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FACULTY OF ARTS

DEPARTMENT OF DEVELOPMENT STUDIES

AN EVALUATION OF THE ROLE PLAYED BY SAVE THE CHILDREN IN REDUCING CHILD MORTALITY IN WARD 13 ZHOMBE AREA, ZIBAGWE DISTRICT .

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE BACHELOR OF ARTS HONOURS DEGREE IN DEVELOPMENT STUDIES.

APPROVAL FORM

The undersigned certify that they have supervised the student, Fadzayi B. Zirobwa R124772b's dissertation entitled: **An evaluation of the role played by Save the Children in reducing child mortality in Ward 13 Zhombe Area Zibagwe District** submitted in partial fulfilment of the requirements of the Bachelor of Arts Honours degree in Development Studies.

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DECLARATION

I, Fadzayi B Zirobwa, do hereby declare that the work contained in this dissertation is entirely a product of my own original work with only the exception of quotations or references which have been attributed to their sources. I further declare that this work has never been previously submitted and is being submitted in partial fulfilment of the Bachelor of Arts Honours Degree in Development Studies at Midlands State University.

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Fadzayi Bridget Zirobwa **Date**

DEDICATION

This project is dedicated to my family for being a source of inspiration in my entire academic life, your words of wisdom, financial support and encouragement has propelled me to sail through this academic milestone. Your efforts to shape my future will not be in vain. May the Lord shower you with blessings. Mostly l dedicate this to my late mother who would have loved to see me being successful in life.

Abstract

The purpose of the research was to evaluate the role played by Save the Children Organisation in reducing child mortality in Ward 13 Zibagwe District. In conducting the study, both the interviews and focus group discussions were employed as the main research instruments. It is evident that most of the rural communities in Zimbabwe, Zibagwe District in particular have been facing child deaths due to various barriers such as poverty, socio-economic challenges and home deliveries to mention a few in their day to day lives. Therefore Save the Children Organisation through their programme of strengthening community participation in health was initiated as a way of trying to reduce the continuous deaths of pregnant women and children under the age of five due to health challenges faced in the community. However, in trying to minimise the death rate of children and pregnant mothers in the community, the organisation successfully brought a change to the community in the health sector though there are a few challenges they encountered that hinder them to fully maximize their capacity to minimise child mortality.

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ACRONYMS

EPI…………………………………… .....Expanded Immunisation Programme

HBM……………………………….......Health Belief Model

HTF…………………… ………………....Health Transition Fund

HCC……………………………………...Health Centre Committees

HLF……………………………………....Health Literacy Facilitator

MDGs……………………………………Millennium Development Goals

MIMS……………………………….....Multiple Indicator Monitoring Survey

MMR……………………………………..Maternal Mortality Rate

MoHCC……………………………......Ministry of Health Child Care

NGO …………………………………… Non-Governmental Organisations

SC ………………………………………Save the Children

SDGs ....Sustainable Development Goals

UNICEF…………………………………United Nations Children's Fund

UN…………………………………… …United Nations

WHO……………………………………World Health Organisation

ZDHS……………………………………...Zimbabwe Demographic and Health Survey

ZEPI……………………………………Zimbabwe Expanded Immunisation Programme

ZINATHA………………………………Zimbabwe National Traditional Healers Association.

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CHAPTER 1

1.0 Introduction

Zimbabwe has been experiencing economic recession due to various upheavals for the past decade due to political instability, floods, drought and also stressful impact of the HIV and AIDS. The result was increasing levels of poverty which became a barrier to normal living conditions in Zimbabwe, particularly in rural areas. A rapid rise in the economy have affected the health sector of the country which is experiencing shortage of enough budget to upgrade child health facilities and to cater for the pregnant mothers. It should be noted that most of the health infrastructure in Zimbabwe have deteriorated to the extent that it cannot accommodate and secure many patients. Child death has become one of the leading problem being faced in Zimbabwe and Southern Africa at large due to the poor economic situations. Zimbabwe has become one of the highest country in the world with the highest mortality rate of 614 deaths per 1000.

However in an effort to address the problem of child mortality faced by majority in rural areas, there were a number of Non-Governmental Organizations (NGOs), Multilateral Institutions and also government departments which assisted in reducing child mortality.

This research therefore mainly focused on the role played by Save the Children (N.G.O) in reducing child mortality in Ward 13 Zhombe area under Zibagwe Rural District.This chapter is going to highlight the background of the study, statement of the problem, significance of the study, purpose of the study, theoretical framework, objectives of the study and its limitations.

1.1Background of the study

The problem of child mortality remains an international concern because a large number of children under five who die from preventable causes in developing countries.

1.2 Child Mortality in Sub- Saharan Africa

Sub Saharan Africa has the highest under five mortality rate in the world with one child in 12 dying before his or her fifth birthday thus more than 12 times higher than the 1 in average in developed countries. Sub Saharan Africa continues to confront a burgeoning under five population which has been projected to increase by almost 30% in the next 15 years attached with persistent poverty in many countries. The main reason for high child mortality in Sub Saharan Africa is because they are less developed economically.

1.3Child Mortality in Zimbabwe

Zimbabwe, like most Sub-Saharan African countries, bears a heavy burden of strikingly high neonatal and child mortality when compared to countries in other regions of the world due to its collapse in the economy. According to the Zimbabwe Demographic and Health Survey of (2005), the under-five mortality rate was 82 deaths per 1,000 live births. The infant mortality rate was 60 deaths per 1,000 live births compared to 82 in 1999.The rate of child mortality can be defined as the number of deaths among children under the age of five per 1000 live births. The rise in mortality has been mostly experienced in Rural areas where many pregnant women, children under-five and new born have no access to best health facilities and lack of knowledge. The Multiple Indicator Monitoring Survey (MIMS) of (2009) estimates under five mortality rate and infant mortality rates at 94 and 67 deaths per 1,000 live births respectively. These indicators were excessively high. This institutes the need for the country to scale up high impact interventions urgently, in order to reverse this trend and develop strategies in order to deliver these proven interventions, confirming its commitment to significantly reduce early child mortality amongst the under-five children by two thirds as promoted in the Millennium Development Goals (MDGs) goal number 4 which is also closely linked to MDG number 5 to improve maternal health.

Malisa Zhombe Clinic is situated in Ward 13 thus the case of study which is located, Zhombe Area under Zibagwe Rural District in Kwekwe. Malisa Zhombe Clinic is the only health centre in Ward 13 which provides its health facilities to about 17 villages.

At Malisa Zhombe, Ward 13 there has been a record of experiencing high rates of maternal death due to social, economic, religious and political reasons. Cases of maternal death has been brought forward for the past decade which increased due to the depreciation of the countries' economy. One out of every eleven Zimbabwean children dies each year before their fifth birthday (approximately 35 500 children per year).

However due to the upcoming of Non-Governmental Organisations and being a signatory of the MDG 4, Zimbabwe managed to reduce its mortality rate for the better. Save the Children organisation in collaboration with other NGOs and the Ministry of Health and Child Care have managed to assist in the Health Sector through various ways and in this instance they managed to educate and Strengthen Community Participation on Health especially   pregnant women, new born babies, trained village health workers and children under five had more to benefit.

1.4 Save the Children (NGO)

Save the Children is the world's leading non- governmental organisation for children. Save the Children organisation Health Nutritional programme emphases on maternal and new-born health, Adolescent, Sexual and reproductive health and Nutrition. They support training of health staff (village health workers), provision of financial support, donates health institutes, improves community participation in health issues and improve also access to maternal reproductive and new born health services. The organisation work closely with the Ministry of Health and Child Care, partner with some organisations and communities to ensure that no woman dies while giving birth and that no child should die before or after birth. According to

Save the Children paper, children from the poorest households are three times more likely to die before their fifth birthday than those from richest households. In Zimbabwe Save the Children Organisation is working with 21 Districts including Zibagwe District with their programme of Strengthening Community Participation on child health hence SC assists in the attainment the 3ps in the child health development which are participation, provision and protection.

1.5 Millennium Development Goal (MDG) 4

The fourth Millennium Development Goal 4 aims to reduce the 1990 mortality rate among under – five children by two thirds. Child mortality is also closely linked to MDG 5- to improve maternal health .Since more than one third of all child deaths occur within the first month of life, improving skilled care mothers during pregnancy and after birth, greatly contributes to child survival. Millennium Development Goals was adopted by the United Nations in 2000 aiming to decrease child deaths world wide by 2015.

However, with the end of the MDG era the international community is in the process of approving on a new framework termed the Sustainable Development Goals (SDGs) where the target is to end preventable deaths of new-borns and children under 5 years of age.

Since 1990, the global under-five mortality rate has fallen by 53 per cent, from 91 deaths per 1,000 live births in 1990 to 43 in 2015. Progress in reducing under-five mortality in Sub-Saharan Africa has been faster than for the world as a whole the annual rate of reduction in that region increased from just 1.6 per cent in 1990–2000 to 4.1 per cent in 2000–2015. Between 2000 and 2015, 21 Sub-Saharan African countries reversed an increasing under-five mortality trend or at least tripled their rate of progress compared to the 1990s due to the adoption of the MDGs.

Thus in order to effectively reduce the childhood mortality trends in Zimbabwe and Malisa Zhombe Health Centre, a child survival strategy outlining the major target killers, key intervention strategies and actions, coupled with a well-defined monitoring and evaluation framework are required for health development.

This study is tailored to evaluate the strengths and weaknesses of the role played by Save the Children in reducing child mortality and to suggest ways of improving programs so as to keep up with international best practices.

