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ANNUAL PROGRESS REPORT

WORLD VISION ZIMBABWE CHILD SURVIVAL PROGRAM

October 31, 1986

GRANT NUMBER:
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919 WEST HUNTINGTON DRIVE MONROVIA CALIFORNIA 91768
(818) 357-7979 / CABLE WORVIS / TELEX 6745341

WORLD VISION RELIEF ORGANIZATION

October 31, 1986

Mr. Thomas McKay
Associate Assistant Administrator
Office of Private and Voluntary Cooperation
U.S. Agency for International Development
Washington, DC 20523

Dear Tom:

Enclosed is the first annual progress report for WVRO's Child Survival grant in Zimbabwe.

We are particularly pleased with the development of this program as it is World Vision's first USAID-funded Child Survival project. The evaluation process upon which much of this report is based has proven to be successful, and it has provided a solid foundation upon which to adjust and strengthen the program in its next two years.

We are also pleased that USAID funding for Child Survival programs has been a healthy impetus within World Vision to support a considered and directed focus upon Child Survival. There is a growing enthusiasm both within the organization and by private individual and corporate donors to support these life-saving programs. With the two additional USAID Child Survival grants for Senegal and Sudan beginning this year, we believe the groundwork is further laid for building interest in private as well as public funding for such programs.

We particularly appreciate the support given by your office for these programs. While not all could be mentioned, several individuals come to our minds as working very closely with us during the developmental process of our programs, including Steve Bergen, Vicky Kunkle, John Grant, Dorri Storms and Hope Sukin.

Prior to your review of our report, we would like to provide several considerations related to this report's preparation so that we might clarify some of our assumptions in preparing this report.

1. The Zimbabwe Child Survival program is implemented and managed by our Zimbabwe field office, with all operational principals in the project being national staff. One of program's greatest strengths is the primary "ownership" felt by our field office; another is the high degree of competency and professionalism with which they have addressed the program. The process for writing this report was field-based, with assistance and consultation provided by Ann Biro of WVRO and Dr. Susi Kessler of APHA. The narrative of the report itself was drafted by the project staff and field office management. The final version of this report reflects only minor additions or format adjustments, in respect for the ability of our Zimbabwe field office to best represent their own achievements.

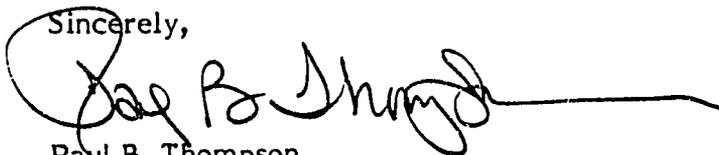
Thomas McKay
October 31, 1986
Page Two

2. We have addressed in this report both the technical recommendations made by USAID's technical review committee and World Vision's revised monitoring and evaluation plan as a natural course of action. However, we were not aware that this was a formal requirement by USAID, since we did not receive any correspondence advising us of such. As a result, we only received verbal notification of this a few days prior to the evaluation itself; and thus we provided increased emphasis in this area to the best of our ability, given the time frame involved.
3. We have made a deliberate effort to follow the Child Survival Annual Report Guidelines which were sent by you on August 7, 1986, as closely as possible. Some additional information has been supplied (for example, a revised three-year budget and all attachments labeled "appendices"). We have recently received the standard Annual Review guidelines for PVC matching grants; however, our understanding is that this annual review was to follow the CS Project Annual Report guidelines provided by your office.
4. Finally, we are submitting this report slightly past the deadline for CS Annual Reports, based upon a previously agreed upon date, due to the revised availability and travel schedules of external project consultants.

Should you have any questions concerning these considerations, we would be glad to discuss them with you.

We trust that this report will convey to you the excitement and degree of accomplishment being experienced because of this program in Zimbabwe.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul B. Thompson", with a long horizontal line extending to the right.

