

Process Evaluation Round 1 for the USAID Kizazi Kipya Project- Children in Mining Component, 2018



USAID Kizazi Kipya Project March 2019



USAID Kizazi Kipya aims to enable more Tanzanian orphans and vulnerable children (OVC)—children, adolescents, and young people orphaned and made vulnerable by HIV and other adversities—to use age-appropriate HIV and AIDS-related and other services for improved care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing.

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Abbreviations and acronyms

ART	Antiretroviral therapy
CHF	Community Health Fund, an insurance mechanism targeting the rural population in the informal sector
CIM	Children in Mining
CMO	Case Management Officer
DHIS2	District Health Information System 2
COBET	Complementary Basic Education in Tanzania; aiming at children who missed out from school during normal school age
CSO	Civil Society Organization
DC	District Council
DMO	District Medical Officer
FCAA	Family and Child Asset Assessment
GBV	Gender Based Violence
HHO	HIV and Health Officer
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
K2 project	USAID Kizazi Kipya project
MEMKWA	Mpango kwa Elimu Maalum kwa Watoto waliokosa, the Swahili equivalent of COBET
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
OVC	Orphans and Vulnerable Children
PE	Process Evaluation
PORALG	President's Office for Regional Administration and Local Government
SOP	Standard Operating Procedures
TIKA	Tiba wa Kadi, the CHF counterpart in urban areas
TASAF	Tanzania Social Action Fund
USAID	United States Agency for International Development
VICOBA	Village Community Bank
VAWC	Violence Against Women and Children
VSLG	Village Savings and Loans Group
WDF	Women's Development Fund
YDF	Youth Development Fund

Executive summary

This report presents the findings from the first round of process evaluation for one specific sub-group of beneficiaries under the USAID Kizazi Kipya project: children living in mining communities. This first of three process evaluation rounds forms part of a broader mixed methods CIM study, which started with a formative research phase to assist the specification of an evidence-informed model for improved integrated health and social service delivery for children working and living in artisanal and small-scale mining communities. The second phase of the CIM study entails an evaluation of process, outcomes and impact of the project.

The specific objective for the process evaluation is to evaluate the process and strength of implementation of the integrated package of interventions, specifically:

- i. To describe the reach, dose and fidelity of the intervention implementation
- ii. To explore the barriers and facilitators to successful implementation of an integrated package of interventions for improving health and social services of children in the mining areas
- iii. To examine the views and experiences of caregivers on the effect of participation in the USAID Kizazi Kipya project on the health and social life of children in the mining areas
- iv. To draw lessons learned for USAID Kizazi Kipya and other similar projects in Tanzania

The intervention package to be evaluated includes a range of health and social services activities aimed at maximizing opportunities to generate demand for HIV services. The case management component is an important aspect of the project, in which case management officers provide customized support for families using standardized tools to assess vulnerability and address them. This aims to reduce barriers to access and uptake of HIV services; ensure tracking to reduce loss to follow-up; and facilitate effective bi-directional HIV and OVC referrals to ensure completion. In addition, the project works to address several root causes of (HIV) vulnerability. It aims to extend and advance the quality of early childhood education (which includes primary, COBET and vocational and apprenticeship to build hard skills for alternative sources of income), as well as to enhance enrollment and retention of adolescents, especially girls, in secondary school; to improve and expand opportunities for developing livelihoods and employment skills and engaging in life skills education; support family reunification (unaccompanied children); para-social workers and Violence Against Women and Children (VAWCPC) protection committees) linkage to access and monitor protection services (for abused or exploited children) and supply chain engagement with traders purchasing minerals from children.

Guided by Normalization Process Theory and using in-depth interviews with beneficiaries and implementers as well as observations of interactions between project actors, we analyzed how the Kizazi Kipya project work is embedded in project actors' routine contexts, how project stakeholders value the new interventions and how they informally and formally appraise its success. We coupled this with analysis of routine monitoring data on 25 indicators spanning 5 domains, i.e. health and nutrition, parenting, education, household economic strengthening and child protection.

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Key positive findings are:

- Implementers understand and value the project goals, components and their own role in the project
-
- Implementers collaborate well with each other and with local government
- Implementers are well trained on most aspects of their job
- Supporting processes such as Standard Operation Procedures (SOP), guides, job aids, tools, supportive supervision and peer learning support effective implementation
- Formulation of WhatsApp group among CMOs provide a good platform for networking, for peer learning and experience sharing
- Stakeholder involvement from most levels has been sufficient in all project stages
- The project (CIM) has a social acceptability in the sense that the beneficiaries and the local government accept its implementation in the respective communities and feel that the project has the potential for sustainability
- The project's integrated nature and multiple components (social, health and economic services) fosters high acceptability among implementers and beneficiaries
- CIM project has managed to mobilize women to various economic strengthening groups, some caregivers have initiated their small businesses after they have been linked to savings groups
- Formative research was important for the design of the project, the findings specifically guided the appropriate strategies to reach children in the mining with health and social services

Key barriers partly or fully amenable to project adaptation are:

- Beneficiaries had a restricted understanding of the project's components. Although the project has several components, surprisingly the beneficiaries only mentioned about the vocational training and economic livelihood components. They rarely pointed to health components such as referral to HIV care and treatment, HIV risk assessment, social protection, birth certificates, COBAT and others
- National level actors felt insufficiently informed and involved after initial (beneficiary identification) stage
- Inadequate number of CMOs hampers full implementation and might compromise quality
- Although nutritional counselling has been provided to nearly all families with malnourished children and to almost half of families with non-malnourished children, CMOs felt unable to provide nutritional counselling of sufficient quality
- Some health workers at health facilities did not serve project participants well, nor fill out feedback forms
- Community actors felt that child labour in mines was a normalized behaviour rooted across generations in local culture and that changing this would require addressing community norms and providing local examples of alternative life trajectories
- Many beneficiaries are located far from the services and therefore high monetary and opportunity costs for accessing them

Suggested solutions are:

- Provide ongoing explanation about the project interventions and expected outcomes during household visits. Specific emphasize should be on the health component including HIV referral and linkages, social protection, birth certificates, COBET and several others which the project addresses beyond vocational training and economic livelihood. Proper understanding of the project components is important for acceptance and access
- Do project promotion in community meetings as this will increase social cohesion in support of the project activities, and awareness about the project in the wider community. As many people become aware about the project it may expands the scope of influence to make people comply with the project interventions
- Keep up ongoing engagement of national government stakeholders
- Employ more CMOs
- Forming HIV support groups that aim for joint ART drug dispensing
- Engage village leaders to assist CMOs on non-technical activities. The hamlet leaders who are mostly closer to the households can be in a better position to assist the non-technical activities instead of relying heavily on the CMOs
- Provide training and supervision to CMOs on nutritional counselling
- Ensure that health workers understand the reasons for the use of MVC referral forms for CIM and that their use is authorized by the government through the ministry of health
- Educate community members on the long-term detrimental effects of child labour in mining
- Form HIV support groups that aim for joint ART drug dispensing. e.g. the HIV support group agrees with the CTC to have one joint date for an outreach visit by CTC staff, or that they assign one person from within the support group to pick up medicine for all stable patients on ART
- Extend escorted referral for other services such as treatment for opportunistic infections and collection of certificates

1. Introduction

Pact, with its stakeholders, is implementing a broad program to improve health and social services for children in mining (CIM). The CIM component is part of the larger “*USAID Kizazi Kipya*” (K2) project that is being rolled out to 81 districts in Tanzania and is being implemented by Pact with partners the Elizabeth Glaser Pediatric Aids Foundation, the Aga Khan Foundation, Railway Children Africa and the Ifakara Health Institute as a five-year (2016- 2021) USAID/PEPFAR funded project to enhance the strengths of families caring for OVC. The consortium aims to provide services to 1 million OVC and 350,000 OVC caregivers to develop lasting change in Tanzania. It works towards the UNAIDS 90-90-90 goals, where 90% of people know their HIV status, 90% of those positive are receiving antiretroviral therapy (ART) and 90% of those receiving ART achieve viral suppression.

Using a child-focused and family-centered approach, the consortium works to strengthen the continuum of care in Tanzania to improve prevention, care and treatment outcomes through strong clinical, social service, community and household entry points. The *USAID Kizazi Kipya* project aims to maximize opportunities to generate demand for HIV services; reduce barriers to access and uptake of HIV services; ensure tracking to reduce loss to follow-up; and facilitate effective bi-directional HIV and OVC referrals to ensure completion. Central to project is the case management component, in which Case Management Officers employed by local CSOs provide customized support for families using standardized tools to assess vulnerability. Children who are HIV+, malnourished or experiencing abuse are the highest priority of focus. Civil Society Organizations receive sub-grants to support families with intensive knowledge and skills-building for household economic strengthening and evaluate family well-being and stability, social capital, income diversity and linkages to local services/support.

As a child-focused project, the *USAID Kizazi Kipya* project also works to extend and advance the quality of early childhood education in Tanzania as well as enhance enrollment and retention of adolescents, especially girls, in primary and secondary school. The project works on improving and expanding opportunities for developing livelihoods and employment skills and engaging in life skills education through village savings and lending groups where youth develop entrepreneurship skills and access to small loans.

In 9 of the 81 districts the *USAID Kizazi Kipya* project focuses on two hard-to-reach populations, i.e. children living and working on the streets (in 6 municipal councils) and children in mining (in 3 district councils); the latter is the focus of a mixed methods operational research study with several components (see chapter 2 for details). The councils in which the CIM components is implemented are Bukombe DC in Geita region, Songwe DC in Songwe region and Chunya DC in Mbeya region.

2. Study objectives

The mixed methods CIM study started with a formative research phase to assist the specification of an evidence-informed model for improved integrated health and social service delivery for children working in artisanal and small-scale mining communities.

