

EVALUATION OF

MSF'S CERVICAL CANCER
INTERVENTION
IN GUTU, ZIMBABWE

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ACRONYMS

AAP	Accountability to Affected Populations
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
DAC	Development Assistance Committee
DDC	District Development Coordinator
DSI	District Schools Inspector
EPI	Expanded Programme for Immunization
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HQ	Headquarters
IEC	Information, Education and Communication
LEEP	Loop Electrosurgical Excision Procedure
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MoHCC	Ministry of Health and Child Care
MoLG	Ministry of Local Government
MoPSE	Ministry of Primary and Secondary Education
MRCZ	Medical Research Council of Zimbabwe
MSF	Médecins Sans Frontières
NatPharm	National Pharmaceutical Company
NGO	Non-Governmental Organization
OCB	Operation Centre Brussels
OECD	Organization for Economic Cooperation and Development
OPD	Out-Patients Department
OR	Operational Research
PED	Provincial Education Director
RHC	Rural Health Centre
SEU	Stockholm Evaluation Unit
TAH	Total Abdominal Hysterectomy
TB	Tuberculosis

TOR	Terms of Reference
UNFPA	United Nations Population Fund
VHW	Village Health Worker
VIAC	Visual Inspection with Acetic Acid and Cervicography
WHO	World Health Organization
WLHIV	Women Living With HIV/AIDS

EXECUTIVE SUMMARY

This evaluation report presents our findings, conclusions, lessons learnt and recommendations from the summative evaluation of Médecins Sans Frontières (MSF) project on “Cervical Cancer intervention in Gutu, Zimbabwe”.

PROJECT BACKGROUND

Médecins Sans Frontières commissioned the cervical cancer project in Gutu in August 2015 (leveraging on its HIV/AIDS and TB project) focusing on cervical cancer prevention, diagnosis and treatment for both women living with HIV (WLHIV) and the general population. The general objective of the intervention was to reduce the morbidity and mortality from cervical cancer in Gutu. The specific objective was to increase access to preventative and curative services. In addition, MSF's project intention was to demonstrate the feasibility of a working decentralized model of cervical cancer services to district and community levels in a rural setting. In collaboration with the Ministry of Health and Child Care (MoHCC), MSF operated at different levels of care such as outreach, four rural health centers, one district and two mission hospitals, offering among others capacity building and technical support. The project also included two operational research studies namely: Human Papillomavirus Virus (HPV) vaccination among HIV-infected adolescent girls and young women aged 15 to 26 years old and Pilot of Xpert HPV Testing and Self-Sample Collection for Cervical Cancer Screening.

EVALUATION OBJECTIVES AND METHODOLOGY

The overall evaluation objective was to assess whether the cervical cancer intervention achieved its expectations with respect to appropriateness, effectiveness, and efficiency criteria as well as to identify the lessons learned that could be considered in similar interventions. This evaluation was conducted in all four intervention rural health facilities (Chimombe, Mukaro replaced by Serima Mission in October 2020, Chinyika, Chitando), one district hospital (Gutu Rural), two mission hospitals (Gutu and Serima) and catchment communities, including outreach areas in the district. In addition, referral or supporting health facilities i.e. Muvonde Mission hospital, Newlands Clinic (Harare) and Masvingo Provincial hospital were included in the evaluation by interviewing key informants to understand their contributions to the MSF project. However, these last ones were not assessed during the evaluation as they did not receive direct MSF support.

To assess how well the cervical cancer intervention in Gutu district met its objectives as well as the overall implementation of the program activities and performance, we used the Organisation for Economic Cooperation and Development - Development Assistance Committee (OECD/DAC) criteria looking specifically at appropriateness, effectiveness and efficiency criteria. Findings from the evaluation questions have supported the development of conclusions and lessons learnt.

The evaluation employed a mixed-methods approach which included desk review of project documents (project plans, log frames and reports), operational research protocols and reports, WHO and MoHCC strategies/guidelines and external literature from related interventions. Secondly, the

evaluation analysed routinely collected data from the project obtained from different services over the implementation period. Thirdly, the evaluation used key informant interviews of stakeholders (47) and interviews (29) and focus group discussions (5) of beneficiaries/potential beneficiaries. Health facility assessments of all intervention facilities (7) were conducted using a standardized checklist adopted from the WHO. Unstructured direct observations were also conducted to triangulate findings from other sources mentioned above during the field visit.

The evaluation encountered some limitations mainly; a weak monitoring and evaluation system which presented gaps in our secondary analysis, COVID-19 pandemic which affected the availability of some key informants, high turnover of key staff members. In addition, communities and beneficiaries/potential beneficiaries were not aware of standard care and this may have limited their capacity to critically appraise the cervical cancer services analysed by this evaluation.

The evaluation team observed protection of confidentiality, human rights, and individual dignity, as espoused in the Belmont Declaration and SEU ethical guidelines. Safeguards related to COVID-19 infection prevention were also put in place to protect human subjects during the collection and subsequent storage of data. Verbal informed consent was obtained before participation and use of audio-recording devices in the evaluation from all selected participants. Information sheets were used to provide relevant details to the participants concerning the purpose and expectations of the evaluation. For girls (under 18 years) their verbal assent and parental or guardian verbal consent was obtained before their enrolment for interviews/discussions.

SUMMARY OF FINDINGS

APPROPRIATENESS

In this first evaluation criteria, we considered the extent to which the project objectives were tailored to the identified needs, the tools (methodologies, situation analysis, needs assessments etc) used to gauge needs, involvement of affected populations in needs assessment, delivery and monitoring of project and alignment of project with others within MSF and with those of MoHCC and its implementing partners.

The MoHCC introduced a cervical cancer screening programme in 2014 at Gutu Mission hospital. However, one health facility was not adequate to cover the needs of women in the whole district. There was no formal needs assessment and community engagement by MSF at the beginning of the project. However, beneficiaries reported that they were able to give feedback informally to MSF/MoHCC which was used in monitoring the intervention. The MSF's cervical cancer intervention was aligned to the MSF's HIV/AIDS and TB project. MSF's cervical cancer intervention contributed to the ongoing efforts by MoHCC and other actors on improving access to cervical cancer services. The approach used in the project included the intention to demonstrate a working decentralized model of care in which health workers were trained in screening and treatment and health facilities were capacitated with equipment and commodities. The project considered socio-cultural norms by allowing women to consult their spouses or male partners, if they requested, before receiving services

such as cryotherapy, LEEP and surgery. Women who were not comfortable being attended to by a male VIAC nurse were given the opportunity to be seen by a female nurse. The communities reported that they had confidence with the MSF's project because they were available on the ground. The beneficiaries also mentioned that the availability of free services improved their usage of the services. There were however shortcomings in the continuum of care for women diagnosed with invasive cervical cancer.

EFFECTIVENESS

The second evaluation criteria that we considered was effectiveness with the focus being on project implementation in the district (e.g. whether defined objectives were achieved, whether project activities reached the target population, success factors of the project, challenges and how they were overcome, the differences the project made to policy/practice locally and what worked well or less etc).

The MSF project in Gutu reached 25,594 women over the period 2015-2020. The number of women treated for pre-cancers with cryotherapy/thermococoagulation was 1,336 over the same period. As more women accessed screening and treatment, the project showed a decline in VIAC positive rate from 19% in 2015 to 4% in 2020. Intervention health facilities were capacitated with trained staff, equipment, infrastructure and commodities to provide cervical cancer services. However, some shortfalls were identified in the monitoring and evaluation system, accountability to affected populations, patient follow-up/monitoring mechanisms, integration of palliative care within the project and referral systems for patients diagnosed with cervical cancer to the next level of care or tertiary health facilities. This evaluation showed some positive unintended consequences of the project including getting more women testing for HIV, and task shifting of cervical cancer services from midwives to general nurses. Some of the unintended negative consequences were dependency creation among beneficiaries, health facilities and health worker attrition. MSF handed over the project to MoHCC in September 2020 and with the support from JF Kapnek services have continued in the district.

The MSF project reached 25,594 women with VIAC screening but the routinely collected data did not include variables which might have been used to analyse access to or use of services by some vulnerable populations such as sex workers, disabled women and women from hard-to-reach areas. This evaluation has identified some of success factors of the project notably; good collaborations with MoHCC and other stakeholders, good relationships with communities as well as competent and motivated human resources. Some of the hindrances to the project were: equipment challenges especially cryoguns and cameras, high levels of loss to follow-up among patients referred for LEEP, biopsies or hysterectomies and long turnaround times for histology results and lack of a robust M&E system. The project had mechanisms to identify to challenges but there were gaps in some of the responses to the challenges. Beneficiaries' feedback mechanisms, which evolved during the project implementation, although informal were also utilized to improve performance. Some barriers to accessing services have persisted mainly: lack of knowledge, religious beliefs, inaccessibility/unavailability of treatment services for invasive disease, limited coverage of services in communities far away from intervention facilities, and long turnaround times for histology results.

Some of the potential improvements include: strengthening awareness and health education including targeted campaigns of some religious groups, strengthening referral pathways to tertiary centres for women with invasive cervical cancer and increasing the coverages of outreach campaigns to reach more women. MSF project influenced policy and practice among other implementing partners in Zimbabwe mainly: decentralization of services including using the outreach approach, 'see and treat' approach in a decentralized model of care, capacity building and task shifting of cervical cancer screening and treatment to general nurses. However, there was no clear advocacy strategy from the inception of the project and the influences realized were indirect through e.g. stakeholder meetings.

EFFICIENCY

We finally considered the efficiency of the project focusing mainly on usage/allocation of resources i.e. human resources, equipment and commodities and timeliness of implementation of the project.

The approach used by MSF utilized a VIAC mentor and driver as dedicated staff. Additionally, the project engaged 35 VIAC nurses, one clinical officer, one government medical officer as well as other support staff from the HIV/AIDS and TB project. Equipment mobilized included cryoguns, thermocoagulators, cameras, laptops/desktops nitrous oxide gas tanks and a LEEP machine and these were strategically allocated in health facilities depending on the nature of services they provided. The commodities which were procured under this project included: acetic acid, cotton wool, nitrous oxide, gauzes, lignocaine and others. Main identified challenges for timely delivery were related to equipment breakdowns at the beginning of the project and more recently the COVID-19 pandemic. The main gap identified was equipment procurement which should have been carefully planned and done to ensure that appropriate equipment compatible and adaptable to the context were sourced. This also points to the criticality of a comprehensive needs assessment which could have informed the requirements/capacities for the project including equipment. The project could have engaged an additional VIAC mentor after one of the mentors left MSF. A gynaecological oncologist/trained gynaecologist could have been involved to stage patients and ensure quality of surgeries for women with cervical cancer.

CONCLUSIONS

CLINICAL ASPECTS

The MSF project was effective in reaching a significant number of women with different services over the six years of implementation. This enabled eligible women who previously had no access to screening to access screening and treatment using the 'see and treat' approach. This potentially prevented them from developing invasive cervical cancer. Though the project was biased towards prevention, it supported diagnosis and surgical treatment of women with invasive cervical cancer. However, most eligible women were not able to have the hysterectomies. For most women who underwent hysterectomies, the surgery was suboptimal care as they were done by non-experts and there was follow-up of these women.

Some women diagnosed with advanced cervical cancer not eligible for surgery were supposed to be referred to tertiary centres for chemo/radiation therapy and palliative care and this was not done. This

potentially discouraged other women from utilizing screening services. In the MSF project there was lack of integration of palliative care services in the treatment of women with advanced cancer. The challenges faced with treatment of women with invasive cervical cancer could have been averted by strengthening referral pathways to tertiary centres at the beginning of the project. Loss to follow-up was identified as a key hindrance to the project among women referred for LEEP, biopsy and hysterectomies due to weak follow-up/monitoring mechanisms in health facilities.

This evaluation could not assess some indicators due to gaps in the routinely collected data.

FEASIBILITY OF THE MODEL OF CARE

The model of care demonstrated by MSF had its own strengths and weaknesses. Notably, it avoided creation of parallel structures by integrating services into already existing health facilities. This allowed the project to be implemented in a timely manner. The MSF model of care demonstrated the feasibility of rapidly scaling up screening and treatment of precancers in a rural setting. This is highly recommendable as lack of access to screening especially for rural women remains a huge unmet need.

PROJECT MANAGEMENT

The MSF project responded to the needs of the affected population which were identified through formal and informal means. The lack of a formal needs assessment was a missed opportunity to clearly identify the people in need, define specific targets and to obtain feedback directly from the beneficiaries as part of the AAP approach.

MSF utilized its existing good collaborations and relationships with stakeholders and beneficiaries in the implementation of the intervention. This resulted in buy-in and support from the communities and local leadership and was one of the key success factors of the MSF project.

This evaluation could have been more comprehensive should all the key data points have been available in the M&E system. Additionally, MSF adopted the M&E tools from the MoHCC which had inherent weaknesses and no further strengthening was conducted during the project implementation.

INTERVENTIONS AIMED AT INFLUENCING POLICY AND PRACTICE

Some of the aspects of the model of care demonstrated by MSF under this project were adopted by one MoHCC partner through multi-stakeholder meetings at the national level and learnings shared informally. The influence of the MSF project on national policy/practice could have been better with a clear advocacy strategy right from the beginning.

LESSONS LEARNT

Our evaluation concludes with some lessons learnt (below) which are targeted primarily at MSF; however, they may be useful to MoHCC and its implementing partners working in the cervical cancer spaces.

GENERAL PROJECT MANAGEMENT

L1. Needs assessment and midterm reviews

- There is need to conduct comprehensive needs assessments or situation analysis before designing or implementing projects. These assessments allow identification of people at risk, people in need and people to be targeted based on clear criteria. These are key also to inform the existing technical capacities in the district/province/country for better planning. Mid-term reviews are recommended to allow for identification of gaps that could be rectified before a project ends

L2. Monitoring and evaluation systems

- Development of robust M&E systems informed by findings from needs assessment or situation analysis before starting projects is critical for programme effectiveness
- It is good practice to identify key performance indicators to be used to monitor project performance

L3. Accountability to affected populations and community engagement

- Obtaining opinions and thoughts directly from the affected population during design, implementation and monitoring of projects is best practice in development or humanitarian interventions
- It is recommended to develop formal feedback mechanisms at community and health facility levels, and these could include suggestion boxes, client exit interviews and surveys
- Adoption of the AAP approach within projects to obtain more buy-in, ensure more community ownership/involvement and better project performance is widely considered as good practice
- There is need to promote engagement and active participation of community members/ actors to set up and improve health interventions
- Engagement of local leadership in the planning, design, implementation and monitoring of interventions is a key success factor for projects

L4. Good collaboration with Ministries of Health and other actors

- There is need to establish good working relationships with Ministries of Health to ensure buy-in and smooth implementation of projects
- NGO partners should also work closely and collaborate with other actors for better coordination and effectiveness

L5. Competent and motivated human resources

- Before implementing a project there is need to identify motivated human resources and provide them with adequate training to ensure effective intervention delivery
- There is need to strive to retain trained staff to ensure that interventions deliver on the expected outputs/outcomes

L6. Advocacy strategies/plans

- For projects aimed at demonstrating the feasibility of new interventions, conducting ORs during project implementation is recommendable as it has a potential to generate information that may influence practice or policy

CERVICAL CANCER DECENTRALIZED MODEL IMPLEMENTATION

L7. Health promotion and awareness

- Health promotion and awareness are essential components of projects designed to improve uptake or access to cervical cancer services
- Awareness campaigns also help to address myths and misconceptions which may be key barriers to utilizing or accessing cervical cancer services especially in rural contexts
- Systematic health promotion and awareness activities may also be used to obtain vital feedback from communities on the performance/acceptance of cervical cancer interventions

L8. 'See and treat' approach

- "See and treat" approach will ensure that most women will receive treatment on the same day of screening thereby reducing loss to follow-up
- Where possible LEEP should also be scheduled on the same day of screening to increase uptake of the services
- Follow-up mechanisms should be established or strengthened for the approach to be more effective

L9. Outreach services

- Offering screening and treatment using the outreach approach will increase access to services including for women in hard-to-reach areas
- Use of thermocoagulation for treatment of pre-cancers makes outreach services more feasible and effective compared to use of cryotherapy

L10. Task shifting in low resources settings

- Due to shortages of qualified health workers in low-resource setting, there is need to identify opportunities for task shifting as part of decentralization of cervical cancer services
- Task shifting is however feasible in contexts with health workers with basic training and who are motivated coupled together with existence of appropriate capacity building and mentoring programmes

L11. Referral pathways and continuum of care

- Commencement of any screening programme will lead to the identification of women with invasive cancers. Therefore, project implementers should develop/strengthen and adopt clear referral plans before commencement of screening interventions
- Engagement of gynaecologist in cervical cancer screening interventions is vital to ensure good quality of care throughout the continuum of screening and treatment. However, a gynaecologist does not work in isolation and he/she needs a strong community of other health professional and a functional health system to provide optimal care
- Continuum of care is a contribution of multiple actors and it requires the government to take a leadership role for it be effective

L12. Integration of palliative care

- Palliative care approach should be embraced as standard practice for chronic disease related interventions
- Psychosocial support is integral part of palliative care and should be strengthened as part of the cervical cancer interventions

L13. Government investment

- NGO partners should advocate to the government to prioritize more investments to strengthen and establish more public cancer treatment centres across the country
- Government should provide leadership to partners at central level to minimize duplication of activities
- Government should establish effective technical working groups responsible for establishing standards of care and guidance on equipment and commodities to be used across the nation

1 INTRODUCTION

This is the Evaluation Report of “MSF’s Cervical Cancer intervention in Gutu, Zimbabwe”, (“the project”) implemented between August 2015 and September 2020. The report presents our evaluation findings, conclusions, lessons learnt and recommendations.

In this section, we give a brief background of the project (Section 1.1) followed by evaluation objectives and methodology (Section 1.2) and finally the structure of the evaluation report (Section 1.3).

1.1 PROJECT BACKGROUND

In August 2015, leveraging on the existing HIV project in the Gutu district of Zimbabwe, Médecins Sans Frontières (MSF) expanded its activities to include interventions focused on cervical cancer screening for both women living with HIV (WLHIV) and the general population. The cervical cancer intervention evolved into a separate project though with significant interlinkages with the HIV/AIDS and TB project. The HIV/AIDS and TB project was completed and handed over together the cervical intervention in September 2020.

The general objective of the cervical cancer intervention was to reduce the morbidity and mortality due to cervical cancer in the Gutu district with the specific objective being improvement of access to both preventive and curative services. In addition, the MSF project had the intention to demonstrate the feasibility of scaling up cervical cancer screening and treatment services for women by MoHCC in a decentralised rural district in Zimbabwe. In collaboration with the Ministry of Health and Child Care (MoHCC), MSF operated at different levels of care such as outreach, four rural health centers, Gutu rural district hospital, and two mission hospitals (namely Gutu, Mukaro until 2020, and Serima from 2020), offering among others capacity building and technical support.

The MSF cervical cancer project’s approach was to capacitate the existing government health facilities with training of health workers, and timely provision of equipment and commodities for the management of cervical cancer. This was done to avoid establishing parallel structures specific to the management cervical cancer (which MSF called “light approach”). The same light approach had been used successfully for the HIV/AIDS and TB project in the same district. The medical package included in the MSF project plans covered screening and treatment of precancerous lesions using the ‘see and treat’ approach. The ‘see and treat’ approach involved women with VIAC positive results being treated on the same visit, hence minimising the risk of losing women to follow-up. MSF also supported histopathological costs for those undergoing LEEP and those with suspected invasive cervical cancer. The initial package involved also referral of suspected or confirmed invasive cancer cases to secondary/tertiary level for surgery and chemo/radiotherapy. However, due to limited availability of treatment services in secondary/tertiary health facilities MSF decided to support eligible women to have surgery in nearby mission hospitals. In addition to the above services, MSF also conducted awareness raising and health promotion/education in the communities and intervention health facilities. This was meant to educate and sensitize the communities and increase uptake of cervical cancer services.

In addition to piloting a model of decentralized service delivery, MSF supported the roll-out of the HPV vaccination among girls aged 9-13 years between 2018 and 2019. Furthermore, MSF conducted two operational research studies to demonstrate the feasibility of HPV screening using self-collected swabs on the Gene Xpert platform and HPV vaccination catch-up campaign among HIV positive adolescents and young women aged 15-26 years (see Table 1.1 and 1.2).

The project was handed over to MoHCC and its partner, JF Kapnek in September 2020. The table 1.1 below outlines the cervical cancer services rolled out as part of MSF cervical cancer project in Gutu district, since its start.