1.6 Problem Statement

There has been a continuous increase in the child mortality rate for the past years particularly in rural areas due to liquidation of the economy. The research concentrate particularly on new born babies, children under the age of five 5 and also pregnant mothers. After carrying out a research there has been a discovery that increase in mortality rate was as a result of poor health facilities, lack of knowledge, religious beliefs, poverty, diseases e.g. HIV/ AIDS, shortage of drugs, insufficient budget for health for Ministry of Health Child Care, home deliveries and also long distance travelling to a nearest health centre. Basically Malisa Zhombe health centre in Ward 13 under Zibagwe District is less developed as it lacks good health facilities and qualified staff to provide good health services to the community at any given time. However a Non-governmental organisation named Save the Children in collaboration with the Ministry of Health Child Care and Local Council have managed to reduce the rate of child mortality through various ways. As a researcher one intents to evaluate the intervention of Save the Children, how it managed to reduce the maternal death at Malisa Zhombe area and how it came to benefit the community. Thus this research emphasizes on the role played by Save the Children Organisation in mitigating child mortality rate at Malisa Zhombe in Ward 13 under Zibagwe Rural District.

1.7 Theoretical framework

This research was guided and supported by the Health Belief Model. HBM is a frame work for motivating people to take positive health actions that uses the desire to avoid negative consequence as the prime motivation. According to Glance et al (2002) HBM is by far the most commonly used theory in health education and health promotion. The underlying concept of the original HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence.

HBM supports the strategies used by Save the Organisation in their motive to reduce child mortality.SC organisation main motive was to strengthen the community participation on health through educating , health promotion, motivating , advocate and supporting the community on child health. The theory encourages people to be health educated and should participate in health activities so as to decrease the possibility of a diseases to occur in this instance the occurrence of child mortality.

Thus the HBM theory assist in explaining the role or methods used by SC in reducing child mortality and allowing the community to change their health behaviours from a negative mind to a positive one.

1.8 Definition of Terms

This section is mainly based on the definition of key terms of my research topic which reads "An evaluation of the role played by Save the Children in reducing Child Mortality rate. A case study of Malisa Zhombe Clinic, in ward 13."

- **Evaluation :** is an appraisal of something to determine its worth or fitness.

- **Role** : the position or purpose that someone or something has in a situation, organisation, society or relationship.
- **Save the children:** is an international non-governmental organisation which aims on improving lives of children. They basically encourage children to obtain their rights through the attainment of the 3ps which are provision, participation and protection.
- **Child Mortality:** child mortality can be defined as the probability per 1000 live births that a new-born baby will die before reaching age of five -under. Child mortality is measured by the child mortality rate also known as the under- 5 mortality or U5MR.the under five mortality rate is a statistical indicator of the probability for a child to die between birth and exact age of 5 and is expressed per 1000.The leading causes of death of children under five include diarrhoea, malaria, malnutrition, pneumonia and preterm Birth conditions.
- **A Case Study:** Creswell (2009) defines a case study as a research strategy, an empirical inquiry that investigates a phenomenon within its real life context.

1.9 Objectives

- To identify the rate and causes of child mortality before SC intervention.
- To overlook at the efforts made to reduce child mortality by SC.
- To evaluate the role played by the SC.

1.10Research Questions

1. What was the child mortality rate before the intervention of the NGO and what caused its rise?
2. What were the efforts made by Save the Children organisation in order to minimise child mortality rate?
3. What was the outcome of the efforts made the organisation?

4. What were the upheavals faced by Save the Children Organisation during their operation in trying to lessen child mortality rate?
5. An evaluation of the role played by Save the Children.

1.11 Justification of the study

Child mortality constitute a significant burden of disease in Zimbabwe and it is an important national challenge to reduce such burden. Being the greatest challenge affecting the community in Ward 13, this research intends to assist the MoHCC, local government, Save the Children Organisation and the community at large on how basically they can reduce child mortality .This research will benefit the community utmost as they will be able to participate in projects which will help them to have the knowledge on safe motherhood, under-five health and new born health in order to prevent child mortality. Therefore my research findings will help the Ministry of Health Child Care, Save the Children and local government Zibagwe Rural Council in planning, formulation and implementation of policy concerning the reduction of childhood mortality so as to improve the quality of child care and health.

1.12 Limitations of the study

The researcher encountered some challenges in conducting this research. To begin with, assembling the community which included women with the new born, mothers of the under-five, pregnant mothers, mothers and fathers was a difficult task since in some communities women were not allowed to attend gatherings by their husbands because they solely believe that they have the right to make decisions (patriarchal) and also some religions prevents their wives to participate in the gatherings. This was a huge barrier because the data collected was limited due to absence of other mothers in the area e.g. apostles and most of them were holding back information distressing them on the issue concerning their welfare on health due to lack of knowledge and self-confidence.

Also the researcher did not afford to acquire all the important requirements to conduct this research since it was conducted at faraway place in rural areas with poor road networks and also high travelling expenses.

1.13 Delimitations

The research was done in Kwekwe under Zibagwe District in Zhombe area Ward 13 where there has been barriers of child death. The focus of this study was to reduce the continuous rise of child mortality in order to build a future generation free from child death.

1.14 Summary

Chapter one looked at the background to the study, statement of the problem, research and research sub-questions, significance of the study and its objectives, limitations, delimitations and definition of key terms. The next chapter sets out to review related literature.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This chapter reviews information and literature that has been researched by other researchers and scholars on child mortality. The review explores the major strides that have been taken by the international, regional and local communities in reducing child mortality. There are numerous studies and articles available on the topic of child mortality and infant mortality written over the last decades. Sub-Saharan Africa and Southern Asia face the greatest challenges in child survival, and currently accounted for more than 80 per cent of global under-five deaths (United Nations Children's Fund, 2012). Several factors had been identified as contributors to the increasing levels of child mortality in most developing countries. With the aim of broadening my insight towards this research, i took note of other line of thinking.

2.1 Sub Saharan African perspective on Child Mortality

Sub – Saharan African countries have the highest child mortality rates in the world, with child mortality of 104 deaths per 1000 live births in 1990's while the child mortality rate for other less developed nations was 71 deaths per 1000 live births Kalipeni (2000). Also in line with this research Frisble's (2000) study demonstrated that even in the 2000's the child mortality rate in Sub Saharan African region remained the highest in the world at 94 deaths per 1000 live births comparison to the rest of Africa at 88 deaths per 1000 live births and 61 deaths per 1000 live births in other less developed nations. It should be noted that most of the Sub African countries are less developed hence cannot afford to solely reduce the child mortality rate due to many challenges faced, one out of every eleven Zimbabwean children dies each year before their fifth birthday. However, many multilateral institutions and non-governmental organisation have come to rescue the continuous increase in child mortality through aid. In this case Save the Children Organisation have assisted Malisa Zhombe health centre Ward 13 to reduce child death by focusing on the 3ps which are participation,

provision and protection. They encouraged or educated the community to participate in the health activities, provided the health facility with health supplies and educate the community on how to protect children from killer diseases.

Scholars such as Omariba et al, (2001) presented the evidence that social cultural factors in sub Saharan Africa have a significant influence on the high rates of child mortality. These social cultural factors include vast ethnic and religious beliefs which exist in Sub –Saharan Africa, cultural practises and beliefs effect on whether or not individual seek bio – medical forms of health care during pregnancy and when their infant is in ill-health. Supporting the thesis, in my research area of study Ward 13 social cultural factors plays a significant role in influencing the increase of child mortality especially when it comes to cultural practises and beliefs. For example members from the apostolic sector does not believe in seeking medical attention from health centres for child health instead they cure themselves using their own methods and some communities believe in seeking health treatment from traditional healers which are not 100 percent effective hence increasing child mortality.

Schell et al (2007) alluded that there is high unemployment rate in Sub – Sharan Africa which results in the inability of parents to seek medical assistance when the child is sick due to lack of finances. During my research one discovered that many pregnant women, mothers of the under-five and mothers of the new born in rural areas are not well educated and employed therefore depends on their husbands for source of income. However, due to the formulation of the user fee policy by the Zimbabwean government to be fully implemented and recognised at rural health centres most mothers could now seek health treatment for children for free. Thus children under-five and the new born now have access to free health treatment since they will be no financial barriers limiting them to access child health treatment hence the child mortality will be reduced .

Macassa et al, (2003) also stressed out that urban areas are equipped with adequate recourses while rural areas lack resources including essential health facilities. This thesis does apply in Zimbabwe where most rural areas lacks adequate health facilities as they have become deteriorated. This is evidenced at Malisa Zhombe Clinic which is experiencing poor health facilities such as shortage of drugs, shortage of health workers for example nurses and also have deteriorated infrastructure (absence of waiting homes). However due to the liquidation of the country's economy the urban health centres has also been affected because there is not enough budget to cater for health services. Therefore the outcome suggested by the above Scholars might not be the same in Zimbabwe as both rural and urban have no both recourses and resources due to the dilapidated economy.

2.2 Effects of Water sources and sanitation on child mortality

WHO (2002) reports that among the ten identified leading mortality risks in high-mortality developing countries, unsafe water, sanitation and hygiene ranked second, while indoor smoke from solid fuels ranked fourth. About 3 per cent of these deaths (1.7 million) are attributable to environmental risk factors and child deaths account for about 90 per cent of the total. Fuentes et al, (2006), found strong evidence that both interventions, improvements in water and sanitation, have a significant effect on mortality decline. In supporting the thesis, it should be noted that most rural counterparts have no access to safe water, practise poor health and sanitation due to failure by the government to develop the rural sectors with municipal water hence paving a way to child death.