The second phase of the CIM study entails an evaluation of process, outcomes and impact with the following primary objectives:

- a) To quantify and qualify the unmet need for HIV Testing and Counselling (HTC) among children in mining
- b) To evaluate the impact of the model on
 - i. Proportion of CIM without a recent HIV test (in past 6 months) who newly tested for HIV
 - ii. Proportion of referred CIM who register for HIV care / for HIV treatment / other health care / social services within 90 days post referral
 - iii. Proportion of newly HIV diagnosed CIM retained in Antiretroviral Therapy (ART) at 3, 6, 9, and 12 months after ART initiation
 - iv. Proportion of children removed from working in gold mines
- c) To evaluate the process and strength of implementation of the integrated package of interventions, specifically:
 - i. To describe the reach, dose and fidelity of the intervention implementation
 - ii. To explore the barriers and facilitators to a successful implementation of an integrated package of interventions for improving health and social services of children in the mining areas
 - iii. To examine the views and experiences of care givers on the effect of participation in the USAID Kizazi Kipya program on the health and social life of children in the mining areas
 - iv. To draw lessons learned for USAID Kizazi Kipya and other similar projects in Tanzania

The secondary objective is to evaluate the impact of the model on a number of other health and social indicators.

Objective c) will be addressed by three process evaluation (PE) rounds, the first one of which was done in August and September 2018, i.e. 5 months after first project activities started. The current report presents the results of process evaluation round 1.

3. Intervention under evaluation

3.1 Package and beneficiaries

The intervention package for the Children In mining component of the USAID Kizazi Kipya project that was defined based on formative research and stakeholder consultation is presented in Table 1 below.

Table 1: Interventions to improve the health and social-economic welfare of children in the mining.

SN	Interventions	Key implementers	Beneficiaries
1	Identification of children involved in or at risk of mining and child labour while avoiding causing children to hide due to penalties	Ministry of Health and Social Welfare Prime Minister's Office, (Policy, Parliamentary Affairs, Labour, Employment, Youth and People living with Disability) Local government at the council and community level Teachers Health Facilities CSOs Community members, youths Mining owners, miners and mining association	a) Girls aged 10-19 who work in direct contact with minerals b) Girls aged 10-19 who provide services at the mines c) Girls aged 0-9 working in direct contact with minerals who are not accompanied by their caregiver(s)/families d) Girls aged 0-19 who are physically or sexually abused e) Girls aged 0-19 who are HIV positive f) Boys aged 0-14 working in direct contact with minerals who are not accompanied by their caregiver(s)/families g) Boys aged 0-19 who are being physically or sexually abused h) Boys aged 0-19 who are HIV positive i) Girls or boys aged 0-19 who have a sibling meeting one of the criteria above (a-h) who already consented for the intervention
2	Economic Strengthening for families with children and youth at high risk for working in mines (for prevention)	Local government CSOs	Care givers of CIM CIM youths (15-19 years)
3	Family re-unification and integration	CSOs Local Government (District Social Welfare Officers)	CIM aged 0-15 years
4	Positive parenting skills for parents and caregivers	CSOs	Caregivers and children
5	Childcare support programs	Government through day care/nursery school (pre-primary)	Children aged 0-5 years
6	Supply chain engagement with traders purchasing minerals from children	CSOs through economic strengthening	Care givers

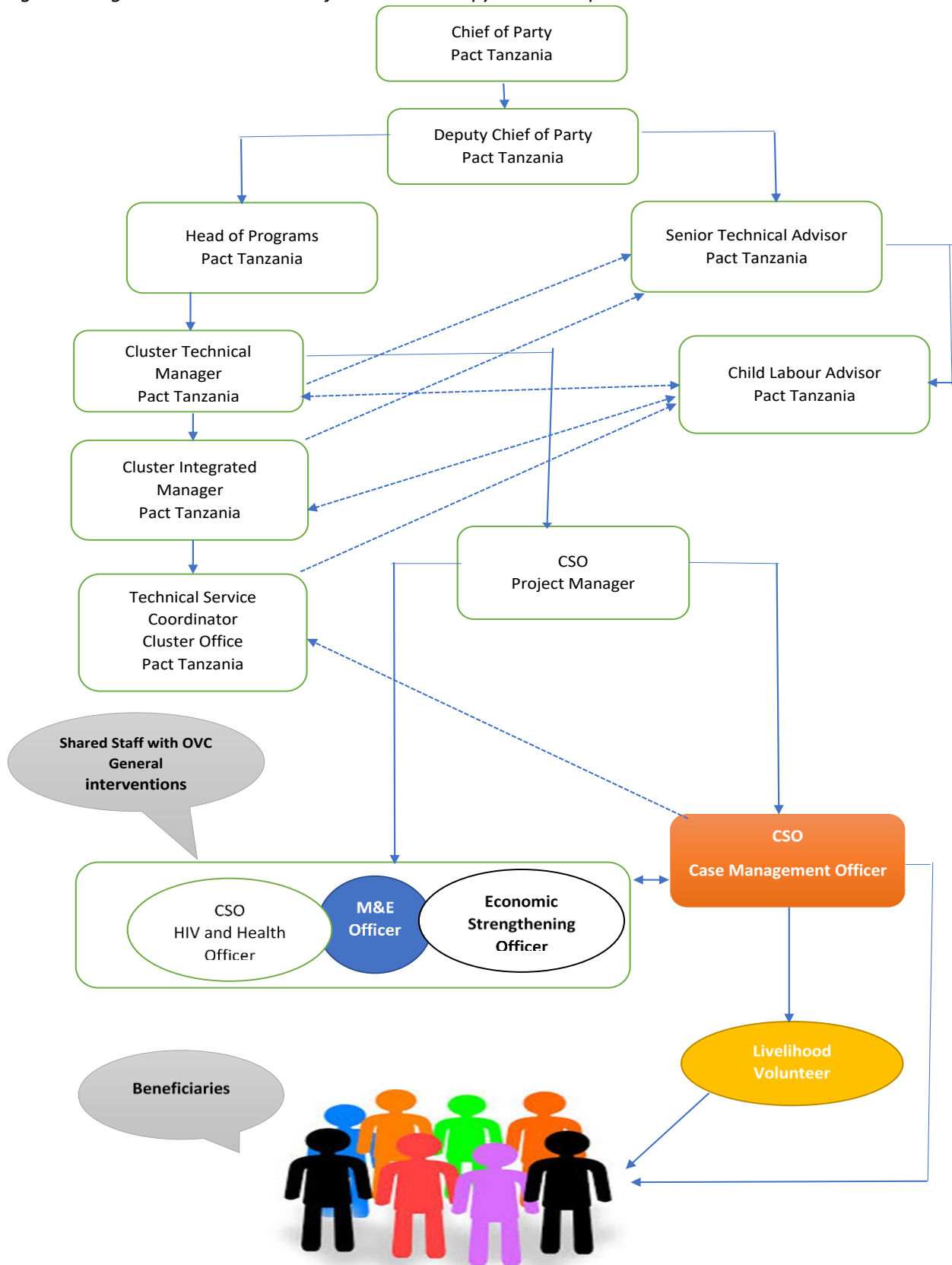
SN	Interventions	Key implementers	Beneficiaries
		Government support through WDF/YDF	
7	Linkage to HIV testing, ART (when HIV positive) and adherence support (if on ART) and other health and nutrition services	CSO for identification and referral Government for service provision	Caregivers and children
8	Reintegration into formal education and COBET using a Whole School Approach, which will have School Development Committees made of leaders and community members, who will need to identify ways to reintegrate and retain mining OVC in school.	CSOs support to Protection committees meetings capacity strengthening Local Council	Children aged 0-14 years
9	Vocational training and market-based livelihoods development among youth miners	CSOs Local Government	Out of school children aged 15-19
10	Linkage to GBV and VAWC Protection Committees, to access protection services and monitor cases of abuse, neglect, or exploitation	For mining interventions CSOs case management officers are responsible for service delivery at the community level	Children aged 0-19 years and caregivers

3.2 Organizational structure for project implementation

These interventions are delivered through an implementation structure in which Case Management Officers (CMOs), employed by local CSOs, play a central role. They are the main interface between the project and the beneficiaries for all activities, except for Household Economic Strengthening services, where they are assisted by Livelihood volunteers. CMOs are supported by CSO Economic Strengthening officer, Health and HIV officer and M&E officer, Education officers and receive technical guidance from Pact's technical service coordinators and Child Labour Advisor (see figure 1).

In Songwe, Chunya, and Bukombe, the general USAID Kizazi Kipya OVC program is also active and some CSO technical staff is shared between the general OVC and CIM components.

Figure 1. Organizational structure of USAID Kizazi Kipya CIM component



4. Methods

4.1 Study design

This study combined quantitative and qualitative methods in a parallel design. Results are presented by method and interpretation of findings is synthesized in the Discussion chapter.

4.1.1 Reach, dose and fidelity of the intervention activities

Reach and dose of the intervention (objective c.i) are addressed by analysing Pact's project monitoring data. Fidelity is measured using primary qualitative (observation) data.

Reach refers to the participation rate, i.e. the proportion of target audience for the specific K2 CIM intervention component that participated in that activity. E.g. for caregivers eligible for parenting skills building, this would be the proportion of eligible caregivers who participated in at least one skills building session. Table 2 presents the definition of the reach indicators measured.

Dose refers to the amount or number of intended units of intervention that were provided by the K2 team. E.g., in the above example, the median number of parenting sessions done by caretakers. For this first round, no dose indicators were included because of the very early stage of project implementation.

Fidelity refers to the quality of the implementation, i.e. was the activity carried out as intended. Because of the very early stage of the project implementation, fidelity was not yet measured in a structured way.