Table 1.1. Cervical cancer services rolled out as part of MSF cervical cancer project in Gutu, Zimbabwe

THEMATIC AREA	SPECIFIC SERVICES
Prevention	<ul style="list-style-type: none"> ▪ Human Papillomavirus Virus (HPV) vaccination (1st and 2nd doses) campaign among girls 9-13 years conducted by MoHCC with support from MSF ▪ Human Papillomavirus Virus (HPV) vaccination among HIV-infected adolescent girls and young women aged 15 to 26 years old implemented as an operational study
Screening	<ul style="list-style-type: none"> ▪ Visual Inspection of the cervix with Acetic Acid and Cervicography (VIAC) at rural health centers and through outreach activities. ▪ Pilot of Xpert HPV Testing and Self-Sample Collection for Cervical Cancer Screening as part of operational research study
Treatment	<ul style="list-style-type: none"> ▪ Precancerous lesions (Thermo-coagulation) by outreach activities. ▪ Precancerous lesions (Cryotherapy) decentralized in five rural health centers (RHCs). ▪ Precancerous lesions (not amenable to cryotherapy and thermo-coagulation) with LEEP (Loop Electrosurgical Excision Procedure) performed at Gutu Rural Hospital. ▪ Referral and payment support for biopsies and total abdominal hysterectomies (TAH) for suspected and confirmed invasive cervical cancer cases ▪ Basic psychosocial support services for women suspected or confirmed of having invasive cervical cancer

The main milestones of the cervical cancer intervention in Gutu from 2015 to 2020, are presented in Table 1.2.

Table 1.2. Main milestones of the project

YEAR	MILESTONES
Phase 1	
2015	<ul style="list-style-type: none"> ▪ Project was started in August ▪ Selection of pilot sites for decentralized service delivery ▪ Four sites (Gutu Rural Hospital, Gutu Mission Hospital, Mukaro and Chimombe rural health centres) were selected ▪ Engaged Newlands clinic for initial staff training and mentorship ▪ Rehabilitated rooms in selected sites for VIAC and provided the required equipment ▪ Cryotherapy initiated at the four sites ▪ Awareness and health education initiated in communities and four intervention health facilities
Phase 2	
2016	<ul style="list-style-type: none"> ▪ Two additional sites (Chinyika and Chitando) rural health centres were added ▪ Awareness and health education initiated in communities and two additional intervention health facilities
2017	<ul style="list-style-type: none"> ▪ LEEP was decentralized to Gutu Rural hospital
2018	<ul style="list-style-type: none"> ▪ MSF supported MoHCC HPV campaign for first dosage ▪ Two operational research studies protocols were developed and approved by the Medical Research Council of Zimbabwe
2019	<ul style="list-style-type: none"> ▪ MSF support MoHCC HPV campaign for second dosage ▪ Outreach campaigns for cervical cancer services were rolled out ▪ Two operational studies were implemented ▪ Thermocoagulation initiated at outreach campaigns and Gutu Rural
2020	<ul style="list-style-type: none"> ▪ Basic psychosocial services initiated as a pilot ▪ Mukaro RHC was replaced by Serima Mission Hospital in October ▪ Accredited VIAC training was conducted in Gutu district ▪ Two operational studies were completed ▪ Project was handed over to MoHCC and its partner, JF Kapnek in September ▪ MSF focused on training, commodities and equipment maintenance from June-September 2020 ▪ Project office and operations closed end of December

1.2 EVALUATION OBJECTIVES AND METHODOLOGY

1.2.1 EVALUATION SCOPE AND OBJECTIVES

The main evaluation objective was to assess whether the cervical cancer intervention achieved its expectations with respect to appropriateness, effectiveness and efficiency criteria (see Table 1.3).

MSF's operational experience in cervical cancer screening was relatively limited with few projects implementing routine cervical cancer screening. Therefore, the appraisal of this intervention offered a unique opportunity for MSF to document the lessons learnt during its implementation and reflect on how it can be adapted and better implemented by MSF in similar contexts. In addition, the evaluation may be crucial to MoHCC and other actors who may be interested in replicating or scaling up similar

interventions in Zimbabwe or similar contexts. The primary users of the evaluation are therefore MSF and MoHCC.

This evaluation primarily focused on MSF supported primary and secondary prevention of cervical cancer, treatment of pre-cancers, diagnosis and referral for treatment of women with invasive cervical cancer including basic psychosocial support between 2015 and 2020. Advocacy, which was an integral part of the intervention strategy was also assessed to the extent to which the intentions or objectives were achieved.

This evaluation was conducted in all four intervention rural health facilities (Chimombe, Mukaro, Chinyika, Chitando), Gutu district hospital and two mission hospitals (Gutu and Serima) and catchment communities, including outreach areas in the district. As alluded to before, Serima Mission Hospital replaced Mukaro in late October, 2020 and there was no coverage data reported from the facility. In addition, referral or supporting health facilities i.e. Muvonde Mission hospital, Newlands Clinic (Harare) and Masvingo Provincial hospital were included in the evaluation by interviewing key informants. However, these last ones were not assessed during the evaluation, as they did not receive direct MSF support. Table 1.3 outlines the evaluation questions based on the three main evaluation criteria.

Table 1.3. Evaluation questions

EVALUATION CRITERIA	EVALUATION QUESTIONS
Appropriateness	<ul style="list-style-type: none"> ▪ Did the cervical cancer intervention's objectives correspond to identified needs? ▪ Was the chosen model/strategy appropriate to achieve the objectives? ▪ Was the intervention appropriate from the beneficiaries' perspective?
Effectiveness	<ul style="list-style-type: none"> ▪ To what extent have the defined objectives been achieved? ▪ What were the enabling and challenging factors at community (awareness), facility and hospital level for achievement or under-achievement of objectives? ▪ How did the project respond to the identified challenges? ▪ What could be done to make the project more effective? ▪ To which extent did the project activities reach the target population? ▪ Were there any factors that hindered access for the population to screening, prevention and curative services? ▪ What difference has the project made in terms of policy/practice locally?
Efficiency	<ul style="list-style-type: none"> ▪ How efficient was the project, in terms of the qualitative and the quantitative outputs achieved

1.2.2 EVALUATION FRAMEWORK

To respond to the evaluation objectives, we used the Organisation for Economic Cooperation and Development - Development Assistance Committee (OECD/DAC) criteria looking specifically at

appropriateness, effectiveness and efficiency criteria^{1,2}. See **Annex 2** for the detailed evaluation questions and sub-questions used in the evaluation based on the TORs. Findings from the evaluation questions have supported the development of conclusions, lessons learnt and recommendations (see Figure 1.2 below).

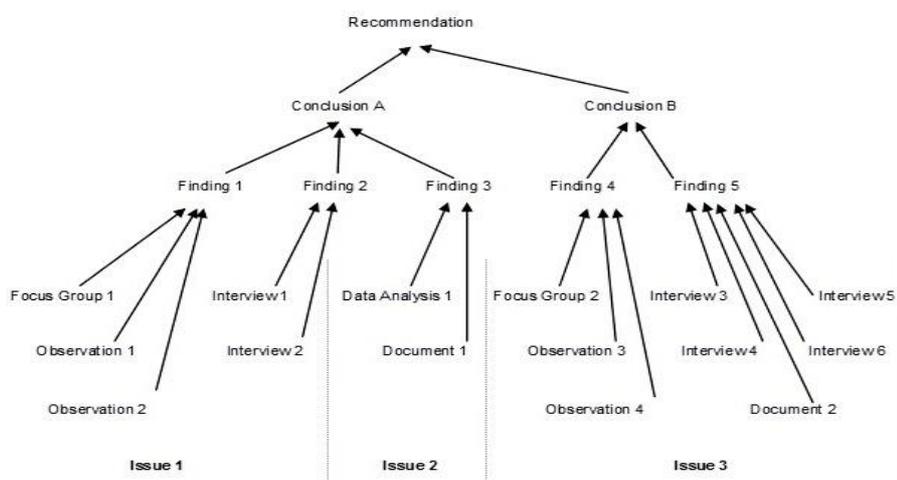


Figure 1.2. Data Analysis Process

1.2.3 EVALUATION METHODOLOGY

The summative evaluation adopted a mixed methods approach, and this included both quantitative and qualitative methods. The quantitative methods included primary data from health facility assessments and secondary data routinely collected during the project. Qualitative methods included desk reviews and primary data from key informant interviews, in-depth interviews, focus group discussions (FGDs) with purposively selected stakeholders and beneficiaries of the intervention and unstructured direct observations. Our approach also included triangulation of findings of all the different methods mentioned above to inform final findings, conclusions and lessons learnt.

A summary of the methods used in this evaluation are presented below:

- **Document review:** including a review of MSF project documents (e.g.. log frames, project plans, monthly/quarterly/annual reports, routine project data, project handover notes, operational research protocols and reports), WHO and MoHCC guidelines/reports, and external literature for similar interventions in other contexts. Annex 3 provides the list of key references, documents reviewed and used in the evaluation;
- **Secondary data analysis:** including an analysis of project data such as project results over the implementation period, 2015-2020. Data from the MSF M&E system were validated with those from the intervention facilities.
- **Interviews and focus group discussions:** including with MSF team (globally and in country- both at project and mission level) as well as other relevant stakeholders (e.g.. MoHCC staff at district, provincial and national levels), implementing partners (i.e. JF Kapnek and Newlands Clinic) and beneficiaries of the intervention. A total of 47 key informant interviews, 32 in-depth interviews

¹ OECD-DAC (1991): Principles for evaluation of development assistance. Paris: OECD/DAC. (www.alnap.org/resource/20830.aspx).

² OECD/DAC. (1999) Guidance for evaluating humanitarian assistance in complex emergencies. Paris: OECD/DAC. (www.alnap.org/resource/8221.aspx).

and five FGDs were conducted during the evaluation. Annex 4 provides the list of evaluation participants.

- **Health facility assessments:** including the assessments of all seven (7) intervention health facilities in Gutu district. Four rural health centres namely; Chitando, Mukaro, Chinyika and Chimombe, Gutu district hospital and two mission hospitals namely: Gutu and Serima. Annex 6 provides the map of the assessed (or visited) health facilities and the structured tool/checklist used in the health facility assessment.
- **Unstructured direct observations** were also conducted during the field visit particularly in selected health facilities (seven intervention and two non-intervention health facilities) and communities to triangulate data from other sources.
- **Triangulation** of findings from the above methods used was conducted to derive final findings, conclusion and lessons learnt presented in this report.

Ethical and Safety Considerations

The evaluation team was committed to the protection of confidentiality, human rights, and individual dignity, as espoused in the Belmont Declaration and SEU ethical guidelines. Safeguards were put in place to protect human subjects during the collection and subsequent storage of data. They included Covid19 related measures such as wearing of appropriate face masks, exercising physical distancing, practice of frequent hand washing or sanitization. The evaluators were trained and certified in the conduct of human research (Good Clinical Practice and Human Subject Research Ethics). The evaluation project did not require ethical approval from the Medical Research Council of Zimbabwe (MRCZ) as this was considered programme improvement and was thus exempted. However, the team observed all ethical principles of SEU and MRCZ in the conduct and oversight of the evaluation.

Verbal informed consent process was obtained before participation and use of audio-recording devices in the evaluation from all selected participants. Information sheets were used to provide relevant details to the participants concerning the purpose and expectations of the evaluation. For beneficiaries and community key informants, the information sheet was translated into the main local language which is Shona. For the rest of the participants the information sheet was in English language. In addition, for women selected to participate in the evaluation, the evaluation team requested for permission from their household heads to interview them where possible. For girls (under 18 years) their verbal assent and parental or guardian verbal consent was obtained before their enrolment for interviews/discussions. In addition, local leadership i.e. DDC, chiefs, village heads, female chaplain/pastor and local female councillors were sensitized of the evaluation project given that some of the interviews or discussions were conducted in their communities or areas of jurisdiction.

Key Evaluation Limitations

- There were some **gaps with the MSF M&E system** which resulted in missingness of routinely collected data leading to failure in determining some indicators from the project. The major gaps identified were on disaggregations such as area/ward of residence of women/patients, HIV status for treatments and referral services and disability to better understand the specific groups who

accessed/did not access services. However, the evaluation team used qualitative methods to try to explore some of the issues.

- Due to the COVID-19 pandemic, **some key informants were not available for face-to-face interviews**. Therefore, some of these interviews were conducted remotely using digital platforms and network challenges affected the quality of some of the interviews. In these cases, the evaluators requested the interviewees to repeat themselves, and used paraphrasing and restating techniques to confirm proper understanding.
- **Turnover of human resources both in MSF and MoHCC** meant that some of the knowledgeable staff were not available/traceable for interviews. The evaluation team increased the data collection phase by one week and managed to trace and interview a significant number of additional key informants.
- **The communities nor beneficiaries who participated in the evaluation did not have any comparator and neither were they aware of standard services**. This may have limited their capacity to critically appraise the cervical cancer services analysed by this evaluation. Evaluators tried to minimize it by triangulating data obtained from with data from key informants, secondary data, health facility assessments and project documents as well as documented similar experiences and international standards.

1.3 STRUCTURE OF THE EVALUATION REPORT

The evaluation report is structured as follows:

- Chapter 2 present analysis and findings across each of the three evaluation criteria of appropriateness, effectiveness and efficiency;
- Chapter 3 presents the evaluation conclusions; and,
- Chapter 4 presents lessons learnt.

Evaluation report is supported by the following annexes:

- Annex 1 presents the original Terms of Reference (ToR);
- Annex 2 provides detailed evaluation framework used;
- Annex 3 lists the key references and documents reviewed and used in the evaluation;
- Annex 4 includes the list of evaluation participants;
- Annex 5 includes a table with MoHCC indicators use by MSF in the project;
- Annex 6 provides the map of the assessed/visited health facilities and the structured tool/checklist used.

2 FINDINGS

2.1 PROJECT APPROPRIATENESS

The evaluation first step was to assess the appropriateness of the project and this was done using three main questions.

2.1.1 ALIGNMENT OF PROJECT OBJECTIVES AND IDENTIFIED NEEDS

Under this evaluation section we considered the extent to which the project objectives were tailored to the identified needs, the tools (methodologies, situation analysis, needs assessments etc) used to gauge needs, involvement of affected populations in needs assessment, delivery and monitoring of project and alignment of project with others within MSF and with those of other sector actors i.e. MoHCC and other NGOs.

Project Objectives Versus Identified Needs

The specific objective of the project was to increase access to preventive and curative services in Gutu district. In addition, the project had the intention to demonstrate feasibility of scale up of decentralised cervical cancer screening and treatment services for women by MoHCC in rural district in Zimbabwe³.

As already mentioned, the MSF's cervical cancer intervention in Gutu district was an extension of an existing MSF HIV/AIDS and TB project. The success of this project resulted in more WLHIV surviving longer but there were anecdotal reports of some women succumbing to cervical cancer despite the good HIV control. This was especially significant considering the high burden (14.9%) of HIV/AIDS in Gutu⁴.

In addition, there were significant unmet needs in the district as only one facility (Gutu Mission Hospital) was offering limited cervical cancer services with support from UNFPA. The main challenge with this centralized model of care introduced by MoHCC was that it limited access especially considering the distances the majority of women had to travel. The one facility set-up to provide cervical cancer services was covering an eligible population of approximately 17,158 women per year. Prior to the introduction of the MSF project, an estimated small number of 401 women had been screened in 2014 in Gutu district⁵. The above was confirmed by feedback from stakeholders who also reported that the **project objectives were aligned to the identified needs of the affected population** in Gutu, especially girls and WLHIV which is a known risk factor for cervical cancer⁵.

The above-mentioned needs were not limited to Gutu but rather to many other areas in Zimbabwe. The MoHCC had started decentralisation of cervical cancer screening services in 2012-2013. However, this was hampered by lack of resources especially frequent breakdown of cryoguns. By providing resources MSF was able to demonstrate the feasibility of decentralised cervical cancer screening

³ MSF (2015) Cervical cancer screening and treatment in Gutu, Zimbabwe Proposal

⁴ ZIMPHIA (2016): Zimbabwe-population based HIV impact assessment

⁵ MoHCC(2016): Zimbabwe Cervical Cancer Prevention and Control Strategy (2016-2020).

services. Therefore, the project's intention to show the feasibility of a decentralized model for cervical cancer, was therefore in line also with an existing need at national level.

Approaches Used to Determine Needs

The evaluation found that there was **no formal needs assessment** carried out prior to the implementation of the project, although it could not identify the reasons why. However, feedback from MSF and MoHCC key informants revealed that the need to increase access to cervical cancer services was identified by MSF through the existing HIV/AIDS project, formal and informal meetings with stakeholders (including local leadership, MoHCC staff at both district and provincial level and WLHIV) as well as external literature on the burden of cervical cancer in Zimbabwe³. These meetings were held mostly by the MSF project coordinators and medical referents, as part of their regular coordination roles. There were no reports or minutes of these meetings identified during the evaluation. All this represented a significant shortcoming in the formal/informal processes used to gather information about the needs of the affected population.

Involvement of Affected Population in Determining Needs, Delivery and Monitoring of Project

The evaluation revealed that there was **no involvement of the affected population** in determining needs and in the design of the intervention. While the implementation of the HIV/AIDS and TB project was as a result of a specific request by local leadership due to high morbidity and mortality rates and inaccessible services in Gutu district among people living with HIV, cervical cancer intervention was an initiative of MSF.

Feedback from community key informants during the evaluation showed that there was **some informal involvement of women/patients in monitoring of cervical cancer services through unstructured feedback mechanisms** to health workers (including village health workers) on challenges and concerns. This feedback was used to improve/adjust services and was partly key in the roll-out of the outreach services to serve hard-to-reach areas in 2019. However, because these feedback mechanisms were informal, it is not clear when and how they took place and neither the nature of the feedbacks received.

Alignment of Project with Others in MSF

The project was **clearly aligned to MSF's Gutu HIV/AIDS and TB project** from which it was birthed. On one hand, cervical cancer intervention was initiated to address the identified needs of increasing access to cervical cancer service in WLHIV (as stated in WHO guidelines⁴). On the other hand, both projects facilitated complementarity for patient management, as women who were presenting to the HIV/AIDS and TB project were referred for cervical cancer services and conversely women presenting for cervical cancer services were also referred for HIV testing services. In addition, the cervical cancer intervention used the same 'light approach' which had been shown to be successful in the Gutu HIV/AIDS and TB project.

During the evaluation, consultations with MSF key informants at OCB, mission and project levels showed that cervical cancer interventions were new to MSF. However, MSF was keen to demonstrate

the feasibility of decentralized services when resources are available from province to district and finally to communities by capacitating government workers in a low-income setting, with the assumption that this decentralized model was more likely to sustainable.

Alignment of Project with Those of Other Sector Actors I.E. MoHCC and Other NGOs

In 2014, MoHCC started offering cervical cancer services at Gutu Mission Hospital with support from UNFPA as part of their national cervical cancer strategy to reduce morbidity and mortality from the disease by improving access to screening and treatment. As the cervical cancer national strategy evolved other partners such as JF Kapnek were involved with similar objectives to improve access to cervical cancer services. The support from JF Kapnek was focused at the national level mainly to assist NatPharm with commodities for cervical cancer services. Its support in Gutu district commenced in 2014 when MoHCC launched the cervical cancer screening programme at Gutu Mission hospital⁶.

The national cervical cancer programme had intentions to decentralize services throughout the country from 2012-13. However, by the time MSF launched their project, the MoHCC's decentralization programme was slowed down by frequent cryotherapy equipment breakdowns as well as competing priorities in MoHCC. MSF project aimed at piloting a model of care, addressing also the equipment challenges which were being faced in the national programme, both in static sites and during outreach campaigns. In this regard, MSF cervical cancer intervention came to contribute to the ongoing efforts by MoHCC and other actors on improving access to cervical cancer services.

Box 2.1: Selected quotes from key informants

Most key informants alluded to the project objectives being aligned with the needs of the affected population. The following are some of the quotes to support this finding:

- “Women on ART were deteriorating due to cervical cancer and this is how the project was formulated to address the needs”
MSF Project staff
- “MSF brought cervical cancer services to the communities to help them understand the disease and there were women dying in Gutu from cervical cancer and some who accessed screening were presenting with advanced disease hence the project met the needs of the people”
MSF Project staff
- “We knew that MoHCC was starting cervical cancer services hence this was a collaborative intervention, we also knew that Zimbabwe had the second highest burden of cervical cancer in the world and that decentralization of services was crucial to meet the needs of more women”
MSF Mission staff

⁶ At the time of the field visit, the support from JF Kapnek had not evolved even after the completion of the MSF project.