2.3 Effects of Socio- economic factors on child mortality

It should be noted that social economic elements welfare of mothers or a family in rural areas differs from that in urban areas. Quoting Wang (2002) and Basu et al (2005), Magarura (2007) noted the importance of mother's education on child survival. It reflects mother's level of knowledge and skills and the degree to which she can effectively make use of the resources

at her disposal to increase survival chances of her infants. Magarura further discovered that years of schooling (education of mother) was found to be significant in influencing child mortality. Mothers with zero years of schooling were more likely to have child death than those with some years of schooling (Girson et al, 2004). It is reported that in Nigeria "mothers with more education are less fatalistic about sickness and therefore tend to seek outside medical assistance for a sick child". Women with more education increase their likelihood of securing steady, high paying employment, wield significant decision making power and control over resources (Frost et al 2005). Also women with authority are more likely to draw attention to their children's illnesses and to take a sick child to the health clinic (Caldwell 1993). Also it was indicated that education equips women with great health knowledge (Bhuiya et al, 1990) and influences women attitude about health (Castro et al, 1995)

The main purpose of this research was to discover ways in which we can minimise the continuous rise of child mortality in Zimbabwe, Zibagwe District ward 13.One tends to differ with Magarura study of Nigeria as it only concentrated on the education of women based in urban whilst women in rural still remains uneducated. During my research in Ward 13 one noted that many mothers in rural areas are not well educated. Most of them are school dropouts, some are married at an early age and some never attended to school due to financial constraints. Thus many of them lack adequate knowledge on health and sanitation. Most women lacks self-esteem hence need to be more empowered in order to be educated in order to be equipped with health knowledge. However, support with the above scholars thesis as now most women in urban are well educated and are aware of health education for their new born babies and pregnancy in order to reduce child mortality.

A study done by Kembo and Van Ginneken (2009) isolated important socio economic and demographic determinants of child mortality in Zimbabwe. The study isolates education as the main determinant in the study of child mortality in Zimbabwe and found that the impact of

mother's education had a maximum impact on child mortality. This finding is consistent with other studies, such as Zerai (1996), which found that maternal education had a huge impact on child's survival in Zimbabwe, in particular, education at a community level rather than at an individual level. One is in support of Zerai's thesis on education as indeed education at a community level allows health members to attend to everyone comments, perspectives and suggestions towards child health and ways to reduce child death rather the at an individual level where it is expensive and the population of people per village can be a challenge to the health educators. For example the role played by SC in a project of strengthening community participation on child health, training of village health workers on health, health literacy facilitators, health community monitor to further educate people per household in their villages.

2.4 Child Mortality in Zimbabwe

According to the ZDHS (2000) in the last 14 years, child mortality in Zimbabwe had shown a steady rise over the years from 40 deaths per 1000 live births to 60 deaths per 1000 live births between 2005 and 2006. Zimbabwe similar to other Sub Saharan African countries has been greatly affected by the HIV / AIDS pandemic, thus it explains significant proportion of child deaths in the country Kalipeni, 2000. However, in the case of Zibagwe District Ward 13 most communities' experiences high rates of child mortality due to social and economic issues such as lack of adequate health facilities, home deliveries and poverty. Poverty has become a great challenge to most people living in rural areas thus they cannot afford to carter for the new born leading to maternal death hence we cannot solely blame HIV/AIDS pandemic to be the cause of child mortality.

Also according to Sanders and Davis, (1998), Zimbabwe faces many challenges with regard to decreasing child mortality within the country. These include the economic insecurity, deteriorated health services and the devastating effects of HIV pandemic within the country

Zimbabwe's economy has a major impact on child mortality as it affects all sectors of a country, including the health and employment sectors, which are directly linked or associated with health outcomes Clemens and Moss, (2005).The economic crisis led to the deteriorated health system within the country Mashamba and Robson, (2001). As a result, the basic health services in Zimbabwe have decreased. Kalipeni (2000) argued that the deteriorated health services were due to decreased expenditure on health care. For example in the period 1991 t0 1994 alone, a 35% decrease on expenditure occurred. This is evidenced at Malisa Zhombe Clinic which is experiencing poor health facilities such as shortage of drugs, shortage of health workers for example qualified nurses and also have deteriorated infrastructure (absence of waiting homes).

Wang (2002) using cross-sectional demographic and health surveys concluded that at the national level, access to electricity, vaccination in the first year of life and public health expenditures can significantly reduce child mortality. In the urban areas, however, only access to electricity has a significant health impact while in rural areas, increasing vaccination coverage is important for reducing mortality. Wang thesis on effect of electricity does not apply in Zimbabwean rural communities, ward 13 however there is need to educate mothers on health issues, importance of vaccinations, hygiene and sanitation can help to reduce child mortality. For example the ministry of health and welfare carries out Expanded Immunisation Programme an outreach to rural areas which offers immunisation services to children under five in health centres very month around the District and in Ward 13.Save the Children assisted in training of village health workers on health issues who will also educate the community on child health. Also Save the Children introduced a programme of Strengthening Community Participation on Health which encouraged people to seek medical assistance.

2.5 Introduction of Child Survival Strategy

The Ministry of Health and Child Welfare of the Government of Zimbabwe has developed the Child Survival Strategy in order to deliver o proven interventions, reaffirming its commitment to significantly reduce early child mortality as promoted in the Millennium Development Goals (MDGs). The Child Survival Strategy was developed in the context of the existing National Health Strategy, and will complement other documents, including the Maternal and Neonatal Roadmap launched in 2009. The mission of the strategy was to provide comprehensive and integrated maternal, newborn and child health services by scaling up proven cost effective interventions at high population coverage through family/community, outreach and facility level care.

The mission will be realized through the successful, integrated implementation of nine strategic objectives focused on 1) increasing coverage of key interventions for universal access; 2) strengthening the capacity of the health system; 3) strengthening the capacity of individuals, families and communities; 4) mobilising and diversifying the resource base; 5) strengthening supervision, monitoring and evaluation; 6) establishing and sustaining partnerships for implementation; 7) strengthen logistics and supply chain systems; 8) establishing a coordination mechanism; and 9) strengthening multi sectoral collaboration in health. The strategy can be applauded for implementing EPI outreach programmes and training village workers making an effort to reduce child mortality rate. However, due to lack of funds and in sufficient budget on health and child welfare the strategy was no a full success.

2.6 STRATEGIES MADE IN ZIMBABWE IN REDUCING CHILD MORTALITY

2.6.1 Expanded Immunisation Programme

The Ministry of Child Health and Child Care embarked on Expanded Immunisation Programme (EPI) which is one of the key interventions aiming to reduce child mortality from

vaccine preventable diseases such as pneumonia, diarrhoea and measles which are the third, fourth and fifth leading cause of mortality in children under five years of age respectively. The government of Zimbabwe through MOHCC is committed to the immunisation programme as a pillar for child survival and improvement of the child health. At Zibagwe Rural embark on outreach of EPI which occurs every month at every health centre in trying to prevent diseases that cause paralysis, loss of hearing, infertility or death on children. EPI services are for free hence all children are required to attain them. The ZEPI has the following broad objectives:

1. Protect more children and women of child bearing age with safe vaccines

2. Accelerate the reduction of morbidity and mortality from vaccine preventable diseases

3. Introduce new and under – utilized vaccines

4. Strengthen EPI surveillance, health information and data management

5. Integrate EPI with other interventions

6. Strengthen advocacy and communication

2.6.2 Introduction of the User fee policy

The year 2012 marked a turning point for Zimbabwe's rate of women and children who die due to pregnancy or related complications as government scrapped user fees in all its clinics in rural areas. Scrapping of maternal user fees in the country has seen an increase in institutional deliveries over the years. According to UNICEF, the collapse of health care meant a woman's lifetime risk of dying of pregnancy complications stands at 1 in 42, and of every 1,000 live births, 80 children die before reaching the age of five. Thus abolishing of user fees for pregnant women and children under five have led to an improvement in maternal and child health care.

2.6.3 Zimbabwe Health Transition Fund

Zimbabwe Health Transition Fund (HTF) is a multi-donor pooled fund whose overall purpose was to improve maternal, new-born and child health in Zimbabwe. The HTF was launched in 2011 and supported efforts to mobilise the necessary resources for critical interventions to revitalise the sector and increase access to care through waiving user fees for mothers and children less than five years. Five donors raised $158 million which supported maternal, new born and chid health MNCH through strengthening obstetric and new born care as well as nutrition capacity. It also purchased medical products and vaccines. HTF was being mainly funded to clinics in rural areas in order to improve its health facilities. For example at Malisa Zhombe Clinic they used their HTF money to buy drugs, build waiting mothers shelter, renovating the clinic and furniture. Thus the HTF project managed to upgrade facilities provided at a health institute. Therefore the HTF came to an end in December 2015 having scored some victories which included lowering child mortality rates, maternal mortality rates and restoring most health facilities.

2.6.4 African Charter on Children's Rights

Zimbabwe showed its concern on children and their health hence ratified in the African Charter on Children Rights Article 5: Survival and Development which states that every child has an inherent right to life**.** African Charter on Children's rights states that every child has a right to health. Article 14: Health and Health Services states that:

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health. 2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:(a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and

malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers;(f) to develop preventive health care and family life education and provision of service;(g) to integrate basic health service programmes in national development plans;(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;(i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;(j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

It is with my research to evaluate on the role played by Save the Children in reducing child mortality at Zibagwe Rural District Ward 13.Thus bridging the gap between policy enforcement and implementation.