Table 2. Indicator definition, by domain

		Indicator	Data source	Numerator	Denominator
Health & Nutrition	1	OVC reached by HIV risk assessment	HIV risk assessment form	Number of OVC who responded to HIV Risk Assessment form	Total number of OVC (n=1175)
	2	Referrals issued as a result of HIV risk assessment form	HIV risk assessment form	Number of OVC who were issued a referral as result of HIV Risk Assessment	Number of OVC who responded to HIV Risk Assessment form
	3	HIV positive OVC receiving HIV referral and monitoring	HIV risk assessment and referral forms	Number of HIV positive OVC reached by HIV referral/monitoring services	Total number of HIV positive OVC
	4	Households supported to get CHF/TIKA card	Family and Child Asset Assessment (FCAA) and monthly service delivery forms	Number of households reached by CHF/TIKA support service	Number of eligible ¹ households who did not yet have a CHF/TIKA card
	5	Caregivers of HIV+ children who received support for disclosure to child	HIV risk assessment and monthly service delivery forms	Number of caregivers with HIV+ child of 8 years and above who received disclosure support	Number of caregivers who had not yet disclosed child's (8+ years) HIV status to the child

		Indicator	Data source	Numerator	Denominator
	6	Caregivers of malnourished children receiving nutrition counseling	Monthly service delivery form	Number of caregivers with severely or moderately malnourished children who received nutrition counseling ²	Number of caregivers with severely or moderately malnourished children ²
	7	Caregivers of non-malnourished children receiving nutrition counseling	Monthly service delivery form	Number of caregivers with non-malnourished children who received nutrition counseling ²	Number of caregivers with non-malnourished children ²
	8	Caregivers linked to external food support & nutritional supplements	Monthly service delivery form	Number of caregivers with severely or moderately malnourished children who were linked to external food support & nutritional supplements	Number of caregivers with severely or moderately malnourished children
	9	Caregivers referred to join HIV support group	Monthly service delivery form	Number of HIV positive caregivers who received referral to HIV support group	Number of caregivers who were HIV positive
Parenting	10	Caregivers receiving parenting messages	Monthly service delivery form	Number of caregivers who receive parenting messages	Total number of caregiver-visits for service delivery
	11	Caregivers linked to Furaha interventions for CIM and their families	Monthly service delivery form	Number of caregivers who were linked to community parenting groups	Number of caregivers who received any parenting service
Educatio	12	Children receiving support to attend vocational training (0%)	Monthly service delivery form	Number of children receiving support to attend vocational training	Number of children eligible for vocational training ³
	13	Children linked to education materials support	Monthly service delivery form	Number of children linked to education support	Number of children in need of education support (6+ years of age)
Household	14	Caregivers who were active members of VSLG	Monthly service delivery form	Number of caregivers who were active members of VSLG	Number of caregivers who had a service delivery form filled
	15	Households linked to temporary consumption support (e.g. VSLG & OVC funds)	Monthly service delivery form	Number of households that were linked to temporary consumption support	Number of households that were eligible ⁴ for temporary consumption support

		Indicator	Data source	Numerator	Denominator
	16	Households linked to cash transfer eg: TASAF	Monthly service delivery form	Number of households linked to cash transfer service	Number of households that were eligible ⁴ for linkage to cash transfer service
	17	Caregivers linked to entrepreneurship trainings	Monthly service delivery form	Number of caregivers who were ever linked to entrepreneurship trainings	Total number of caregivers
	18	Caregivers supported to establish income generating activity (IGA)	Monthly service delivery form	Number of caregivers who were supported for IGA	Total number of caregivers who had received any HES service
	19	Caregivers linked to agricultural extension support	Monthly service delivery form	Number of caregivers who were linked to agricultural extension support	Number of caregivers who were in need of agricultural extension support ⁵
	20	Caregivers receiving at least one household economic strengthening (HES) service	Monthly service delivery form	Number of caregivers who received at least one of the HES service	Total number of caregivers
Child Protection	21	Children who were supported to get a birth certificate	Monthly service delivery form	Number of children who were supported to get a birth certificate	Number of children who had ever received any child protection service
	22	Children who were provided with emergency care and support services	Monthly service delivery form	Number of children who were provided with emergency care and support services	Number of children who had ever received any child protection service
	23	Children who were linked with social welfare office	Monthly service delivery form	Number of children who were linked with social welfare office	Number of children who had ever received any child protection service
	24	Children who were linked with Violence Against Women and Children Protection Committees (VAWC-PC)	Monthly service delivery form	Number of children who were linked with MVCC/Child protection team	Number of children who had ever received any child protection service
	25	Children who were provided with general child protection awareness	Monthly service delivery form	Number of children who were provided with general child protection awareness	Number of children who had ever received any child protection service

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¹ Household with an HIV positive OVC aged 0-19 years, a child headed household, household with an HIV positive caregiver and a household with an elderly caregiver (aged 65 or above) from a destitute household with no CHF/TIKA card

² In Q3 and Q4 of PY3

³ Currently out of school and 15+ years of age

⁴ Severely ill or elderly caregiver who is not being supported by TASAF according to FCAA form

⁵ Everyone reported farming/poultry as their source of income

4.1.2 Barriers and facilitators for implementation, views and experiences of caregivers

We used mixed qualitative data collection methods to address objectives c.ii and c.iii, guided by the Normalization Process Theory (NPT). NPT focuses on how the work that people do is routinely embedded in their contexts.¹ The theory explains how the embedding of the implementation process is achieved with reference to 4 generative mechanisms, i.e. coherence, cognitive participation, collective action and reflexive monitoring. **Coherence** considers how implementers of the USAID Kizazi Kipya project and other stakeholders make sense of what they need to change different from the usual situation, how they understand the project aims and what might need to happen to promote the routine embedding of the desired interventions (whether they know what to do and whether the new interventions or new ways of working make sense to them). **Cognitive participation** considers the actions of implementers in order to engage with the new interventions (whether they know what actually needs to be done by different people and how to do it). **Collective action** comprises the work that implementers as a team or group need to do in order to enact the new practice (whether they can do the work). **Reflexive monitoring** is how beneficiaries and implementers value the new interventions and how they informally and formally appraise its success (whether they think that the interventions have been successful or not and why).

4.2 Data collection and participants

4.2.1 Quantitative data

Data for this analysis come from the routine monitoring data system of the USAID Kizazi Kipya program. The database is based on DHIS2 software embedded with quality checks to ensure data quality. Information used to generate these results was collected between January 2018 and September 2018. A standardized questionnaire is used to collect information from beneficiaries by case management officers, data is then entered using multiple interfaces including CommCare technology and a mobile application, and hardcopies of the filled questionnaire are kept at the USAID Kizazi Kipya M&E office for data quality.

Data extracted was then cleaned and analyzed using STATA[®] software. Frequency and proportions were used to describe the key indicators.

4.2.2 Qualitative data

A mix of qualitative data collection methods was used to address objectives c.ii and c.iii, namely:

¹ May C, Rapley T, Mair F.S, Treweek S, Murray E (2015). Normalization Process Theory On-line Users' Manual, Toolkit and NoMAD instrument. Available from <http://www.normalizationprocess.org>

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1. Desk review of USAID Kizazi Kipya project documents such as technical proposal, SOPs, project timelines to understand the different components of the CIM project, key implementers and beneficiaries
2. Individual semi-structured interviews with 9 beneficiaries and 17 project implementers, and stakeholders at the project level, national, regional and district levels of the health system who have been directly or indirectly participating in the implementation of interventions (annex 1). These captured stakeholders' opinions and perceptions regarding the meaning of the CIM project, project goal, value of the project, enactment process, and the overall contextual determinants of implementation process. Specifically, we interviewed:
 - Caregivers (4 females)
 - Adolescents (3 females, 2 males)
 - Livelihood volunteers (1 female)
 - Case management officers (3 males, 2 females)
 - Community case workers (2 males)
 - Health care providers (3 females)
 - District education coordinators (2 males)
 - Districts social welfare officers (2 females)
 - Social welfare officer at PORALG (1 male)
 - Technical advisors at Pact (2 males)
 - Project managers at Pact (2 males)
 - Labour officer at government (1 female)
 - Monitoring and evaluation officers at implementing CSO (Males 2)
 - Child labour advisor at Pact (1)
3. Observations of the interactions between project staff, service providers and beneficiaries in the following situations: CSO office, during VSLG meetings, at health facilities, and during household visits for education, WORTH group activities, health facilities, at the CTC, birth certificate, nutritional assessment and education and HIV risk assessment and testing. Since vocational training of adolescent beneficiaries had not yet started, though this was included in the research protocol, this activity was not yet observed.
4. Document review of service tracking sheets at the service centers and of project activity monitoring data

Though included in the study protocol, due to the very early stage of project implementation, diarists were not yet recruited to document the various project events/activities around the mining areas and how they think that the referral to social and health services has been beneficial or detrimental to the beneficiaries. This will be done in next PE round.

4.3 Ethics

Ethical approval for the process evaluation was obtained from Institutional Review Board of IHI (IHI/IRB/No: 001-2017 and IHI/IRB/AMM/ No: 07-2018) and National Research Ethics Committee of NIMR (NIMR/HQ/R.8a/Vol. IX/2483).

Written informed consent was obtained for IDIs and observations.



Figure 3. Research team and CIM staff paying courtesy call at the District Executive Director (DED) of Chunya.

5. Results

5.1 Reach and fidelity

5.1.1 Reach

Reach indicator results are presented overall and by district, broken down by sex (table 3). Note that in Pact's monitoring system, Chunya and Songwe data are reported together under Chunya district.

Health

About three quarters of all CIM enrolled in the program were reached by HIV risk assessment so far (aim is 100%), and 5% of these were issued a referral. Not all were reached because of the timing of the HIV risk assessment round (April-May 2018) coincided with that of the baseline survey for some households and assessment was relayed to next round (April-May 2019). Non-traceable OVC and their caregivers migrated to non-project communities for new mining discoveries and some families stopped mining activities and migrated back to their home of origin for farming. Of the 41 CIM who (were) self-reported to be HIV positive, 36 reported to already be in care and treatment. Seven children (17%) received HIV referral and monitoring services (3 CIM in Bukombe and 4 CIM in Chunya/Songwe). Disclosure support is available for caregivers who have HIV positive children who are aged 8 years or above and have not yet told the child about his/her HIV status. Out of the 41 HIV positive CIM, 28 were aged 8 years or above, 22 of whom already knew their own HIV status. None of the caregivers of the 6 remaining HIV positive CIM aged 8 years or above (all in Chunya/Songwe) have received disclosure support yet. 225 HIV positive caregivers out of 367 who filled the FCAA form would benefit from sensitization for and receiving referral to a HIV support group. 2 (0.9%) have been referred to this service; this is partly low because few groups

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exist. The majority of HIV infected OVC and caregivers received adherence support at their HIV care and treatment clinic though.