2.1.2 APPROPRIATENESS OF STRATEGY

We considered the extent to which the approach used in the project was able to meet affected people's needs. Protection and ethical issues in addition to sensitivity of the project to socio-cultural norms in the target communities were also considered.

Project Approach

From a clinical perspective, the techniques used by the project supported services (from screening using VIAC, treatment using cryotherapy and later thermocoagulation to diagnosis of invasive cervical cancer using histology) were in line with national policies⁵ and WHO guidelines⁶.

However, **specific gaps were identified in the continuum of care** for women diagnosed with invasive cervical cancer. This seemed to be due to lack of proper planning of referral mechanisms which resulted in women diagnosed with invasive cervical cancer being managed at district/mission hospitals instead of tertiary facilities where there is appropriate expertise. This will be elaborated further in the report in section 2.2 under *Project Results*.

Using the programmatic lens, **decentralizing cervical cancer services to rural clinics and hospitals as well as communities through outreach campaigns** seems to be adequate to improve access to services⁷, considering the mentioned barriers in the project context. In addition, **training and mentorship of health workers in health facilities as well as capacitating them with necessary equipment and commodities**⁸ seems to be appropriate and adequate to address specific needs of the project context.

Protection and Ethical Issues

The evaluation found that the **project considered protection of women and girls against e.g. domestic violence and material deprivation**⁸ by engaging many stakeholders at the community level including community leadership and men with awareness and health education. The awareness and health education covered the importance of women participating in cervical cancer services and the need for partner/family support. Domestic violence and material deprivation are some of the negative consequences for women seeking cervical cancer services or suffering from cervical cancer, due to lack of knowledge among men⁹. Awareness and education from MSF also **promoted support from spouses/male partners which has been shown to improve uptake of services in other similar contexts**¹⁰. A review of project documents and health worker interviews also showed that **some important ethical aspects were considered at the service level**, such as request of verbal consent by patient before cryotherapy or thermocoagulation and request of written consent before LEEP, biopsy and hysterectomy procedures³.

⁷ MSF (2020) Decentralized cervical cancer service provision in Gutu, Zimbabwe. Capitalization Report

⁸ Ministry of Women Affairs and Gender (2012) Zimbabwe National Gender Based Violence Strategy (2012-2015)

⁹ WHO (2000) World Medical Association Declaration of Helsinki. [https://www.who.int/bulletin/archives/79\(4\)373.pdf](https://www.who.int/bulletin/archives/79(4)373.pdf)

¹⁰ Assefa, A.A., Astawesegn, F.H. & Eshetu, B (2019). Cervical cancer screening service utilization and associated factors among HIV positive women attending adult ART clinic in public health facilities, Hawassa town, Ethiopia: a cross-sectional study. BMC Health Serv Res 19, 847

Interviews and FGDs with health workers and beneficiaries indicated, as mentioned above, significant gaps in the continuum of care for women diagnosed with cervical cancer. These gaps prevented some of these women to access specialized services (such as radical hysterectomies, chemo and radiotherapy, or palliative care). These identified shortfalls raised important questions on some medical ethics (see section 2.2.1 under *Project Results*).

Sensitivity to Socio-Cultural Norms

Socio-cultural norms in Gutu were preserved during the project as revealed by community, MSF and MoHCC key informants. Some of the sensitivities to cultural values, during the project, were shown in allowing women who would request to consult their partners before cryotherapy/thermocoagulation or LEEP or hysterectomy. In addition, through spouse or male partner awareness and education, there were reports from key informants from both MSF and MoHCC suggesting a reduction in cases of women refusing treatment due to spouse/male partners' resistance. This may also have been strengthened by the involvement of local community leadership who sensitized their communities including men to support women to utilize cervical cancer services.

In addition, while one health facility had a male nurse trained in VIAC, female nurses were in charge of screening patients. This was confirmed by women who said they were comfortable with female nurses screening them and this was observed.

Alignment of the project to socio-cultural norms and traditions was facilitated by the early engagement of community leaders as well as leveraging on the existing HIV/AIDS and TB project from which lessons had been learnt.

2.1.3 APPROPRIATENESS OF INTERVENTION TO BENEFICIARIES

The evaluation considered the extent to which the project was appropriate to beneficiaries as well as sensitivities to vulnerable groups and socio-cultural norms.

Perspectives of Beneficiaries

The evaluation showed that most of the beneficiaries found the **project appropriate to meeting their needs**. Communities mentioned that they benefited from awareness, health education, screening, diagnosis and treatment including hysterectomies which were offered free of charge. **MSF's removal of user fees was aimed at improving uptake of services in Gutu district and this was shown to be effective in similar interventions**¹¹.

In addition, beneficiaries also reported that **MSF project team was present on the ground to address some of their concerns or challenges** and this resulted in good relationships between the project team and communities. There was for instance support with transport funds and in some cases MSF vehicles would transport women to health facilities to access services. During the initial phases of the project

¹¹ Nyengidiki T K, Inimgba N, Bassey G, Ogu R N (2019). Does introduction of user fees affect the utilization of cervical cancer screening services in Nigeria?. *Niger J Clin Pract* ;22:745-9

MSF in collaboration with Newlands Clinic would send some patients for LEEP services in Harare, with all costs being covered by MSF. **The success of these procedures gave confidence to communities about the project.** Women who needed hysterectomies had all the costs covered by MSF up to the operation though **they were required to cover the costs of histology for the hysterectomy specimens.**

Beneficiaries consulted for this evaluation reported that project services were accessible to all eligible women and girls. This was also stated by elderly women, accessing the services by outreach campaigns, who were interviewed during the evaluation. The evaluation did not obtain any feedback by other vulnerable groups, such as sex workers or women or girls with disabilities in order to obtain their perspectives.

Feedback from women diagnosed with cervical cancer and their partners revealed that when MSF support ended, at the diagnosis or hysterectomy stage, **there was no clarity on further referrals for treatment services or social welfare support to access services** such as radiation and/chemotherapy. **Women strongly felt that MSF should have considered supporting them to get adjuvant treatment as they were unable to afford on their own.** This was identified as a major gap in the project and may have downplayed utilization of cervical cancer services among some women, in addition to causing distress and entrenching myths and misconceptions.

Additionally, **communities also felt that MSF should have continued with the project beyond 2020** because they did not have confidence that MoHCC and its partners would continue at the scale and quality.

Box 2.3: Selected quotes from beneficiaries

Majority of beneficiaries reported that the project was appropriate to them and was tailored to meet their needs. Some of the selected quotes to illustrate this finding:

- “I am on ART and when I came to collect my medication, I was introduced to VIAC services and to date I have been screened for cervical cancer for at least 3 times”
- “I was bleeding for about a month and when I came to the clinic, I was referred for VIAC”
- “I was advised by our VHW that I was required for VIAC (via outreach) and after screening I was told my cervix was not looking good and I was requested to come to Gutu Mission for treatment, which I did”
- “I am satisfied with the cervical cancer services I received from this health facility and I have never had any woman complain about poor services received from this facility”

SUMMARY: FINDINGS ON PROJECT APPROPRIATENESS

The MoHCC introduced a cervical cancer screening programme in 2014 at Gutu Mission hospital. However, one health facility was not adequate to cover the needs of women in the whole district. There was no formal needs assessment and community engagement by MSF at the beginning of the project. However, beneficiaries reported that they were able to give feedback informally to MSF/MoHCC which was used in monitoring the intervention.

The MSF's cervical cancer intervention was aligned to the MSF's HIV/AIDS and TB project. MSF's cervical cancer intervention contributed to the ongoing efforts by MoHCC and other actors on improving access to cervical cancer services. The approach used in the project included the intention to demonstrate a working decentralized model of care in which health workers were trained in screening and treatment and health facilities were capacitated with equipment and commodities.

The project considered socio-cultural norms by allowing women to consult their spouses or male partners, if they requested, before receiving services such as cryotherapy, LEEP and surgery. Women who were not comfortable being attended to by a male VIAC nurse were given the opportunity to be seen by a female nurse. The communities reported that they had confidence with the MSF's project because they were available on the ground. The beneficiaries also mentioned that the availability of free services improved their usage of the services. There were however shortcomings in the continuum of care for women diagnosed with invasive cervical cancer.

2.2 PROJECT EFFECTIVENESS

The second evaluation criteria that we covered was the project effectiveness with the focus being on project implementation in the district (e.g. whether defined objectives were achieved, whether project activities reached the target population, success factors of the project, challenges and how they were overcome, the differences the project made to policy/practice locally and what worked well or less etc).

2.2.1 DELIVERY ON EXPECTATIONS AND DEFINED OBJECTIVES

We considered the results obtained in the project, whether relevant standards were met and unintended consequences (positive and negative) of the project.

Projects Results

The evaluation reviews the project expectations and objectives based on project plans, logframes, reports, secondary data, health facility assessments and feedback from key informants and

beneficiaries. The project did not have specific targets set for different activities/services hence our findings will be based on absolute results. MSF used key performance indicators from the MoHCC VIAC registers, and these were used as main quantitative data for this evaluation.

In terms of **screening using VIAC**; 25,594 women accessed services of which 30% were HIV positive over the period 2015-2020, with the majority (98%) of the services having been delivered at static sites (see Figure 3.1). Outreach services were only provided in 2019 and 2020 and they were focused in Chitando and Chepiri communities. Most (85%) of the women were screened between 2016 and 2019. There were fewer women screened in 2015 as the project began in August in four sites. In 2020, there were fewer women screened and this is because only data for Q1-2 was reported as the project handover occurred in June.

With regards to **VIAC annual coverage**, there was an exponential increase from 4.9% in 2015 to 24.5% in 2019⁸ (see Figure 3.1). The increase of 19.6 percentage points in annual VIAC coverage in five years was a phenomenal achievement of the project. This finding was more than expected, when compared with the review of the Zimbabwe Cervical Cancer Prevention and Control strategy¹². This shows the impact of massive awareness campaign and high cervical cancer screening service supply and utilization in Gutu district.

The **cumulative VIAC coverage** was estimated by the evaluators as 45%⁸ and this exceeded the provincial coverage reported as 10.5% in 2015¹³ and the results also exceeded the target of 26% set by the MoHCC for 2020⁵. It is important to note that in the MSF Gutu project internal report produced late 2019 cumulative VIAC coverage was reported as 65.2% in the sex health facilities¹⁴. However, this last figure could not be independently verified during the evaluation.

Calculating a reliable cumulative VIAC coverage was challenging in this evaluation, partly due to lack of a clear target at the beginning of intervention. In addition, it was difficult to estimate the number of women eligible (18-65 years) for VIAC without conducting a comprehensive needs assessment. This challenge is not only specific to cervical cancer services but common to many public health interventions. The main aspect of this challenge is defining the target populations, the catchment area for the interventions as well population dynamics such as inward or outward migrations. In addition, it is not always easy or even possible to conduct comprehensive needs assessments to identify people in need or to be targeted. This means that the denominators and numerators that are used in calculating intervention coverages tend to change over time and this may affect the interpretation of the outcomes or impact of interventions. Therefore, the cumulative coverage of VIAC services Gutu district need to be interpreted with caution considering the above-mentioned limitations.

¹² Tapera et al., (2021). Gaps and opportunities for cervical cancer prevention, diagnosis, treatment and care: evidence from midterm review of the Zimbabwe Cervical Cancer Prevention and Control strategy (2016-2020). BMC Public Health

⁸ Calculated using proxy denominator (number of women 18-49 years) of 57,439 in Gutu district based on UN projected population in 2020. Cumulative VIAC coverage was derived from $25,594/57,439 * 100 = 45\%$

¹³ Zimbabwe National Statistics Agency and ICF International (2016). Zimbabwe Demographic and Health Survey 2015: Final Report. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.

¹⁴ MSF (2019) Gutu project internal report.

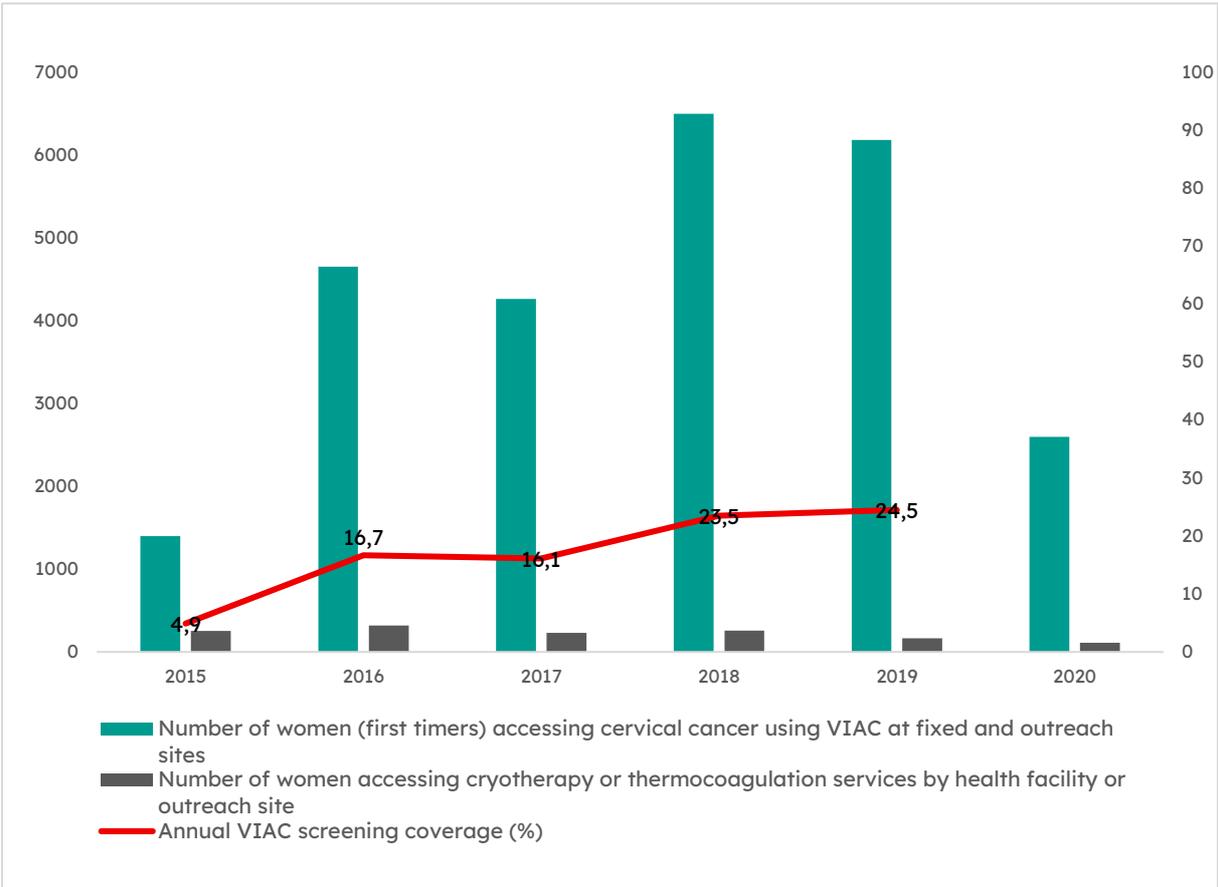


Figure 3.1. Trends in reach of women with screening, treatment and annual VIAC coverage (%)

Figure 3.1 above shows the trends of women reached with screening and pre-cancer treatment as well as annual VIAC coverage (%) in Gutu district from 2015-2020.

In 2015, the VIAC positivity rate was quite high (19%) and it came down to 4% in 2020 and this is expected because as more testing is done and treatments are provided less women will test positive to VIAC¹⁵ (see Figure 3.2). In a similar context, Zambia, showed a decline of 30 percentage points (from 47% to 17%) in their 5-year cervical cancer screening project¹⁶. Similarly, a decreasing trend was also observed on the number of women eligible for pre-cancer treatment, 270 in 2015 to 114 in 2020.

The project supported histological assessment of biopsy/LEEP specimens from women suspected of cervical cancer and those undergoing LEEP. The investigations were done in private laboratories in Harare and results would be sent back to the referring facilities. Of the 380 women eligible for biopsy/LEEP or those who eventually had a biopsy taken or LEEP done, only 202 came for the procedure or returned for results, showing a **loss to follow-up of 47%**. This figure is quite high, when compared with one of the auditable standards the National Cervical Cancer Screening Programme in

¹⁵ WHO (2013) Monitoring national cervical cancer prevention and control programmes: quality control and quality assurance for visual inspection with acetic acid (VIA)- based programmes

¹⁶ Mwanahamuntu et al., (2013). Utilization of cervical cancer screening services and trends in screening positivity rates in a ‘Screen and Treat’ programme integrated with HIV/AIDS care in Zambia. Plos One;8(9): e76407

the United Kingdom uses, it recommends that loss-to-follow up should not exceed 15%¹⁷; although it is similar to other documented experiences in similar context¹⁸. The evidence collected during this evaluation seems to indicate that this high loss to follow-up was multi-factorial and some of the key drivers were **high transport costs, fear of the unknown, lack of knowledge, misconceptions, long turnaround times for biopsy results** (see section 2.2.2 under *Challenges to The Achievements of The Project and MSF’s Response*) and **unavailability of LEEP/biopsy on the day of screening. VIAC nurses working in this project conducted follow-up on patients referred to other services**, by calling them directly or through family members/neighbours/VHWs, though this was not systematic.

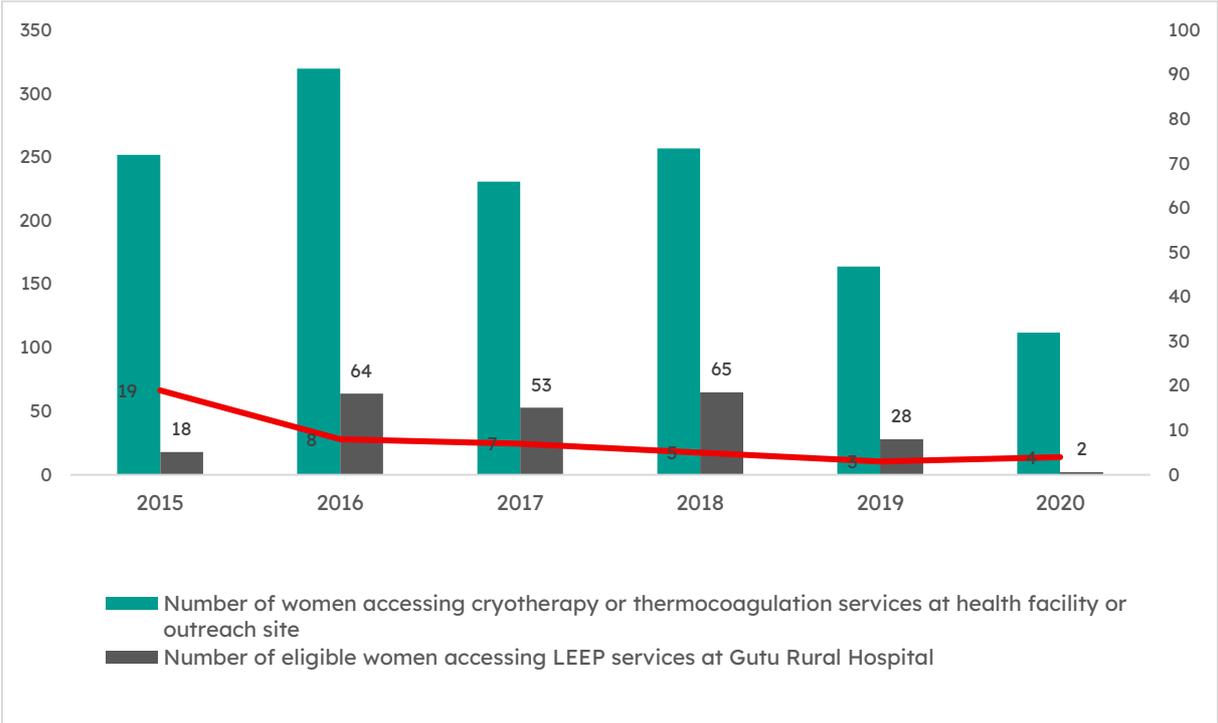


Figure 3.2. Trends in women treated for pre-cancers and VIAC positive rate in Gutu district

The above figure illustrates the trends in the number of women reached with treatment for pre-cancerous lesions using cryotherapy or thermocoagulation and LEEP in Gutu district during the project.

