplied with fortified porridge to improve nutrition and will be monitored at their local clinic.

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<sup>22</sup> <https://municipalities.co.za/overview/125/zululand-district-municipality>

Lulamaphiko is contracted by the “Do More Foundation” to implement their Young Child Programme in uPhongolo. The project ensures that those at risk of malnutrition and stunting have access to proper nutrition, stimulation and attachment as three critical elements to ensure their optimal development and growth. The young child programmes therefore focus on bringing these elements to life through several nutrition, early learning and parenting support-focused interventions.

### 6.3.3.2. Project outputs against Project goal

The partner’s goal is to ensure that malnourished babies and young children up to the age of five years are supported to get back on track in respect of their health, growth, development and learning. The evaluation established that the partner is on track to be able to achieve the proposed outputs as there was evidence that work had already started.

IP	Proposed Outputs	Observed Progress		Description / Source of Information
		Yes	No	
<b>LULAMAPHIKO</b>	Profiled Families.		X	Feasible
	Parents and children access social, health and other services.	X		Booklets from Do More
	Parents understand the impact of making healthy food choices.	X		Interviews with Mothers and Dietician
	Parents understand the importance of child immunizations and exclusive breastfeeding.	X		Interviews with Mothers and Dietician
	Statistics of children’s nutritional status.	X		Dietician and Nutrition Advisor
	Parents trained to support stimulation and early learning at home.	X		Parents, ECD Teachers and CHWs
	Parents encouraged to adhere to clinic appointments and understand the importance of clinic visits	X		CHW and Mothers
	Partnerships formed between ECD centres and clinics.	X		Interviews with ECDs, Dietician and Clinic Management
	Strong relationship with the hospital Dietician.	X		IP Management, IP staff, Clinic Management and Dietician
		<b>89%</b>	<b>11%</b>	

Table 14: Project outputs against project goal

### 6.3.3.3. Project targets

In the first few months of implementing the project, the partner was able to reach the following number of beneficiaries against the set targets.

Category	Planned numbers	Numbers achieved
Children in ECDs	200	Ongoing
Children <5 years visiting local clinic	100	Ongoing

<b>Clinics</b>	4	4
<b>ECD centres</b>	4	4

Table 15: Project targets

#### 6.3.3.4. Participants / Respondents

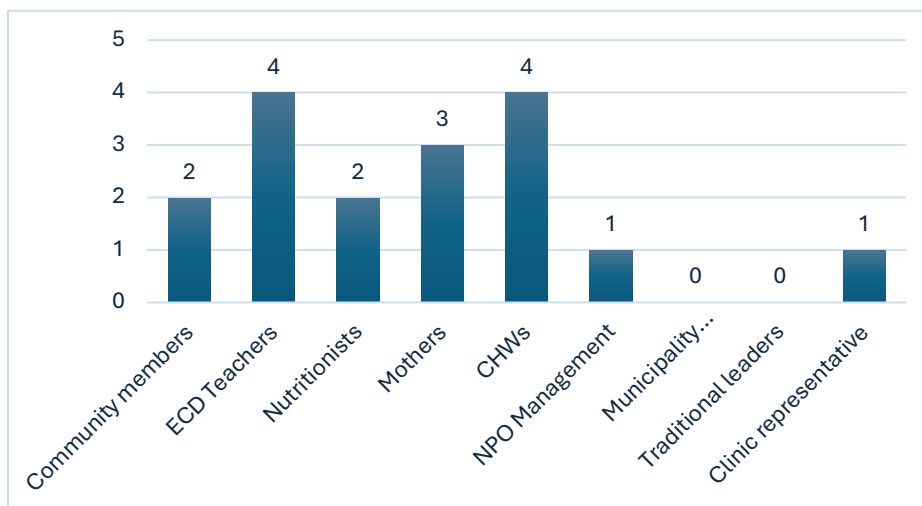


Figure 10: Respondents

#### 6.3.3.5. Human resources and skills

The partner organisation does not have any CHWs in their employ, but work with the local clinic where there are four CHWs appointed by the department of health. This number is not enough for the amount of work that they do as each has to visit a minimum of 12 households per week and they travel long distances. CHWs identify children under five and review their nutrition status. They test the children using a MUAC tape (Mid-Upper Arm Circumference) for malnutrition and those who are found to be malnourished get referred to the clinic. They do not use scales. They provide Vitamin A gel to malnourished children.

