

613-0201 001501

CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

PD-AAI-676

1. PROJECT TITLE

ZIMBABWE RURAL HEALTH SERVICES

2. PROJECT NUMBER

613-0201

3. MISSION/AID/W OFFICE

USAID/ZIMBABWE

4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)

REGULAR EVALUATION SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES

A. First PRO-AG or Equivalent FY <u>80</u>	B. Final Obligation Expected FY <u>81</u>	C. Final Input Delivery FY <u>81</u>
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6. ESTIMATED PROJECT FUNDING

A. Total \$ _____
B. U.S. \$ 2,000,000

7. PERIOD COVERED BY EVALUATION

From (month/yr.) May 1980
To (month/yr.) May 1981

Date of Evaluation Review X

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)

B. NAME OF OFFICER RESPONSIBLE FOR ACTION

C. DATE ACTION TO BE COMPLETED

A final implementation status report on all clinics rehabilitated under this project should be prepared in tabular form. The report should include the final status of:

- a. Construction of clinics and staff housing
- b. Supplies of furnishings, equipment and drugs
- c. Restoration of water supplies and latrines
- d. Installation of AID Symbols
- e. Staffing
- f. Cost per clinic

MOH Project Administrative assistant and REDSO/EA Health Economist

August, 1981

The report is being prepared by MOH

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A. Continue Project Without Change
B. Change Project Design and/or Change Implementation Plan
C. Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Constance Collins, RHDO/Swaziland *C Collins*
Edward Spriggs, RLA/REDSO/EA *E Spriggs*
Anita Mackie, Health Economist REDSO/EA *A Mackie*

12. Mission/AID/W Office Director Approval

Signature _____

Typed Name _____

Date _____

13. SUMMARY

This Project was developed on an emergency basis (in approximately one and one half months) in order to be ready for signing on Zimbabwe's Independence Day. Despite delays in AID disbursements, MOH financial management of the U.S. two million grant has been very satisfactory and the Rural Health Services Project has progressed with few significant implementation problems. Monitoring of implementation by the MOH was started late and has been less effective.

At the onset of the project it was known that U.S. two million would not fully cover the restoration of 159 clinics. During Project implementation it became apparent that costs for restoring water systems had been severely underestimated and only about 90 clinics will have piped systems. Drugs and equipment have also been inadequate as sufficient stocks are not presently available in Zimbabwe. Shipments of equipment from UNICEF are expected to supplement stocks in the near future, and MOH annual drug tenders will be increased in the next fiscal year (July, 1981).

In the twelfth month of the project all of the funding has been expended and 118 clinics have been reopened; 24 clinics are under construction; and 17 clinics have been unable to reopen due to insecure conditions and staff recruitment problems. Twentyone clinics, never closed, which were damaged or lost equipment in the war have been repaired and equipped.

All of the 24 clinics under construction and 13 of the 17 remaining closed clinics are expected to be reopened by August 1981, and EOPS will be reached at that time.

14. EVALUATION METHODOLOGY

Geographic distances and the large number of clinics involved did not permit any quantity or quality site assessment during the nine days of this evaluation. Therefore the evaluation was conducted almost exclusively through a review of MOH records on implementation and expenditures, and interviews with Government of Zimbabwe (GOZ), USAID/Zimbabwe, and REDSO/EA personnel involved in the project. Provincial authorities, involved in actual implementation were interviewed from seven of the eight provinces in Zimbabwe. Site visit records prepared by the GOZ project funded administrative assistant (AA) were an important source of information as were personal interviews with the AA.

The available records were reviewed for actual numbers of clinics opened and those closed for construction, lack of staff or other reasons. Expenditures were also looked at in terms of accomplishments. For those clinics that were opened, records were reviewed for: (1) quantity of staff and staff housing; (2) adequacy of

equipment, drugs, and furnishings; and (3) status of the water supply and latrines.

The available records were not complete. In some cases provincial authorities were able to supplement information, however the evaluation would probably have been more effective had the MOH established a provincial reporting from early in the project to chart progress.

15. EXTERNAL FACTOR

The major external factor which impacted on the project was the decision by the GOZ to provide free medical care to all Zimbabweans earning under Z\$150 per month (or the majority of the population) starting in September, 1980. The staff of the MOH were not aware that free medical care would be established so soon and no planning for a major increase in services was included for the fiscal year which began in July, 1980.