One third of the households in need were supported to get a CHF/TIKA card. This might be low because districts temporarily stopped issuing cards for the “old” CHF program while the rollout of the new iCHF program is delayed. The CIM project pays for its beneficiaries’ membership in the ICHF. The project pays only once then the beneficiaries are linked to the economic livelihood groups so that they continue to pay by themselves. The project pays the iCHF for the households which meet the following criteria: household with an HIV infected person, the household whose head of the household is very aged and cannot afford, the child headed household/ unaccompanied household and households with poor economic status.

Nutrition

Nearly all malnourished children lived in Chunya/Songwe and nearly 90% of their caregivers received nutritional counseling in quarters 3 and 4 of the program. The caregivers of the 26 children who were reported to be severely or moderately malnourished would benefit from external food support and nutritional supplements, however none have been linked yet to e.g. nutritional rehabilitation services in health facilities. This can be partly explained by the complete lack of these services at community level, and lack of quality services at local health centers and dispensaries, while the nearest district hospital offering comprehensive nutritional rehabilitation services is 60-80 km away from the target communities. This is time and cost-prohibitive for the beneficiaries. Of the caregivers of non-malnourished children, 40% received nutritional counseling in quarters 3 and 4 of the program, with reach for this activity being higher in Bukombe than Chunya/Songwe.

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Table 3. Reach of project activities by domain, district and sex

		Bukombe				Chunya/ Songwe				Overall			
		Male		Female		Male		Female		Male		Female	
1	OVC reached by HIV risk assessment	97/125	78%	96/126	76%	319/457	70%	339/467	73%	416/582	72%	435/593	73%
2	Referrals issued as a result of HIV risk assessment form	4/97	4%	8/96	8%	19/319	6%	13/339	4%	23/416	6%	21/435	5%
3	HIV positive OVC receiving HIV referral and monitoring	0/0	N/A	3/3	100%	3/23	13%	1/15	7%	3/23	13%	4/18	22%
4	Households supported to get CHF/TIKA card	9/22	41%	11/55	20%	27/83	33%	48/166	29%	36/105	34%	59/221	27%
5	Caregivers of HIV+ children who received support for disclosure to child	0/0	N/A	0/0	N/A	0/5	0%	0/1	0%	0/5	0%	0/1	0%
6	Caregivers of malnourished children receiving nutrition counseling	0/1	0%	0/0	N/A	8/8	100%	15/17	88%	8/9	89%	15/17	88%
7	Caregivers of non-malnourished children receiving nutrition counseling	39/72	54%	107/219	49%	27/101	27%	78/221	35%	185/440	42%	66/173	38%
8	Caregivers linked to external food support & nutritional supplements	0/1	0%	0/0	N/A	0/8	0%	0/17	0%	0/9	0%	0/17	0%
9	Caregivers referred to join HIV support group	0/11	0%	0/29	0%	0/6	0%	2/120	2%	0/76	0%	2/149	1%
10	Caregivers receiving parenting messages	14/98	14%	48/275	18%	68/187	36%	154/417	37%	82/285	29%	202/692	29%
11	Caregivers linked to community parenting groups	0/14	0%	0/58	0%	0/68	0%	0/162	0%	0/82	0%	0/220	0%
12	Children receiving support to attend vocational training	0/17	0%	0/32	0%	0/47	0%	0/48	0%	0/64	0%	0/80	0%
13	Children linked to education materials support	1/103	1%	0/107	0%	6/301	2%	11/338	3%	7/404	2%	11/445	2%
14	Caregivers who were active members of VSLG	1/22	5%	3/60	5%	2/93	2%	13/207	6%	3/115	3%	16/267	6%
15	Households linked to temporary consumption support (e.g. VSLG & OVC funds)	11/33	33%	25/77	33%	5/95	5%	10/183	6%	16/128	13%	35/260	13%

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		Bukombe				Chunya/ Songwe				Overall			
		Male		Female		Male		Female		Male		Female	
17	Caregivers linked to entrepreneurship trainings	0/98	0%	0/275	0%	24/187	13%	56/417	13%	24/285	8%	56/692	8%
18	Caregivers supported to establish income generating activity (IGA)	0/22	0%	0/60	0%	7/93	8%	12/207	6%	7/115	6%	12/267	5%
19	Caregivers linked to agricultural extension support	0/9	0%	0/16	0%	0/36	0%	1/63	2%	0/45	0%	1/79	1%
20	Caregivers receiving at least one household economic strengthening (HES) service	12/26	46%	36/68	53%	38/107	36%	89/256	35%	50/133	38%	125/324	39%
21	Children who were supported to get a birth certificate	2/23	9%	0/25	0%	64/135	47%	78/152	51%	66/158	42%	78/177	44%
22	Children who were provided with emergency care and support services	0/23	0%	0/25	0%	16/135	12%	14/152	9%	16/158	10%	14/177	8%
23	Children who were linked with social welfare office	0/23	0%	1/25	4%	2/135	1%	4/152	3%	2/158	1%	5/177	3%
24	Children who were linked with MVCC/Child protection team	0/23	0%	0/25	0%	0/135	0%	3/152	2%	0/158	0%	3/177	2%
25	Children who were provided with general child protection awareness	21/23	91%	24/25	96%	82/135	60%	90/152	59%	103/158	65%	114/177	64%

Parenting

One third of all caregivers who had ever filled the service delivery form had received parenting messages. This proportion was much higher among caregivers in Chunya and Songwe than Bukombe. None of them had been linked to community parenting groups, because there were no existing groups and the Furaha program had not yet started at the time of study.

Education

Four out of the 144 children (12% of all CIM) who met the eligibility criteria for vocational training were enrolled within the observation period – though this was not yet reflected in the monitoring data. Only about 2% of all CIM aged 6 years or above were linked to educational support, i.e. external programs that provide school uniforms and materials. Reintegration into primary school or complementary education programs had not yet started at the time of study.

Household Economic Strengthening

Thirty-eight percent of all caregivers received at least one household economic strengthening (HES) service, most commonly linkage to temporary consumption support. Though in Bukombe more caregivers had received at least one HES service than in Chunya / Songwe, this solely consisted of linkage to temporary consumption support. In Chunya/ Songwe a wider variation of services was offered, including linkage to TASAF, entrepreneurship training, support for establishing IGA but so far only to a few of the eligible caregivers. Very few received linkage to agricultural extension because these services hardly existed.

Child protection

Over 4 in 10 eligible children were helped to get a birth certificate, nearly all were from Chunya/Songwe. Thirty children, again all from Chunya/Songwe, lived in such dire circumstances that they were provided with emergency care and support services. Ten children were linked to social welfare or Violence Against Women and Children Protection Committees at district level, only one of these was from Bukombe. Nearly all families in Bukombe and two thirds of families in Chunya / Songwe were sensitized on child protection in general.

5.1.2 Fidelity

Qualitative observations on interactions between CMOs, beneficiaries and district and ward officers done this PE round will inform the design of the structured observation checklists in next PE round to solidly measure fidelity (funds permitting). The research team observed interactions between project staff, service providers and beneficiaries in the following situations:

Situation	Observations
CSO office	<ul style="list-style-type: none">▪ Each office at the implementing site had project SOPs▪ SOPs have been posted on the wall for easy reference▪ Some CMOs when passing the wall of their offices, they frequently put an eye on the SOPs posted on the wall

Situation	Observations
<p>Household visits on birth certificates</p>	<ul style="list-style-type: none"> ▪ CMOs were making follow-ups to the families which they had given referral for birth certificates ▪ Some people who had received those referrals were saying that they don't have money for transport to go to the District Administrative Secretary (DAS) office which is located in Ushirombo area, Bukombe DC ▪ Some beneficiaries were saying that they lost the referral forms, or they had misplaced the forms and they were requesting for the new forms ▪ At the households we saw the CMOs asking the beneficiaries who were still holding the referral forms why they have not gone to pick their birth certificates ▪ We observed the beneficiaries saying that they have not picked the certificates because they did not have money to pay for transport and 1000 to pay for such certificate ▪ We could see some beneficiaries saying that, even if the CMOs gives them those referral letters, they will not go to pick the certificates, because they do not have transport fare ▪ Other beneficiaries were refusing to receive the referral letters from the CMOs
<p>Village Savings and Loans groups</p>	<ul style="list-style-type: none"> ▪ It appears that, the CIM beneficiaries participates in several economic group meetings ▪ Some groups had very few members, and it took a long time to wait for other members to join the meeting ▪ Some members were saying that the reason for the low turn up is the difficult economic situation which discourage those with loans not being able to attend the meetings. Others were saying that, some members do not have money to contribute to the groups ▪ Some group members were complaining that the contribution amount set for the groups is a lot and not all members cannot afford it (2000 to 2500 TSh) ▪ During the meetings, the beneficiaries usually wait until every member has arrived and do the following: <ul style="list-style-type: none"> - they review their previous milestones - they contribute money, repayment from the loans that they have borrowed - they review the total contributions - they motivate each other's on the importance of contributions and investment - they share business ideas and they design business which will generate profit to expand their funds - they discuss about loans - they follow up on those who have borrowed - they discuss about how much interest they have collected from the loans ▪ One CMO at Kaloleni, followed the chairperson of the VICOBA group. The CMO advised the chairperson to meet with the group members and explain to them about the procedures of the group