They provide basic education to mothers about nutrition, feeding (what children should eat at the different ages of growth), and healthy growth for infants and young children under 5. Each CHW works with more than 60 households a month and they mentioned that the number is manageable.

#### 6.3.3.6. Needs and challenges

The CHWs raised the issue of not having an office at the clinic, and that they also do not have transport and they usually walk long distances in rural areas. They also raised a concern that they are not getting counselling after an encounter with a difficult situation (after a child or a person they used to help passes away).

### **6.3.3.7. Stakeholder responses**

#### *6.3.3.7.1. Community members*

One of the community members interviewed owns an ECD with a total of 100 children, 4 Teachers and 1 Caregiver, She reported that the partner provided teachers and parents with training on malnutrition, nutrition and how to start a vegetable garden and sustain it. The second community member was a mother to one of the owners of ECDC and she reported that the community is very supportive of Lulamaphiko and appreciative with the work they do for the creches

#### *6.3.3.7.2. Municipality representatives*

There was no municipality representative, and it was reported that there is no formal relationship with the municipality

#### *6.3.3.7.3. Clinic representative*

The clinic serves people from disadvantaged backgrounds, the area has limited job opportunities and most people work in the sugar cane companies. Due to its close proximity to Swaziland, the clinic serves a lot of cross-border children, most of whom suffer from severe acute malnutrition. The clinic also has a special project they are working on which includes children 40 children from 0-19 years. They usually plan support group events, however, the government is not supportive in terms of providing food, water, toys on the day of the event. The partner organisation was introduced to Itshelejuba hospital and the MOU is still in progress. They have not been introduced them to the clinic committee, but since the inception of the project, there is a significant decrease in the number of severe, acute malnutrition.

#### *6.3.3.7.4. Dietician*

He indicated that Lulamaphiko invites him to their community outreach and the ECD centres they work with to give health education. They work together so well that Lulamaphiko helps him to reach areas he normally would not reach or does not constantly go to. Lulamaphiko also provides other services like MUAC measurements and food not provided by the hospital.

The relationship between the Dietician and Lulamaphiko is working well, however, the Dietician reported that he is unable to use the statistics collected by Lulamaphiko as he did not see the patients himself. This is a shortcoming that needs a discussion to find a solution so that the intervention by Lulamaphiko can be used to contribute to official district health statistics.

#### 6.3.3.7.5. *Early Childhood Development Centre (ECDC)*

It was reported that ECDs were selected purposely based on their proximity to the clinic and because they were known by the Dietician. The ECD teachers would then be trained to work together with parents and guide them on how to identify and monitor children for signs of malnutrition. Parents come for monthly trainings at the ECDs to be taught about how to care for a child, from pregnancy (talking to the child while in the tummy), to child birth and from 0-5 years). Lulamaphiko also trains the mothers about nutrition and on how to establish and sustain a vegetable garden.

The ECD teachers spoke highly of the Do More project and their collaboration with other stakeholders to help the children at ECD's. They seem not to know the difference between the two projects (Do More and NMCF), and this could be attributed to the fact that because they have known Do More since 2012 while they have known Lulamaphiko and NMCF since April 2024. With that being said, it is imperative that the partner ensures that the beneficiaries know the contribution made by NMCF in continuation of their work.

#### **6.3.3.8. Impact and Sustainability**

The partner is visible in the community and is actively supported by the stakeholders. They have strong ties with the Hospital, Clinics, ECDs, Dietician and Nutrition Advisor. The project staff and CHWs are empowered and motivated in their work. The partner has a long standing and good relationship with the Do More Foundation, and it is recommended that NMCF contact the Foundation to determine if they could establish a working relationship or partnership.

#### **6.3.3.9. Challenges raised by the Implementing Partner**

- The whole process of the project being approved took long (almost a year of delay), and changed almost all of the submission made by the IP.
- There are long delays in payment, but NMCF is very strict with how the money is to be spent. The IP had to set up an account specific for NMCF money, and despite this being done, they waited for months to get the second tranche of money. However, it is expected that work should continue without the funds. This is a problem as they would not be able to carry out work if they did not have savings, and they could also not be able to use funds from other funders. An explanation was provided by NMCF, and the IP hopes this will be sorted out.
- The IP does not have a relationship with the municipality as they do not respond to anything that the IP sends to them, and do not provide help when needed.