Drug supplies were inadequate for increased caseloads and as the Central Medical Store procures drugs through an annual tender, no immediate increase in drugs was possible during the early months of the project. This problem should be alleviated in July, 1981, with the issuing of a new tender. However, due to these shortages few of the reopened clinics received a complete three month initial supply of drugs and in addition the estimated quantities of drugs required for three months were no longer adequate with the increased patient caseloads.

16. INPUTS

A. Historical Background of Project

A three person team from REDSO/EA made the initial visits to Zimbabwe in March, 1980 to decide on the nature and specific form of the first \$2 million of AID assistance to Zimbabwe, which was expected to be signed on Independence Day, April 18, 1980. The team visited key officials in the Ministries of Agriculture, Education and Health as well as Treasury officials and selected PVO personnel. During these visits plans for reconstruction and rehabilitation were discussed and an assessment made of each organization's ability to mount a rapid program to attain their goals.

The original reasons for the selection of a project with the Ministry of Health (MOH) to reconstruct rural health clinics included the following:

- (a) Visibility - the reconstruction would involve all Provinces and indicate U.S. interests in assisting rural Zimbabweans of all parties.
- (b) Organizational Ability - the MOH had already given thought to this endeavor and had an intact infrastructure capable of delivering goods and services in the rural areas.

- (c) Government Priority - discussions with GOZ officials revealed that restoration of rural clinics was one of the new Government's highest immediate priorities.
- (d) Quick Disbursement - given the capabilities of the MOH and the priority assigned to clinic reconstruction by the GOZ, it was anticipated that funds could be rapidly and effectively utilized and fully disbursed within 6 months to one year.
- (e) Multiplier Effect - since most of the building reconstruction would use local contractors, building components were all produced in Zimbabwe and most furniture supplies and drugs were manufactured locally, the financing would allow money to start to flow in rural areas.
- (f) Refugee Resettlement - many people were still living in protected villages and others were refugees living away from areas of origin. Restoration of rural health services would compliment the GOZ's refugee resettlement effort by providing an inducement to people to return home rather than to migrate to urban centers.

When the project was designed the MOH estimated that there were a total of 277 approved council clinics* of which 159 were closed. Rough estimates of the damage to 59 clinics had been obtained from the District Commissioners as part of the initial GOZ effort to estimate general reconstruction costs. From the cost estimates for restoration of these 59 clinics, which were considered a satisfactory sample, an average figure of \$8,800 for repair of the buildings was allocated for all clinics.

The MOH then prepared the following estimates (in U.S. dollars) for restoring primary care clinics:

Repair of buildings	160 x \$8,800	\$ 1,408,000
Equipment & Furniture	160 x \$2,667	426,720
Drugs (initial 3 months)	160 x \$1,000	160,000
Water supply repairs	160 x \$ 333	53,280
Sub-Total		\$ 2,048,000
Supervision + transport - 10%		204,800
Inflation - 25		<u>563,200</u>
Grand Total		<u>\$ 2,816,000</u>

*Before the war, council clinics were run by local (African) councils in cooperation with Provincial Authorities with little contact with the Central Administration of MOH.

Therefore at the time of the design of the project it was known by the GOZ and AID that the \$2 million grant initially made available for Zimbabwe would not be sufficient to fully restore all 159 clinics. This fact was later reflected in both the project paper and grant agreement. It was assumed that the least damaged buildings would be restored first. At the time of the original estimates, the maximum rebuilding cost attributed to a severely damaged clinic was \$25,000.

After extensive discussions with the GOZ a final decision was made to allocate the funding to the Ministry of Health for reconstruction of council clinics. This decision was based on the following verifiable assumptions:

- (a) The MOH with the assistance of a local administrative assistant, hired with project funds, had the capacity to manage and monitor the project.
- (b) Provincial authorities would take the major responsibility for determining the priority order for clinic reconstruction and for the supervision of the construction.
- (c) Local contractors were available to undertake the work in each province.
- (d) All basic construction materials, equipment, and furnishings were available in Zimbabwe or could be locally manufactured.
- (e) The standard drug list contained drugs normally available for the treatment of the most common illnesses in Zimbabwe, that almost all drugs or chemical agents conformed to US safety standards for safe prescription and use and that sufficient quantities of drugs to meet anticipated demand (based on historical experience) would be available from the GOZ's central medical store.
- (f) Staffing would be available for all reopened clinics.