2.6.5 Millennium development goals (MDG) on child mortality

Child mortality is an essential indicator of child health and wellbeing. In 2000, the world leaders agreed on the Millennium Development Goals (MDGs) and called for reducing the under-five mortality rate by two thirds between 1990 and 2015 known as MDG 4 target. According to Sachs and Mc Arthur, (2005) the aim of the Millennium Development Goal is to lessen mortality in the world by up to two thirds in the year 2015.

Zimbabwe has shown a cumulative trend in the country over the past decade. It has been stated that three quarters of all child hood mortality in Zimbabwe occurs during infancy, furthermore one quarter of these deaths transpire in the first month of life Zimbabwe

Demographic and Health Survey, (2007).However, Zimbabwe approval to the MDG 4 managed slightly to reduce child mortality, to consider child's health and to carter for the child's right to survival. According to the National Status and Perspectives the under-five mortality rate declined from 102 deaths per 1,000 live births in 1999 to 84 per 1,000 in 2010/ 2011. The infant mortality rate declined from 65 deaths per 1,000 live births in 1999 to 57 deaths per 1,000 live births in 2010/2011. This reduction was so with the aid from Non-governmental Organisations such as Save the Children, Multilateral Institutions such as UNICEF.

However, Zimbabwe was incapable to meet the child mortality rate target by 2015 as the capacity of the health care system has deteriorated significantly and the MMR has increased. Rural counter parts have a higher mortality rate than their urban counter parts and the main findings indicates that socio economic status and the level of education of the mother lead to lower mortality rates for children. More efforts and investment are required to strengthen the health care system and scale up coverage of maternity waiting homes, including adopting and implementing pro poor, predictable and enhanced health financing policies and mechanisms

2.7 Progress in the MDG era

Major progress has been done in tumbling child mortality all over the world. Receptively, this progress has been hastening in recent years and has saved millions of lives of children under the age of five. According to the UN Inter agency Group for Child Mortality Estimation the number of the under five deaths worldwide has declined from 12.7 million in 1990 to 5.9 million in 2015.Since 1990, the global under five mortality rate has dropped 53 percent from 91(89,92) deaths per 1,000 live births in 1990 to 43 (41,46) in 2015. The world as a whole has been progressing in reducing the under-five mortality rate of reduction increased from 1.8 percent in 1990- 2000 to 3.9 percent in 2015. It should be noted that developed countries have

low mortality rates due to well-developed economy thus they are able to cater for the welfare of children under five and also acquire aid from donors and organisations.

Also Sub Saharan region with the highest under five mortality rate in the world has registered its annual rate of reduction increased from 1.6 percent in 1990's to 4.1 in 2000-2015. Most of the countries which adopted the MDG 4 and 5 have experienced great reduction in the mortality rate and also with the aid from Non-Governmental Organisations and Multilateral Institutions such as Save the Children and World Health Organisation which contributed to the progress of the programme. However, many African countries are still facing a great challenge of maternal death because they are less developed and unable to cater for the health welfare of children due to the poor economy.

2.8 Summary

This chapter gave an overview of the literature available concerning perspectives on child mortality causes together with strategies used around the globe including Zimbabwe. Various thoughts and strategies have been drawn regarding the ways to reduce child mortality and has been used to indicate how the Ministry of Health and Child Care can configure to support its mission. The next chapter focuses on the rationale behind the methodology used and indicates how the research was conducted.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

Chapter three explains the rationale behind the methodology used and indicates how the research was conducted. The nature of this study is a qualitative research. In order to capture

and understand the strategies done by Save the Children in reducing child mortality, qualitative methodology was used which Bailey (1982) claims, allow researchers to look at people and settings wholly. This means the researcher was in a better position to evaluate successes and failures of how Save the Children programs managed to reduce the child mortality rate at Zibagwe Rural District Ward 13 community. It further explains the steps that were taken to ensure data gathering was properly done. As such, the research design, data collection instruments, the population, sample and sampling techniques, procedures of collecting data, data presentation and analysis sum up the chapter.

3.1 An Overview of Qualitative Research

The research was qualitative in nature. Qualitative research methods are usually associated with inductive approaches that are based on empirical evidence. Babbie (2004) notes that qualitative analysis involves a continual interplay between theory and analysis, thus employing such survey one is able to discover patterns such as changes over time or possible causal links between variables.

Burns and Grove (2003:19) describe a qualitative approach as “a systematic subjective approach used to describe life experiences and situations to give them meaning”. Parahoo (1997:59) states that qualitative research focuses on the experiences of people as well as stressing uniqueness of the individual. Holloway and Wheeler (2002:30) refer to qualitative research as “a form of social enquiry that focuses on the way people interpret and make sense of their experience and the world in which they live”. Adopting a qualitative approach for this type of research will help to explore the behaviour, perspectives, experiences and feelings of pregnant mothers, mothers of new born babies, mothers of the under-fives and the community at large towards the increasing of child mortality in the area.

The rationale for using a qualitative approach in this research was to explore and understand the challenges faced reducing child mortality. A qualitative approach would be appropriate to capture the opinions, views and responses of community regarding ways of improving health services and upgrading health institute in order to reduce child mortality. It further explains the steps that were taken to ensure data gathering was properly done. As such, the research design, data collection instruments, the population, sample and sampling techniques, procedures of collecting data, data presentation and analysis sum up the chapter.

3.2 Research Design

Burns and Grove (2003:195) define a research design as “a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings”. Parahoo (1997:142) describes a research design as “a plan that describes how, when and where data are to be collected and analysed”. Lewis (2003) identifies some of the dimensions of a research process as the ‘practical constraints of time and money and the reality of the research context and setting. ‘Following from this definition of a research design, this research is designed as a case study.

Gerring (2007) defines a case study as ‘the intensive study of a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases (a population). Yin (2003) also argues that a case study ‘… investigates a contemporary phenomenon within its real-life context …and that the boundaries between phenomenon and context are not clearly evident’. He further argues that a case study ‘relies on multiple sources of evidence’ and a ‘prior development of theoretical propositions to guide data collection and analysis.’ In a case study, the data collection methods (e.g. interviews, observation and documentary analysis) are often of a qualitative nature (Neuman, 1994, Lewis, 2003). In addition the researcher has no control over events. Moreover, Yin again argues that a case study is often answered by ‘how’

and ‘why’ questions although ‘what’ questions can also be asked, particularly in an exploratory way (Robson, 2002).

The focus of the research was to evaluate of the role played by Save the Children in reducing child mortality and the use of a case study was for understanding the complexities attached to the implementation and effectiveness of such challenges faced of child deaths. There is a need to look at the role played by Save the Children in trying to reduce the continuous increase of child death in rural areas.

3.2.1 Limitations of a case study

Like all other researches, case studies have their own limitations caused by the integrity and sensitivity of the investigator (Reis, 2009). The researcher is the primary instrument of data collection and analysis. Although it has minimal advantages, training in observation and interviewing though necessary, is not readily available to aspiring case study researchers. Nor are there guidelines in constructing the final report. The researcher is left to rely on his or her instincts and abilities throughout most of this research effort. ‘Further the limitations involve the issues of reliability, validity and generalizability. Humel (1993: 23) observes, the case study has basically been faulted for its lake of representativeness…and its lack of rigor, construction, and analysis of the empirical materials that give rise to this study. He goes on to argue that this problem of rigor is linked to the problem of bias…introduced by the subjectivity of the researcher and others involved in the case. ‘Both the readers of case studies and the authors themselves need to be aware of biases that can affect the final product.

3.2.2 Longitudinal research design

The researcher also used the longitudinal research design or approach. According to Schwartz E. (1999), the design illustrates the impact of health state changes on an individual’s quality

of lifewhich has gained increased attention in social and medical clinical research. In an effort to stimulate research on response shift, the design present methodological considerations and promising assessment approaches for measuring it in observational and interventional clinical research. The design describe and evaluate individualized methods, preference-based methods, successive comparison methods, design approaches, statistical approaches and qualitative approaches. In a bid to obtain findings the researcher was able to observe longitudinal difference in the mortality rate from the period of 2012 to 2015. Thus the design was used to do comparisons of the child mortality rate before the intervention of SC organisation and changes brought down after the organisations innervations.

3.2.3 Population

Ruttiend (1990) defines population as the total of all members from which the sample is selected. In this study population are all individuals or members of particular concern. The population for this study was made up of 50 members which consist of 10 pregnant and nursing mothers, 15village health workers, 10 health workers and 15 representatives from government ministries at Malisa Zhombe Health Centre Ward 13. Out of the whole population, the researcher only managed to use 10 pregnant and nursing mothers, 10 village health workers, 10 representatives from government ministries5 health workers and 5 officers from Save the Children.

3.3 Data Collection; methods and process

The researcher used qualitative data collection methods, observing a complete picture of the case being studied. Main methods that were employed as data gathering instruments were interviews, focused group discussions and observation.

For a practical appreciation of health programmes, focus group discussions were held by village health workers, representatives from government ministries, health workers and

pregnant and nursing mothers while information was being recorded when SC officers were explaining the importance of strengthening community participation on health in order to reduce child mortality in the Ward. Rays (2004) defines focused groups discussions as a conversation with specific inclination for generating concepts. For the purpose of this study, focus group discussions were used as they were more time saving than interviewing participants individually. These discussions allowed the participants to say out their views and they were used in the mother language (Shona) and it was an advantage to those who were literate as they were able to understand what was being asked.