Based on the interaction with another partner in the same district, it is recommended that the Lulamaphiko improve their interaction with the municipality through established government platforms like Operation Sukumasakhe.

#### **6.3.4. HUMANA PEOPLE TO PEOPLE**

##### **6.3.4.1. Background information on the area**

Humana People to People in South Africa (HPPSA) is a registered non-profit organisation founded in 1995, with the mission of empowering the poor to lift themselves out of poverty and contribute to the development of their own communities.

Humana People to People aims to implement the Child Survival, Development and Thriving programme in eDumbe local municipality of Zululand District in KwaZulu Natal Province. The eDumbe Local Municipality borders the Mpumalanga Province in the north and it is the smallest of the five municipalities that make up the district, accounting for 13% of the geographical area.

The location of the head office is in Paulpietersburg, which is 50km north of Vryheid and 59km south of Mkhondo (previously Piet Retief). The municipal area of jurisdiction is demarcated into eight wards that are predominantly rural in nature, and covers an area of 1 943km<sup>2</sup>. The population of the district, with an increase from 2016 to 2022, and the target group for the programme (0-14 years age category) with a total declining from 41.3% to 34.0% of the total population<sup>23</sup>.

##### **6.3.4.2. Project outputs against Project Goal**

The partner's stated goal is to reduce child mortality in eDumbe local municipality of Zululand district, covering all the 31 villages.. Based on interviews with selected stakeholders, as well as perusal of documentation, the partner is on course to achieve the activities despite the low percentage of the status quo during the evaluation.

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<sup>23</sup> <https://municipalities.co.za/overview/125/zululand-district-municipality>

IP	Proposed Outputs	Observed Progress		Description	
		YES	NO		
HPPSA	Trained CHW who are focused on MCH.		X	CHWs trained, but focussed MCH training recommended.	
	Increase in knowledge on Maternal Child Health (MCH)		X	Will be increased through training	
	Improved attitude and practices on MCH and its related issues.		X	Will be increased through training	
	Mindset changes for men on MCH issues.		X	The response was low, but effort ongoing.	
	Improved knowledge in exclusive breastfeeding and its advantages	X		Interviews with Mothers and perusal of CHW reports	
	Empowered clinic committees who become functional and active		X	Clinic Committee not in place. Efforts noted with the Clinic Management, but committee not appointed yet.	
	Access to healthy and nutritious food	X		Ongoing efforts	
	Increase in number of children whose annual check-ups are done at ECD.		X	ECDs are not very operational	
	Decrease in number of women with STI infections which could lead to child mortality.	X		Work with sex workers and truck drivers in the area.	
	Improve in knowledge and mental well-being of the women.		X	Not observed, but feasible	
	Improved number of children supported in accordance to developmental needs		X	Feasible	
			<b>26%</b>	<b>74%</b>	

Table 16: Project outputs against project goal

### 6.3.4.3. Project targets

The target group include under five year olds, pregnant women, mothers/caregivers, males, families and communities.