Paul B. Thompson
Associate Director

PT/sds

Enclosure

TABLE OF CONTENTS

<u>Item</u>	<u>Content</u>	<u>Page No.</u>
	Introduction/Executive Summary	i
	Abbreviations	ii
I.	Project Description Summary	1
I.1	Statement of Project Objectives	2
I.2	Identification of Target Groups	3
I.3	Health Problems Addressed by the Project	5
I.4	Health Interventions and Services Provided by the Project	5
I.4	a. Health Interventions and Services That the Project is Providing	5
	b. Health Interventions and Services That the Project Will Provide	7
	c. Changes in Type and Scope of Services	7
	d. Linkages Between Existing Health Services and New Child Survival Activities	8
II.	Description of Major Activities/Actions in First Contract Year	10
II.1	Inputs:	11
	a. Description of Staff Hired	12
	b. Materials Procured	13
	c. Itemization of Funds Spent, Three-Year Budget and Narrative	14
	d. Use of Technical Assistance	19
II.2.	Outputs	21
	a. Baseline Survey	22
	b. Training Curriculum Developed	22
	c. Training of Health Workers	25
	d. Agreements with GOZ on CSP	28
	e. Health Committees Established	29
	f. Health Services Provided	29
	g. Other Outputs	30
III	Indicators of Effectiveness	32
IV.	Problems and Constraints	38
V.	Project Strategies for Overcoming Constraints	44
VI.	Progress and Constraints with Implementation of Monitoring and Evaluation System	46
VII.	Revised Work Plan	49
VIII.	Headquarter Activities in Support of Child Survival Projects	54

TABLE OF CONTENTS (Continued)

<u>Item</u> <u>Content</u>	<u>Page No.</u>
TABLE	
I. Target Population and Project Area	4
II. Response/Action to Technical Recommendations	9
III. Itemization of Funds Spent by Budget Item FY86	14
IV. Revised Three-Year Project Budget	16
V. Budget Explanation by Line Item Compared to Original Budget	17
VI. Training of Health Workers	27
VII. Child Survival Interventions by Project Area	37
VIII. Organizational Chart	34
IX. Revised Work Plan	48
Annex 1 AID Reporting Requirements	62
Annex 2 PVO Project Reporting Information Sheet	79
Annex 2a Tables 1-5 Indicators (from indicator sheets attached to Child Survival Annual Progress Report Guidelines	80
Annex 3 Monitoring and Evaluation Plan	92
Annex 4 Baseline Survey Instrument and Analysis	103
Annex 5 Personnel Job Descriptions and Resumes	119
Annex 6 Photos	120
 <u>Appendices</u>	
A - Project Map	} 127- 175
B - Health Committees Formed	
C - Response to Technical Recommendations	
D - Training Officers Report	
E - Headquarter Approved Project Proposal Form for Child Survival and Immunization Support	
F - <i>Chronology of WV Zimbabwe Child Survival Project</i>	
G - Original AID ^{CS} Annual Report Guidelines	
H - WV Child Survival Strategy Paper	
I - WV Child Survival Press Kit Contents	

INTRODUCTION/EXECUTIVE SUMMARY

World Vision's Child Survival project in Zimbabwe seeks to contribute significantly to the reduction of infant and child mortality and morbidity in Zimbabwe by enhancing and supporting existing Ministry of Health systems in the Murewa District. The following Child Survival activities are being carried out:

1. Supporting and enhancing the government of Zimbabwe's immunization program.
2. Instituting an active control of diarrheal diseases program.
3. Nutrition and growth monitoring promotion.
4. Other measures to promote MCH, especially for high risk groups (antenatal care, TBA training, FP).

Training, health education and vigorous social mobilization play central roles in carrying out these activities. During the first year, a project office was established; staff was seconded by World Vision to the project; additional staff were hired; a number of staff training programs were started; a baseline survey was carried out; a monitoring and evaluation plan was developed; and a family registration system was designed, tested and introduced after staff had training in its use. Collaborative relationships were developed with the Ministry of Health, and a partnership with St. Paul's Hospital was established for the project.

Despite an unforeseen need to change the project site, the Child Survival interventions and project activities have now been implemented in the pilot area, and a plan for expansion of the program to the entire district of 150,000 people has been developed.

In addition, World Vision has undertaken an extensive range of activities to make this Child Survival program an integral part of its development assistance programs.

This report details the project's progress. The report was developed by World Vision Zimbabwe project staff with inputs from the World Vision senior technical consultant, the World Vision primary health care specialist, and a consultant from APHA.