Data from the project shows **that 182 women were suspected of cervical cancer between 2015 and 2020 and only 73 (40%) had biopsies taken for histology**. Between 2015 and 2020 only 18 women out of the suspected women with cancer (10%)^{&&} had hysterectomies performed in Muvonde and Gutu Mission Hospitals respectively (see Table 3.1 and Figure 3.3). This coverage met the MoHCC target of 10% for 2020²⁴. Review of patient notes and interviews with health workers in the intervention sites also showed that most women who had hysterectomies did not have staging tests done i.e. ultrasound scans and chest X-rays and some blood tests prior to the surgeries as required under standard practice.

¹⁷ Public Health England (2016). NHSCSP Colposcopy and Programme Management
¹⁸ Kiptoo et al., (2018). Loss to follow-up in a cervical cancer screening and treatment programme in Western Kenya. JCO Global Oncology;4(2).
 &&The calculation is based on women suspected to have cervical cancer but the denominator might be an overestimation as some may not have cancer after histological investigation.

In addition, the procedures were conducted by government medical officers, who are not trained to do such complex surgeries which ideally should be done by gynaecological oncologists or gynaecologists after extra training¹⁹. Although there are some ongoing trials evaluating the role of a simple hysterectomy in women with cervical tumours less than 2cm²⁰, it is not yet standard of care. Women with macroscopic tumours should have a radical hysterectomy with lymphadenectomy and none of the patients who had macroscopic tumours at VIAC had this treatment done. Even after the hysterectomies were done, there were no clear follow-up mechanisms to regularly monitor patients. Most of the hysterectomy samples were incinerated as patients could not afford histological investigations and the project did not support postoperative histology investigations.

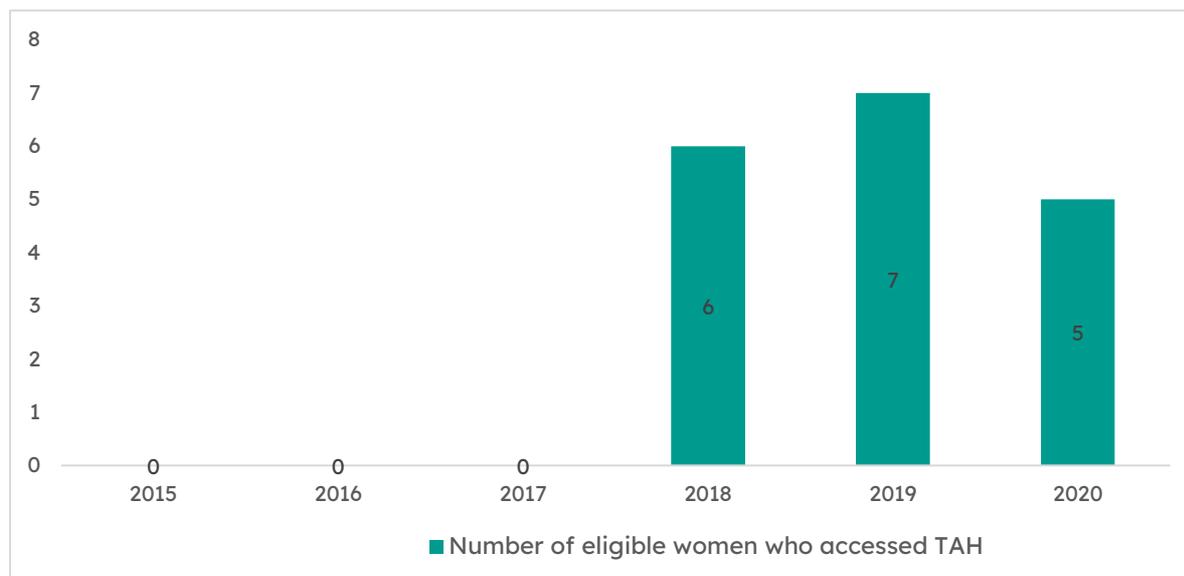


Figure 3.3. Trends in number of eligible women who accessed TAH

Figure 3.3 shows the trends of number of eligible women who accessed TAH over the project period, 2015-2020.

Feedback from MSF key informants revealed that, from its design, the MSF project did not plan to support radiation or chemotherapy as these services were largely expensive and in addition the project was focused on preventing cervical cancer and reducing the number of people who will be diagnosed of the disease. The MoHCC had set a target of 65% by 2020 for eligible women to be provided with chemo and/radiation therapy. There was no evidence of any successful referral of patients diagnosed with invasive cervical cancer to tertiary facilities such as Parirenyatwa and Mpilo Hospitals for chemo/radiation therapy in that period.

Table 3.1 shows some additional key project indicators that were evaluated.

¹⁹ Bhatla et al (2019). Revised FIGO staging for carcinoma of the cervix uteri. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.12749>

²⁰ Kato et al (2015). Clinical tumor diameter and prognosis of patients with FIGO stage IB1 cervical cancer, <https://pubmed.ncbi.nlm.nih.gov/25662625/>

Table 3.1. Results against some key project indicators

INDICATOR	ADDITIONAL INFORMATION/COMMENTS
Number of eligible women referred for other treatment services who successfully received services in the referral facilities	No data
Number of eligible women who had LEEP or biopsy with documented histological results*	202 (out of 380 eligible, 53%)
Number of basic psychosocial support service sessions conducted**	2642 Service only offered in 2020

* The challenge was those eligible for the histology either did not come for sample collection or did not come for the results in the clinics.

** Psychosocial support was not being provided and was started in 2020 after a toolkit was developed and nurses were trained accordingly.

Structured basic psychosocial support to women suspected or diagnosed with cervical cancer only started in 2020 after training of health workers in November 2019. In 2020; a total of 2,642 sessions of psychosocial support were provided to eligible women (a total of 2,436 women benefitted from these sessions). While these services had always been available in the MSF's HIV/AIDS and TB project, cervical cancer specific ones were introduced late in the project as a pilot. Many patients especially those diagnosed with invasive cervical cancer could have benefitted from an earlier roll out. Additionally, feedback from implementing partners and MoHCC staff revealed that there were five trained MoHCC palliative care nurses in the district who were never utilized in the project. There no evidence suggesting that eligible women had benefitted from palliative care services showing lack of **integration of these services within the project activities**. This was a significant gap given the number of women (182⁷) who were suspected of cervical cancer over the period 2015-2020.

In 2018, MSF provided logistical support to MoHCC to roll out HPV vaccination in Gutu district among girls aged 9-13 years and the national coverage for the 1st dose was reported as 93.3%⁸. In Gutu, 14,265 (86%) were reached with the 1st dose in 2018 and 13,423 (90%) were reached with the 2nd dose in 2019 (see Figure 3.4). The coverages exceeded the national targets set by the MoHCC of vaccinating 80% of eligible girls by 2020⁵ suggesting the effectiveness of MSF support.

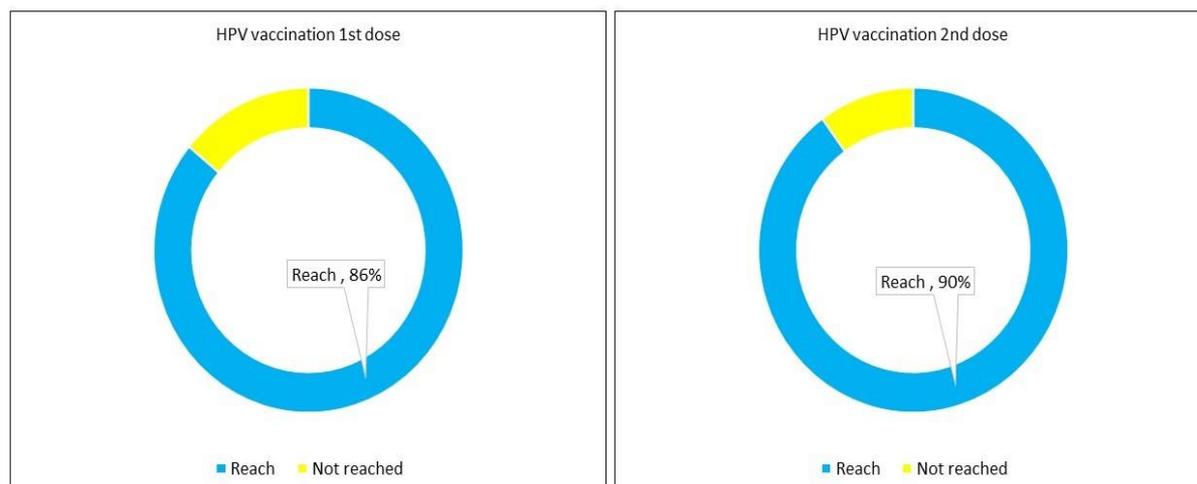


Figure 3.4. HPV vaccination reach for 1st and 2nd doses in Gutu district

The figure above shows the coverages of HPV vaccinations for both 1st and 2nd doses conducted by MoHCC with support from MSF between 2018 and 2019 among girls 9-13 years in Gutu district.

Two operational research studies were planned under the project i.e. HPV self-sampling and testing using Gene Xpert machine and HPV vaccination among HIV positive young women aged 15-26 years. Both studies were successfully conducted, and some preliminary reports were produced^{21, 22}. The HPV screening study showed that there was no difference in performance of cervical cancer screening using self-collected high vaginal swabs compared to nurse collected swabs. Since the Gene Xpert platform is widely used by the MoHCC in HIV and TB programmes and more recently in COVID-19, this will potentially make it easier to migrate from VIAC to HPV based screening. The HPV vaccination operational study found that the integration of HPV vaccination into HIV care was feasible and acceptable to both recipients and health staff^{23,24}.

While the MSF project included awareness and health education for cervical cancer, there were no specific targets set and this activity did not have an indicator. There was no available data to confirm the number of people reached with awareness and health education throughout the project. However, MoHCC had targeted to reach 90% of the people with awareness of cervical cancer screening across the country by 2020⁴.

Through the MSF project, 35 MoHCC health workers (32 nurses, 1 doctor and 1 clinical officer) were **trained in VIAC, cryotherapy/thermocoagulation and LEEP (doctor and clinical officer)** in the Gutu district (see Table 3.2). This was a big cohort of health workers considering that they were based in only seven out of the 29 health facilities across the whole district. This approach has allowed services to continue even after the handover of the project to MoHCC in September 2020 and feedback from district and provincial level MoHCC managers showed that services will continue at the same scale and quality as before.

²¹ MSF (2020) Validation of Xpert HPV testing and Self Sample collections for cervical cancer screening in Gutu District, Zimbabwe, Progress Report

²² MSF (2020) Implementation of HPV vaccination among HIV positive adolescent girls and young women aged 15 to 26 years old in Gutu District, Zimbabwe, Progress Report

Table 3.2 below shows the number of health professional trained during the MSF project in Gutu.

Table 3.2. Health workers trained during the project, 2015-2020

INDICATOR	2015	2016	2017	2018	2019	2020
Number of MoHCC VIAC nurses trained	4	7	4	7	0	10
Number MoHCC doctors/clinical officers trained in VIAC and LEEP	0	0	2	0	0	0
Number of MSF VIAC mentors trained	1	1	0	0	0	0

Based on the findings presented above, **MSF's project partially achieved the intended specific objective of increasing access to preventive and curative cervical cancer services in Gutu.** While the project increased access to screening and precancer treatment, there were significant unmet needs for women diagnosed with invasive cervical cancer. In addition, most of surgeries that MSF supported were not done by cancer surgery experts and due to lack of follow-up mechanisms, the long-term outcomes of these women are not clear.

Health Facility Assessment

The evaluation assessed all health facilities (7) which were supported under the project and these included: Gutu Rural hospital, Gutu Mission hospital, Serima Mission hospital, Mukaro, Chitando, Chinyika and Chimombe rural health centres. Mukaro clinic was replaced by Serima Mission Hospital in late October 2020, (see Annex 6 for the map of the intervention health facilities) **due to underutilization and frequent disruptions of the services by a prolonged power outage and the redeployment of the VIAC nurse to support OPD services.**

Most of the health facilities had basic resources and only a few gaps were identified in availability of functional telephone/mobile lines and sterilizers (see Figure 3.5).

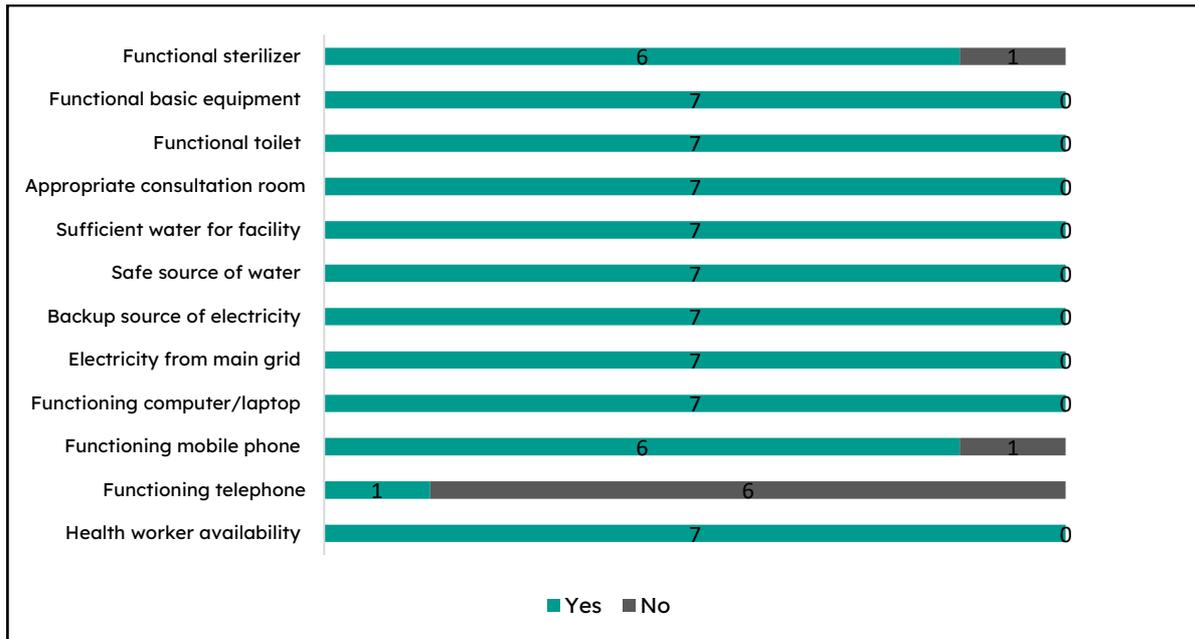


Figure 3.5. Availability of basic resources in project facilities

In addition, Figure 3.5 shows that **most health facilities had adequate resources** (e.g. trained health workers and guidelines) and were providing services in line with the project objectives. All facilities were providing screening, cryotherapy and basic psychosocial support services, while Gutu Rural was also in addition providing regular LEEP and thermocoagulation (see Figure 3.6). None of the health facilities reported stock-outs of essential commodities for cervical cancer services in the previous month prior to the assessment. Four of the health facilities i.e. Gutu Rural, Chimombe, Chitando and Chinyika conducted outreach campaigns in 2019 and 2020 and cumulatively reached 550 women with screening and treatment services.

All intervention health facilities had **adequate essential equipment and commodities** as per the project plans and log frames. At the time of the field visit, a few gaps were identified in the availability of functional laptop/desktop for data management, nitrous oxide gas for cryotherapy and IEC materials for HPV vaccinations (see Figure 3.7). Feedback from MSF and MoHCC key informants revealed some **incompatibilities between cryoguns (Wallach brand) and nitrous oxide gas tanks and breakdown of cameras leading to frequent interruption of services** at the start of the project implementation. However, these challenges were later addressed as the project evolved.

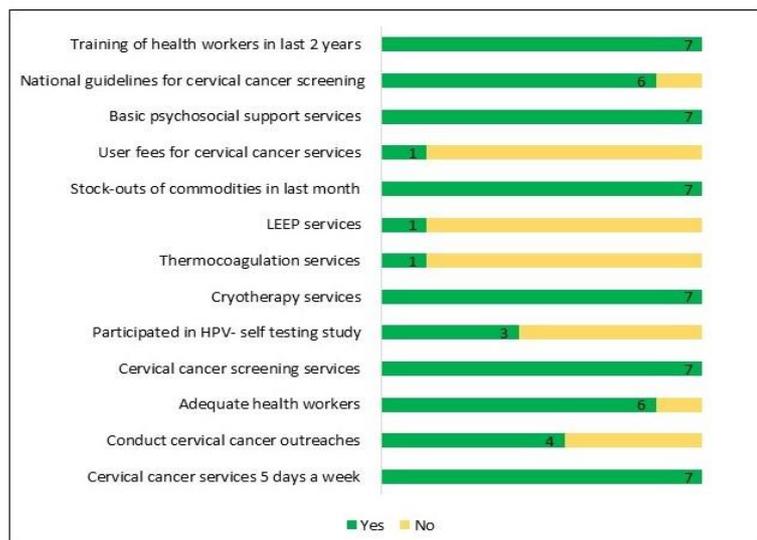


Figure 3.6. Availability of services and key resources

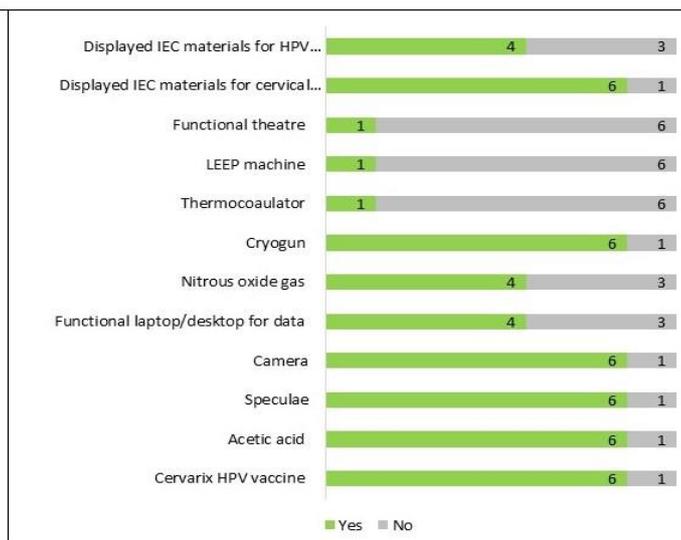


Figure 3.7. Availability of cervical cancer equipment and commodities

Box 3.1: Selected quotes from key informants

Below are some selected quotes from key informants to illustrate the findings:

▪ “In a way, we were on track, we hope JF Kapnek will continue with outreaches though they may face resource challenges along the way”

MSF Project staff

▪ “Targets were met, and we are happy with the services. We wish if there was more funding to continue especially with the outreaches”

MSF Mission staff

▪ “We continued to monitor the six sites and we managed to achieve a 45% cumulative VIAC coverage”

MSF project staff

Relevant Standards

The evaluation revealed that **most qualitative clinical standards were met** in the project mainly screening, pre-cancer treatment and diagnosis standards based on national (MoHCC)^{5,7} and WHO guidelines⁴. However, as mentioned already, gaps identified were in the **treatment of patients with invasive cervical cancer and referral pathways to tertiary facilities** for radiation or chemotherapy (see section 2.2.1 under *Project Results*).

From a programmatic perspective, some more gaps were identified as follows:

- **Monitoring and Evaluation system**- used in the project had its own weaknesses namely: lack of key data such as number of eligible women who received LEEP and number of women eligible for basic psychosocial support. In addition, there was missing data on the following variables:

area/ward of residence, HIV status on other services apart from screening, follow-up mechanisms/indicators on cervical cancer patients referred for biopsies, LEEP and other treatments. It was not possible to measure the performance of some key indicators for this project. In addition, the M&E system used in the project, did not include mechanism to measure the project intention regarding the feasibility of the model of care.

- As already mentioned, the project did not have a formal needs assessment (relied on national level data and informal assessments). Additionally, there was no mid-term review to measure progress. The lack of these two processes seems to be a missed opportunity for programme improvement and learning. For instance, some of the critical areas that could have been identified in the mid-term review were **gaps in M&E system, treatment of invasive cervical cancer, referral pathways, feedback/monitoring mechanisms from beneficiaries and integration of palliative care.**
- **Accountability to affected populations²³** – although the project engaged in conversations with community leaders before and during the project implementation, the project did not solicit for opinions and thoughts from the beneficiaries (women, girls, boys and men) in designing and implementation of the project. This will be further elaborated in section on *Feedback Mechanisms at The Community/Beneficiary Level* above.