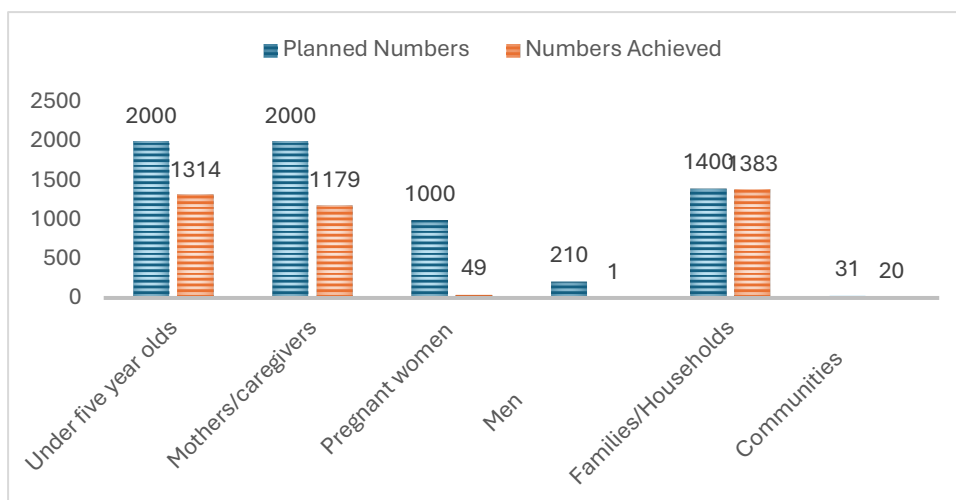


Figure 11: Project targets

#### 6.3.4.4. Participants / Respondents

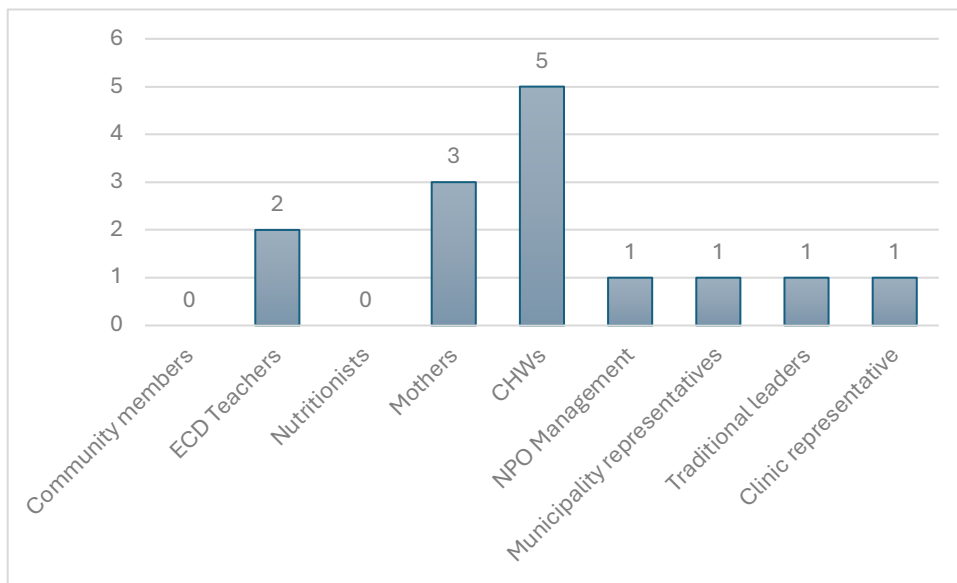


Figure 12: Respondents

#### 6.3.4.5. Human resources and skills

The CHWs are supposed to visit 15 households a week and the visit also depends on how many targets are in the homes. In some homes you find a pregnant woman, a mother with a child under 5 and a man. The organisation provides them with money for transport and airtime monthly, they provide food during their monthly meetings, CHWs are also able to call the manager to ask for advice when faced with difficult situations.

CHWs conduct home visits to educate mothers/caregivers (2000 target) and pregnant women about the importance of receiving antenatal Care (ANC), postnatal care, and ensuring their children get all the vaccinations. Forty nine (49) pregnant women have been reached so far (the target of 1000 will not be reached as there are less pregnant women in the selected communities).

CHW also conduct follow-up home visits for pregnant women to ensure their clinic attendance. They also ensure practice of good nutrition and exclusive breastfeeding by new mothers. Because of the great relationship they have with the community leaders (Induna), they get invited to community meetings to talk about the project.

In villages that are hard to reach, the team do health educational through an outreach instead of home visits. The CHWs also identify the needs of communities and organize relevant stakeholders to come/provide the service required (e.g. IDs and child certificates – there are old people and children who live in remote areas and they don't have them). At the time of the interview, they had only visited 1 ECD centre out of 14

targeted ECDs to do the check-ups. They were planning to visit the second ECD at the time of the evaluation.

They have respectively attended various training like Counselling, Home Based Care, Basic nursing (18 months), and they still need more training Nutrition, Maternal Health, MUAC and Immunisation. They also require training in the completion of the household form that they use.

#### **6.3.4.6. Needs and challenges**

- i. The CHW indicated that they do not have pamphlets or posters for demonstrations when doing health education.
- ii. In some areas, there are no government CHWs, they work alone., and in some areas, community members are not allowing them in their homes
- iii. They need more t-shirts to change with the current one they have, and they need hats as it is hot when they do home visits

#### **6.3.4.7. Stakeholder responses**

##### *6.3.4.7.1. Community members*

The community member that was interviewed indicated that he is aware of the project, and its purpose as it was introduced in one of the war rooms held by the municipality. He also reported that the IP has a great working relationship with the municipality, and partake in Operation Sukuma Sakhe” (stand up and build), a call for the people of KwaZulu-Natal to overcome the issues destroying communities such as poverty, unemployment, crime, substance abuse, HIV and tuberculosis.