Situation	Observations
Household Visits Nutrition -	<ul style="list-style-type: none"> ▪ The CMO accompanied a nurse who was visiting some households. They were educating women on how to prepare nutritious food ▪ The CMO and the nurses used MUAC Tapes to assess the health status of the children ▪ The CMOs were referring children to the health facility for treatment of severe malnutrition
Household Visits Education -	<ul style="list-style-type: none"> ▪ The CMOs were with the district social welfare officers visiting the households to follow up on children who refused to go to school ▪ The social welfare officer was asking the children why they had not gone to school, and she was explaining to the children about the importance of school
Household visits - HIV	<ul style="list-style-type: none"> ▪ The CMOs accompanied nurses who were walking with the HIV testing kits to the households ▪ The nurses used the HIV testing kits to assess the children's HIV status ▪ But before testing the children, the nurse requested parental consent ▪ Some CMOs were holding a paper conducting HIV risk assessment and were asking children some questions that aimed to assess their HIV risk ▪ At the household, nurses were conducting HIV counselling to the children and advised them on ways to prevent HIV infection
Household visits general -	<ul style="list-style-type: none"> ▪ Some CMOs were entering one household to another, accompanied by village leaders ▪ CMOs were well received by the household members ▪ Some adolescents were running to welcome CMOs, when they were entering the households ▪ Public transport takes a long time to reach the beneficiaries sites
Health facility service	<ul style="list-style-type: none"> ▪ Some beneficiaries were complaining that they come from long distance and it has been difficult for them to make a timely report to the health facilities ▪ Sometimes we used the motorcycles to go to the beneficiary's sites, we observed that, the motorcycles are not comfortable at all, because the sites are located quite far and scattered, the roads have corrugations with some hills. By the time you arrive at the beneficiary's site it is already late ▪ The beneficiaries were carrying the referral forms and were giving these forms to the nurses ▪ Some children were accompanied by their parents. This this was an observation study we did not capture their age.

5.2 Barriers and facilitators

Since this was qualitative work and to prevent causality attribution, the word 'facilitators' and 'barriers' in this study context entail the contextual and project implementation aspects that implicitly contribute to, respectively challenge or hinder, CIM project implementation success. Although the evaluation was implemented in the three study districts with different contexts, there was high convergence of views

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among respondents, probably because the implementation modality was the same. The findings are thus presented for all districts combined, and some key differences have been highlighted where relevant.

To safeguard ethical considerations and preserve good relationships, the identifiers in the excerpts and in the participants' description are limited to general terms.

5.2.1 Coherence – Facilitators

Understanding of individual roles in the project

All project implementers reported comprehensively about their roles in CIM project and the specific components within the project. The roles played by each cadre, e.g. CMOs, at each implementing site were similar, which reflects harmonization of roles in the implementation process. Most project implementers mentioned that CMOs are the pillars of the CIM project since they engage in all the components of the project. The main responsibilities of CMOs as reported by the project implementers includes visiting the beneficiaries, conducting case identification and preparation of the care plan, conduct HIV risk assessment. Depending on the case, they may refer beneficiaries to HIV testing and treatment services, nutritional services and for birth certificates. They may link the beneficiaries to education opportunities, village savings groups and social protection committees. CMOs also collect data during household visits and enter the data for future analyses and monitoring. CMOs also make regular follow up visits to the households.

Coherence in understanding of the roles among the key implementers is an important ingredient for their engagement in the project implementation process. One CMO comprehensively described his roles as follows:

“One of my roles is to identify children of age 0-19 who are at risk situation; working in the mining and those who are HIV infected. I identified children and their caregivers and enrolled them in the project. I also evaluate the household economic status and HIV risk conditions. Then we empower the family enabling them to develop a service plan and provide appropriate services based on the service plan. My role is also to follow up on the enrolled families to ensure that they are linked to all the required services” [CSO_03]. (It should be noted that, this role was practiced during the initial stage of the project, identification and enrollment was done once, no more enrollment in CIM was ongoing)

One M&E staff member described her role as follows:

“My main role is data management. I am obliged to ensure that all data coming from the field site collected by CMOs are in good quality. I also provide support in case there are challenges in data collection. If the challenges are not within my capacity, I refer them to the cluster M&E. You know, the data need to respond to our project indicators. For instance, data need to reflect whether all the beneficiaries have received equal services and ensuring that all children from 0-19 years have accessed the HIV services. As an M&E I also need to provide feedback to the CMOs about the status of the data and the related project activities” [M&E_01].

Another M&E (02) officer explained how his roles contribute to the implementation of CIM project activities:

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“Well collected data help us to understand the project. Without M&E you cannot understand the project because data is used to evaluate the project and make the necessary follow up, to ensure all the necessary services are provided as intended. I think I do play a significant role in project implementation, because I also ensure that the report is well constructed.”

An education coordinator described his roles as follows:

“You know the school reintegration process is very important especially for those children who dropped out from school. This is what I have been doing in support of the project (CIM) work. We have regular contact with the project implementers (CMOs) to share feedback about how the children and caretakers respond to the referral provided under the project” [MEK_02]

A representative from PORALG described his role as follows:

“I remember I participated in the review and piloting of the guideline/criteria, which was used to identify the vulnerable children. Initially the criteria were very hazy, but after a series of implementation, the ideas were clear. We started using the guideline to identify the beneficiaries in Bukombe and moved on to Chunya and Songwe. The guideline kept on improving as we moved on from one district to another” (Representative from PORALG)



Figure 4. Economic Strengthening Group in Songwe

Understanding the CIM project components

Most implementers appeared to be well conversant regarding CIM components. But there was limited understanding about project's components among the beneficiaries. Coherence in understanding the

project's components is potentially a crucial element for active engagement in implementation process. One CMO described in detail the project components as follows:

"The CIM project has several components and one of them is health, the health component includes HIV testing and treatment. We do follow up visits at the households and conduct an HIV risk assessment. We provide referral for those who are at high risk of HIV infection to ensure that they are tested and those who have been infected are able to use treatment. We follow up the infected individuals to ensure that they continue with treatment until their viral load is reduced. Within the health component, we conduct nutritional assessment of children in the household and if we find the child has severe malnutrition, we refer to the health facility. Those with moderate malnutrition we advise them to eat nutritional food. Another project component is the economic empowerment where we link the caregivers with our WORTH program so that they can improve their economic status and support their children. We also identify children who did not advance their education career and link them with the appropriate people to ensure that they continue with their education" [CMO, 4].

Another CMO provided a specific description of how they link children with education and social protection opportunities:

"For the kids of age 15-19 we will link them with vocational training centers. So far, we have like 31 children in Songwe and Chunya. In three months to come, these children will begin their studies in the vocational training centers. We just wait for Pact to bring funds. We also use MEMKWA program to return children to schools, especially those who missed their education opportunities [...]. MEMKWA program target children of age 9. We also have a program called FURAHA, which seek to educate caregivers on good parental care. Within MEMKWA program, these parents are empowered so that they can protect their children from violence. We also have an emergency service which seek to assist children to receive support from the social welfare officer immediately when the children have been exposed to violence or abuse" [CMO_5]

One participating child only knew that the project deals with education component which will help them secure employment:

"CIM project deals with education. They (CIM staff) told us that, we need to choose the area of interest in education career i.e. tailoring, mechanics, and in July they will take us to school. So, this is a good thing because it will help us get employment" [Girl_01].

Understanding the goal of CIM project

Understanding of the project goal can influence how people value the project and its components. It can also influence their engagement in the implementation process. One project staff had the following view regarding the goal of the project:

“This project (CIM) is funded by USAID, and it has the goal of reaching children who are HIV infected because they are also living in the risk environment (working in the mining areas). Also, the project aims to help caregivers of children working in the mining areas by linking them with village economic groups so that they can strengthen their economic status, receive entrepreneurship skills and build network” [M&E officer_01].

Another CIM project staff described the goal of CIM project as follows:

“This project seeks to help children who live in risk situation in the mining areas and those who have already been infected by HIV. The targeted children are of age 0-17 and youths of age 18-20. The main goal of the project is to ensure that children and youths who lives in the mining areas are removed from their risk environment and are kept in the safe environment by providing them with health, social and economic services. We intend to reach the UNAIDS three 90s” [HHO_02]

As compared to project implementers beneficiaries had a much more limited understanding about the goal of the project. Most beneficiaries thought that the project **only** focused on improving education opportunity for children living in the mining areas. Both children and their caregivers frequently cited ‘provision of vocational training to girls and boys’ as the main goal of CIM project. One caregiver had the following explanation:

“You know I was not sure about how I could support my children’s education, mining activities are not so good for children of this age, but due to challenges in life, I had no means (to support their education career). But now I am in this project (CIM) which will provide opportunity for my child to continue with the vocational training. I am ready to give my child, so that he can go anywhere, as long as he gets enough education that will help him secure employment” [Caregiver_01].

Perceived importance of CIM project

Beneficiaries and implementers indicated a positive opinion regarding the importance of the CIM project. According to beneficiaries, the main importance of CIM project is the promise that children will have an opportunity to advance their training in vocational schools. Some caregivers also thought that, the project is importance because it provides education on how to raise their children. The fact that the beneficiaries hold a positive opinion regarding the CIM project, is a crucial aspect, and can be a key ingredient that potentially influence their acceptance of the project and support its implementation.

One adolescent girl who has been working in the mining areas explained that the CIM project has brought a new hope by caring about the welfare of the children living in the risk environment (mining areas). She mentioned in Kiswahili that ‘mradi umetutambua’ meaning ‘the CIM project has recognized us’. She further mentioned that the project has opened their mind to think about education as a new opportunity in life :*“The project is of great importance because before the project came we had already given up with this environment that surround us (working in the mining areas), but when the project came, we have the*

CIM implementation facilitators that relates to Coherence included the following:

- a) Understanding of individual roles
- b) Sense making of the project’s goal
- c) Understanding of the project’s components
- d) Perceived importance of CIM project

These aspects potentially improved individual agency to engage and operationalize CIM activities.

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new hope and it opened our minds to recognise that ooh there are people who value us (children) (.....). Because we had already accepted this habit of working in the mining areas, but the project has recognised us and opened our minds, and we can now see other opportunities like education, to be honest the project has helped us a lot” [Girl _01].