B. Status of Inputs

1. Construction. Almost all of the construction has been carried out by local contractors. The contractors have used bricks made locally for basic construction and items such as door and window frames and cement were purchased and delivered by the provincial authorities.

Prefab construction was used for most clinics that were completely destroyed. In one province local bricks were not available in sufficient quantities and there would have been

a long delay in construction. Another province chose prefabs as the most expeditious way to restore the selected clinics. Prefab construction costs were estimated to be 25 percent higher than local construction methods. However, with escalating costs of materials and labor in Zimbabwe, probably only negligible savings would have been realized if construction had been delayed until materials or contractors were available, and in many areas with large influxes of returning displacees, time was of the essence.

Conventional building supplies were generally available. Occasional shortages were experienced but were not long term and construction proceeded with only short periodic delays.

Since local contractors are limited in number and size, it was sometimes difficult to find one to work on clinics. This was less of a problem at the onset of the Grant period since the MOH funding was the first to reach the rural areas. It became more difficult to find rural contractors late in 1980 and early in 1981 when major school reconstruction was underway. Builders then became more selective and were not interested in minor clinic reconstruction where small sums of money were involved. Supervision of the clinic work on the construction phase was carried out by the staff of the Provincial Authorities. These men were experienced, they knew the local contractors and on-the-whole standards of workmanship on the buildings were high. Substandard work was caught early and in one situation a local contractor was made to redo a section at his own expense.

The lack of an adequate cash flow (discussed under MOH Management) created problems for the Provincial Authorities since most of the small contractors lacked capital and required frequent prompt reimbursement to meet their expenses. Provincial Authorities also had difficulty in obtaining AID-required source and origin documentation from contractors because the requirement was not understood or the contractors did not have the information. Complaints about this requirement ultimately reached the Ministerial level. Transport was in short supply throughout the reconstruction. The Provincial Authorities often had only one lorry to perform all duties. Hiring lorries to deliver building materials to sites was sometimes difficult. The problem was exacerbated when clinics were in remote areas, on bad road, or near insecure rural areas. Transport problems caused delays, but no cases were reported where clinics were not reconstructed because of lack of transport.

2. Furnishings. Basic furnishings for the clinics (benches, tables, and chairs) have generally been made by local carpenters. In some provinces such as Manicaland a bulk order for furnishings was placed early in the reconstruction period and held for

distribution until the clinics were ready to open. Other provinces were not as organized and procurement has taken longer. Beds and mattresses have had to be purchased and usually are obtained from urban centers.

3. Clinic Equipment. Due to shortages of stocks of small supplies and equipment, the Central Medical Stores have been unable to supply all of the items on the standard list. Sterilizers and such items as stainless steel bowls are not immediately available. However, most clinics without sterilizers are able to manage by boiling or using other methods to sterilize instruments. The majority of clinics did not have refrigerators before the war but are receiving them as part of the equipment. UNICEF will be supplying a number of refrigerators but the MOH has not as yet received the shipment.

4. Drug Supplies. The project provided for an initial three month supply of drugs for each reopened clinic. The MOH placed orders with Central Medical Stores for 112 clinics early in the project. The actual delivery date of the drug supplies has been difficult to verify because the MOH receives no confirmation that drugs were delivered. However, the PMOH's do receive such notification. In addition general shortages of drugs have compounded the problem of distribution.

With the introduction of free medical services in September, 1980 there has been an enormous increase in the demand for drugs. Additionally the drugs and mixtures are almost all purchased in bulk on an annual tender and mixed at General Medical Stores or in District facilities where a pharmacist and suitable equipment exists. They were not advised ahead of the expected increases from the decision to give free medical care to all earning less than Z\$150 per month, nor could they have responded completely sooner than the next annual tender scheduled for July, 1981. Supplementary tenders have been issued to meet the most urgent needs.

While all of the Provincial Medical Officers complained of shortages of drugs, the clinics have had limited supplies of the most essential drugs. The problems of the supply of adequate quantities of common disease entity drugs are beyond the scope of this project but will need to receive more attention from the MOH in the future. USAID/Zimbabwe will be funding a new Medical Stores facility in Bulawayo which should alleviate some of the distribution problems.