3.4 Research Instruments

This section discusses the data collecting instruments used during field work carried out at Zibagwe Rural District Ward 13 Malisa Zhombe between August and September 2015. Data for this research came from secondary and primary sources. First, secondary data (e.g. published books and journal articles) informed the conceptual and analytic framework discussed in chapter 2 and in the analysis of child mortality as a whole. Second, primary data (e.g. interviews, focused group discussions and observation) were employed as data gathering instruments.

3.4.1 In-depth Interviews

Data was collected through one-to-one semi-structured interviews. Semi-structured interviews, as Robson (2002) describes them, have predetermined questions which can be modified, re-worded, explained to the interviewee, or omitted as when the situation is deemed appropriate. Semi-structured interviews are often contrasted with structured interviews that have predetermined, but fixed worded questions and unstructured interviews that have no present questions. One of the disadvantages of structured interviews is that they can constrain a conversation and often interesting data can be ignored. On unstructured interviews, Denscombe (2003) argues that the discussion risks straying away from the focus of the study

and the interview also requires more time which more often than not the researcher might not have. For the above reasons against structured and unstructured interviews, semi-structured interviews were preferred over the other two types for this research.

The semi-structured interviews were intended to answer both research questions of the research because of the emphasis put on subjective meanings and interpretation of social reality by research participants. A semi-structured interview, as Legard et al. (2003) argues, permits interviewer-interviewee interaction that has greater potential to generate new revealing data on a subject. In this context, as Robson (2002:272) argues, semi-structured interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives.

However, semi-structured interviews as a data collection technique have disadvantages which are also shared by other types of interviews. For instance, small sampling caused by a biased selection of informants may distort the objectivity of a wider population. The researcher may also misinterpret data given by informants due to his or her preconceived viewpoint about the subject of research Mikkelsesn,(1995). In addition, face-to-face interviews are often criticised for unmaking the 'natural setting' necessary for the interviewee to give unbiased or self-censored responses to questions. There is also the risk of the researcher asking leading questions hence compromising the validity and quality of the research (Creswell, 2003:186; Legard et al., (2003). The solution to the above drawbacks of the interview technique might, as Robson (2002) argues, just as well depend on the professionalism of the researcher and the training on interviewing techniques or research methods in general.

In this study, the researcher used the topic guide approach during the interviewing process to overcome some of the problems identified above. Arthur and Nazroo (2003) define an interview topic guide as a framework that identifies broad topics or themes to be explored. It helps to ensure that relevant issues are covered systematically and with some uniformity,

while still allowing flexibility to pursue the detail that is salient to each individual participant (Arthur and Nazroo, 2003). For this research and in broad terms, the guiding topics and questions focused on the attributes of child mortality in the area.

In order for the researcher to triangulate information obtained from the questionnaires the researcher carried out in depth interviews with the SC members, village health workers, Health workers, Government ministries for example representative from Ministry of youth and representative from ministry of women, community and pregnant mothers and nursing mothers. The interviews were handy as they helped the researcher in finding information about personal feelings, perceptions and opinions as people were given a chance to air out their views in this case even suggest further recommendations. These interviews were also not influenced by others in the group since respondents were able to individually express their views. However the interviews also had their own loopholes, the researcher realized that participants will in some cases give biased information and some showed little knowledge about the topic in discussion meaning that the respondent wouldn't be in a position to give answers to a number of questions.

3.4.2 Observation

The research also utilised observation as a data collection method. Ritchie (2003) and Burns (2000) posit that the technique of collecting data using observation is often associated with anthropology and ethnography researchers, where the aim is to observe a community or group of people over an extended period of time, months or years. However, this research is not of any of these designs and therefore did not enjoy the privilege of an undefined time span for collecting data. So, how was observation used in this research? To begin with, observation is an unavoidable process of collecting data when one engages directly with research participants. As Yin (2003) argues, 'by making a field visit to the case study ''site'', the researcher is creating the opportunity for direct observations. Hence… some relevant

behaviours or environmental conditions will be available for observation.' There are therefore two ways in which observation was used in this research. First, the researcher was attached to Zibagwe Rural Council and went to workshops with Save the Children as well during the work related working and therefore worked towards strengthening community participation on health. In a sense therefore, an analysis of the role played by SC in reducing child mortality is the lived experience of the researcher. Naturally, there are dangers of a subjective or biased-approach to a subject that one is part of it. To allay these fears, the researcher adhered to the dictates of academic research. Thus, direct observation in this first usage did not entail that the researcher should be literally present at all activities.

During the process of collecting data at Malisa Zhombe Ward 13 community, the researcher was able to 'observe' the interaction of services provided at the clinic and the community participation towards child health and health at large. Thus when interviews or focus discussion were encountered one was familiar with what was being suggested or discussed since one had a baseline survey.

3.5 Sample

Strandes (1998) defines a sample as a group of subjects from which information is obtained and is representative of the entire population under study. In this research, the sample comprised of 5 Malisa Zhombe Health Workers, 10 Village Health Workers, 10 from government ministries and 10 mothers who were selected using the non-probability sampling method.

3.5.1 Sampling Procedures

Ritchie et al (2003) argue that a researcher cannot study all cases or units that make up the study population. Instead, the researcher needs to design and define a sample population to be representative of the study population. An important criterion for designing and defining a sample population, Ritchie et.al (2003) argue, is that the process must 'stand up to

independent scrutiny.' Mason(2002); Ritchie et al(2003),all see sampling as a process of identifying and selecting relevant sources of data (e.g. people, organisations, settings, actions, etc) and discussing the rationale for choosing a case (or cases) and for rejecting others. There are two broad models of sampling: probability and non-probability sampling. Ritchie et.al (2003:78) argued that probability sampling is the preferred model by quantitative researchers who aim to ensure that all cases in the study population have an equal probability of being selected into the sample population so that the sample can statistically be generalised to a wider population. Because probability sampling is suited for quantitative studies, I did not use it to select the sample population of this research.

I employed the non-probability sampling model. This model does not aim to achieve any statistical representation of cases. As Ritchie et. al (2003) argue the sample units are chosen because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study. There are two types of non-probability sampling – theoretical and purposive. Theoretical sampling is common in grounded qualitative research designs. It entails a stage process sampling, where the first sample generates categories and theories that are refined by the next sampling process, and the next, until a point of 'data saturation' is reached. At each given stage of sampling, emphasis is placed on 'theoretical purpose and relevance' of the sample unit (Glaser and Strauss, (1967); Ritchie et. al, 2003). This model was deemed inappropriate and the researcher used the purposive sampling model to select the sample population.

Purposive sampling is also discussed in various literature as criterion based sampling (Ritchie et. al, 2003) or strategic sampling (Mason, 2002). Ritchie et. al further argue that the criteria for choosing samples are dependent upon the research questions or the themes to be explored. The sample must aim for diversity so as to explore all possible strictures or factors of the subject as well as to allow in-depth analysis of interdependent variables. In terms of the

sample size, less or equal to fifty [50] is desirable because ‘much larger than 50 [the sample] start to become difficult to manage in terms of data collection and analysis that can be achieved’ (Ritchie et. al, 2003). The third criterion alludes to the advantage of flexibility as the researcher can add more sample units whilst in the field. Hence it was useful for the researcher to use purposive sampling to interview the village health workers at Malisa Zhombe Heath Centre in Ward 13 as they have direct links with the pregnant women, mothers of the under-five and those with new born in improving skilled care to mothers during pregnancy and after birth which greatly contributes to child survival and could give accurate information on what actually happens in the community basically what constitutes to high child mortality in the area since they are familiar with the areas. In order to achieve purposive sampling, village health workers, health workers, SC members and pregnant and nursing mothers were identified and thus availed for in-depth interviews and focus group discussions.

3.6 Data Presentation and Analysis Procedures

Following data collection, compilation and analysis was done. The data was presented qualitatively and the researcher used bar graphs, pie charts, tables and descriptive approach to data presentation. Data was presented in themes and in line with important aspects to consider which arose from the research question. Oliver (2000) highlights that; recurring themes are the main issues in the study, hence in this study the collected data was presented in themes and categories to answer the broad questions of the research.

3.7 Research Ethics

Assurances were given both in oral and in written form that information gathered would be used solely for the purpose of the study. Walsh (2001) says it is ethically sound to obtain informed consent from all participants. Participants in research were freely giving their free

consent to be involved and the aims of the research were explained prior to the research. Participants voluntarily agreed to participate in the research.

Confidentiality on the part of the participants was highly observed. Walsh (2001:p57) says that it is important in any research work to protect the participants' right to privacy and confidentiality. According to Haralambos and Holborn (2008) social scientists have to disguise the identity of participants where possible to guarantee confidentiality. Thus in this research, questionnaire respondents were instructed not to write their names or signature on questionnaires to conceal their identity. Ethically social researchers are expected to avoid harm or discomfort on respondents (Haralambos and Holborn, 2008). This research made every effort to promote the comfort of the participants. A local language that is Ndebele and Shona were used where applicable to enhance communication and the comfort of the participants. Appropriate dress code was adhered to, to enhance optimum cooperation of participants. Pictures are only attached in the research with the consent of the participants.

3.8 Research Structure

The research is structured into five chapters. Chapter one brings out the problem and its setting, containing the introduction, background to the study, statement of the problem, research objectives, and research questions, justification of the study and limitations of the research. Chapter two contains literature review. The third chapter is on methodology, explaining the methods used to extract information, and then the fourth chapter is on analysis, data presentation and interpretation. The fifth and last chapter contains the summary of the study, conclusion and recommendations.