##### *6.3.4.7.2. Municipality representative*

The Representative reported that he is aware of the project and its purpose as it was introduced in one of the war rooms held by the municipality. They have a great working relationship with the municipality and the municipality consider the project as part of what they call “Operation Sukuma Sakhe which is a call for the people of KwaZulu-Natal to overcome issues destroying communities such as poverty, unemployment, crime, substance abuse, HIV/ AIDS and tuberculosis. The municipality is willing to provide transport to the CHWs in case they need to attend training or transport outside eDumbe.

##### *6.3.4.7.3. Clinic representative*

She mentioned she is aware of the project and was introduced to it. They had a Primary Health Care meeting where people from HPPSA came to make a presentation

about the project. She was one of the people who interviewed the CHWs. The relationship is good but there is room for improvement, especially in terms of sharing data with the clinic for better, collaborative interventions, and for community mapping and outreach. She mentioned she does not request/ask for reports from them She provided them with training material but they did not train the CHWs as they do not have a Facilitator.

#### *6.3.4.7.4. Traditional leadership*

The current chief is young and open minded, he was able to make changes to the old system of doing things. He involved women and young men in the committee. The Project Leader approached them and explained the project, and she was then formally introduced to the community and made a presentation about the project. Department of Health has only 8 Community Health Workers in the area and there is more demand, and they are too few to cover all the communities in the area. The clinics are usually slow in providing service so people sometimes come to the clinic but not get help in time, so they go back home and never come back.

#### *6.3.4.7.5. Mothers*

CHWs help mothers by educating them on how to feed the children, the types of food a child should eat, and they also encourage exclusive breastfeeding from 0-6 months. One of the mothers mentioned that she cannot breastfeed due to health complications and would appreciate more information from CHWs on what to do in such a situation. They ensure that mothers take their children to the clinic for vaccinations, and for check-ups when they are sick. They also help pregnant women go to the clinics for ANC and also help sick mothers go to the clinic

#### **6.3.4.8. Impact and sustainability of the project**

The project is supported by all the stakeholders, and has a dedicated and hard working team. They are part of a larger programme that already had an impactful focus on child survival and they do appear to be sustainable.

#### **6.3.4.9. Challenges**

The organisation covers a very large area with limited public transport, and they do not have a program vehicle. This could have an impact on the successful implantation of the project.

## **6.3.5. ONE TO ONE AFRICA CHILDREN'S FUND**

### **6.3.5.1. Background information on the area**

One to One Africa Children's Fund was established in 2012 as a Non-Profit Organisation with the aim of improving the wellbeing and life chances of children, young people and families affected by dislocation, poverty, and chronic illness. The organization is affiliated with One to One Children's Fund in the UK, which was established in 2001. One to One Africa is however an independent entity.

The organisation has been pioneering evidence-based interventions that leverage local knowledge and lived experience to fill core gaps in healthcare and psychosocial services for children and young people. One to One Africa Children's Fund will implement the Child Survival, Development and Thriving Programme. Their interventions will contribute towards reducing child mortality and improving child development in the Eastern Cape Province, in OR Tambo District.

The NPO operates mostly in the Nyandeni Local Municipality, a Category B municipality located within the OR Tambo District. It is bordered in the north by Mhlontlo, in the south by the Indian Ocean, in the east by Port St Johns, and in the west by King Sabata Dalindyebo and covers 2 474km<sup>2</sup>. 79% of households reside in traditional or village type settlements. These settlements are scattered throughout the entire municipal area and are surrounded by communal grazing and arable lands.. Apart from a few trading stores, there is little sign of any significant economic activity within the rural settlements.<sup>[4]</sup> About 77% of households can be regarded as indigents with access to either no income or incomes of less than R800 per month.<sup>[3]</sup>

### **6.3.5.2. Project outputs against Project goal**

The partner's stated goal is to reduce child mortality and improve development of children in the most remote areas of the Eastern Cape's O.R. Tambo district, and based on the work already done, they are on course to achieve the goal. The evaluation established that the partner is on track to be able to achieve the proposed outputs as there was evidence that work had already started (Table)