One caregiver provided her view regarding the importance of the project as follows:

“The CIM project is important because it trains parents on how to care for their children. Those project people will come and train you on various important aspects that will help you raise your child in the right direction. They can also provide advises on how you can make progress economically” [Caregiver_02]

Another caregiver thought that the project can help children avoid risk behaviours:

“We can see the importance of the project (CIM), some children did not have any hope for life, some decided to engage in unsafe sex due to economic difficulties of their families, but now, this project will help the children to stay in the straight line (avoid risk behaviours) because of the project activities” [Caregiver, 01]

One of the project implementers had the view that CIM project support activities that will prevent children from working in the mining areas and link them to health and education opportunities:

“I could think about several benefits of CIM project but one thing that I consider important is that the project is supporting activities that will help prevent children from working in the mining areas and link them with services that will help improve their health and give them opportunity to advance their education career. In the mining areas you will see very young children who are not even expected to work in there, some of them left school long ago and so, the project is working hard to ensure that those children re-join their families and continue with education” [M&E_02]

5.2.2 Coherence –Barriers

Limited understanding of the project’s goal and its components

Beneficiaries’ limited understanding regarding the project’s components and its goal could be one of the challenges under coherence. If the project beneficiaries are not broadly informed about the project, this may constrain their sense making of the project and the enactment process. CIM is an integrated project with several interventions; confining the project’s component and goal to education component only, potentially affects the operationalization of a set of practices and accessing the services provided under CIM project.

Uncertainty on how the CIM project will help the poor households

Some caregivers and providers mentioned that they were not certain about how the project will help the poor households meet their needs. They compared the CIM project with other previous projects such as TASAF which has been providing funds for poor households. One health care provider expressed her uncertainty as follows:

“Previously TASAF project provided the poor families with money. This was very helpful because in case if the caregiver is depleted of maize, he/she could use the money to buy maize. You know in every end of the

month; the caregiver could receive the money (from TASAF) and assist the family by buying enough food which could help prevent the family from hunger. But we are not sure about how this project (CIM) is going to assist the poor families meeting their household needs such as food” [Caregiver_02]

One community development officer was of the view that it would be better if CIM project could provide some financial capital to caregivers instead of only linking them to economic groups:

“I think the project (CIM) is important because it help us reach this group (children working in the mining areas). But we need to be realistic here, one thing that is being missed is that, linking them (caregiver) to the village savings groups is not enough to assist these people economically. Just ask yourself that how

much they (caregiver) contribute to these groups (village savings groups) and how much capital they expect to borrow from these groups. At the end of the day you will find that what they get as a loan is very little considering their responsibilities such as initiating some businesses, educating their children, health care and so forth. If I had the chance to advise the project, I could ask them to provide capital to these poor households, I think this could help them much” [Community development officer_02]

The key ingredients related to implementation success under the cognitive participation are the **collaboration and strong project initiation process**. Practices were set by the project implementers to support the implementation process. Some of the best practices included:

- a) collaboration between actors which strengthened the relations and enhanced collective contribution of resources
- b) project SOPs have activated the implementation process, provided procedures for each project’s component and sustains the enactment process
- c) formative research informed the pathways and needs of the children in the mining, and guided the project design and appropriate interventions
- d) community engagement has promoted trust between the project staff and the community members

When asked whether the fact that the project does not provide capital to poor families could have any effect on the implementation of the CIM project, the

community development officer had the following view: *“Remember that some of these children went to the mining areas because they wanted to improve the economic life of their parents, so, if the project is not assisting the caregivers enough, the children will remain in the mining areas” [Community development officer_02]*

5.2.3 Cognitive participation- Facilitators

Collaboration

In the context of cognitive participation, collaboration among the project implementers and the district officials and community members emerged as one of the key drivers of successful implementation. Implementers also pointed out that collaboration among project staff allows the culture of flexibility in sharing of duties and responsibilities. They cited instances where CCW have been assisting CMOs in

training the beneficiaries on nutrition and on savings programs and in conducting follow up visits to the beneficiaries' sites, especially in Songwe and Chunya (the districts where the general USAID Kizazi Kipya OVC program also runs). They also mentioned that, CMOs collaborate well with social welfare officers, health care providers, DMOs, village chairpersons and hamlet leaders which allows sharing of resources, gaining trust from the respective communities and receiving their support. They further mentioned that the district officials, especially the social welfare officers, have been responsive to events of child abuse and conflicts between parents as they happen at the field sites.

One project staff described how she usually works with the local government members and joins them during the children's social protection committees' meetings: *"As an HHO I work with the government officials to implement some of CIM project activities. We usually meet during the children's social protection committees' meetings. This committee comprises of various government stakeholders including the council health management team members. [...]. These are the people that we work together in the implementation of our CIM project. I also collaborate with CMOs, CCW and CHW. For example, when children are referred to the health services the CHW are the ones who provides nutrition training to our project beneficiaries"* [HHO_01]

A social welfare officer had the following view: *"what I could say is that, one of the good thing about this project is that we have a good collaboration with CIM project staff [...] sometimes they ask for a car to attend emergency at the field sites, we give them and they put fuel"* [District Social Welfare officer_01]

A project beneficiary explained about how they benefit from the collaboration with project implementers: *"By collaborating with the project implementers we receive training on how to initiate village savings groups (VSLGs), these groups are important because they can help us improve our income. Through this collaboration we are also taught on how we could use the income generated from the business to buy food"* [caregiver_03]

Project Standard Operating Procedures (SOPs), Guides, Job aids and tools

Project implementers reported how the project has set the means to sustain the community of practice by developing the SOPs and other guides for each project component. They had the view that availability of SOPs helps to remind them about the implementation procedures and enhance their efficiency in work. One CMO had the following view: *"SOPs reminds us about what we need to do, I remember there is a time I was dealing with the issue of child abuse and it was difficult for me to remember the steps that I needed to follow in order to address the problem, really I was not sure about where to begin, so I went back to the SOPs and I was able to follow all the processes including the legal steps that need to be taken in order to help the child, I went to inform that child protection committees and the district welfare officer and the issue was solved"* [CMO_4]

Another implementer explained that each project component has its SOP which help to attain a community of practice, efficiency and harmony around the implementation process. Considering that CIM is different from other projects that they have been previously implemented it is helpful that the project recognizes the importance of availing SOPs and other guides for each project component:

“Each project component has SOPs, so we don’t implement components haphazardly but there are clear procedures on how to provide referral and linkages for all the project services such as HIV services, nutritional services, social protection, economic strengthening, psychosocial support and counselling and birth certificates. This helps to ensure that the project activities are implemented in harmony, not this one is doing this and this one is doing that. I think it also helps to improve efficiency in the implementation process because there is a documented direction on how to implement the activities. Remember that it is our first time to implement such an integrated project in the mining context, so I could imagine implementing such a project without SOPs”

[Project manager_02]

Formative research

The project implementers mentioned that the decision to undertake the formative research before the implementation of project interventions was crucial because it provided significant information that helped the key implementers to the design of the project. They also mentioned that the initial plans for the project were re-organised to meet the needs of children living in the mining areas based on the evidence from the formative study. One

technical advisor specifically mentioned that *the formative study assisted Pact to develop a broad program to improve health, social and economic services for children living in the mining areas* [Project technical advisor_02]

Community engagement

Both the project implementers and the community members mentioned that one of the important aspects that facilitated the success of CIM project is the fact that the project staff engaged the community members at the initial take-off stage. One community leader had the following explanation: *“the good thing with CIM is that they engaged us at the initial stages of the project, I remember we also participated in the identification of the project beneficiaries, this aspect has promoted trust among the community members”* [Community leader_03]. One CMO also reported that the identification of the beneficiaries was very successful due to the fact that they engaged the community leaders in the identification process [CMO_03]

Escorted referral

To enhance inclusion in accessing the social-economic and health services, CIM project has been providing support to some beneficiaries who cannot afford transport to the health facilities. One CMO felt that this strategy is an important element of the project because not all people can afford transport costs to the facilities located far from where they reside. *“I am happy that the project design integrated this option (escorted referral) such that, for those beneficiaries who cannot afford transport fare, the project can assist them. You know if you do not think about the poor people in your program, your interventions will exclude other vulnerable groups. Although the project does not provide escorted referral to all identified cases, but I think that what is being provided helps [...] usually one CMO is required to accompany the beneficiary to the respective health facility and make the payment (escorted referral)”* [CMO_05].

Key barriers to project implementation that relate to cognitive participation include:

- a) Culturalization of the mining activities
- b) Health care provider’s attitude
- c) Inadequate support from parents
- d) Long distance and unfriendly transport to beneficiaries’ sites
- e) Limited communication network
- f) Inadequate funds to support comprehensive escorted referral
- g) Mobility nature of the beneficiaries
- h) Poor economic status of the households

5.2.4 Cognitive Participation-Barriers

Culturalization of the mining activities

It was also mentioned that the behaviour attached to working in the mining among the families has its own cultural history, and that this behaviour may not be easily eliminated. Because this behaviour is normalized, it is likely that children may not be easily detached from the mining work as they will continue to believe that working in the mining is the only way to survive. This may place an important barrier for them to access the social-economic and health services as intended by CIM project. One community development officer had the following view: *“the issue of children working in the mining is historically inherited from their parents. This is a cultural aspect which has been existence from generation to generation. Therefore, it will be difficult for children to stop working there as they continue to see their parents engaging in the mining areas. If children continue to work in the mining areas there is a possibility that the project goal may not be fully achieved since children will not be fully linked or referred to the social-economic and health services as intended by the CIM project. As the society evolves, you will see that children continue to believe that the only way to survive is by working in the mining areas because they have also seen their parents working in the mining areas”* [Community development officer_01]

Health care providers’ attitude

The project implementers reported some instances where they encountered complaints from the beneficiaries regarding mistreatment by the health care providers. They said that, some health care providers exhibit unfriendly welcome to CIM project beneficiaries, sometimes they may refuse to fill the referral forms or provide the services claiming that they have never been informed by the district medical officers about the CIM beneficiaries. Such attitude discourages some beneficiaries from complying with the referral services resulting into poor health outcome. One CMOs had the following view:

“[...] beside several nutritional education sessions provided to one caregiver together with the referral services, still her baby’s health remained poor, this was strange to me! When I followed up, I found that the caregiver was not treated well with the health care provider, so, she stopped taking her child for nutritional care” [CMO_03]

Inadequate support from parents

The project implementers reported that some parents are not happy to see their children detached from the mining areas since some children also support the economy of the family. Therefore, despite efforts by the CIM project to ensure that children leave the mining work and join school, it has been difficult for this to happen due to limited support from the caregivers: *“For some families where children are the ones who support their parents economically, it is hard for parents to support these initiatives (CIM). We usually advise parents that they should encourage their children to go to school, and they should discourage them to work in the mining. However, during the visits we find that some children are still working in the mining areas because their parents are still supporting this behaviour. That is why I think that this problem will take time to be tackled because parents are not fully encouraging their children to stop working in the mining”* [CMO_04]

One DMO advised that there is a need for the communities to formulate bylaws at the community level which will reinforce legal actions for parents who allow their children to work in the mining areas: *“we have the national law that prevent child labour, this is well known, but sometimes we need to formulate specific bylaws at the community level that will help prevent acts of abuse against children. These bylaws are those that have not been covered by the national law. The bylaws should aim to hold accountable those parents who allow their children to engage in the mining work”* [DMO_02]

Long distance to the project beneficiaries’ sites and difficult transport

The implementers, especially CMOs, felt that long distance plus rough roads to the beneficiaries’ sites, coupled with scattered households and difficult transport (motorcycles), affect their implementation efficiency by constraining their visits to the households and time spent with beneficiaries. On the other hand, it is difficult for the beneficiaries to comply with some referral services since they may not have received the adequate support from the project staff.

One CMO broadly explained about the related concern: *“you (researchers) have seen the distance from where the beneficiaries are to this point (at the dispensary where the interviews were held). This is the difficulty that affects our (CMO) ability to make effective follow up visits. It usually takes a long time to travel all the way with a motorcycle to where the beneficiaries are, you also saw how scattered the households are, sometimes we plan to make several visits to the households, but we fail because we are human beings and we get tired. At least if the transport was friendly, that could have helped. It is not easy to come this side with motorcycles especially during rainy seasons. I feel bad because some beneficiaries especially children require frequent follow up especially at these early stages of the project to help them comply with the referral services and we see some children do not comply with their referrals”* [CMO_4]

Similarly, some children mentioned that, they like the project (CIM project), but they were concerned about the way project staff stays long without visiting the households. One child felt that, this challenge affects his understanding about the project as well as the quality of support received from project implementers: *“I like this project because they tell us about the importance of education and that we can get opportunity for vocational training. But sometimes I find difficult to understand the project better, since the staff stay long without visiting us, they do not visit us frequently so although they have explained to us about the project but that was not enough as they were supposed to come back and explain to us more”* [Boy_03].

One caregiver had the opinion that limited staff visits to the beneficiaries’ site can be a barrier for children to access social, economic and health services [Caregiver _4]

Long distance to the referral services

Both beneficiaries and the project staff reported the difficulties encountered by the beneficiaries when accessing the referral services. This problem is critical in Chunya and Songwe where the field sites are located several miles from where the CMOs reside. They mentioned that most health facilities are located far from where the beneficiaries stays, and some beneficiaries have financial inadequacy and so they can’t afford transport fare to the health facilities. One CIM project coordinator explained that he has heard

cases of caregivers who stays long without accessing the referral services such as collecting children's birth certificates from the district offices while complaining about lack of transport fare [Project coordinator_01]

Inadequate funds to support referral services

CIM project implementers mentioned that inadequate funds to support comprehensive escorted referral, pose a strong challenge in ensuring that the project beneficiaries adhere to all the referral services. They reported that CIM project has adequate funds to support escorted referral that relates to child violence, nutritional services and HIV services but there are no funds allocated for other health conditions such as problems related to eyes, fever, birth certificates and so forth.

One CMOs had the following explanation: *"You know that CIM project only support escorted referral for health conditions such as HIV, nutrition and violence. Sometimes you may refer the beneficiaries to certain services as per the service plan, but after sometimes you may receive a call that a beneficiary wants escorted referral since they have no fare. But you may realize that the health condition that need assistance does not fit within the allowable cases for escorted referral. So, there will be no support provided to such cases. Some caregivers may decide not to attend the referral services, or they may take a long time to respond to the refereed services because they do not have funds. If the project fails to support something like birth certificate, is very serious because it can be a missed opportunity to protect children from violence because the information on age matters a lot in such context"* [CMO_3]

Limited communication networks

Both the project implementers and beneficiaries reported that there is no smooth network at the beneficiaries' sites. They said that this problem is contributed by lack of electricity, poor communication infrastructures and lack of solar system, because people cannot charge their phones. One CMO mentioned that lack of smooth communication especially in Songwe and Chunya increases the cost and work load to the CMOs as they are forced to return to the field services several times. Poor communication network can delay appropriate action towards events of child abuse that requires immediate report to the people concerned: *"You know some problems could just be solved by having a smooth network, but sometimes we are forced to go back to the field sites several times just because we could not reach the beneficiaries through phone. This also increases the transport costs. Lack of electricity and solar system makes difficult for people to charge their phones but all in all the network is very poor in the mining areas"* [CMOs, 02]

Poor economic status of the households

Affordability of transport costs to health facilities is a challenge and hampers attendance at services to which beneficiaries are referred. The project implementers have noticed this challenge and they had plans to link the beneficiaries with mobile services such as HIV testing services provided by other organizations and they promote joining VSLGs: *"I have seen several beneficiaries who were referred to various services, but it is almost 2 months now, they have not gone to these services. When I ask them, they said that they do not have transport fare. That is why we are trying much to link them with the village savings groups because we believe that through these groups they will improve economically"* [CMO, 01]

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Another caregiver expressed his concern regarding financial constraints: *“They (CMO) told me to collect my child’s birth certificate but I have not managed, I do not have transport fare, you know it is very expensive!, it costs about 50,000/= from Ifumbo to Chunya”*

[Caregiver _02]

Mobility of the population

The project implementers were concerned about the mobility of the beneficiaries since the beneficiaries keep on moving to newly discovered mining areas. This has created a barrier for effective follow up and compliance to the referral services. A technical advisor had the following view: *“I think most of the challenges that we experience (in CIM project) can be fixed, but our beneficiaries are very mobile and so far, we have several of them that we cannot trace. This is a real challenge to the project because our key goal is ensuring that the beneficiaries’ health and social economic life is improved. You understand that we need to reach the UNIADS three 90s goals so it is important that those who have been diagnosed with HIV infection are able to comply with the services so that their viral load could be reduced. As these people move to different areas in search for minerals, it has been hard for our staff to reach them”* [Technical advisor_01]

5.2.5 Collective action-Facilitators

Training

The implementers felt that training is one of the key ingredients that drives the wheel of CIM project. They reported how during the training sessions, they are equipped with relevant knowledge and skills that enable them to implement their roles. They further added that during the training sessions they have been guided through the various project SOPs. Training set relevant skills and enhances staff's ability to engage in the required set of practices. It also provides staff with confidence to perform their daily work. One CMOs expressed how the training component is part of CIM implementation process:

"The good thing with all USAID Kizazi Kipya projects (including CIM), is that training is part and parcel of the implementation process. I remember at the initial stages of the project, they trained us on how to conduct the case identification, referral, linkages, HIV risk assessment and psychosocial support. Each project's component is preceded by a relevant training. This makes us confident and capable of engaging in our works because you engage in your roles while you are already aware about the implementation process. Like now there is a new component which is about to be launched (FURAHA), and we will soon attend the training" [CMO_2]

Implementation facilitators that relate to collective action concerned mainly the conducive context that supports the project implementation:

- a) Regular training, build accountability, maintain staff confidence and set skills for practices
- b) WhatsApp groups creates friendly avenues for interaction and learning
- c) Regular supervision provides opportunity for consultation and feedback

Some beneficiaries also pointed that, they are also trained on economic aspects which helps them to engage in village savings groups: *"apparently, we are being trained on how to start the savings groups, how to initiate the business and how we can make savings out of our businesses. I think this will help us because, there are sometimes when you need to solve the problem immediately; sometimes a child has fallen sick or the child need school fee, so if you have some savings you can solve these problems* [Caregiver_03]

Supervision

The CIM project staff possessed a positive opinion regarding the regular supervision which has been conducted by technical advisors from the national and cluster levels. They said that these supervisions enhance their engagement in work because they get an avenue to consult and they receive immediate feedback. Supervision enhances interactional workability where sets of practices are managed through on-the-job orientation sessions, meetings and discussions.

WhatsApp groups and face to face meetings

The interaction among the project implementers is an important element for them to engage well in the implementation process. The project staff reported that each CIM staff is connected through a WhatsApp group which provides an avenue for staff to communicate and learn from each other's experience. *We are all connected through WhatsApp group, through this group we receive project updates, we also exchange views and experience. We share events that we come across during our daily routine [...]. The*

Whatsapp group connects all staff from where CIM is being implemented (Songwe, Chunya and Bukombe). I think this is good because I have seen people asking for help from other staff and some of us have been learning from those clarifications [CMO_03]. Apart from the WhatsApp group, the CMO reported that they usually meet with other staff working for the general OVC project to discuss about areas of collaboration and improvement.