3.9 Summary

The chapter provides an overview of how the procedure was undertaken showing also that it was a qualitative research which relied on in-depth interviews, focus group discussions,

observation and document analysis for data collection. A section of the participants was highlighted and the technique used to choose them was purposive sampling.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.0 Introduction

Chapter four contains data presentation and a concise discussion of the responses produced from in-depth interviews, focus group discussions and observations contrasted against reviewed literature and academic opinion cited in preceding chapters. Data is going to be presented in recurring themes which Oliver (2000) defines as the main issues recurring throughout the study. Data is in the context of evaluating the role played by Save the Children in reducing child mortality and will be presented as data from interviews, focus group discussions and observation.

4.1 Interviews

The researcher conducted interviews at Malisa Zhombe Clinic regarding the project of strengthening community participation on child health formulated by Save the Children and how it has contributed to the reduction of child mortality. It should be noted that many mothers in rural areas still lives in the past as they are still backward especially in their beliefs pertaining health knowledge and importance of seeking medical attention. Responses from the community showed that the community benefited a lot from the project as many mothers attained education on health, importance of seeking medical assistance earlier and also importance of participating on child health. The following groups were being interviewed: 10 village health workers, 10 pregnant mothers, 10 representatives of government ministries and 5 health workers. The following responses were highlighted in the table.

Table 1: showing responses from interviews

Respondents population	Sample size	Response	Positive ratings	Negative ratings
Village health workers	10	10	9	0
Pregnant mothers	10	10	8	2
Representatives government ministries	10	5	4	1
Health workers	5	3	3	0

Source :(Primary Field work) Ratings of strengthening community participation on child health programme by SC

The table above shows the ratings of the strengthening community participation on child health programme at Malisa Zhombe Clinic. The sample size of 10 pregnant mothers, 10 village health workers, 10 representatives' government ministries and 5 health workers was taken. Although most respondents responded to various questions they were asked, it was difficult to get responses from representatives from the government ministries such as ministry of youth and ministry of education as they were occupied with other works. However, it can be noted that most pregnant women, villages and nurses were in support of the project of strengthening community participation on child health as not to compromise the life of the future generation. Out of 10 pregnant mothers 8 of them responded positively towards the programme and they vowed to continue supporting as it concerns their child's health and also educating them on the importance of delivering at the health institution whilst the other two were against the project due to their religious beliefs for example the apostolic

sect of Johane Marange do not believe in seeking medical attention from the hospital but rather practise their own medication.

Adding more, out of 10 village health workers 9 respondents responded positively towards the project of strengthening community participation on child health. The trained village health workers educated the community on child health, encouraged pregnant women to go for check-ups and to deliver at the clinic for safe delivery. Thus the project became success through the trained village health workers who encouraged community participation on health hence reducing child mortality. During the interviews one mother of a new-born said, "I benefited from the education that the village health worker gave me on hygiene and sanitation and also on importance of immunising my child despite the fact that l did not go to school". Thus the village health workers played an essential role in educating the community at a community level.

More so, the representatives of the government ministries respondents responded positively to the project were four ministries for example ministry of education, ministry of youth and ministry of health appreciated the programme as they spread the advantages of seeking medical attention from a clinic. However, one group of respondents from the ministry of ZINATHA in the area refused to participate as they only believe in traditional healing.

Out of 5 health workers which the researcher expected only 3 were present due to shortage of health workers at the clinic. The health workers appreciated the project as it produced good results to pregnant women, mothers of the new born and the under-five who were turning up at the institution to seek medical attention. The respondents who were in favour of the programme were only 3 and on the negative side there was 0. The health workers were prepared to work with the community in order to build a strong future generation free from child mortality.

4.2 Discussion

It was essential for this research to also analyse services offered at the Malisa Zhombe Health Centre, causes of child mortality and way forward in reducing child death. In a focus group discussion, pregnant women, mothers of the under-five had complains towards services offered at the clinic. They complained about the following issues: failure by the health workers to open the clinic and serve on time as some will be travelling long distance to the clinic, shortage of drugs and poor reception. This is supported by one pregnant woman who commented on the services provided during the discussions saying she travelled 10km from her homestead to the clinic for a check-up and the clinic was still closed around 8.00am and was later on opened and attended by a nurse aid who was unreceptive. However, some respondents valued the reception they were being provided by the health workers especially pregnant women as they will be waiting for their delivery day in the mothers waiting home.

Also during the focus group discussion it was discovered that home deliveries has become a major challenge causing child death in the area. In response to such issue most women supported the banning of home deliveries by the community and if one commits such a crime a fine will be charged. Existence of women in the community who are still delivering at home has become a burden to the community as it will be having a negative impact towards child health. However the community agreed in enforcing a law which prohibits home deliveries which is a fine of a domestic animal. In supporting this the councillor emphasized that,

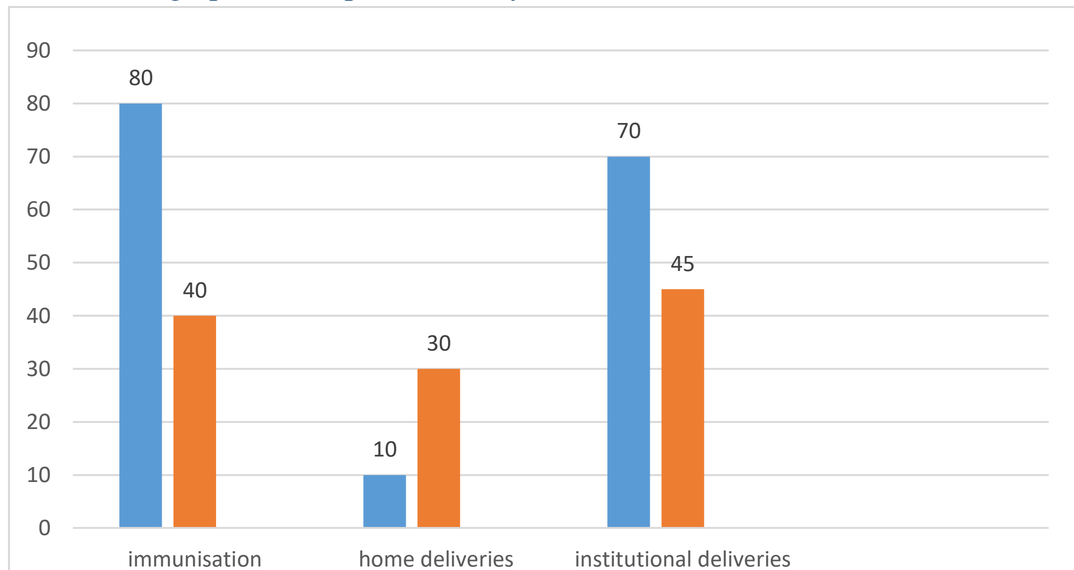
“If any woman delivers at home a goat or a cow will be charged so all women are required to deliver at the clinic”

Therefore the enforcement of such a law in the community encourages or pushes women to practise safe delivery by visiting a medical institute hence reducing child death.

More so, during focus group discussions the respondents were complaining on the issue of long distance travelling to the nearest health centre. In ward 13 there is only one health centre covering about 17 villages and some are far from it. Thus it has become a barrier especially for the sick children as they are failing to travel on foot to the near health centre as there are no vehicles to transport them hence contributing to the failure of accessing health on time. During the discussion a mother of five complained of travelling from her homestead to the health centre as she covered about 15km to the clinic which is a huge challenge. Therefore the discussion assisted in recognise challenges being faced by the community towards attaining health services.

Thus the discussions attained benefited both the community and the health workers in creating a better working environment, identifying problems faced by the community, identifying possible solution as a community and reducing the probability of losing a child through unsafe delivery.

4.3 Bar graph 1: Comparative analysis of child health services from 2012 to 2015



KEY

Source: field work

The diagram above shows the results of child health services offered at Malisa Zhombe clinic during the years 2012 and 2015 of Save the Children's project of strengthening community participation in child health.

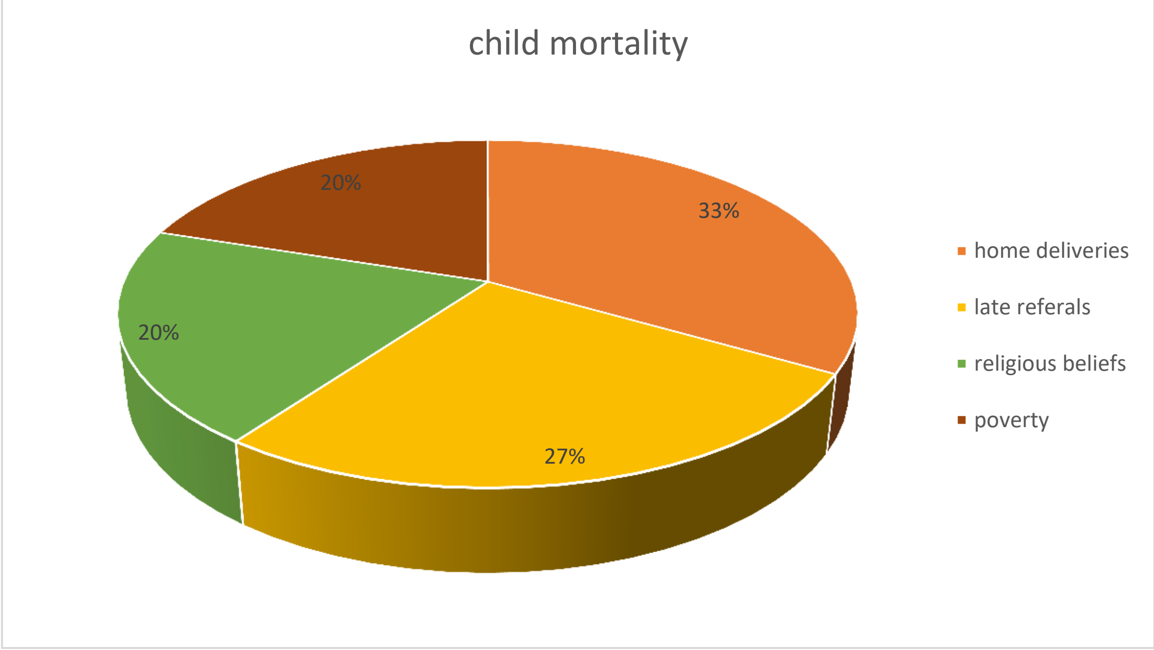
In terms of child health, the data shows there was a decrease in the immunisation, institutional deliveries and an increase in home deliveries during the year 2012 before the intervention of SC. The immunisation rate during 2012 was 40 %, home deliveries was 30% and institutional deliveries was 70 %. The decrease in immunisation was due to lack of funds and drugs and institutional deliveries was due to travelling of long distance and lack of money to pay for maternity fee and also high home deliveries due to religious beliefs, poverty and lack of