IP	Proposed Outputs	Observed Progress		Description / Source of Information
		YES	NO	
<b>ONE TO ONE CHILDREN' S FUND AFRICA</b>	Maternal and child health services rendered in 16-20 villages through a mobile health clinic.	X		Successful in very trying and inaccessible terrain.
	Community based health ambassadors recruited and trained to provide maternal and child health support and community awareness.	X		Interviews with ambassadors and CHWs
	Improved caregivers' knowledge on maternal and child health	X		Training provided and ongoing
	Improved knowledge and participation of men in maternal and child health	X		Going number of men involved
	Established and empowered clinic committee that provides regular feedback to respective communities.		X	Was unable to meet the clinic committee, but met a nurse in the local clinic
	Improved family and community knowledge on nutrition	X		Interviews with community members
	Established food gardens	X		Food gardens observed
	Advocacy reports on identified advocacy issues in CSDT		X	Not measured
	Improved skills and knowledge on Mobile Clinic Data management	X		Presentation by, and discussions with the M&E Officer showed good reporting and alignment with the DOE systems.
		<b>78%</b>	<b>22%</b>	

Table 17: Project outputs against project goal

### 6.3.5.3. Project targets

In the first few months of implementing the project, the partner has already made big inroads and achieved most of the targets. The Mentor mothers that to various villages and in the interview with one of them, it was established that they average close to 100 children and more than 50 mothers in the areas where they work They partner has an MOU with the Provincial Department of Health and is able to access their facilities and resources, mainly medicine. They also have a mobile clinic that enables them to reach far flung areas.

- Under five year olds- **2000**
- Mothers/caregivers - **400**
- Pregnant women - **400**
- Men - **200**
- Communities - **16-20 Villages**

#### 6.3.5.4. Participants / Respondents

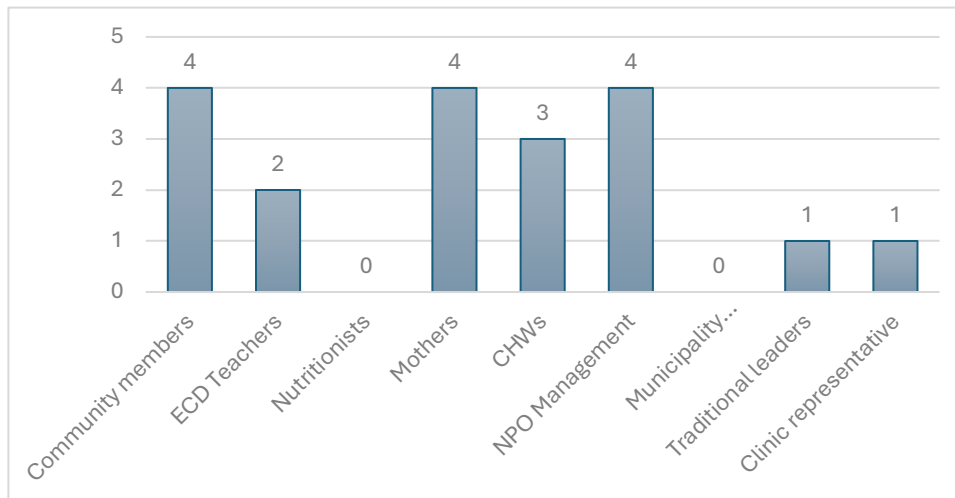


Figure 13: Respondents

#### 6.3.5.5. Human resources and skills

The programme has thirty (30) Mentor mothers of which eleven (11) are assigned to the CSDT project. Mentor mothers are trained to do home visits and offer support in various health components like pregnancy test and malnutrition, antenatal advice, breastfeeding education and immunisation, as well as running Early Child Development programmes. They also weigh the children as part of the nutrition programme.

The IP have developed a special app and is used by the Mentor mothers for reporting and it is compatible to the DOH system, making it easy for quality data to be submitted on time.

#### 6.3.5.6. Needs and challenges

The budget for the Professional Nurse is low and it will be difficult to entice her to stay. They also have limited transport to access the areas they work in. The terrain is very rural with bad roads, and require off-road type of vehicles. The Mentor Mothers also travel long distances as there is no local transportation in some areas.

#### 6.3.5.7. Stakeholder responses

##### 6.3.5.7.1. Community members / Mothers

Four mothers were interviewed and they were very appreciative of the work done by the IP. They outlined the work that the IP does with them, including *education on the*

*importance of immunisation, bonding with the child, the importance of buying nutritional foods for the child and starting home gardens*

#### *6.3.5.7.2. Clinic representative*

The clinic representative was a Nursing Sister who spoke highly of One to One, and reported that they enjoyed a good working relationship. The evaluation team was able to observe the collaboration in action when they found the team from One to One accommodated and working in the clinic.