5. Water Systems. Prior to the war all clinics had adequate water supplies. Sources varied, some used deep boreholes, wells, streams, some had pumps and others rams. A few were hooked to a rural municipal water system serving several buildings or an entire village. During the war, piping and pumps were stolen, storage tanks damaged, and in some cases wells were contaminated. It was found that almost all of the

clinics required fairly major repairs or reconstruction to restore safe water supplies and that the original MOH estimate of Z\$200 per clinic for water systems was much too low. Project funding has not been sufficient to restore water systems to all clinics. A larger issue is also involved in the restoration of water supplies to rural service centers. Restoration of the clinic supply in isolation is rarely possible. Costs will have to be shared with other Ministries, and there is a question of which Government entity is responsible.

6. Latrines. Latrine construction was included in the project to assist clinics to maintain a higher standard of environmental sanitation. The Blair pit latrine, which is odorless and flyless, is of local design and all health assistants are taught to construct it so that the provision of improved pit latrines is within the capabilities of the local technicians.

7. Staff Housing. The majority of clinics had one or two adjacent staff houses before the war. This housing suffered the same destruction as the clinics. As availability of housing is an important factor for staff recruitment in rural areas, funds were provided for the reconstruction and repair of housing. Again funding was inadequate in the category because both the number of houses and the extent of reconstruction were underestimated.

8. Clinic Staffing. Clinic staffing generally consists of a medical assistant and a nurse. During the war large numbers of soldiers were trained as medics and are now being assimilated into the MOH system. The level of training of the medics has varied, with some receiving relatively extensive training in Eastern Bloc countries and others have had very short term training in neighboring countries. The medics are generally able to deliver basic curative services but are not trained in maternal child health care or deliveries.

Reports on staffing available from opened clinics indicate that 107 clinics have qualified staff, however, only 33 of them have two staff. Another 13 clinics were staffed by medics or unqualified staff and were mainly located in insecure areas. No information was available on staffing for 19 clinics.

Although there are enough medics to temporarily staff clinics and deliver curative services, redeployment of qualified staff may be difficult over the long run. Many nurses and medical assistants moved to urban areas during the war and will probably not return to rural services. Training additional and upgrading existing rural health personnel will need to be addressed by the MOH in the near future.

9. Project Management. The MOH has been responsible for determining levels of funding for each province, disbursement of funds to the provincial authorities, financial summaries and analyses, preparation of AID fiscal reports, and general monitoring of the provincial implementation schedules.

The provincial authorities have had the responsibility for establishing construction priorities, hiring contractors, making construction payments, collecting invoices and preparing financial records, ordering and/or purchasing drugs, equipment, and furnishings, and preparing progress reports.

In the first three months of the project, there were severe cash flow problems which persisted, though in less serious form after corrective actions were taken by AID. The MOH had estimated that an initial disbursement of Z\$300,000 would be sufficient for three months and an advance of that amount was requested and approved by AID in late April of 1980. Upon receipt, the MOH disbursed the advance to the 8 provinces to enable work to start immediately. The advance was exhausted in July, however, and with the small contractors requiring frequent payments to meet the costs of labor and building materials, work stopped while further funds were awaited. Under AID's project disbursement system, reimbursement checks could not be issued until actual costs were documented and considerable time was required before the central MOH could receive and consolidate expense documentation from the provinces, which in turn had to collect this data from the districts where clinics were located. This process took one to two months. Further delays (in excess of one month) were encountered in the preparation, mailing and receipt of the AID check once expense documentation was received. At the request of USAID/Z RFDSD staff visited in July 1980, and recommended an emergency disbursement of Z\$300,000 as an additional advance. This disbursement was received in September, 1980. The most severe aspects of the cash flow problem were alleviated with the second disbursement but cash flow continued to be a problem throughout the project because payments to contractors had to be made promptly and frequently, which proved difficult given the time gap involved in AID's preparation and making of reimbursement checks and their receipt by MOH from RFC Paris

The MOH's financial records have been very satisfactory and well prepared with all of the required documentation. The records contain breakdowns for expenditures on: construction; materials; labor; furnishings; equipment and drugs; and transport.