knowledge. However, during the year 2015 there were changes in the immunisation with 80% and institutional deliveries with 70% as the clinic was being funded and donated drugs, construction of waiting mother's shelter and health equipment by Save the Children and other non-governmental organisation. Also home deliveries reduced to 10 % due to payment of fines if one delivers at home, advocacy and education obtained from Village Health workers who were trained by SC and Ministry of Health and Child Care thus home deliveries reduced by 30% which was a great achievement. The positive results shown led to the decrease in the child mortality of the clinic hence SC should be applauded for managing to reduce child mortality.

4.4 Causes of child mortality at Malisa Zhombe Clinic

Malisa Zhombe Clinic in Ward 13 has reported that child mortality in their area has been due to the following challenges: home deliveries, religious beliefs (apostolic sect), failure to acquire immunisation, poverty and late referrals. These are the main challenges causing high child mortality at Malisa Zhombe Clinic.

4.5 Pie Chart: Causes of Child death at Malisa Zhombe year 2015



Source: Primary (field work) results showing main causes of child mortality in Ward 13.

The data shows the causes of child mortality at Malisa Zhombe during the year 2015. Home deliveries had the highest percentage of child deaths consisting of 33%. During the research one discovered that most women in the area practise unsafe delivery at home due to (mbuya nurse). People in rural areas are still backward and believes that their method of delivering a pregnant woman at home is safe. Thus home deliveries at Malisa Zhombe community has resulted to causing loss of lives in children due to unsafe delivery practise. Late referrals has been recorded as the second highest cause of child death at the clinic with 27%. It should be noted that there has been four reported cases at the clinic of pregnant women who have lost their babies after being late referred to District Hospital. Malisa Zhombe clinic it's a small health centre which does not practise complicated deliveries hence should quickly transfer a patient if a problem is encountered. Religious beliefs of the apostolic sect has also compromised the health of their children with about 20% recorded deaths. The apostolic sect does not believe in seeking medical attention for a child hence their children are not immunised leading to the seven child killer diseases which results to a death. Lastly poverty with 20% has also resulted to child deaths as most of the families in the area are poor and less privileged. Due to the poor economic situation in the country most parents are not employed hence strive to have access to adequate food. Thus failure to provide food to a child results to death.

4.6 SC INTERVENTIONS IN REDUCING CHILD MORTALITY

Save the Children works to improve maternal, new born, infant and child health and survival in the most vulnerable communities around the world by targeting the major causes of death and providing access to high impact, low cost care that saves lives. They help to train and keep front line health workers to deliver care in the health sector and are dedicated to ensuring children's voices are heard and their needs are addressed giving them a best chance for a healthy productive life through the power of policy analysis and advocacy. Basically SC

promotes children rights through the attainment of the 3ps which are protection, participation and provision towards child health.

4.6.1Training work shop for village health workers, HCC, HLF and community monitors

SC organised a training workshop for the village health workers, health Centre Committees, Health literacy facilitators and community monitors. The main aim of the work shop was to train these members on child health issues and to later pass on the same information to the community. Basically these members were representing the community of Malisa Zhombe. During the training workshop all members were trained or reminded on their roles, duties and responsibilities towards strengthening community participation on child health.

The village health workers plays a significant role in the community as they work hand in hand with the community or are the inter mediator between the community and health workers for example nurses. Village health work is a community based initiative to provide basic maternal and child health skills through local trained teams. Thus the organisation helps to strengthen local delivery of family planning education and services, especially to adolescents. Examples include training community health workers to provide a wide range of methods including injectable contraception.

The role of HCC members is to educate women on maternal, new-born and child health information, educate patients on patient's charter, encouraging people to visit clinic and also to take care of the welfare of health workers. HCC also develops strategies to deal with emergency cases involving pregnant women. For instance during the interviews conducted at Malisa Zhombe Clinic a mother of a two months baby appreciated the role played by the HCC in helping her to get a quick transport to the District hospital after given a referral as she was facing complications for her delivery. HCC members are supposed to meet every month to give feedback from the community.

The role of the HLF is to teach the community to be able to read and write about health, to improve communication, teach people on patients charter and knowledge on health cases. During interviews most pregnant women appreciated the user fee policy as they were no longer paying at the clinic when seeking medical attention.

Picture 1 **taken by Fadzayi Zirobwa: showing training of Village Health Workers at Malisa Zhombe clinic**

The fig above shows the training session of the village health workers, HCC members, Community Monitors and the HLF by Save the Children Organisation.

4.6.2 Child health education and advocacy

The SC organisation provided child health education on pregnant women, new borns and under five. Mothers were educated on the importance of immunisation in order to prevent seven killer diseases that might occur to a child. Immunisation services are for free to every child hence they are encouraged to attain the services. Socio-economic factors including immunizations, exclusive breastfeeding and the adoption and usage of insecticide-treated nets have been revealed by several studies have strong predictors of child mortality

Also women were educated on health and sanitation as lack of it may result to child death. Availability of balanced diet food results to a healthy child and lack of it may result to kwashiorkor which will rapidly cause death.

SC advocated for the women to have the knowledge about the User fee policy and patients charter. Patients Charter reviews about the rights and responsibilities of a patient at a Health institute. Also the user fee policy allow pregnant women to get medical assistance for free.

SC educates people to understand and overcome practical and cultural barriers to better reproductive health practices by communities and health care providers. Also SC educates women to be independent and be able to take care of their children's health.

4.6.3 Provision of services

In the area of study, Save the Children provided services to the clinic and the community to boost health services of the community. At Malisa Zhombe Health Centre the organisation built mothers waiting home for pregnant women till their time of delivery especially to those who travel long distance and also for constant check-up of the baby so as to avoid loss of a child. It should be noted that some of the villages are located far away from the community and there is only one clinic hence it becomes risky to pregnant women. Thus the construction of the mother`s shelter and toilets for hygiene and sanitation was a huge advantage and assist in reducing the death of children. The organisation donated 10 beds for the new mothers waiting homes for them to feel more secured.

The organisation also sponsored the health facility with drugs and money to buy equipment for health facilities needed in order to provide good services needed for the community.

During an interview at the clinic one of the pregnant women appreciated the efforts made by SC in building the mothers waiting home and their donation of beds as she was waiting for her time of delivery.

Picture 2 : **Showing the mothers waiting home constructed by SC picture taken by Fadzayi Zirobwa.**

Source: field work

The diagram above shows the opening of Zhombe Malisa mothers waiting home constructed by Save the Children organisation.

4.7 Results after SC's intervention

Save the Children Organisation and Community Working Group on Health work in partnership with the Ministry of Health and Child Care to implement the project of Strengthening Community Participation on Health. This project contributed to the increase of the number of patient's especially pregnant mothers, new borns and those under the age of five turn up to the Malisa Zhombe Clinic. Also participation of the community on health and nutrition issues increased.

It should be noted that the community became health educated and health conscious due to the attainment of education provided by the trained Village Health Workers, HCC, HLF and community Monitors.

The encounter of the SC resulted in the reduction of child mortality in the area especially the deaths of children being delivered at home (home deliveries) and also children's nutrition and health increased due to the effective training of the Village Health Workers who educates and monitors pregnant women , newborns and the community at large.

Improved policies, enhance systems and services and build local capacity for health care providers to provide respectful maternity care to all girls and women. For example the organisation managed to educate women on the patient's charter in order for them to observe their rights as a patient. Also they educated the community to upgrade their health institute by providing volunteering services such as making the environment of the clinic is always clean, fetching water for the pregnant women at the mothers waiting home and creating professional relationship between the community and the health workers.

Increase in the health and sanitation awareness. It should be noted that most women became aware of good health and sanitation practises such as having access to clean water and giving their children a balanced diet.

4.8 Effectiveness of the role played by SC

After a thorough research Save the Children can be applauded for making an effort to reduce child mortality rate at Malisa Zhombe clinic in Ward 13. It managed to reach out to their aim of strengthening community participation on child health by 2016. The organisation in collaboration with other non-governmental organisations , multilateral institutions and the ministry of health child care have successfully managed to reduce the mortality rate at Malisa Zhombe , Zibagwe District and Zimbabwe at large. The number of children who die due to

poor services provided at the clinic, home deliveries, poor hygiene and sanitation and failure to acquire immunisation decreased abruptly. SC provided with education services, funds, donations, training workshops and advocating which managed to upgrade services offered at a health institute and also increased attendance of people seeking health aid.