Unintended Consequences of The Project

Our evaluation pointed to some positive and negative unintended consequences of the project in Gutu.

Positives include the following:

- **Women received HIV testing services as part of the cervical cancer screening package.** Through linkages with the MSF's HIV/AIDS and TB project, women screened for cervical cancer were offered HIV testing services and those eligible were immediately started on ART.
- **High motivation among health workers and community leaders towards the project.** Health workers were motivated to gain new skills and community leaders wanted to have cervical cancer services available in their communities given the reported high morbidity and mortality rates from the disease.
- **Task shifting in cervical cancer screening and treatment to general nurses.** The MSF project demonstrated that general nurses could be trained and mentored to provide cervical cancer services which were initially performed by midwives. In the long run there was minimum disruption of services due to unavailability of staff.
- **Improvements in health facility infrastructure and availability of basic equipment and commodities for other essential services apart from cervical cancer.** MSF renovated and equipped intervention health facilities and supported other essential services apart from cervical cancer services such as supply of basic drugs like analgesics and antibiotics.
- **Identification and discouragement of the vaginal herb use practice (meant to improve partner sexual pleasure) among women.** Through awareness and education, the use of vaginal herbs was discouraged among women who practiced it. Some of the women who used vaginal herbs were identified during routine screening and counselled against the practice by health care workers.

²³ WHO (2017). Operational guidance on accountability to affected populations, Health Cluster. https://www.who.int/docs/default-source/documents/publications/operational-guidance-on-accountability-to-affected-populations.pdf?sfvrsn=ec7fb6c8_1

Negatives include the following:

- **Limited access to treatment for invasive cervical cancer.** As mentioned in section 2.2.1 under *Project Results* this may have been a source of distress among families and may have downplayed early/regular screening among women.

Creation dependency among health facilities and beneficiaries. Feedback from MoHCC staff and beneficiaries indicated that the MSF project created some dependency among health facilities for equipment and commodities and in the long run frustration/demotivation may set in if the government or its partners fail to keep up to the standard set by MSF through this project. In addition, dependency was also fostered among beneficiaries, and this made it difficult to refer them e.g.. for histology investigations or hysterectomies where they will be required to pay user fees.

Health worker attrition. Feedback from MSF and MoHCC staff revealed that the training of nurses in VIAC and treatment of cervical cancer equipped them for other opportunities especially in the NGO sector. Indeed, some of the nurses trained under the MSF's project had left government service for better opportunities due to the prevailing poor remuneration in the public sector.

SUMMARY: FINDINGS ON PROJECT EFFECTIVENESS (1 of 2) **- Delivery on Expectations and Defined Objectives**

The MSF project in Gutu reached 25,594 women over the period 2015-2020. The number of women treated for pre-cancers with cryotherapy/thermococoagulation was 1,336 over the same period. As more women accessed screening and treatment, the project showed a decline in VIAC positive rate from 19% in 2015 to 4% in 2020. There was an increase of 19.6 percentage points in annual VIAC coverage in six years which was a phenomenal achievement of the project.

Intervention health facilities were capacitated with trained staff, equipment, infrastructure, and commodities to provide cervical cancer services. However, some shortfalls were identified in the monitoring and evaluation system, accountability to affected populations, patient follow-up/monitoring mechanisms, integration of palliative care within the project and referral systems for patients diagnosed with cervical cancer to the next level of care or tertiary health facilities.

This evaluation showed some positive unintended consequences of the project including getting more women testing for HIV, and task shifting of cervical cancer services from midwives to general nurses. Some of the unintended negative consequences were dependency creation among beneficiaries, health workers/facilities and health worker attrition. MSF handed over the project to MoHCC in September 2020 and with the support from JF Kapnek services have continued in the district.

2.2.2 ENABLING AND CHALLENGING FACTORS FOR ACHIEVEMENT

Under this section we considered the mechanisms used to identify challenges during the design and implementation of the project, feedback mechanisms available to communities/beneficiaries and the factors which promoted and/hindered the success of the project.

Challenge Identification Mechanisms at The Project Level

Several mechanisms, based on key informant consultations, were used to identify challenges during the design/implementation of the project, and these include:

- Multi-stakeholder consultations **provided platforms for identification and mitigation of challenges** at both the project design and implementation stages;
- M&E tools including MoHCC VIAC registers at health facilities were **used to monitor progress and identify challenges**;
- VIAC mentor(s) was/were tasked to **visit all project health facilities on a regular basis and a checklist was used to assess progress and challenges at the facility level**;
- **Quarterly quality control meetings** were held to share/validate project data and come up with solutions to identified challenges;
- At the facility level, **VIAC images were routinely reviewed and discussed among VIAC nurses and mentors to solve complicated cases**. Some images were shared with Newlands Clinic at the beginning of the intervention as part of quality control;
- **Regular field visits were conducted** by MSF project members for mentorship and occasional visits by mission and headquarters level staff to assess the progress/performance of the project and identify constraints.

Feedback Mechanisms at The Community/Beneficiary Level

At the community/beneficiary level, no formal or structured feedback mechanisms were put in place as recommended under the AAP approach¹⁷. While feedback from MSF key informants showed that community leaders were engaged before and during the project implementation, there remains a missing link between the project design and delivery with beneficiaries' opinions and thoughts which could be different from those of the community leaders or MSF implementers. However, unstructured feedback mechanisms emerged as the project evolved as reported by key informants and beneficiaries. These included the following:

- Community/beneficiaries would **communicate with health workers at service delivery points and village health workers at community level**;
- Community/beneficiaries would also **communicate with MSF staff** to provide them with feedback;
- Community leaders and village health workers **had the opportunity to provide feedback to MSF and MoHCC during stakeholder meetings** which were held regularly in the district;

From a beneficiaries' perspective the unstructured feedback mechanisms were reported to have worked and provided platforms to air concerns or challenges. However, from a programme management perspective, unstructured and undocumented feedback mechanisms are difficult to assess and evaluate their effectiveness.

Factors That Promoted Success of Project

There were success factors reported by key informants and revealed in project document review which included:

- **Elimination of barriers.** User fees is a known barrier to access of services¹⁴ and the MSF project removed this barrier by offering free services. Multiple visits for screening services increase the loss to follow-up rate and the MSF project removed this barrier by using the 'see and treat' approach.
- **Interlinkages with the existing HIV intervention and collaboration with the community and its leadership.** The project was an extension of the HIV intervention and therefore it leveraged on the resources and lessons from that project. In addition, the community had trust towards MSF which had been built during the HIV/AIDS and TB project and had been fostered by their presence on the ground and interacting with the communities. Community leaders were forthcoming and supportive, and this culminated in good collaboration which was key to the achievements of the project. Furthermore, the community was self-driven and supportive of the project. This made the implementation and acceptance of the project by community easier.
- **Resources (human resources, commodities and capacity building).** Reports from key informants from MSF mission and project levels showed that Newlands clinic had provided a lot of support in training, mentorship and quality control of VIAC, cryotherapy and LEEP at the beginning of the project. This ensured that there were competent and motivated human resources on both MSF and MoHCC sides especially nurses and doctors within the district. MSF supplied all the commodities that were needed for this intervention from 2015-2018 and this eliminated supply chain bottlenecks often experienced in the national system managed by NatPharm.
- **MSF OCB support.** MSF OCB and mission level key informants mentioned that there was invaluable support from MSF OCB from the start of the project and this resulted in the successful implementation and handover of the project.

Challenges to The Achievements of The Project and MSF's Response

- **Technical resources.** Feedback from MSF and MoHCC stakeholders revealed that the project's main challenges related the incompatibilities between Wallach cryoguns (Wallach Surgical Devices Inc, USA) and nitrous oxide gas tank connection. This challenge was addressed by engaging machinists who customized the connections on the tanks and the cryoguns (2015-2018). Additionally, a compatible and more durable brand of cryoguns was procured from the USA (2019-2020). The other challenge faced related to frequent breakdowns of cameras and data cables to transfer images from cameras to laptops/desktops. Standard operating procedures and trainings were developed and conducted respectively among VIAC nurses to ensure proper use and troubleshooting of cameras and data transfers. In addition, several backup cameras and data cables were procured to ensure that services would not be disrupted (2015-2020). The responses to above challenges were reported to have been adequate.
- **Patients' management.** There were reports of limited access to services among women living far away from health facilities and high loss to follow-up among women referred for procedures e.g. LEEP, biopsy and hysterectomies. Long turnaround times for histology results were also reported. To solve these challenges, in 2019-2020, MSF initiated outreach campaigns to reach women in hard-to-reach areas though this was not adequate and needed further strengthening to reach more women. In addition, to mitigate the high loss to follow-up VIAC nurses would regularly check

up on patients directly by calling them or through family members/neighbours/VHWs though this was not systematic (2015-2020) and hence inadequate to solve the challenge. To improve on the turnaround times of histology results, MSF/MoHCC started following up delayed results telephonically. However, from this evaluation there was evidence that there were still gaps in the timely delivery of histology results.

- **Human resources and project management.** This evaluation identified gaps in the M & E system especially with reporting of routine data needed to assess key performance indicators. This challenge was not solved during the project and lessons learnt/recommendations will be made at the end of the report. The other challenge reported was high human resource turnover/reassignment especially with nurses moving to greener pastures. MoHCC tried to mitigate this by training more nurses to ensure there were more than one per facility (2015-2020). The evaluation did not find any human resource shortages at the time of the field visit.

2.2.3 MEASURES TO IMPROVE EFFECTIVENESS OF THE PROJECT

In this section we considered solutions to improving access to cervical cancer services from both the stakeholder and beneficiaries' perspectives.

- **Awareness.** Both stakeholders and beneficiaries felt that there was need to sustain awareness and health education in the district as there were some areas which had not been adequately reached. Beneficiaries reported that door-to-door awareness campaigns by VHWs were effective in increasing knowledge and promoting early health seeking behaviours. There were also suggestions of targeting leaders of Johanne Marange Apostolic sect with advocacy communications, awareness and health education so that they would allow women and girls to be screened and vaccinated against HPV²⁴.
- **Expansion of services.** There were a lot of hard-to-reach areas which were not served under this project (see section 2.2.4), therefore some stakeholders suggested capacitating all health facilities and training nurses in the facilities to conduct cervical cancer screening and treatment as well as well expanding outreach campaigns across the district. Some beneficiaries suggested that every village should be represented by a VHW for better coordination of awareness and outreach campaigns as well as strengthen feedback mechanisms between communities and health facilities/implementing partners. Stakeholders also suggested offering services out of normal working hours to facilitate access to (e. g evening to allow women from the Apostolic sect to visit health facilities under the cover of darkness).
- **Clinical management.** Due to the identified shortfalls with referral pathways, stakeholders advocated for developing clear plans and referral pathways for women diagnosed with cervical cancer from the start of the project. In addition, to improve turnaround times for histology results both stakeholders and beneficiaries suggested engaging with private laboratories to increase early uptake of treatment services among eligible women as long waiting periods may result in loss to follow-up.

²⁴ In Gutu, there is an influential religious group known as the Johanne Marange apostolic sect is an influential religious group which prohibits its members from utilizing both preventive and curative services from health facilities.

2.2.4 REACH OF SERVICES TO TARGET POPULATION

We considered the extent to which the project reached the eligible women and girls with appropriate services and whether the project was able to reach vulnerable groups such as HIV+, elderly, disabled and women and girls living in hard-to-reach areas.

Reach of Eligible Women and Girls

Figures provided in section 2.2.1 indicates that the project succeeded to reach a significant number of women (25,594), meaning that 45% of estimated women in the catchment areas were screened by VIAC. However, as also indicated already, the project faced some challenges in facilitating access in the rest of the treatment cascade: for instance, only 10% of eligible ones accessed a hysterectomy.

Reach of Vulnerable Groups

Routinely collected data did not include variables which might have been used to analyse access to or use of services by some vulnerable populations such as sex workers, disabled women and women from hard-to-reach areas. Although this issue was explored in other ways, the information gathered (see below) could not be crosschecked with quantitative data.

HIV positive women and girls were reached through the HIV/AIDS project while HIV negative women were reached through family planning and MNCH services. Conversely, women who came for cervical cancer screening and had unknown HIV status were also encouraged to test for HIV.

Although the project did not conduct any activity specifically targeting them, there were reports from **sex workers** and their sexual partners who were reached with awareness and health education to improve their access to cervical cancer services. From the sex workers' perspective, the awareness and health education were helpful to them to understand the importance of cervical cancer screening.

In addition, while cervical cancer services were supported in seven (out of 29) health facilities, women from any community (even outside project catchment areas) could access services. Women in hard-to-reach areas were also served through outreach services though these were only conducted in 2019 and 2020, and only in two communities. It seems to indicate that **some gaps remained in reaching women in hard-to-reach areas** as the outreach services were short-lived and focused on a few areas.

The project did not conduct any activity to specifically target women/girls with disabilities and elderly women. Review of project report **revealed that of the 25,594 women who accessed VIAC services** (August 2015-December 2019), **18% were elderly women (at least 55 years old)**²⁵. Elderly women interviewed in the evaluation mentioned that they benefited from outreach services and received logistical support from MSF to access health facilities for cervical cancer services.

As already mentioned, the evaluation could not interview any women or girls living with disabilities, so their perspectives were not explored. However, based on the review of project materials and direct

²⁵ MSF (2020) Decentralized cervical cancer service provision in Gutu, Zimbabwe. Capitalization Report

observation, **the evaluation identified areas to improve cervical cancer services to be more sensitive to people living with disabilities** such as conducting awareness in sign language, printing materials like fliers in Braille for blind people and ensuring that facilities/equipment can accommodate people living with disabilities.

2.2.5 FACTORS HINDERING ACCESS TO SERVICES

We considered the barriers to accessing cervical cancer screening, prevention, and curative services among the affected population. Project document review, key informant and beneficiary feedback revealed some barriers to accessing services which include the following:

- **Person level (knowledge, misconceptions).** This evaluation revealed some persistent barriers to accessing cervical cancer services including lack of knowledge or ignorance and misconceptions which are known major barriers to seeking early screening/treatment among women, as highlighted by stakeholders and beneficiaries. In addition, fear of the unknown was another identified hindrance to early/regular screening for cervical cancer especially among women who knew someone diagnosed with invasive cervical cancer. This barrier could also emanate from limited access to treatment and palliative care for invasive cervical cancer which results in women dying in pain and in miserable conditions such as heavy bleeding and producing bad odours. Some stakeholders and beneficiaries reported that religious beliefs among the Johanne Marange Apostolic sect prohibited women and girls from accessing cervical cancer services.
- **Service level.** Inaccessibility to treatment and screening services in women with invasive cervical cancer and those in hard-to-reach areas respectively remain as challenges among women (see section 2.2.1 under *Project Results*). Limited financial resources for transport to visit health facilities, which is beyond the reach of most women given the prevailing harsh economic situation in Zimbabwe was also highlighted as a significant hindrance to accessing services.

Box 3.2: Selected quotes from key informants and beneficiaries

Below are some selected quotes from key informants and beneficiaries with regards to barriers to accessing services:

Key informants

- “More outreaches could be done to reach those women who are not able to access the nearest health facility”
MSF Project staff
- “The main barrier to accessing services is lack of knowledge”
MSF Project staff
- “Advanced cases have no concrete solutions to date”
MSF OCB staff

Beneficiaries

- “I was afraid to test positive after being screened due to lack of knowledge”
- “Challenges arose when you were screened positive for VIAC as transport is expensive to visit the health facility for further management”
- “Most women do not want to get screened because of fear of the unknown and denial in the event of a cancer diagnosis. It is better not to know than receive a cervical cancer diagnosis”

2.2.6 CONTRIBUTIONS TO POLICY AND PRACTICE

We considered the contributions of the project towards policy and practice in Zimbabwe. The contributions of the project on policy and practice at the national level are as a result of multiple stakeholder engagements as well as the results from the project which speaks of a good model of care. The influences of the project on policy/practice at the national level reported by key informants were:

- **Decentralization of cervical cancer screening and treatment.** A key informant from one implementing partner indicated that they adopted the MSF's outreach approach to reach women in hard-to-reach areas in other rural districts in Zimbabwe they were supporting. They also adopted the 'see and treat' approach using cryotherapy during the outreach campaigns.
- **Decentralization of LEEP services.** This was done by organizing eligible patients on certain days to improve efficiency in service delivery. This approach was adopted by some MoHCC implementing partners in their activities in other districts in Zimbabwe. There are reports from a key informant from one of MoHCC's implementing partner that the approach was also presented as good clinical practice in one meeting involving the MoHCC and its implementing partners supported by the United States government.
- **Task shifting of cervical cancer screening and treatment to general nurses from midwives.** Feedback from an MoHCC key informant showed that implementing partners of the MoHCC adopted the recruitment and training of general nurses to provide cervical cancer services in other districts across the country leveraging on the lessons learnt from the MSF Gutu project.
- **Capacitating already existing health facilities and health workers.** One MoHCC implementing partner involved with cervical cancer screening in Zimbabwe noted that after facing challenges with deploying parallel nurses to health facilities to provide cervical cancer services ended up adopting MSF approach of capacitating already existing health workers. The MSF approach was adopted in other districts/provinces e.g. Bulawayo, Chitungwiza, Matabeleland South and Masvingo.

This evaluation has shown some influence of the MSF Gutu project as mentioned above. However, feedback from key informants outside MSF and review of project documents did not show a clear advocacy plan and strategy of the project to influence other sector actors to adopt the demonstrated model of care. This was also in line with lack of knowledge about the project by key MoHCC policy makers i.e. Directors of HIV/AIDS and TB, Planning and Policy, Health Promotion and EPI manager. At the time of reporting, the two OR study results had not been shared or published. Additionally, there was no evidence of other MSF missions having adopted the Gutu model of care though this could happen later.

SUMMARY: FINDINGS ON PROJECT EFFECTIVENESS (2 of 2)

The MSF project reached 25,594 women with VIAC screening (44% of eligible women) but the routinely collected data did not include variables which might have been used to analyse access to or use of services by some vulnerable populations such as sex workers, disabled women, and women from hard-to-reach areas.

This evaluation has identified some of success factors of the project notably; good collaborations with MoHCC and other stakeholders, good relationships with communities as well as competent and motivated human resources. Some of the hindrances to the project were: equipment challenges especially cryoguns and cameras, high levels of loss to follow-up among patients referred for LEEP, biopsies or hysterectomies and long turnaround times for histology results and lack of a robust M&E system.

The project had mechanisms to identify to challenges but there were gaps in some of the responses to the challenges. Beneficiaries' feedback mechanisms, which evolved during the project implementation, although informal were also utilized to improve performance. Some barriers to accessing services have persisted mainly: lack of knowledge, religious beliefs, inaccessibility/unavailability of treatment services for invasive disease, limited coverage of services in communities far away from intervention facilities, and long turnaround times for histology results.

Some of the potential improvements include strengthening awareness and health education including targeted campaigns of some religious groups, strengthening referral pathways to tertiary centres for women with invasive cervical cancer and increasing the coverages of outreach campaigns to reach more women.

MSF project influenced policy and practice among other implementing partners in Zimbabwe mainly: decentralization of services including using the outreach approach, 'see and treat' approach in a decentralized model of care, capacity building and task shifting of cervical cancer screening and treatment to general nurses. However, there was no clear advocacy strategy from the inception of the project and the influences realized were indirect through e.g. stakeholder meetings.

2.3 PROJECT EFFICIENCY

The third and final evaluation criteria that we assessed was the project efficiency focusing mainly on usage/allocation of resources i.e. human resources, equipment and commodities and timeliness of implementation of the project.

2.3.1 EFFICIENCY OF THE PROJECT

This section considered the resources mobilized by MSF during the project implementation and an assessment of the adequacy or inadequacy of these resources.