The MOH has been less effective in monitoring project implementation. Project Implementation Letter no. 2, issued April 28, 1980, set out requirements for quarterly progress reports by

MOH. However, although reporting systems for expenditures were established, the provincial reporting system for implementation progress was less than adequate. Moreover, the administrative assistant (AA), provided for in the USAID grant to monitor implementation, was not hired until October, 1980. The AA is only now completing adequate status reports for all provinces and the data is now almost complete. Almost all of the data has been collected through site visits. Interim reports from provinces as follow up to the site visits would have assisted in keeping project progress reports up to date. The appointment of a Deputy Secretary for Rural Health Services early in 1981 has strengthened the MOH administration of the project and relieved some of the heavy supervision responsibilities from the Deputy Secretary formerly in charge of the project.

Management at the provincial level also is generally satisfactory with performance varying somewhat from province to province. The provincial authorities interviewed were knowledgeable about the project and were making concentrated efforts to complete the clinic reconstruction. They were especially pleased with the fact that funds were advanced to the provinces for implementation and felt that this disbursement method had expedited construction in spite of the cash flow problems.

Communication between the MOH and its PMOH's, as well as Provincial Authorities, in terms of the selection of the clinics for reconstruction and the magnitude of funding for each clinic appeared to be a problem. This has resulted in some provinces reconstructing clinics not approved by the MOH and in overruns of estimated funding which will have to be absorbed by the MOH. Some of these problems were inevitable given the lack of good baseline data and the decentralized GOZ system, but others could probably have been avoided had the provinces submitted implementation reports.

10. AID. The project has been technically monitored by the Health Economist from REDSO/EA as part of her responsibility for AID health inputs for Zimbabwe. The Health Economist has made four visits for monitoring purposes, some in conjunction with visits on other activities. One emergency visit was necessary early in the project when the cash flow problem became serious. Otherwise project monitoring has been routine and the MOH has assumed the major responsibility. In comparison to contractor-implemented project assistance in the Southern African region this project appears to have imposed minimal management burdens on REDSO/EA and USAID/Zimbabwe, although considerable TDY time was required, especially during initial stages, to explain AID's project assistance procedures and requirements, prepare PILs and resolve implementation issues.

11. Clinic Reconstruction Costs

<u>Province</u>	<u>Total Clinics</u>	<u>Approximate Total Funding Z\$</u>
Manicaland	18	107,662
Mashonaland East	23	107,733
Mashonaland Central	16	79,312
Mashonaland West	19	131,583
Matabeleland North	15	197,418
Matabeleland South	15	101,172
Midlands	61	439,649
Victoria	13	105,933
<hr/>		
Total	180	1,270,462
	or US \$	1,880,284

The MOH's estimates of US \$8,800 or Z\$5,945 per clinic for those clinics that required minor repair and the estimates of US \$25,000 (Z\$16,798) for destroyed clinics were on target.

Clinic costs ranged from Z\$256 for equipment to Z\$33,098 for a large prefab clinic with a maternity and two staff houses. The average cost for reconstruction of clinics, with extensive damage or destruction, carried out by local contractors was Z\$14,470 or US \$22,000. In Matabeleland North where prefab construction was used for destroyed clinics the average cost of six reconstructed clinics was US \$25,000.

17. OUTPUTS

The output target for the Zimbabwe Rural Health Services Project is 159 rural health clinics reconstructed, reopened, and delivering primary health services.

The project inputs provided for repair and reconstruction of clinics and staff housing; furnishings, equipment and a three months supply of standard drugs; restoration of water supplies and latrines, and MOH staffing of the clinics.

Progress toward Outputs

A. Status of Reconstruction Program by Province

Province	Total Clinics Recon-structed/ Repaired	No. of Clinics Opened	Clinics Under Con-struction	Clinics Closed
Manicaland	18	13	2	3
Mashonaland East	23	15	3	5
Mashonaland Central	16	12	2	2
Mashonaland East	19	15	3	1
Matabeleland North	15	11	2	2
Matabeleland South	15	11	4	0
Midlands	61	52	5	4
Victoria	13	10	3	0
Totals	180 ⁽¹⁾	139	24	17 ⁽²⁾

(1) Number includes approximately 21 clinics never closed but which suffered damage or loss of equipment and were therefore included under the Project.

(2) Clinics closed include facilities without staff (13 clinics) or not yet under construction.