#### *6.3.5.7.3. Traditional leadership*

The local iNkosi was well informed about the work of One to One, and was very appreciative and supportive of the programme. He even reported that he has made land available to One to One to build a facility so that they are close to the community. He also requested that the IP expand their services to other villages as there are other people that do not receive health services due to bad roads and distance, and he felt that locally based CHWs would be a solution.

### **6.3.5.8. Impact and Sustainability**

The partner is well-established, with own resources and an active relationship with the Department of Health. They are innovative and have developed a useful and trustworthy App that is compatible with the Department of Health systems, and so are able to contribute to the government data and statistics. They own an ambulance and provide Primary Health and Maternal Care to the villages, with medical supplies from the department of health. Their impact in communities is visible and the community members and stakeholders hold them in high esteem.

## **6.3.6. WELLBEING AFRICA**

### **6.3.6.1. Background on the project**

Well-Being Africa (WBA) is a Non-Profit Organisation established in May 2018. The organisation positions itself to lessen the challenges of poverty and poor health prevalence in their targeted communities (Tshwane and Bushbuckridge Districts) through nutrition and nutrition-related services, capacity development, and psychosocial support. Through this project, Well-Being Africa aims to promote child health and development focusing on the first 1000 days of a child's life until 5 years. The project aligns with the Fund's child Survival, Development and Thriving program and will be implemented in Bushbuckridge communities, in Ehlanzeni district, Mpumalanga province.

### 6.3.6.2. Project outputs against Project goal

The partner set a goal of decreasing infant and young child morbidity and mortality rates in the Bushbuckridge area and contributing to the increased number of children whose physical growth and early learning milestones are compromised.

Because the project had not started yet due to finalisation of the MOU with the Provincial Health Department, no data is available to provide a proper presentation of the status quo.

IP	Proposed Outputs	Observed Progress		Description / Source of Information
		YES	NO	
WELLBEING AFRICA	Pregnant women, women and caregivers of children 0 – 5 (five) years are well informed about maternal and children’s health, good nutrition and access to health services.		X	Not observed, project had not started
	Pregnant mothers and mothers with babies attending Ante-Natal Care (ANC) and Post-Natal Care (PNC).		X	Not observed, project had not started
	Community members equipped with information on maternal and child health.		X	Not observed, project had not started
	Men equipped with information on maternal and child health, and early childhood development.		X	Not observed, project had not started
	Functional partnerships between Well Being Africa, local clinics and stakeholders are formed and maintained for effective and efficient coordination of services for children.		X	Not in place at the time of the evaluation, community entry and MOU negotiations were still in progress
	Children under 5 supported for health and development monitoring including immunization uptake, healthy eating, and early childhood development access.		X	Not observed, project had not started
	Support 8 ECD centres for early childhood development milestone monitoring.		X	Number reduced to 4

Table 18: Project Goal and Outputs

## 7. CONCLUSION

The baseline was able to collect data necessary to provide detailed information about the projects and the challenges they are responding to, as was expected. The results provide information about the status quo of children in the priority areas, and collect information about challenges faced by children in different relation to child mortality and morbidity. Information on services available to children, as well as support from other organisations, government departments and community structures was collected and evaluated. The baseline also identified gaps, strengths, and weaknesses that affect or impact on access to quality health care services for children and pregnant mothers.

The following conclusive statements provide the outcome of the baseline evaluation:

### 7.1. The CSDT strategy

The baseline also established that CHWs do promote child and maternal health knowledge, and also strengthen links through family visits, which are the second and third components of the CSDT strategy.

It was established that the Training of CHWs on maternal and child health is not standardised, and that some CHWs have not been trained in the field at all. They have been trained in the use of data collection tools, but they data collection tools are not standardised, and are not aligned to the data collection tools used by the Department of Health.

The last component of the strategy, the training of Clinic Committees, does not show propensity to be achieved in this round of off funding as Clinic Committees have not been appointed in any of the areas.