Resources Mobilized

- **Human resources**

- **Direct provision of care.** One medical doctor and one clinical officer were engaged in the project, after being trained in VIAC as well as treatment of eligible women with LEEP. Thirty-five VIAC nurses from the seven intervention facilities engaged in the project, after being trained in VIAC and treatment of eligible women using cryotherapy and later thermocoagulation. The health workers trained were certified by Newlands Clinic after training and three mentorship visits in the field. One pharmacy technician was involved in the project to dispense/supply the requisite medication and cervical cancer screening commodities. MSF also had a patient support officer whose main role was to cater for the welfare of women accessing cervical cancer services.
- **Health promotion and awareness.** Two health promotion officers were engaged in the project by MSF, however one of them was from the MoHCC. Their roles involved community engagements and mobilization, awareness raising and health education campaigns. As the project evolved, they also supported beneficiary unstructured feedback mechanisms. In addition, nurses (mentioned above) were also involved in awareness raising and health education at their respective health facilities.
- **Supervision and capacity building (medical referent, VIAC mentor and field coordinator).** At the start of the project MSF engaged one VIAC mentor to support the trained VIAC nurses across all the intervention health facilities. In 2016, a second VIAC mentor was engaged but left the project in March 2017 and she was not replaced until the completion of the project. For this project, MSF also had a medical referent whose role was to supervise medical personnel. The field coordinator was also involved in the project primarily to provide leadership oversight for the intervention.
- **Equipment service and maintenance.** The MSF logistics coordinator was also responsible for equipment servicing and maintenance with support from the mission level. Towards the end of the project, MoHCC provincial technical staff trained district level (MoHCC) technicians, at the request of MSF, to continue supporting maintenance and servicing of equipment.
- **Support (admin, finance, data officer, data entry clerk, logistics coordinator, driver).** In addition to the above staff, MSF also had the support of a finance and human resources manager, data officer, data entry clerk, logistics coordinator and a dedicated driver. There was regular support from an epidemiologist from the mission level.

- **Laboratory services.** A laboratory scientist/manager was engaged to support Gene Xpert operational research study. There was no evidence any supported provided for routine cervical cancer services. Histological services were outsourced to private laboratories.

This evaluation revealed that while most of the staff were enough for the intervention, there were reports that the VIAC mentor was overwhelmed and MSF should have considered replacing the mentor who had left in March 2017 or empowering MOHCC VIAC focal person at an earlier stage to share responsibilities with MSF mentor.

In addition, given the shortcomings that were revealed by this evaluation in the continuum of care, MSF should have considered engaging a gynaecological oncologist/trained gynaecologist to support with staging and appropriate surgery like radical hysterectomies. The gynaecological oncologist/trained gynaecologist would have been responsible for assessment and appropriate referral of patients for chemo/radiation therapy as well as planning for the long-term follow-up of patients. However, having a gynaecologist alone with no functional health system and other support health workers might not have been enough to improve quality of care. Given the availability of trained palliative care nurses in the district, MSF should have integrated their services into the cervical cancer intervention.

- **Equipment.** For the intervention, MSF procured cryoguns, nitrous oxide tanks, cameras, laptops/desktops, gynaecology beds and LEEP machine. As the project evolved, a thermocoagulator was procured for outreach campaigns and was also used to treat eligible women at Gutu Rural Hospital. To provide screening and treatment MSF also procured speculae, punch biopsy forceps, loop and rollerball electrodes. There was one vehicle dedicated to the project to support logistics of equipment, commodities and transporting women for treatment services outside the catchment facilities.

As mentioned in the section *Challenges to the achievements of the project and MSF's response* under 2.2.2 above, there were challenges with the first brand of cryoguns which were procured and frequent camera/data cable breakdowns. This could have been avoided by careful planning to ensure that appropriate equipment compatible and adaptable to the context were sourced. This also points to the criticality of a comprehensive needs assessment which could have informed the requirements/capacities for the project including equipment. However, this was resolved as the project progressed. This evaluation showed that there was adequate equipment and maintenance services during the duration of the project.

- **Commodities.** As outlined in section 2.2.2 under *Factors That Promoted Success of Project*, MSF support intervention facilities with commodities like acetic acid, nitrous oxide, cotton wool, gauzes, lignocaine and others. This eliminated supply chain bottlenecks usually experienced in the national system managed by NatPharm.

This evaluation did not find any shortages or challenges with commodity supply chain during the field visit.

Timely Implementation of Project

Our findings, from review of project documents and feedback from key informants, suggested that the project was **implemented in a timely manner in line with MoHCC strategy**. The approach used by MSF enabled the **project to deliver services although there some significant shortfalls that the evaluation identified**. Had the project considered setting up parallel structures/vertical approach, the project would have required much longer time to deliver on its objectives and it may not have been feasible for MSF to implement it considering their short-term modus operandi. In addition, the project was able to deliver in a timely fashion as it also leveraged on the existing HIV/AIDS and TB project that had started in 2011.

Some of the challenges which had the potential of affecting the timely implementation of the project were frequent equipment challenges at the start of the project as well as the COVID-19 pandemic which impacted on the service delivery. Operational research studies were also slowed down due to the COVID-19 pandemic though this did not impact significantly on the project.

Box 3.3: Selected quotes from key informants

Below are some selected quotes in line with the findings on efficiency of the project.

MSF key informants:

- “The model we used made it efficient, although challenges were experienced, for example, maintenance of equipment”
MSF project staff
- “There was efficient use of human resources, equipment and commodities”
MSF project staff
- “MSF intervention was efficient as more nurses were trained, although more trainings should take place to avoid staff turnover”
MSF project staff
- “Timing of the implementation of the project was appropriate”
MSF project staff

SUMMARY: FINDINGS ON PROJECT EFFICIENCY

The approach used by MSF utilized a VIAC mentor and driver as dedicated staff. Additionally, the project engaged 35 VIAC nurses, one clinical officer, one government medical officer as well as other support staff from the HIV/AIDS and TB project.

Equipment mobilized included cryoguns, thermocoagulators, cameras, laptops/desktops nitrous oxide gas tanks and a LEEP machine and these were strategically allocated in health facilities depending on the nature of services they provided. The commodities which were procured under this project included: acetic acid, cotton wool, nitrous oxide, gauzes, lignocaine and others.

Main identified challenges for timely delivery were related to equipment breakdowns at the beginning of the project and more recently the COVID-19 pandemic. The main gap identified was equipment procurement which should have been carefully planned and done to ensure that appropriate equipment compatible and adaptable to the context were sourced. This also points to the criticality of a comprehensive needs assessment which could have informed the requirements/capacities for the project including equipment.

The project could have empowered MOHCC VIAC focal person at an earlier stage to share responsibilities with MSF mentor. A gynaecological oncologist/trained gynaecologist could have been involved to stage patients and ensure quality of surgeries for women with cervical cancer.

3 CONCLUSIONS

The conclusions from this summative evaluation have been informed by the findings presented in above. The conclusions are grouped into the emerging thematic areas identified during the evaluation.

3.1 CLINICAL ASPECTS

The MSF project was effective, in reaching a significant number of women with different services over the six years of implementation. This led to increased screening rates by five times in a rural setting. By using the 'see and treat' approach using cryotherapy or thermocoagulation, most women who were VIAC positive were able to access treatment, preventing them from getting invasive cervical cancer. Though the project was biased towards prevention, it supported diagnosis and surgical treatment of invasive cervical cancer. However, most eligible women were not able to access the surgical treatment through a simple hysterectomy. This potentially caused distress among women with cervical cancer and their families. Of the women who had hysterectomies done, the surgeries were done by non-experts and potentially led to suboptimal treatment and outcomes. Ideally the adequacy of the surgery should be assessed using the histological specimens which were unfortunately incinerated because of lack support from the MSF project. Due to lack of the histology reports it was not feasible to audit the surgical outcomes. This is likely to create challenges in the long-term care for these women.

Some women diagnosed with advanced cervical cancer not eligible for surgery were supposed to be referred to tertiary centres for chemo/radiation therapy and palliative care. Since this was not done, this may likely have caused distress among these women. This has a potential to discourage other women from early screening. Some of the pain and suffering of these women could have been alleviated by integrating palliative care into the project using the existing trained human resources in the district. This represents a huge, missed opportunity to the intervention.

The challenges identified in this evaluation could have been averted by strengthening referral pathways to tertiary centres at the beginning of the project. Loss to follow-up was identified as a key hindrance to the project among women referred for LEEP, biopsy and hysterectomies due to weak follow-up/monitoring mechanisms in health facilities. This is a common problem faced by most screening programmes in Zimbabwe and other low-middle income countries.

This evaluation showed some key areas that could not be assessed due to lack of data from the routine system such as treatment rate and number of eligible women for psychosocial support. This presents some limitations in the proper assessment of the intervention and could have been avoided by conducting a needs assessment as well as a midterm review of the project.

3.2 FEASIBILITY OF THE MODEL OF CARE

The model of care demonstrated by MSF had its own strengths and weaknesses. One the main strengths was that it avoided creation of parallel structures by integrating services into already existing health facilities. This allowed the project to be implemented in a timely manner and is more likely to be sustainable as services have continued even after handover to the MoHCC.

The MSF model of care demonstrated the feasibility of rapidly scaling up screening and treatment of precancers in a rural setting. This is highly recommendable as lack of access to screening especially for rural women remains a huge unmet need. However, the MSF's approach fell short of sustaining women diagnosed with invasive cervical cancer in the continuum of care.

3.3 PROJECT MANAGEMENT

The MSF project responded to the needs of the affected population which were identified through formal and informal means. The lack of a formal needs assessment was a missed opportunity to clearly identify the people in need, define specific targets and to obtain feedback directly from the beneficiaries as part of the AAP approach. Involving the communities/beneficiaries in the planning and delivery of the intervention could have allowed MSF to plan better for women (including their caregivers) especially those diagnosed with invasive cervical cancer.

MSF utilized its existing good collaborations and relationships with stakeholders and beneficiaries (from the pre-existing project) in the implementation of the intervention. This resulted in buy-in and support from the communities and local leadership and was one of the key success factors of the MSF project.

The project did not have specific targets for performance assessments hence some of the data gaps identified. This evaluation could have been more comprehensive should all the key data points have been available in the M&E system. Additionally, MSF adopted the M&E tools from the MoHCC which had inherent weaknesses and no further strengthening was conducted during the project implementation.

3.4 INTERVENTIONS AIMED AT INFLUENCING POLICY AND PRACTICE

Some of the aspects of the model of care demonstrated by MSF under this project were adopted by one MoHCC partner through multi-stakeholder meetings at the national level and learnings shared informally. MSF did not have a clear advocacy plan developed and implemented for this project. The influence of the MSF project on national policy/practice could have been better with a clear advocacy strategy right from the beginning. In addition, two operational research studies were also conducted under this project. It was early to assess the influences of the ORs on policy/practice in Zimbabwe or internationally because the studies have not been published yet or widely shared.

4 LESSONS LEARNT

Lessons learnt specially targeted at MSF are listed below although these would also be relevant to MoHCC and its partners. They are listed against identified gaps and good practices from our evaluation findings and are based on relevant local/international guidance.

GENERAL PROJECT MANAGEMENT

L1. Needs assessment and midterm reviews

- There is need to conduct comprehensive needs assessments or situation analysis before designing or implementing projects. These assessments allow identification of people at risk, people in need and people to be targeted based on clear criteria. These are key also to inform the existing technical capacities in the district/province/country for better planning. Mid-term reviews are recommended to allow for identification of gaps that could be rectified before a project ends

L2. Monitoring and evaluation systems

- Development of robust M&E systems informed by findings from needs assessment or situation analysis before starting projects is critical for programme effectiveness
- It is good practice to identify key performance indicators to be used to monitor project performance

L3. Accountability to affected populations and community engagement

- Obtaining opinions and thoughts directly from the affected population during design, implementation and monitoring of projects is best practice in development or humanitarian interventions
- It is recommended to develop formal feedback mechanisms at community and health facility levels, and these could include suggestion boxes, client exit interviews and surveys
- Adoption of the AAP approach within projects to obtain more buy-in, ensure more community ownership/involvement and better project performance is widely considered as good practice
- There is need to promote engagement and active participation of community members/ actors to set up and improve health interventions
- Engagement of local leadership in the planning, design, implementation and monitoring of interventions is a key success factor for projects

L4. Good collaboration with Ministries of Health and other actors

- There is need to establish good working relationships with Ministries of Health to ensure buy-in and smooth implementation of projects
- NGO partners should also work closely and collaborate with other actors for better coordination and effectiveness

L5. Competent and motivated human resources

- Before implementing a project there is need to identify motivated human resources and provide them with adequate training to ensure effective intervention delivery
- There is need to strive to retain trained staff to ensure that interventions deliver on the expected outputs/outcomes

L6. Advocacy strategies/plans

- For projects aimed at demonstrating the feasibility of new interventions, conducting ORs during project implementation is recommendable as it has a potential to generate information that may influence practice or policy

CERVICAL CANCER DECENTRALIZED MODEL IMPLEMENTATION

L7. Health promotion and awareness

- Health promotion and awareness are essential components of projects designed to improve uptake or access to cervical cancer services
- Awareness campaigns also help to address myths and misconceptions which may be key barriers to utilizing or accessing cervical cancer services especially in rural contexts
- Systematic health promotion and awareness activities may also be used to obtain vital feedback from communities on the performance/acceptance of cervical cancer interventions

L8. 'See and treat' approach

- "See and treat" approach will ensure that most women will receive treatment on the same day of screening thereby reducing loss to follow-up
- Where possible LEEP should also be scheduled on the same day of screening to increase uptake of the services
- Follow-up mechanisms should be established or strengthened for the approach to be more effective

L9. Outreach services

- Offering screening and treatment using the outreach approach will increase access to services including for women in hard-to-reach areas
- Use of thermocoagulation for treatment of pre-cancers makes outreach services more feasible and effective compared to use of cryotherapy

L10. Task shifting in low resources settings

- Due to shortages of qualified health workers in low-resource setting, there is need to identify opportunities for task shifting as part of decentralization of cervical cancer services
- Task shifting is however feasible in contexts with health workers with basic training and who are motivated coupled together with existence of appropriate capacity building and mentoring programmes

L11. Referral pathways and continuum of care

- Commencement of any screening programme will lead to the identification of women with invasive cancers. Therefore, project implementers should develop/strengthen and adopt clear referral plans before commencement of screening interventions
- Engagement of gynaecologist in cervical cancer screening interventions is vital to ensure good quality of care throughout the continuum of screening and treatment. However, a gynaecologist does not work in isolation and he/she needs a strong community of other health professional and a functional health system to provide optimal care
- Continuum of care is a contribution of multiple actors and it requires the government to take a leadership role for it be effective

L12. Integration of palliative care

- Palliative care approach should be embraced as standard practice for chronic disease related interventions
- Psychosocial support is integral part of palliative care and should be strengthened as part of the cervical cancer interventions

L13. Government investment

- NGO partners should advocate to the government to prioritize more investments to strengthen and establish more public cancer treatment centres across the country
- Government should provide leadership to partners at central level to minimize duplication of activities
- Government should establish effective technical working groups responsible for establishing standards of care and guidance on equipment and commodities to be used across the nation

ANNEX 1: TERMS OF REFERENCE

Doctors without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects. For more information see: evaluation.msf.org.

Subject/Mission:	Evaluation of Cervical Cancer Intervention in Gutu (Zimbabwe)
Starting date:	September 2020 (date TBD)
Duration:	Final report to be submitted by latest December 14 th , 2020

MEDICAL HUMANITARIAN CONTEXT

Cervical cancer is the fourth most commonly diagnosed cancer among females worldwide²⁶. In 2012, the International Agency for Research on Cancer (IARC) recorded 527,624 new cervical cancer cases and 265,672 related deaths²⁷. An estimated 90% of the globally recorded cervical cancer-related deaths are in low-and middle-income countries (LMICs), for which 8 in 10 are recorded within the Sub-Saharan African region²⁸. Infection with HIV substantially increases the risk of cancers such as cervical cancer.

Morbidity and mortality related to cervical cancer can be considered as a significant public health issue in Zimbabwe. Cervical cancer is the most frequently occurring cancer in women of all races and ages in the country²⁹, with a recorded mortality rate of 64% has been recorded³⁰. Access to specialized cancer treatment such as Loop Electrosurgical Excision procedure (LEEP) or hysterectomy or radiotherapy for the advanced stage of cervical cancer is extremely limited especially for those living in rural areas. HIV prevalence in Zimbabwe is 12.7% among adults³¹.

Gutu is the third largest district in Masvingo Province in southern Zimbabwe. It has an estimated catchment population of 203 000 people (2012 census). The population is mostly the Karanga, a Shona sub-tribe. Its population density of 22.08 per square kilometer is among the highest in the country. Gutu district is served in total with 29 health facilities including 6 rural hospitals hospital well scattered to cover the district population accessing health care. As everywhere else in the country medical gaps

²⁶ International Agency for Research on Cancer (IARC), WHO, 2012.

²⁷ Idem

²⁸ Idem

²⁹ Chokunonga E, Borok MZ, Chirenje ZM, Makunike-Mutasa R, Ndlovu N, Nyakabau AM, Vuma S. Zimbabwe National Cancer registry: 2014 Annual Report. Pattern of cancer in Zimbabwe

³⁰ Information Centre for Cancer. Human papillomavirus in Zimbabwe report. Accessed on 31 January 2017

³¹ UNAIDS, Data from Zimbabwe, 2018.

exist and are worsened by the economic situation that Zimbabwe has been going through in this last decade.

In the frame of an existing HIV project in Gutu district of Zimbabwe, MSF decided to expand its activities to include, starting in 2015, interventions focused on cervical cancer for both women living with HIV and the general population. With the general objective to reduce the morbidity and mortality due to cervical cancer in Gutu district, the interventions were aimed at increasing access to both preventive and curative services for cervical cancer.

In collaboration with the Ministry of Health, MSF operated at different levels of care (such as outreach, six rural health centers and Gutu rural hospital), offering capacity building and technical support. The MSF intervention in cervical cancer includes the following medical activities:

Prevention

- Implementation of Human Papillomavirus Virus (HPV) vaccination among HIV-Positive Adolescent Girls and Young Women aged 15 to 26 years old³²

Screening

- Visual Inspection with Acetic Acid and Cervicography (VIAC) at health centers and through outreach activities
- Pilot of Xpert HPV Testing and Self-Sample Collection for Cervical Cancer Screening³³
-

Treatment

- Precancerous lesions (Thermo-coagulation) by outreach activities
- Precancerous lesions (Cryotherapy) decentralized in six rural health centers
- Advanced lesions with LEEP (Loop Electro Excision Procedure) performed at Gutu Rural Hospital.
- Referrals (TAH) and basic psychosocial care for suspected/ confirmed cancer cases.

In addition to the specific objectives stated above, the project defined a clear intention to demonstrate the feasibility of new models of care (cervical cancer) both facility-based and through outreach. These new models of cervical cancer prevention and care can catalyze and enable change to improve outcomes through their adoption at national level and beyond. With this intention advocacy activities were also considered as part of the intervention strategy.

Since 2015, more than 20,000 women have been screened for cervical cancer in Gutu. Amongst those screened, 6% were VIAC positive. 71% of them were managed by Cryotherapy (1,026 out of 1,442) and 642 were referred to tertiary facility for further management. The project plans to handover to the Minister of Health and other partners by the end of 2020.

REASON FOR EVALUATION / RATIONALE

The approaches implemented by MSF in this cervical cancer intervention are relatively innovative in Zimbabwe, especially regarding the “see and treat approach”, aimed at decentralizing screening and

³² Idem

³³ Implemented in the frame of an operational research. It will, therefore, not be included as part of the scope of this evaluation.

treatment services to primary health level. The documentation of such interventions offers then an excellent opportunity to inform policy decision makers in Zimbabwe and other countries in the region. In addition, MSF operational experience in cervical cancer is also relatively limited with few projects implementing routine CCS³⁴. Therefore, the appraisal of this intervention offers a unique opportunity for MSF to document the lessons learned during its implementation and reflect on how it can be adapted and better implemented by MSF in similar contexts.

OVERALL OBJECTIVE AND INTENDED USE

OVERALL OBJECTIVE is to assess the operational strategies and interventions implemented in the cervical cancer project in Gutu, with special attention to their appropriateness and effectiveness (both for women living with HIV and for general population), and to identify the lessons learned that should be considered in similar interventions.

INTENDED USE of this evaluation is aimed at informing MSF-OCB in their conversations with Zimbabwe/Masvingo Ministry of Health or other relevant actors, potentially interested in learning the experiences and/or taking over from MSF, to replicate or scale-up CCS prevention and curative services implemented by MSF. The evaluation findings will also be used by MSF to inform operational decisions on how to address cervical cancer management in similar contexts.