B. Status of Equipment and Furnishings for Clinics Reopened

Province	Total Clinics Open	Clinics fully Equipped and Furnished	Clinics missing Equipment & Furnishing.
Manicaland	13	3	10
Mashonaland East	15	15	0
Mashonaland Central	12	12	0
Mashonaland West	15	15	0
Matabeleland North	11	5	6
Matabeleland South	11	6	5

Province	Total Clinics Open	Clinics fully Equipped and Furnished	Clinics Missing Equipment Furnishing
Victoria	10	0	10
Totals	139	56	83

Only 56 of the 139 clinics reopened reported adequate furnishings and equipment. For those reporting equipment and furnishings missing, refrigerators and sterilizers were the most common items. Refrigerators should be available later as UNICEF stocks are received. The majority of clinics were missing some chairs or benches which are being supplied as they become available.

C. Drugs

The MOH placed staggered orders for the initial three month drug supply for 112 clinics early in the project. As the MOH receives no information on date of actual delivery of the drugs, no significant information was available on the number of clinics supplied by date and completeness of initial standardized order. Although all of the personnel interviewed complained of shortages of drugs, clinics appear to have essential drugs but in limited quantities.

D. Water Systems for Reopened Clinics

Province	Number of Clinics	Water Systems In Place	Missing Pumps/Pipes	Water Problems
Manicaland	13	8	5	-
Mashonaland East	15	6	9	-
Mashonaland Central	12	9	2	-
Mashonaland West	15	-	13	2
Matabeleland North	11	9	2	-
Matabeleland South	11	10	1	-
Midlands ⁽¹⁾	52	20	16	13
Victoria	10	7	3	-
Totals	139	69	52	15

About half (67) of the clinics reopened (139) have no piped water systems. Fifteen of the 67 clinics either lack boreholes

(1) No report from three clinics

or wells or have problems with contaminated water. Most of the 24 clinics under construction are expected to have completed water systems when finished. Project funding is not sufficient to replace all of the equipment needed and in many areas the clinic water systems are a part of a larger community system. To restore water to these clinics the MOH will have to coordinate with other ministries and establish a method of cost sharing.

E. Latrines

Latrine construction appears to have progressed fairly well. Midlands Province reports eleven clinics either with poor facilities or lacking latrines, other provinces reported no significant problems. Most new latrines being constructed are of the Blair type. It appears that at least 128 of the 139 clinics opened have either flush toilets or latrines, and toilets or latrines are being placed in clinics under construction (24). It was not possible to determine if toilet or latrine facilities were adequate for both staff and patients but only that such facilities were present.

F. Staff Housing for Reopened Clinics

Province	Number of Clinics		
	2 Staff Houses	1 Staff House	No Housing
Manicaland	5	7	1 (1)
Mashonaland East	8	6	1
Mashonaland Central (2)	6	4	1
Mashonaland West	2	12	1
Matabeleland North	7	4	-
Matabeleland South	6	2	1
Midlands (2)	40	8	1
Victoria	5	5	-
Totals	79	48	6

Of the 139 clinics reopened 79 had two or more staff houses,

(1) Within commuting distance of Umtali

(2) Reports not complete from Mashonaland Central and Midlands

48 had one staff house, and six had never had housing. Most of the 24 clinics under construction have housing which is being restored.

While restoration of staff housing is progressing satisfactorily, the clinics with only one house lack adequate facilities for two clinic staff. In most cases the houses were designed to be shared by two nurses without families. Nurses with families must share the housing which is inconvenient, and the assignment of male medics to clinics with limited housing has created problems of sharing with female personnel.

G. Publicity

Plaques for the clinics were ordered rather late, and delivered in November, 1980. The inscription is in English and reads "This clinic was reopened with assistance from the people of the United States of America". Underneath is the AID handclasp symbol and the Zimbabwe bird and a space for the clinic name.

All of the provincial authorities interviewed were aware of the plaque requirement and are installing them. Some provinces such as Matabeleland North and South have been much more prompt in installing the plaques. During the evaluation a second type of plaque was encountered which is not acceptable and the MOH has been asked to replace it with the original design.

The AA for the project will verify that all of the clinics have plaques when he visits each province over the next two months to finalize the implementation report.

The American Ambassador and AID Director each participated in various opening ceremonies for newly reconstructed clinics assisted under the Project, and these ceremonies were covered by the news media.

18. PURPOSE

The purpose of this project was to assist the GOZ to provide for the health needs of the rural population through the rehabilitation of approximately 519 rural health clinics that were abandoned or damaged during the war.