Figure 5: CMOs meet the LVs and CCWs at every end of the month to discuss about project progress

5.2.6 Collective action-Barriers

Inadequate human resource

CIM project implementers mentioned that the CMOs are few compared to the workload. They compared the amount of staff available for the CIM project with those who work for OVC general. They felt that the workload reduces their efficiency and capacity to conduct effective follow up for all project beneficiaries. One CMO had the following description: *“at each month, each CMO is required to provide referral and linkages services for about 80 to 100 households (most of the households lives in long distance/scattered villages). Specifically, each CMO need to prepare a care plan, provide psychosocial support, economic education, nutritional education, child protection services, follow up visits and data entry”* [CMO_05]

Financial challenges

The CIM project implementers felt that although there is timely disbursement of funds from Pact, bureaucracy in accessing funds at the field site is a critical challenge. They further advised that it would be important for each implementing office to have an accountant who will facilitate quick transactions at the field sites because so far, the field sites do not have accountants. One CMO reported that constraints

in accessing funds at the implementation sites affect their response towards emergency events: *“CIM project is adequately funded but the challenges is for us (CMOs) to access funds at the field sites for field operations. There are some instances where we need to rush to the field for emergencies for issues such as child abuse, but remember our transport modality (motorcycles) is not friendly, so we must borrow a vehicle from the district, but when we apply funds for fuel it takes so long to receive it, by the time you reach the field site it is too late to act. They told us that we can use our money and be reimbursed but once we have used our money, it also takes so long to be reimbursed”* [CMO_01]

Perceived incompetence in conducting economic and nutritional work

Project staff especially CMOs, felt incompetent in conducting economic and nutritional sessions with the beneficiaries since they have not yet received adequate training in those components. This may potentially limit their full capacity to deliver the related services: *“As I said, we have been exposed to a number of training sessions for each CIM project component, but I still feel that we have not been trained enough on economic and nutrition. But they (Pact) have promised to conduct such training soon”* [CMO_04]

5.3 Views and experiences

Views and experiences of beneficiaries (caregivers and children) as well as of implementers are addressed under the Reflective monitoring construct of NPT.

5.3.1 Acceptability of the project

The project implementers, beneficiaries and partners appraised the CIM project, indicating their strong acceptability of the project’s interventions. They felt that the CIM project is important and well accepted by the people who are in the project and those who are outside the project. Some felt that the project is accepted because of it comprises of multiple interventions. They advised that the project should be well managed to ensure that the project meet its goal: *The way I see is that this project is accepted by most people, those who are in the project and those who are outside the project. But the project should be well managed to ensure that the children receives good education which will help advance their employment career* [Caregiver_02].

Acceptability of the project is one of the key elements that contribute to the successful implementation. One project leader felt that CIM project is acceptable because it is focused on multiple services: *“This project is different from other projects that we have seen here, I think people accept it because it (project) does not only provide health services, but it also helps children to proceed with education. Women are also encouraged to be in the economic groups, and I have seen some parents being motivated to pick their birth certificates and so forth. I also sit at the village social protection committee and I am pleased to see how the project people have awoken us to follow up on children’s welfare”* [Ward executive officer_01]

One implementer mentioned that he likes the project because of its integrated nature and that they receive adequate support from Pact: *the uniqueness of this project is that the health component is positioned within several other social-economic components. I also like this project because we can always consult and seek support from Pact people* [Project manager_02]

5.3.2 Perceived changes due to CIM project

In the process of appraising the project, the beneficiaries and the project implementers felt that although the project has not been implemented for a long time, they could still see some changes. They reported that the main changes include women's engagement in economic savings groups and business activities such as gardening and groceries, and children improved nutritional status and re-enrolment to schools. One woman had the following view: *What I see now is that more women are now passionate to start small businesses such as vegetable gardens and small groceries. I think they are using the money from VSLGs. I can also see improvement in children's health, you know, before the project we used not to take our children to the hospital for nutritional check, only we knew is deworming them. But after the education (nutritional education) we not only deworm them, but we assess their health if we see that they are not growing well, we take them to the health facility for nutritional advises* [Caregiver_04]

One adolescent also felt that there are changes associated with the project activities: *"I think that we have changed our behaviours because these project staff teaches us different aspects such as how to protect from violence, how to avoid HIV infection and the importance of education. Like me now, what I want is vocational training, I don't want to continue working in the mining anymore, I know, if I get education, I will get a job and will help my parents"* [Boy_03]

5.4.3 Perceived sustainability of CIM project

When there is an intrinsic motivation among the stakeholders to support the implementation process and support its success, it is possible that there may be willingness to sustain the project interventions. The project partners, especially the district officials, indicated a positive opinion regarding the sustainability of CIM project. Firstly, they mentioned that they are happy if the project could be sustained because it has reached the hard to reach population (children in the mining) which the government has never managed to reach. Secondly, they felt that, there is a potential for CIM project to be sustained since the implementers collaborated with various partners:

Participant's discourses that relates to reflective monitoring depicted that:

- a) CIM project is accepted due to its multiple interventions and integrated nature
- b) There are already some changes which are linked to CIM project
- c) There is a potential for CIM to be sustained due to collaboration with the district and local leaders however
- d) Limited feedback to government offices at national level about the progress of CIM project is a potential threat to the already established collaboration between the ministry and Pact. This is something that can potentially affect the effective implementation and sustainability of the project services

"First of all, I think Pact is our partner who have assisted us to reach the 'hard to reach population (children in the mining)' which we (government) could not reach. They reached out to us with the idea and were interested to collaborate with us. It is us who accepted this project. This is a very challenging group and we had no idea on how we could reach children in mining. Therefore, the modality (referral and linkage) which is being used (by CIM) to provide services to the mining community, should be sustained and should only focus the hard to reach population" [DMO_01]

Sustainability is a challenging issue but since the project staff collaborated with most of us (partners), there is a possibility to sustain it, but this also need a discussion among the CHMT members [DMO_02]

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In contrast, at national level, one representative from PORALG in reflecting about the changes and sustainability of the project was concerned that Pact had not shared progress reports with them. He felt that there was an opportunity for them to advise the project in a way that the effectiveness and the sustainability could be achieved, but they are not in a position to do so, because apparently there has been limited interaction between PORALG and Pact about the CIM project. He considers this to be a challenge:

“What is good about the project is that it targets the vulnerable population groups and HIV is the main health targeted area. However, my concern is that although we participated in the initial setting up of the project but have never been informed about the progress. So, when you ask me about the changes, I have nothing to say about that because apparently I do not know what has been implemented and what are the changes [.....]. If pact (CIM) project could be sharing their progress with us, we would advise them on how the services could be sustained. Remember Pact signed an MoU with the ministry of the government but now the feedback on their progress is lacking, I consider this to be a big gap! [Representative_ PORALG]

Similarly, another staff from the child labour department had the concern that she has not received reports from Pact, and thus she is not aware about how the project has evolved, what has been implemented and what not. She felt that she cannot provide advice because she has never had opportunity to meet the project people since she participated in the identification process [Labour officer_01]

6. Discussion and recommendation

This process evaluation, carried out 5-6 months after start of project activities, shows that important conditions for an effective implementation process have been satisfied: most of the project's components have been implemented, implementers understand the project goals and find them relevant and important. They know the project's components and their own role in the project. They collaborate well with each other and district officers. They are well trained on most, but not yet all, aspects of their job including nutrition and economic livelihood. Supporting job aids such as SOPs are present, understood and used and supervision and peer-learning through a WhatsApp group for weekly conference calls further supports effective implementation. The stakeholder involvement process during project design, beneficiary identification and project implementation has resulted in many engaged collaborators at district, ward and community levels. Beneficiaries and implementers alike appreciate the project. Its integrated nature, i.e. that the project addresses many domains simultaneously, fosters high acceptability.

However, there are several barriers cited, some of which may be addressed by project adaptation, whereas others are inherent to the setting of mining communities or are limitations of the project's mandate.

Stronger ongoing engagement after the initial stage *is needed at national level*. Most beneficiaries had a rather restricted understanding of the project's components, which could be a reflection of the early stage the project is in and can be addressed by **more explanation during subsequent household visits**. Also, **project promotion in community meetings** could lead to broader community awareness of the project's goals is important because the success of the project will also depend on how significant others support the project beneficiaries.

For improved reach of the CIM intervention components, it is important to **employ more CMOs**. We recommend at least 4 CMOs per site, this will help exchange of responsibilities and division of beneficiaries. Current inadequate number of the staff hampers full implementation and might compromise quality. In the meantime, **the village leaders especially the hamlet leaders who are closer to the beneficiaries can assist the CMOs** doing follow up for non-technical activities. Also, CMOs need to be **capacitated to provide quality nutritional counseling**.

Health care providers' unfriendly attitude to project participants may be related to their view that USAID Kizazi Kipya participants bring more work because additional referral feedback forms have to be filled. This might be solved by e.g. **a formal directive from the DMO, frequent interactions between the CMOs and the respective health care providers**, and more **explanation on the reasons for the use of the national MVC referral forms** for this hard-to-reach population.

Changing the culture of working in mining that has persisted throughout generations will take time, and replacing this with an alternative narrative of possible life trajectories will need examples of families who succeeded in reducing their reliance on mining income brought in by the children and ongoing opportunities to do so for other families – which the project is offering. The project might further contribute to this process through **more community education on the long-term detrimental effects of child labour in mining**.

The long distances between beneficiaries' homes and service sites and therefore high cost for transport are inherent to the context, but some services (e.g, ART dispensing) might become available in the future

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through community distribution and/or mobile clinic outreach. The project could support this process e.g. by **forming HIV support groups that aim for joint ART drug dispensing**. Pilots for these are currently being evaluated in Tanzania, and the government would need to endorse this model for application in various settings. Extending **escorted referral for other services, paid for by the project** is another solution, but is sometimes hampered by late disbursement of funds at the field site level. The limited communication network in the mining areas and the mobile nature of the beneficiaries are probably difficult to address by the project.

During next, second, process evaluation round, planned for July – August 2019, all project activities will have been fully operational for at least 6 months. During that PE round, a more restricted set of in-depth interviews will focus on the barriers that have been identified in this round. Funds permitting, a full set of structured observations will be done by research assistants ‘shadowing’ CMOs during their work to assess fidelity of project implementation. Lastly, all quantitative indicators calculated from monitoring data will be updated and compared to PE round 1 levels.