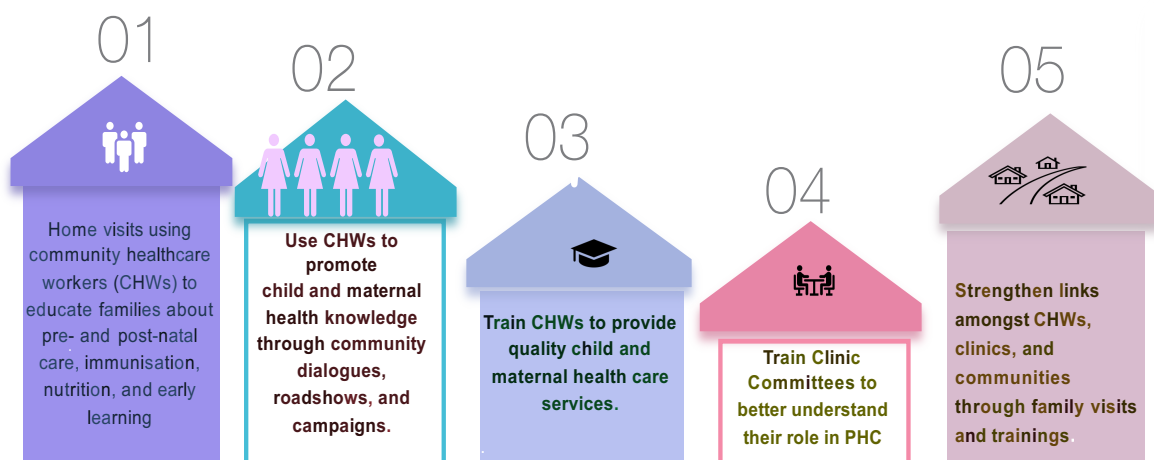


Figure 14: CSDT Strategy

## *7.2. Feasibility of achieving the respective goals*

The progress of five of the six projects is indicating a positive trajectory towards attainment of the goals of the respective projects, and that of the CSDT programme. Only one project was not satisfactorily measured as it was still in the process of MOU and community entry finalisation.

All the partners undertake home visits by CHWs to educate client families on various issues. The information from the project reports were substantiated by interviews of the mothers who are beneficiaries and part of the projects, community members who were selected as independent observers as well as government stakeholders and traditional leadership.

## *7.3. Progress of the projects*

The progress of five of the six projects indicates a positive trajectory towards attainment of their respective goals and targets, and that of the CSDT programme. Only one project was not satisfactorily measured as it was still in the process of the signing of the MOU and finalisation of community entry processes.

## *7.4. Target values*

### *7.4.1. Under-five mortality and morbidity*

Perusal of secondary data indicates that the selected areas still have relatively high mortality of children under five, although there has been a slight general decrease nationwide. The data is not readily available per district and is mostly reported per province. The primary data collected by the implementing partners did not cover these statistics as these are normally available through government health establishments.

### *7.4.2. Malnutrition*

There were no significant reports of malnutrition, however, the areas have a challenge of water and unemployment, and the intervention of home gardens by CHWs assists the families in having nutritious relish to go with the staple porridge.

### *7.4.3. Access and quality of services related to child and maternal health care services*

Five of the partners have a good relationship with their respective local clinics, making it easy to make referrals for mothers needing ante-natal care, as well as children needing to receive vaccination. The sixth partner had not started work at the time of the evaluation.

#### *7.4.4. Role of CHWs in the child and maternal health care system*

In all the areas evaluated, the CHWs are the interface between the mothers and the health care facilities. They provide education and advice services both in the homes of the mothers and in the clinics where the mothers go for consultation. No formal agreements were observed during the evaluation, however, interviews with the clinic management indicated a mutual and cordial relationship between the clinics and the CHWs.

### **8. RECOMMENDATIONS**

- i. To properly measure impact, the KPIs and agreements need to be addressed and made clear to all partners and should be part of the reporting tool for the grant.
- ii. The duration of one year for the project is too short to measure impact and is recommended that an extension, at least for another year, be considered.
- iii. CHWs and other project staff need to be provided with a standardised training to enable them to contribute with consistency to the goal and strategy of the CSDT programme.
- iv. The clinic committees are not functional in any of the focus areas, and it is recommended that they be removed as part of the CSDT strategy.
- v. Consistency of Project Activities outlined in the project synopsis document. Out of the six partners, only three had provided a list of activities outlined under the CSDT outcomes 1 to 4, and the remaining three partners only listed activities. Despite these outcomes being listed, the activities under those outcomes are not consistent amongst the three partners who listed them. This will make it difficult to measure the final indicators in the final end of project review and needs to be addressed.