4.9 Challenges encountered by SC during their operation.

The organisation faced a few challenges in trying to reduce child mortality in Ward 13. Problems encountered most was lack of funds from its donors. SC did not only provide services to Malisa Zhombe clinic in Zibagwe but also worked in 21 other Districts in Zimbabwe thus it became a challenge for them to fully fund for health facilities at Malisa Zhombe .

Lack of funds from donors is also another challenge being faced by the organisation as they cannot full provide for the less privileged especially those in the rural sector.

Also there was some cultural groups for example people from the apostolic sector which did not participate in the programme due to their belief of not seeking medical attention from health Centres . Thus it became a challenge in the sense that they did not fully strengthen the community in participating on health.

4.10 Challenges faced by Malisa Zhombe clinic in reducing child mortality

Due to the deteriorating of the Zimbabwean economy the government budget for the Ministry of Health Child Care have not been enough. Such an economic situation has led to so many challenges to many health institutions.

At Malisa Zhombe Clinic have been experiencing shortages of drugs, vaccines, health equipment and qualified health workers. For instance there is only one qualified nurse at the clinic who serves about 15 villages from the whole community.

Community Challenges in Accessing Health Services there are also challenges being faced by the community in accessing health services for example distance to the clinic, some mothers are walking 30 km to the nearest clinic. This becomes a barrier to many people in the community to have access to health services and also leading to home deliveries.

Transport or shortage of ambulances in the district. It has been discovered that only one ambulance cover the whole 24 rural health centres in Zibagwe District. Referral patients are facing a challenge of having access to transport hence are being urged to hire private transport hence becoming a huge barrier since most of the mothers in the rural areas are unemployed and have no source of income. Thus shortage of ambulances to transport referral patients to the District Hospital has become a barrier to the health institute at Malisa Zhombe area.

Deteriorating of infrastructure is also a challenge being faced. The government premises have become deteriorated and the available one cannot accommodate many patients because the government does not have funds to improve quality of services offered at the clinic.

4.11 Summary

Chapter 4 presented a summary of the findings from qualitative data collection method used to gather information for the assessment of the study. Generally it was noted that SC played a significant role in reducing child mortality at Malisa Zhombe Clinic and also strengthened the community participation on child health as shown above.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The previous chapter covered data presentation, analysis and interpretation. It is worth mentioning that data display is important but of greater importance is the interpretation of the data as this gives meaning and weight to facts and figures obtained during the research process. This chapter focused on the summary of the study, conclusions drawn in relation to the objectives of the study and recommendations.

5.1 Summary of the study

The study evaluated the role played by Save the Children organisation in reducing child mortality rate at Malisa Zhombe Clinic, Ward 13. It was set against the background that child mortality was alarmingly high despite the fact that the Ministry of Health and Child Care has embarked on child health strategies that strive to reduce child death. Thus, the study was guided by the following objectives:

- To identify the rate and causes of child mortality before being intervened.
- To overlook at the efforts made by Save the Children in reduce child mortality when intervened.
- To evaluate the role played by the NGO.
- To give recommendations for improvement and offer solutions in which the child health can have a productive life.
- Also the Health Belief Model theory was useful to understand the interventions made by SC organisation in an attempt to reduce child mortality has the community were giving positive responses towards the project implemented by SC organisation of strengthening community participation on health.
- The research broadly established the reality that Zimbabwe has been facing economic challenges which resulted in the deteriorating of health facilities and health services

particularly in the rural counter parts. Such results contributed to the decrease of child health (life expectancy) and increase of child mortality. Child survival strategies implemented by the government were not fully effective due to the lack of funds for example the user fee policy in some clinics pregnant women are still paying in order to be served. Effective child health strategies indulged by the government were the launching of Expanded Immunisation Programme specifically in Rural Districts and also the global Health Transition Fund assisted in boosting child health and health services. However, with the aid from the NGO's Save the Children in this instance managed to improve the child health in the community and also reduce child mortality from its peak by strengthening the community participation on child health.

5.2 Evaluation of the role played by Save the Children

5.2.1 Successes

Save the Children played a significant role in reducing the high levels of child mortality at Malisa Zhombe Health Centre in Ward 13. The organisation assisted the community by empowering women through educating them health issues, removing financial for example the user fee policy, social barriers to accessing basic services, developing innovations that make supply of critical services more available to the poor increasing local accountability of health system interventions that have allowed health system to improve equity and reduce child mortality. Thus the community of Malisa Zhombe benefited a lot from the organisation through the attainment of the 3ps which are participation, provision and protection of children under five.

5.2.2 Challenges

The organisation faced some constrains during their operation such as religious and social barriers. Religious constrains were that of the apostolic sect of Johane Marange who were not willing to participate in the health issues. The sect religious belief does not allow its followers to seek medical attention hence creating medical challenges to children utmost. Thus the children under five have no access to vaccinations and safe deliveries hence fuelling the death of children. Therefore rejection by the Johane Marange sect to participate in the health issues became a challenge to the organisation.

More so, the organisation faced financial constrains as they did not have enough budget to fully implement their programme of strengthening community participation on health. They failed to train large numbers of village health workers from each village in the community due to low budget attributing one village health worker to cover two villages.

Therefore, Save the Children had its success more than challenges towards reducing child mortality in Ward 13of Zhombe as shown above thus it played a significant role in reducing child mortality.

5.3 Conclusion

This study set to evaluate the role played by Save the Children in reducing child mortality rate at Malisa Zhombe Clinic in Ward 13. Child mortality in Zimbabwe has been at its peak due to economic challenges which is having an effect towards the health sector particularly in rural areas. However, it serves to conclude that Save the Children played a fundamental role in reducing child death in the area through their project of strengthening community participation on child health, promoting child health, child survival and they fostered permanency of the project through integration with Ministry of Health and Child Care workers thus offering exit strategies that ensure the project will continue after funding culminates. Scholarly opinion converges on the deduction that Save the Children succeeded in

their mission of reducing children though they encountered religious and political problems from the community. The study strengthened the notion that the community should be involved in the partaking of child heath so as to protect children of the future generation.

It is very important for the Zimbabwean government to improve the implementing strategies in order to realise its objective of reducing child mortality for their successful improvement on child health. Non-governmental organisations can not solely provide for the countries welfare hence the government should step up and consider child health as a priority in their budget as they got much to attend to since most health institutions have deteriorated.

5.4 Recommendations

In light of the findings, the study would be incomplete without providing some recommendations to the problems discovered. It is hoped that the following recommendations will assist to reduce child deaths at Zhombe Malisa Health Centre:

Government

- The government should put enough budget towards the Ministry of Health Child Care in order to cater to the needed health resources at a health institute especially those in rural areas.
- There is a need for the government to retrench more health workers (nurses) in rural counter parts because there is a shortage of qualified nurses to attend patients.
- Improved maternal and child health should remain one of the national strategic goals to reduce the prevalence of maternal mortality and redundant children.
- The Government should review one of its strategic dreams of having a healthy facility at every 10 km radius especially in the rural districts to reduce the effects of long distant referral system. Also government should provide at least two more ambulances to each district in order to accommodate referral patients.

Non-governmental organisation

- The presence and the purpose of having Non –Governmental Organisations in the country is to complement the government efforts. Therefore, there is need to integrate Maternal Health and Care in every health project. The operation of the overwhelming numbers of health oriented non – governmental organisations should be guided statutorily to focus on maternal health. Resource mobilisation and budgetary processes should ensure that maternal health is top priority within the health sector.
- Non-governmental organisations should continue giving aid to health institutions and in order to improve develop in the health sector in developing countries.

Educational Sector

- Efforts are needed to extend educational programmes aimed at educating mothers on the benefits of exclusive breast feeding, improvement in maternal health services, together with services targeting children from the poor families that cannot afford basic needs should be put in place. This is the responsibility of the government through the line ministries, NGOs and Local government.
- Also Educational programmes aimed at creating public awareness especially those that are related with child survival should be put in place targeting parents, religious leaders, and other opinion leaders like local council members. The best approach here should be participatory guided discussions in preference to formal lectures. This may take place at community level, say local council meetings and religious congregations or at health centres for pregnant mothers.

Community

- Community participation in the Health Sector can lead to child health Development. Involvement of the whole community in health issues enables the people to live in a child mortality free generation.

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APPENDICES

1.1 Focus group discussions

Focus group discussions were done between the researcher and the selected pregnant mothers, mothers of the new born, village health workers and health workers.

FOCUS GROUP DISCUSSIONS GUIDE QUESTIONS

1. What are your views towards services provided at your clinic (opening and closing time, presence and absence of nurses)
2. What do you understand about child mortality?
3. Are you in good relations with health workers?
4. Are you getting medication needed for child health care?
5. What challenges are you facing within the clinic setting in order to reduce child mortality?
6. What are changes have you encountered in reducing Child mortality?

1.2 Interviews

Interviews were done between the researcher and the selected group of who were the key informants.

INTERVIEW GUIDE QUESTIONS

1 What are your opinions towards the Save the Children's project of Strengthening Community Participation on child health particularly Child mortality?

2 What has the Save the Children organisation done or what is it doing to rectify child mortality problems or challenges?

3 How has the project benefited you?

4 What impact and effect does the project have towards reducing child mortality?

5 what advice would you give to those who are against the project?