The rural clinics were to be restored to their former condition. Each clinic was to have a treatment room, waiting area, storeroom, washing facilities either within the compound or as part of the clinic structure itself, and simple housing for one or more paramedical workers. The largest clinics were to be staffed by two or three paramedicals, and in addition to the above facilities, would have a labour ward, waiting room for expectant mothers and an office. Most clinics, however, were to be of the

smaller type and will be staffed by medical assistants who in most cases would have received three years of training. Some clinics had nurses on staff. Each clinic was to be equipped with simple furnishings, a basic kit of medical instruments, drugs and medical supplies, in accordance with a standard list developed by the Ministry of Health.

The Project Agreement was signed on April 18, 1980, Zimbabwe's Independence Day, and the MOH received the first disbursement of funds on May 21, 1980. Implementation began immediately with the funding. Although delays have been experienced, the progress toward the EOPS and purpose level has been very good for a project that mainly involves construction.

Some difficulties were experienced in actually determining the number of clinics closed. Adequate baseline information was not available at the time of project design as many rural areas were insecure and inaccessible to provincial authorities. Due to population movements clinics were abandoned or resited to temporary quarters and it has taken time to identify original clinic sites. Provincial authorities have estimated another six to eight clinics should have been included in the number of clinics closed. Another 21 clinics which remained open during the war but suffered damage or loss of equipment were not included in the original estimates but have received assistance.

The project was designed on the basis of information available and even with this information it was known that the \$2 million grant would not be sufficient to fully restore the 159 clinics identified and this fact was reflected in both the Project Paper and Grant Agreement.

Although not foreseen during the design stage of the Project, the restoration of water systems has presented the greatest problem. Due to extensive repairs required and the amount of equipment that had to be replaced (pipes, pumps, tanks) only about 90 of the restored clinics will have piped systems. Another 52 clinics have a reasonable source of safe water nearby such as a borehole, well, or dam. A few clinics (15) reported serious water problems due to contamination of wells or no convenient source of water. Provincial authorities are requesting additional funds from the Water Development Board to restore the water systems of the clinics not covered in this project.

The majority of clinics still lack equipment and drug stocks are incomplete and limited in quantity. The MOH expects that this problem will be alleviated as drug orders are increased in the next fiscal year, and equipment and supplies from other donors such as UNICEF are received. The capacity of the rural health services has been strained over the last nine months with establishment of free medical services for the majority of the population.

BEST AVAILABLE DOCUMENT

No advance planning was carried out for the increased patient caseloads and it will take some time to determine revised adequate requirements for clinics and to provide sufficient stocks.

Staffing levels of the 118 clinics reopened and the 21 clinics repaired are not adequate for the most part but basic coverage is provided. The redeployment of qualified staff who left rural areas during the war is difficult as some of these staff have settled in urban areas. Medics trained during the war are being absorbed into the rural health system and are being assigned to clinics, however, their skill levels vary widely and most are not trained adequately for maternal-child health services. Only about 15 clinics currently remain closed due to staffing problems. As the security situation is continuing to improve, these clinics should be opened shortly.

Staff housing is being restored but is generally inadequate for the clinic staff and must be shared. Five clinics did not previously have housing and staff either lived in the clinics or commuted. Increasing the quantity of staff housing was not in the scope of this project but is an issue the MOH will have to address in the near future. With the problems in the recruitment of qualified rural staff, the provision of adequate housing is essential if clinics are to be fully staffed.

The EOPS for the achievement of purpose for the project remains valid. The EOPS can be expected to be achieved by August, 1980. By that date the 24 clinics under construction and the 13 clinics awaiting staff should be opened bringing the total number of clinics reopened to 156. Another four clinics for which limited information was available will probably not be completed and opened under this project. However, the MOH was able to re-open 21 clinics that were never closed but were not fully functional so that the project outputs are within if not above the goals anticipated.

19. GOAL

The Rural Health Services Project contributes to the USAID/Zimbabwe goal of "improving the quality of life of the poor black majority of Zimbabwe".

The outputs of the project permit the GOZ to increase primary health care facilities in rural areas through the reopening of clinics that were closed during the war. The approximately 156 clinics reopened represent more than half of the 277 GOZ clinics that existed before the war. Almost all of these clinics are located in Tribal Trust Lands (TTLs) where about half of the poor black majority reside.