SPECIFIC OBJECTIVES

APPROPRIATENESS

- *Do cervical cancer interventions' objectives correspond to identified needs?*
- *Is the chosen model/strategy appropriate to achieve the objectives?*
- *Is the intervention appropriate from the beneficiaries' perspective?*

EFFECTIVENESS

- *To what extent have the objectives been achieved?*
- *What were the main enabling and challenging factors at community (awareness), facility and hospital level for achievement or under-achievement of objectives?*
- *How did the project respond to the identified challenges?*
- *What can be (or could have been) done to make the intervention more effective?*
- *To which extent do the activities reach the target population?*
- *Are there any factors that hinder access for the population to screening, prevention and curative services?*

³⁴ MSF has supported national health ministries to provide screenings and early treatment in some countries like Kenya (VIA and referrals for treatment); Malawi (VIA, thermo-coagulation and referrals for LEEP) and Swaziland (VIA, cryotherapy, referrals for LEEP). MSF has also supported HPV vaccination campaigns for schoolgirls in South Africa (2015) and the Philippines (2017)

EFFICIENCY

- *How cost-efficient is the program, in terms of the qualitative and quantitative outputs achieved?*

EXPECTED DELIVERABLES

1. Inception Report

- As per SEU standards, after conducting initial document review and preliminary interviews. It will include a detailed evaluation proposal, including methodology.

2. Draft Evaluation Report

- As per SEU standards. It will answer to the evaluation questions and will include conclusions, lessons learned and recommendations.

3. Working Session

- With the attendance of commissioner and consultation group members. As part of the report writing process, the evaluator will present the findings, collect attendees’ feedbacks and will facilitate discussion on lessons learned.

4. Final Evaluation Report

- After addressing feedbacks received during the working session and written inputs.

5. *Other dissemination deliverables to be defined in a separate dissemination plan.*

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory/ies. It will be reviewed and validated as a part of the inception phase in coordination with the SEU.

RECOMMENDED DOCUMENTATION

- Project documents (project proposals, logistical frameworks, situational reports, annual reports, field visit reports)
- Documentation regarding the ongoing operational research initiatives in the project
- National and regional documentation (Zimbabwe SRH national policies, Zimbabwe reports)
- External literature and documentation of similar experiences

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	<i>TBD</i>
Timing of the evaluation	Sep-Dec 2020

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

- **Requirements:**
 - > Proven evaluation competencies (minimum 5 years)
 - > Formal background/studies on public/international health
 - > Experience in Sexual and Reproductive Health programing (minimum 5 years)
 - > Experience in Southern Africa region
 - > Language requirements: English (Fluent)

- **Assets:**
 - > Experience in cervical cancer and HIV
 - > Experience in Zimbabwe
 - > MSF experience and/or understanding

ANNEX 2: EVALUATION MATRIX

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
Appropriateness	<p>EQ 1: Did the cervical cancer intervention’s objectives correspond to identified needs?</p> <p>1.1. To what extent was MSF’s intervention aligned with and tailored to the needs of affected populations?</p> <p>1.2. What tools (i.e.. methodologies, situation analysis, needs assessments, data systems etc.) were used to gauge these needs? /What was the quality/appropriateness of these tools?</p> <p>1.3. To what extent have affected populations been involved in and influenced needs assessments, delivery and monitoring of cervical cancer intervention?</p> <p>1.4. Was the intervention aligned with others (e.g.. disease outbreak response, HIV/AIDS, TB, SRH, MNCH etc) in MSF?</p> <p>1.5. Was the intervention aligned with those of other actors in the sector e.g.. MoHCC and other NGOs?</p>	Extent to which the project and its objectives are aligned with identified needs	Stakeholders’ perceptions of the alignment between identified needs and the project and its objectives	Program documents, program reports; Key informant interviews
	<p>EQ 2: Was the chosen model/strategy appropriate to achieve the objectives?</p> <p>2.1. Was the cervical cancer intervention the best approach to meet the needs of the affected populations and intended beneficiaries?</p> <p>2.2. Were protection and ethics issues considered in the design and implementation of the intervention?</p> <p>2.3. To what extent were the services provided by MSF sensitive to socio-cultural norms in the targeted communities?</p>	Extent to which the chosen model/strategy is appropriate to achieve the objectives	Stakeholders’ perceptions of the alignment between model/strategy and the intervention objectives	Program documents, program reports; Key informant interviews

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
	<p>EQ 3: Was the intervention appropriate from the beneficiaries' perspective?</p> <p>3.1 Was the cervical cancer intervention the best approach to meet the needs of the affected populations?</p> <p>3.2 Was the intervention sensitive to vulnerable populations such as HIV+, elderly, disabled and women and girls living in hard-to-reach areas?</p> <p>3.3 Was the cervical cancer intervention sensitive to socio-cultural norms?</p>	Extent to which the project is appropriate to the beneficiaries	Beneficiaries' perceptions of appropriateness of intervention	Program documents, program reports; Key informant and in-depth interviews and focus group discussions
Effectiveness	<p>EQ4: To what extent have the defined objectives been achieved?</p> <p>4.1 Were the results in line with the project's expectations and objectives?</p> <p>4.2 Were relevant standards met by the intervention?</p> <p>4.3 Were there any unintended consequences of the intervention (positive and negative)?</p>	Extent to which the activities have achieved the project objectives to date	Evidence demonstrating outputs / results of the project to date are contributing to / in line with the project objectives	Program documents, program reports; routine and operational research data
	<p>EQ5: What were the enabling and challenging factors at community (awareness), facility and hospital level for achievement or under-achievement of objectives?</p> <p>5.1 What mechanisms were used to identify challenges during design/implementation of intervention?</p> <p>5.2 What feedback mechanisms were available for communities or beneficiaries?</p> <p>5.3 What factors contributed to success and what factors constrained MSF's success? (e.g.. human</p>	Extent to which enabling and challenging factors at community, facility and hospital level influenced achievement or underachievement of objectives	Stakeholders' perceptions of the enabling and challenging factors for achievement or under-achievement of the objectives	Key informant and in-depth interviews and focus group discussions

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
	<i>resources capacity, staff turnover, adequate funding etc.) at the community, facility and hospital level?</i>			
	<p>EQ6: How did the project respond to the identified challenges?</p> <p>6.1 What measures were put in place to overcome challenges in the design/implementation of the intervention?</p>	<i>Extent to which project responded to challenges</i>	<i>Stakeholders' perceptions of how the project responded to challenges</i>	<i>Program documents; Key informant interviews</i>
	<p>EQ7: What could be done to make the project more effective?</p> <p>7.1 What are some of the solutions to improve access to cervical cancer services?</p> <p>7.2 How can access to cervical cancer services be improved from beneficiaries' perspectives?</p>	<i>Extent to which strategies/ activities have changed based on changing contexts or lessons learnt</i>	<i>Evidence linking changed strategies/ activities to contextual changes</i>	<i>Program documents, program reports; routine and operational research data; external literature; Key informant interviews</i>
	<p>EQ8: To which extent did the project activities reach the target population?</p> <p>8.1 To what extent were eligible women and girls accessing appropriate cervical cancer services?</p> <p>8.2 Was the intervention able to reach vulnerable populations such as HIV+, elderly, disabled and women and girls living in hard-to-reach areas?</p>	<i>Extent to which project activities reach the target population</i>	<i>Evidence linking project activities reaching the target population</i>	<i>Program documents, program reports; Key informant and in-depth interviews and focus group discussion</i>
	<p>EQ9: Were there any factors that hinder access for the population to screening, prevention and curative services?</p>	<i>Extent to which other factors hinder access for the population to screening, prevention and curative services</i>	<i>Stakeholders' perceptions of the other factors hindering access for the population to</i>	<i>Program documents, program reports; routine and operational research data</i>

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
	9.1 What are the barriers to accessing cervical cancer screening, prevention and curative services among the affected populations?		screening, prevention and curative services	Key informant and in-depth interviews and focus group discussion
	EQ10 What difference has the project made in terms of policy/practice locally? 10.1 How has the intervention contributed to policy and practice in Zimbabwe?	Extent to which the project has influenced policy/practice locally	Evidence showing policy or practice changes	Program documents, program reports; external literature; Key informant interviews
Efficiency	EQ11: How efficient was the project, in terms of the qualitative and the quantitative outputs achieved 11.1 Was the MSF cervical cancer intervention efficient in terms of human resources, equipment and commodities? 11.2 Was the MSF cervical cancer intervention implemented in a timely way?	Extent to which efficient use of MSF resources was made	Evidence of best use of MSF resources and time	Program documents, program reports; external literature Key informant interviews

ANNEX 3: LIST OF DOCUMENTS REVIEWED

MSF PROJECT DOCUMENTS

- Project monthly reports, 2015-2020
- Project quarterly reports, 2015-2020
- Project field visit reports,2015-2020
- Project M&E Framework and reports, 2015-2020
- Project log frames, 2015-2020
- Xpert study protocol, 2018
- Xpert study final report,2020
- HPV vaccination study protocol,2018
- HPV vaccination study final report,2020
- UNITAID CEA Evaluation Report ,2019
- Cervical cancer screening and treatment in Gutu, Zimbabwe. Project Plan,2015
- Decentralized cervical cancer service provision in Gutu, Zimbabwe. Capitalization report,2020

MOHCC NATIONAL GUIDELINES

- VIAC based cervical cancer screening and management Practical Manual, 2012
- Zimbabwe Cervical Cancer Prevention and Control Strategy, 2016-2020
- Zimbabwe National Cancer Prevention and Control Strategy, 2013-2017

WHO GUIDELINES

- Global strategy on the elimination of cervical cancer,2018
- Working Group on HPV, Report to SAGE, 2018
- Guide to introducing HPV vaccine into national immunization programmes, 2016
- Scaling-up HPV vaccine introduction, 2016
- Monitoring national cervical cancer prevention and control programmes: quality control and quality assurance for visual inspection with acetic acid (VIA)-based programme,2013
- Comprehensive cervical cancer control. A guide to essential practice. Second Edition,2014
- World Medical Association Declaration of Helsinki, WHO,2000. [https://www.who.int/bulletin/archives/79\(4\)373.pdf](https://www.who.int/bulletin/archives/79(4)373.pdf)
- Operational guidance on accountability to affected populations , Health Cluster, WHO, 2017

EXTERNAL LITERATURE

- Principles for evaluation of development assistance. Paris: OECD/DAC,1991: (www.alnap.org/resource/20830.aspx).
- Guidance for evaluating humanitarian assistance in complex emergencies. Paris: OECD/DAC, 1999. (www.alnap.org/resource/8221.aspx).
- Zimbabwe-population based HIV impact assessment, ZIMPHIA, 2016

- Ministry of Women Affairs and Gender (2012) Zimbabwe National Gender Based Violence Strategy (2012-2015)
- Cervical Cancer screening update and challenges in Malawi from 2011 to 2015: retrospective cohort study, Msyamboza et al., 2016
- Zimbabwe Demographic and Health Survey 2015: Final Report. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2016
- Health systems challenges in cervical cancer prevention program in Malawi, Maseko et al., 2015
- Cervical cancer in Zimbabwe: a situation analysis, Kuguyo et al., 2017
- Health service delivery models entrenching inequities to treatment and care among women with cervical cancer in Harare, Zimbabwe, Tapera et al., 2019
- Gaps and opportunities for cervical cancer prevention, diagnosis, treatment and care: evidence from midterm review of the Zimbabwe Cervical Cancer Prevention and Control strategy (2016-2020), Tapera et al., 2020
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- Utilization of cervical cancer screening services and trends in screening positivity rates in a 'Screen and Treat' programme integrated with HIV/AIDS care in Zambia, Mwanahamuntu et al., 2013
- NHSCSP Colposcopy and Programme Management, Public Health England, 2016
- Loss to follow-up in a cervical cancer screening and treatment programme in Western Kenya, Kiptoo et al., 2018.

ANNEX 4: LIST OF PARTICIPANTS

LIST OF KEY INFORMANTS

Name of Participants	Organization/Function	Mode of interview	Level
Daniella Garone	MSF Deputy Medical Coordinator of Operations; Former Medical Coordinator (Zimbabwe)	Zoom	HQ
Severine Caluwaertz	MSF Obstetrician & Gynaecologist	Zoom	
Helen Bygrave	MSF Chronic Disease Manager	Zoom	
Reinaldo Ortuno Gutierrez	MSF Medical Coordinator (Zimbabwe)	Zoom	Mission
Sandra Simons	Former MSF Medical Coordinator (Zimbabwe)	Zoom	
Kuziwa Kuwenyi	MSF Deputy Medical Coordinator (Zimbabwe)	Zoom	
Caroline Gwature	MSF Communication & Advocacy Manager	Zoom	
Paul Matsinise	MSF Health Promotions Officer	Face-to-face	Project
Rinako Uenishi	MSF Gutu Field Coordinator	Face-to-face	
David Some	MSF Gutu Medical Coordinator	Face-to-face	
Dr Mapfumo	MSF Program Manager (SRH)	Zoom	
Yuster Rono	MSF Gutu Epidemiologist	Zoom	
Sister Mercy Mandizvo	MSF VIAC Mentor	Telephone	
Rufaro Machakaire	MSF Gutu Finance & Human Resources Manager	Face-to-face	
Christopher Mushweshwe	MSF Patient Support Officer	Telephone	
Geoffrey Mwedzindira	MSF Logistics & Supply officer	Face-to-face	
Sister Tendai Chigura	MSF VIAC Mentor	Telephone	
Dr Pamela Magande	JF Kapnek HIV/AIDS Program Manager	Zoom	National
Sister Chinaka	JF Kapnek VIAC Mentor	Face-to-face	Project
Sister Petronella	Newlands Clinic VIAC Mentor	Face-to-face	National
Dr Margaret Pascoe	Newlands Clinic Clinical Manager	Face-to-face	
Dr Bernard Madzima	MoHCC Former Director of Family Health	Face-to-face	National
Muchaneta Mandara	MoHCC Former VIAC Officer; OPHID VIAC Manager	Face-to-face	
Dr A Shamu	MoHCC Masvingo Provincial Medical Director	Face-to-face	Provincial
Dr Chirengwa	MoHCC Masvingo Gynaecologist	Face-to-face	
Mr Chitiga	MoPSE Masvingo Provincial Education Director	Face-to-face	
Mr Muganhu	MoPSE Gutu District Schools Inspector	Face-to-face	
Dr Takayidza	District Medical Officer	Face-to-face	

Mr Kuchicha	Gutu District Nursing Officer	Face-to-face	
Mr Chinduru	Gutu Rural Pharmacist	Face-to-face	
Mr Zikiti	Gutu District Health Promotion	Face-to-face	
Dr Mupepi	Gutu Medical Officer (Trained in LEEP)	Face-to-face	
Dr Banda	Muvonde Medical Officer	Face-to-face	
Chief Gutu	Gutu District Chief	Face-to-face	
Pastor Chityatya	Gutu Female Pastor	Face-to-face	
Mrs C Tafireyi	MoLG Gutu District Development Coordinator	Face-to-face	Facility
Sister King	Gutu Mission VIAC nurse	Face-to-face	
Sister Mutemera	Chitando VIAC Nurse	Face-to-face	
Sister Chaoma	Gutu Rural Focal VIAC nurse	Face-to-face	
Sister Machingura	Chimombe VIAC Nurse	Face-to-face	
Sr Munarwo	Munyikwa nurse (non-intervention site)	Face-to-face	Community
Loice Mwashiri	Female village Health Worker (Intervention)	Face-to-face	
Munyaradzi	Female village Health Worker (Intervention)	Face-to-face	
Mrs Mudyiwa	Female village Health Worker (non-intervention)	Face-to-face	
Mrs Samatanga	Female local counsellor (Intervention)	Face-to-face	
Mrs Chiname	Female local counsellor (non-intervention)	Face-to-face	
Ms Munyaniki	Female Village Head	Face-to-face	

LIST OF IN-DEPTH INTERVIEW PARTICIPANTS

Interview	Characteristics of participant	Location
Woman	Cryotherapy, HIV+, 27-35 years	Gutu Mission
Woman	TAH, HIV+, 27-35years	
Woman	Never accessed cervical cancer services, HIV+, 27-35years	
Adolescent girl	No HPV vaccination 15-19 years	
Woman	No HPV vaccination 20-26years	
Man	Partner accessed TAH, HIV-, 46 years +	
Woman	Cryotherapy, HIV+,27-35 years	
Woman	Thermocoagulation, HIV-, 27-35years	Gutu Rural
Man	Partner received cryotherapy, thermocoagulation or LEEP, HIV -, 36-45 years	
Woman	LEEP, HIV-, 27-35years	
Woman	Referral for invasive cervical cancer, HIV-, 36-45years	
Adolescent girl	HPV vaccination 1st dose,15-19years	
Man	Partner received cryotherapy, thermocoagulation or LEEP, HIV -, 36-45years	
Woman	HPV screening, HIV-, 27-35years	
Woman	LEEP, HIV + 46+years)	
Woman	Never accessed cervical cancer services, HIV-, 36-45years	

Man	Partner accessed cervical cancer screening using VIAC, HIV+, 36-45years	Chitando
Woman	HPV screening, HIV-, 27-35years	
Woman	VIAC, HIV-, aged 46+years	Chinyika
Woman	Thermocoagulation, HIV+, aged 46+years)	
Woman	Referrals for treatment for invasive cervical cancer and basic psychosocial	Chimombe
Woman	VIAC, HIV+ ,aged 27-35 years	
Woman	Cryotherapy, HIV- woman aged 46+ years	
Woman	Referrals for treatment for invasive cancer and basic psychosocial support, HIV+ aged 46+years	
Woman	HPV vaccination 1st dose only, 20-26years	
Man	Partner accessed HPV vaccination (HIV+ aged 27-35years)	
Woman	HPV screening, HIV- aged 46+	Mukaro
Woman	TAH, HIV- aged 46+years	
Woman	HPV vaccinations at least 2doses, 20-26years	
Man	Partner accessed cervical cancer screening using HPV test, HIV- aged 46+years	
Woman	Caregiver of patient who died of cervical cancer	
Woman	HPV screening, HIV- aged 46+	

LIST OF FOCUS GROUP DISCUSSIONS CONDUCTED

Focus groups	♂	♀	Characteristics	Location
Women		6	HIV+, accessed cervical cancer screening and HPV testing, cryotherapy/thermocoagulation or LEEP <ul style="list-style-type: none"> • 3 aged 46 years+ • 3 aged 36-45 Years 	Gutu Mission
Women		6	20-26 years who received HPV vaccination (4) and those who did not receive it (2)	
Girls		7	15-19 years, who had HPV vaccination (1 st and 2 nd doses)	Dewure High School
Women		7	HIV- and HIV+ who accessed cervical cancer screening or HPV testing, cryotherapy/thermocoagulation or LEEP, aged 27-35years	Chitando
Men	6		Partners of women who have accessed cervical cancer interventions <ul style="list-style-type: none"> • 3 elderly aged 46+years • 3 middle aged 36-45years 	Chinyika

ANNEX 5: MOHCC INDICATORS USED BY MSF

Table 3.2: MoHCC key performance indicators and reach for the MSF project²⁴

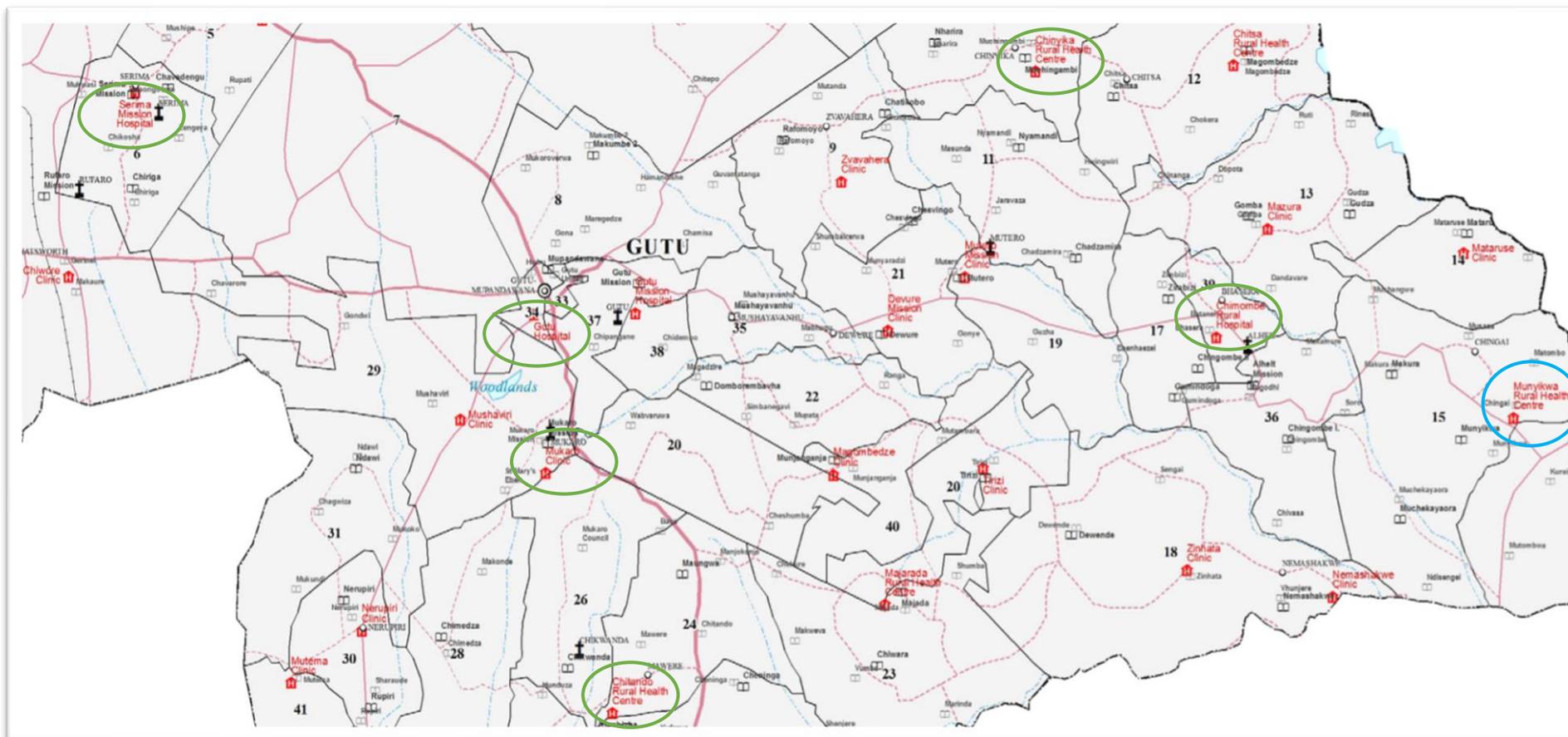
Key indicators	MSF Target (2015)	MSF results (2020)	MoHCC Target (2020)	Comments/Analysis
% of women and girls who ever heard about cervical cancer	No data	No data	90%	There no target set at the start of the project
% of women with precancerous lesions who received treatment.	No data	No data	80%	There no target and complete data to calculate this indicator
% of women eligible for LEEP or suspected with cervical cancer who access histological investigations	380	53%	50%	MSF project exceeded the national target set by MoHCC.
% of women with operable cervical cancer who had surgery	No data	3%	10%	MSF underperformed on this indicator however, MSF data was not disaggregated into operable and non-operable cancers
% of women with cervical cancer who received radiotherapy and chemotherapy services	No data	Not applicable	65%	MSF project did not support chemo/radiotherapy

Table 3.2 above summarizes key performance indicators set by MoHCC and how the MSF project performed where applicable. Due to M&E limitations from the MSF project, there was no complete data to determine the pre-cancer treatment rate which is key performance indicator. The MoHCC midterm review of 2019 revealed a treatment rate of 66% (versus a target of 80% by 2020)³⁵. In the MSF project 53% of women who had LEEP/biopsy for suspicious cancer lesions had their results documented and this exceeded the MoHCC target of 50% by 2020²⁴.

³⁵ MoHCC (2019): Zimbabwe Cervical Cancer Prevention and Control Strategy Midterm Review

ANNEX 6: MAP OF HEALTH FACILITIES ASSESSED/VISITED AND CHECKLIST

KEY: Assessed project supported health facilities Visited non-project health facility



HEALTH FACILITY ASSESSMENT CHECKLIST/QUESTIONNAIRE

FIND THE MANAGER, THE PERSON IN-CHARGE OF THE FACILITY OR THE MOST SENIOR HEALTH WORKER RESPONSIBLE FOR CLIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING:

Hello. My name is _____ and I am working with SADTAP Health Research Institute. We are assessing health facilities in Gutu district as part of MSF cervical cancer intervention evaluation. Your health facility has been selected because you have been supported by MSF to provide cervical cancer prevention and/ curative services. We will be asking you questions about the availability of cervical cancer services, related commodities and equipment as well as IEC materials available. Information collected about your facility during this evaluation may be used for improving services. The interview will take not more than 30 minutes and I am going to ask to see some of the facilities, equipment and commodities related to cervical cancer services. For this interview I am going to be using a smartphone to collect your responses and would that be okay with you?

Do you have any questions for me before we proceed?

Would you like us to proceed with the interview?

HF101	Interview date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="0"/>	
HF102	Study Staff ID [2 digits]	<input type="text"/> <input type="text"/>	
HF103	Facility Number [4 digits]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
HF104	Facility Name	_____	
HF105	Location of the health facility (Ward)	<input type="text"/> <input type="text"/>	
HF106	District	_____	
HF107	Type of health facility	<ol style="list-style-type: none"> 1. Central Hospital 2. Provincial Hospital 3. District Hospital 4. Health Centre/Clinic 	
HF108	Managing authority	<ol style="list-style-type: none"> 1. Government/public 2. Private (including NGO run) 3. Mission/Faith-based 4. Other (e.g.. military, prison, police) 	
HF109	Urban/rural	<ol style="list-style-type: none"> 1. Urban 2. Rural 	
BASIC AMENITIES			
BA101	Is there a health care worker present at the facility during working hours, to provide cervical cancer services e.g. health education, screening, treatment and psychosocial support?	<ol style="list-style-type: none"> 1. Yes 2. No 	
BA102	Does this facility have a functioning land line telephone that is available to call outside at all times when client services are offered?	<ol style="list-style-type: none"> 1. Yes 2. No 	
BA103	Does this facility have a functioning mobile phone or a private mobile phone that is supported by the facility?	<ol style="list-style-type: none"> 1. Yes 2. No 	
BA104	Does this facility have a functioning short-wave radio for radio calls?	<ol style="list-style-type: none"> 1. Yes 2. No 	
BA105	Does this facility have a functioning computer or laptop?	<ol style="list-style-type: none"> 1. Yes 2. No 	

BA106	Is there access to email or internet within the facility?	1. Yes 2. No	
BA107	Does this facility have a functional ambulance or other vehicle for emergency transportation for clients that is stationed at this facility or operates from this facility?	1. Yes 2. No	
BA108	Does this facility have access to an ambulance or other vehicle for emergency transport for clients that is stationed at another facility or that operates from another facility in near proximity?	1. Yes 2. No	
BA109	Is fuel for the ambulance or other emergency vehicle available today?	1. Yes 2. No	
BA110	Does your facility have electricity from any source (e.g., electricity grid, generator, solar, or other) including for stand-alone devices (EPI cold chain)?	1. Yes 2. No	
BA111	What is the facility's main source of electricity?	1. Central supply of electricity (e.g., national or community grid) 2. Generator (fuel or battery operated generator) 3. Solar system 4. Other (specify) _____	
BA112	Other than the main or primary source, does the facility have a secondary or backup source of electricity? If yes: what is the main secondary source of electricity?	1. No secondary source 2. Central supply of electricity (e.g., national or community grid) 3. Generator (fuel or battery operated generator) 4. Solar system 5. Other (specify) _____	
BA113	During the past 7 days, was electricity available at all times from the main or any backup source when the facility was open for services?	1. Always available (no interruptions) 2. Often available (interruptions of less than 2 hours per day) 3. Sometimes available (frequent or prolonged interruptions of more than 2 hours per day)	
BA114	On average, how many hours per day is this facility open?	1. 4 hours or less 2. 5 to 8 hours 3. 9 to 16 hours 4. 17-23 hours 5. 24 hours	
BA115	On average, how many days per week is this facility open?	<input type="text"/>	
BA116	What is the most commonly used source of water for the facility?	1. No water source 2. Piped into facility 3. Piped onto facility grounds	17.

		<ol style="list-style-type: none"> 4. Public tap/standpipe 5. Tubewell/borehole 6. Protected dug well 7. Unprotected dug well 8. Protected spring 9. Unprotected spring 10. Rainwater collection 11. Bottled water 12. Cart with small tank/drum 13. Tanker truck 14. Surface water (lake, pond, dam, river) 15. Don't know 16. Other (specify) 	
BA117	Where is the main water supply for the facility located?	<ol style="list-style-type: none"> 1. On the premises 2. Up to 500 metres 3. 500 metres or further 	
BA118	Is there enough water to fulfil the needs of the healthcare facility?	<ol style="list-style-type: none"> 1. Yes 2. No 	
BA119	At what frequency do you have access to water?	<ol style="list-style-type: none"> 1. Every day, all the time 2. Every day, only sometimes 3. 5 days or more per week 4. Less than 5 days per week 	
BA120	Is there a room with auditory and visual privacy available for patient consultations? <i>Observe.</i>	<ol style="list-style-type: none"> 1. No privacy 2. Auditory privacy only 3. Visual privacy only 4. Both auditory and visual privacy available 	
BA121	Is there a modern toilet or pit latrine in functioning condition that is available for general outpatient client use? If yes: What type of toilet? <i>If multiple toilets are available, consider the most modern type.</i>	<ol style="list-style-type: none"> 1. No functioning facilities/bush/field 2. Flush toilet 3. Ventilated improved pit latrine (VIP) 4. Pit latrine with slab 5. Pit latrine without slab/open pit 6. Composting toilet 7. Bucket 	8.
BA122	Is there a handwashing sink or station at less than 5 metres from the toilet/latrine? <i>If possible, inspect more than one toilet/latrine.</i>	<ol style="list-style-type: none"> 1. Yes, with water and soap 2. Yes, but not functional or missing soap, water or hydroalcoholic gel/hand-sanitizer 3. No 	
BASIC EQUIPMENT			
	Please tell me if the following basic equipment and supplies used in the provision of client services are available and functional in this facility today. <i>Ask to see the items.</i>		
BE101	Adult weighing scale	<ol style="list-style-type: none"> 1. Observed and functional 2. Observed, not functional 2. Reported, not seen 	

		3. Not available	
BE102	Child weighing scale [250 gram gradation]	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE104	Measuring tape-height board/stadiometer	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE105	Thermometer	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE106	Stethoscope	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE107	Digital blood pressure apparatus	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE108	Manual blood pressure apparatus	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE109	Light source <i>Flashlight acceptable.</i>	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE117	Intravenous infusion kit (adult)	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE118	Sterilizer or Autoclave	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
BE119	Fridge/Cold room for vaccines	1. Observed and functional 2. Observed, not functional 3. Reported, not seen 4. Not available	
INFECTION CONTROL PRECAUTIONS			
	Please tell me if the following resources/supplies used for infection control are available in the general outpatient area of this facility today.		
	<i>Ask to see the items.</i>		

IC101	Clean running water (piped, bucket with tap, or pour pitcher)	1. Observed 2. Reported, not seen 3. Not available	
IC102	Hand-washing soap/liquid soap	1. Observed 2. Reported, not seen 3. Not available	
IC103	Alcohol-based hand rub	1. Observed 2. Reported, not seen 3. Not available	
IC104	Waste receptacle (pedal bin) with lid and plastic bin liner	1. Observed 2. Reported, not seen 3. Not available	
IC105	Sharps container (“safety box”)	1. Observed 2. Reported, not seen 3. Not available	
IC106	Disinfectant/antiseptics (e.g., chlorine, alcohol)	1. Observed 2. Reported, not seen 3. Not available	
IC107	Single-use standard disposable syringes with needles	1. Observed 2. Reported, not seen 3. Not available	
IC108	Auto-disable syringes with needles	1. Observed 2. Reported, not seen 3. Not available	
IC109	Gloves (examination or surgical)	1. Observed 2. Reported, not seen 3. Not available	
IC110	Medical masks (surgical or procedural)	1. Observed 2. Reported, not seen 3. Not available	
IC111	Eye protection (goggles or face shield)	1. Observed 2. Reported, not seen 3. Not available	
IC112	Surgical scrubs	1. Observed 2. Reported, not seen 3. Not available	
IC113	Waterproof (e.g., plastic) aprons	1. Observed 2. Reported, not seen 3. Not available	
IC114	Gowns (sterile)	1. Observed 2. Reported, not seen 3. Not available	
IC115	Coveralls/Hazmat suits	1. Observed 2. Reported, not seen 3. Not available	

IC116	Closed work shoes (e.g.. boots) or shoe covers	1. Observed 2. Reported, not seen 3. Not available	
CERVICAL CANCER SERVICES			
Ask to be shown the location in the facility where women are seen for cervical cancer screening, diagnosis and treatment. Find the person most knowledgeable about provision on cervical cancer services in the facility. Introduce yourself, explain the purpose of the assessment, and ask the following questions.			
CS101a	How many days in a month are cervical cancer services available in this facility? <i>Use a 4-week month to calculate days</i> Put 30 if open everyday	<input type="text"/>	
CS101b	Does your health facility conduct outreach campaigns for cervical cancer preventive and curative services?	1. Yes 2. No	
CS101c(i)	Does this facility have adequate health professionals to provide cervical cancer services?	1. Yes 2. No	
CS101c(ii)	If no how many health professionals do you have?	<input type="text"/>	
CS101c(iii)	What is the ideal number of health professionals required to provide optimal cervical cancer services?	<input type="text"/>	
CS101d	Does this facility conduct HIV testing or status reviews on patients?	1. Yes 2. No	
CS102	Do providers in this facility screen for cervical cancer?	1. Yes 2. No	
CS103a	Do providers in this facility use VIAC to screen cervical cancer?	1. Yes 2. No	
CS103b	How many women were screened using VIAC (first time) in this facility by year?	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	
CS104a	Do providers in this facility support HPV self-sample collection and transportation to the testing laboratory?	1. Yes 2. No	
CS104a	How many women were supported with HPV self-sample kits in this facility by year?	2019 <input type="text"/> 2020 <input type="text"/>	

CS105	Do providers in this facility treat cervical precancers?	1. Yes 2. No	
CS106a	Which treatment methods do providers in this facility usually use?	1. Cryotherapy 2. Thermocoagulation 3. LEEP 4. Surgery	
CS106b	How many women were treated with cryotherapy in this facility by year? Put 9999 for "Not applicable"	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	
CS106c	How many women were treated with thermocoagulation in this facility by year? Put 9999 for "Not applicable"	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	
CS106d	How many women were treated with LEEP in this facility by year? Put 9999 for "Not applicable"	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	
CS106e	How many women were treated with surgery (TAH) in this facility by year? Put 9999 for "Not applicable"	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	
CS107a	Does this facility conduct histological investigations to diagnose cervical cancer?	1. Yes 2. No	
CS107b	If no, where do you refer patients for histological investigations?	1. Private Laboratories 2. Government Laboratories	3.
CS107c	How many women were referred for biopsies for cervical cancer diagnosis (including from LEEP) in this facility by year? Put 9999 for "Not applicable"	2015 <input type="text"/> 2016 <input type="text"/> 2017 <input type="text"/> 2018 <input type="text"/> 2019 <input type="text"/> 2020 <input type="text"/>	

CS108	Does the facility charge user fees for cervical cancer screening?	1. Yes 2. No	
CS109	If yes, how much is charged?	_____ ZW\$	
CS110	May I see your cervical cancer screening pictures/results?	1. Observed 2. Reported available, not seen 3. None available today	
CS111	How many days of stock-outs of cervical cancer commodities occurred in the past four weeks?	1. Less than 7 days 2. 7-14 days 3. More than 14 days	
CS112	Does the facility charge user fees for cervical cancer treatment?	1. Yes 2. No	
CS113	If yes, how much is the average charge for full cycle of treatment?	_____ ZW\$	
CS114	Does the facility offer basic psychosocial support service to women suspected or diagnosed of cervical cancer?	1. Yes 2. No	
CS115	Do you have the national guidelines for the screening, diagnosis and treatment of cervical cancer available in this service area? <i>Acceptable if part of another guideline</i>	1. Observed 2. Reported, not seen 3. Not available	
CS116	Have you or any provider(s) of cervical cancer received any training in cervical cancer screening, diagnosis and treatment in the last two years?	1. Yes 2. No	
CERVICAL CANCER COMMODITIES AND EQUIPMENT			
Ask to be shown the main location in the facility where medicines and other supplies are stored. Find the person most knowledgeable about storage and management of medicines and supplies in the facility. Introduce yourself, explain the purpose of the assessment and ask the following questions.			
	Are any of the following cervical cancer medicines and commodities available today in this facility? <i>Check to see if at least one of each medicine/commodity is valid (not expired)</i>		
CM101a	Analgesics (e.g. Paracetamol etc)	1. Observed, at least one unit valid 2. Observed, none valid 3. Reported available, not seen 4. Not available today 5. Never available	
CM101b	Any stock-out of analgesics in the last 4 weeks?	1. Yes	

		2. No	
CM102	Gardasil HPV vaccine	1. Observed, at least one unit valid 2. Observed, none valid 3. Reported available, not seen 4. Not available today 5. Never available	
CM103a	Cervarix HPV vaccine	1. Observed, at least one unit valid 2. Observed, none valid 3. Reported available, not seen 4. Not available today 5. Never available	
CM103b	Any stock-outs of any HPV vaccine in the last 4 weeks?	1. Yes 2. No 3. Not applicable	
CM104	Acetic acid for VIAC	1. Observed, at least one unit valid 2. Observed, none valid 3. Reported available, not seen 4. Not available today 5. Never available	
CM104b	Any stock-outs of acetic acid in the last 4 weeks?	1. Yes 2. No	
CM104c(i)	Availability of speculae?	1. Yes 2. No	
CM104c(ii)	Does the facility have adequate speculae?	1. Yes 2. No	
CM105a(i)	Camera for VIAC	1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available	
CM105b	Any breakdown (including lack of batteries) of camera in the last 4 weeks?	1. Yes 2. No	
CM106a	Laptop or Desktop for entering VIAC data	1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available	
CM106b	Any breakdown of laptop/desktop in the last 4 weeks?	1. Yes 2. No 3. Not applicable	
CM107	Reference VIAC Images (Printed or on laptop/desktop)	1. Observed 2. Reported available, not seen 4. Not available today 5. Never available	

CM108a	Nitrogen gas for cryotherapy	<ol style="list-style-type: none"> 1. Observed 2. Reported available, not seen 4. Not available today 5. Never available 	
CM108b	Any stock-out of nitrogen gas in the last 4 weeks?	<ol style="list-style-type: none"> 1. Yes 2. No 3. Not applicable 	
CM109a	Cryogun	<ol style="list-style-type: none"> 1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available 	
CM109b	Any breakdown of cryogun or stock-out of essential consumables in the last 4 weeks?	<ol style="list-style-type: none"> 1. Yes 2. No 3. Not applicable 	
CM110a	Thermocoagulation machine	<ol style="list-style-type: none"> 1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available 	
CM110b	Any breakdown of thermocoagulation machine or stock-out of essential commodities in the last 4 weeks?	<ol style="list-style-type: none"> 1. Yes 2. No 3. Not applicable 	
CM111a	LEEP machine	<ol style="list-style-type: none"> 1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available 	
CM111b	Any breakdown of LEEP machine or stock-out of essential consumables in the last 4 weeks?	<ol style="list-style-type: none"> 1. Yes 2. No 3. Not applicable 	
CM112	Operating Theatre	<ol style="list-style-type: none"> 1. Observed, at least one functional 2. Observed, none functional 3. Reported available, not seen 4. Not available today 5. Never available 	
CM113	Does the facility receive adequate support from district or province for repair/maintenance of essential cervical cancer equipment?	<ol style="list-style-type: none"> 1. Yes 2. No 	
CM114	Does the district/province have adequate engineers/technicians to repair/maintain cervical cancer equipment?	<ol style="list-style-type: none"> 1. Yes 2. No 	

INFORMATION, EDUCATION AND COMMUNICATION ON CERVICAL CANCER		
IEC101	Have you or any provider(s) in this facility received any education on cervical cancer? (e.g., symptoms, how it is caused, screening) from the health facility?	1. Yes 2. No
	Are culturally appropriate Information, Education, Communication (IEC) materials displayed in the facility for:	
IEC102	Cervical cancer causes	1. Displayed 2. Not displayed
IEC103	Cervical cancer early symptoms	1. Displayed 2. Not displayed
IEC104	Cervical cancer screening	1. Displayed 2. Not displayed
IEC105	HPV vaccination	1. Displayed 2. Not displayed
IEC106	HPV screening	1. Displayed 2. Not displayed
We have now completed all of the questions in this checklist. Thank you for your participation.		

INTERVIEWER'S OBSERVATIONS
To be filled out after completing interview

Observations

Comments on specific questions

Any other comments

THE END

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Médecins Sans Frontières

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