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In interviews with rural people in Zimbabwe, health services were perceived as the most important for rural communities. The reopened clinics not only provide basic health services but also serve as highly visible symbols of the GOZ's response to the needs of the rural poor.

The scope of this project permitted only marginal involvement with the quality of services provided. However, it is evident that the MOH needs to begin focusing on quality in the near future because inadequate services will cause the loss of public confidence. Incidental information obtained from the evaluation indicated the need for:

- a preventive approach to health care;
- training of all levels of personnel in community health; and
- a more effective planning and management system for health services.

The Rural Health Services Project was the first USAID project and was one of the first donor assisted projects in newly independent Zimbabwe. The MOH has since received Program Grant funds to complete clinic reconstruction. In addition, under Program Grant AID assistance is currently being utilized to build a new Medical Stores building in Bulawayo and to construct a fabricated training school for medical assistants in Gwelo. These efforts address constraints identified with further expansion of the rural clinic system.

20. BENEFICIARIES

The direct beneficiaries of this project are the black rural poor of Zimbabwe residing in the TTLs. The TTL population presents approximately 50 percent of the total black population of Zimbabwe.

The re-establishment of approximately 156 health service delivery points, closed during the war, coupled with the government decision that health care will be free for the poor, provides more equitable access to health care for the poor rural population.

It is estimated that with the reopening of the clinics approximately 40 percent of the TTL residents reside within eight kilometers of a clinic (considered reasonably accessible by WHO) and an estimated 40 percent are within 15-20 kilometers. Before the restoration of the clinics much of the TTL population lived between 30-60 kilometers from the nearest health facility.

Improved access to curative care should serve to alleviate and control the most common diseases in all ages of the population.

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21. UNPLANNED EFFECTS

Although not a planned output, a fairly complete set of baseline data on rural clinics reopened is emerging from the project. If data from other clinics is brought up to date, the MOH and each province should have a set of comprehensive data which will be useful for future planning of rural health services. This has been recognized by the MOH and plans for regular collection of the necessary management information are being formulated.

22. LESSONS LEARNED

The Rural Health Services Project was not a typical AID project and may not be applicable outside of Zimbabwe. The project implementation has proceeded well given the accelerated pace of project design and negotiations, and the political situation and the assumptions of the MOH capacity to manage the project have been verified.

Both monitoring and evaluation of the project would have been facilitated had baseline data been verified early in the project and a comprehensive reporting form for the provinces established at the onset of the project. In the future if a similar type project is designed, more attention should be given to the monitoring of physical process and development of progress reporting documentation in addition to the normal financial reporting.

The cash flow shortages, which were a hindrance throughout implementation of the Project, but particularly in the beginning, as a practical matter unavoidable under AID's project assistance financing system. This problem could have been considerably reduced had it been possible to either advance 100 percent of project funds or pre-position checks with USAID/Z for delivery to the GOZ upon presentation of disbursement documentation. Where implementation capability and financial accountability within a Grantee's implementing body are satisfactory and a sufficient AID monitoring presence can be maintained, large advances of the program grant approach should be seriously considered as an alternative to conventional project financing.

23. SPECIAL COMMENTS

The Rural Health Services Project can be expected to reach implementation within sixteen months after the signing of the project agreement. As noted this was not a typical AID project, however, the achievements are quite remarkable considering most AID projects require 18-24 months to reach the implementation stage.

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The assumptions of the project that the MOH had the capacity to manage and implement the project have been verified. Considerable savings were also realized by hiring a local administrative assistant (AA) rather than an expatriate technician. The AA, a recent Zimbabwean university graduate, gained valuable work experience through the project and is now expected to be hired by the MOH on a full time basis for general health administration tasks. Considerable time and financial savings were also realized by relying on AID and host government personnel, rather than contractors, to design and implement the project.

The project also provided a positive image for U.S. assistance. An advance of AID funds was available to MOH within a month of the signing of the project agreement and was immediately disbursed to the provinces. The provincial authorities interviewed were pleased with the advance disbursement of funds, a departure from the usual procedure, and appreciative of the assistance. Within a few months there was visible evidence of the assistance (reopened clinics) and the project has provided direct benefits to the rural poor in the TTLs.

While there have been some weaknesses in monitoring of implementation, the project has been successful at the purpose. AID monitoring of the project has been routine and has cost less time than the average AID funded contract.

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