ABBREVIATIONS

APHA	American Public Health Association
CBD	Community Based Pill Distributor
CHC	Child Health Card (Road to Health Card)
CIDA	Canadian International Development Agency
CSEP	Child Survival Enhancement Team
CSOT	Child Survival Outreach Team
CST	Child Survival Team
DIP	Detailed Implementation Plan
EPI	Expanded Programme on Immunization
FP	Family Planning
FRS	Family Registration System
GOZ	Government of Zimbabwe
HC	Health Centre
HNT	Health Nutrition Team
MCSP	Musami Child Survival Project
MES	Monitoring and Evaluation System
MOH	Ministry of Health
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PMD	Provincial Medical Director
SCF(UK)	Save the Children (United Kingdom)
SSS	Salt & Sugar Solution
TB	Tuberculosis
VHW	Village Health Worker
VIDECs	Village Development Centres
WARDCO	Ward Development Committee Members
WCBA	Women in the Child Bearing Age
WHO	World Health Organization
WVI	World Vision International
WVRO	World Vision Relief Organization
WVZ	World Vision Zimbabwe

PART I

PROJECT DESCRIPTION

I. PROJECT DESCRIPTION

STATEMENT OF PROJECT OBJECTIVES

1. Objectives of the project as related to indicators for monitoring and evaluation.

a. Strengthen and support government of Zimbabwe Immunization program in the project area.

(1) Seventy percent of all under ones will complete EPI program by their first birthday.

(2) Eighty percent of all under fives will be completely immunized.

Facilitate and institute an active diarrheal disease control program in the project area within the Ministry of Health framework.

(1) Fifty-five percent of WCBA will demonstrate competence in the preparation of oral rehydration solution.

(2) Fifty-five percent of WCBA will use salt and sugar solution as a first method to prevent dehydration when their children have diarrhea.

(3) Ninety-five percent of WCBA will know of oral rehydration therapy.

(4) Fifty percent of WCBA will have basic knowledge of hygiene and environmental sanitation to combat diarrhea.

(5) Thirty percent of families will have access to safe water source within a five kilometer radius.

(6) Twenty percent of families will have a Blair toilet.

Improve nutritional status of the children who are under five years.

(1) Seventy-five percent of under twos will participate regularly in weighing sessions.

(2) The children under five classified "at risk" and below the demarcating line on the Child Health Care Family registration sheet will be reduced by 50 percent from baseline measurements.

(3) The percentage of under ones not receiving weaning foods at six months will be reduced by 50 percent from baseline measurements.

(4) Ninety percent of mothers will maintain breast feeding for a minimum of 12 months.

d. Assist in the provision of antenatal delivery care and FP services.

- (1) There will be at least a 30 percent increase of pregnant women who will at least have one ANC checkup (defined as tetanus toxoid injection or Fe/folic acid distribution or pregnancy counseling or fundal height measurement from baseline measurements).
- (2) The number of WCBA utilizing a modern method of contraception will be increased by 25 percent from baseline measurements.
- (3) Fifty percent of TBAs will be trained/retrained.
- (4) Child mortality rate will be reduced by 25 percent from baseline measurements.

The preceding objectives have not changed from the detailed implementation plan and AID technical recommendations. However, the strategy and expected quantifiable accomplishments have been adjusted (by less than 10 percent) to accommodate baseline survey findings and technical recommendations.

I. 2. Identification of Target Groups

The project will work in the Murewa District of Zimbabwe. For project implementation purposes, Murewa district has been divided into Area 1, Area 2 and Area 3. The "target groups" in these areas are the following:

- a. Children under five for nutrition and immunization.
- b. Mothers with children under five and WCBA (see Table 1, following page, for a description of these target groups).

Changes in Target Group (from figures noted in the DIP)

Compared to the original plan, the total population to be covered by the project has increased from the targeted 75,000 to 152,000. This reflects the government's desire to have the project support the Child Survival intervention of the whole of Murewa district. Projects' interventions in Area 3 will cover only immunizations and ORT. This was decided primarily in light of the realities of what the project staff can cover and in light of the MOH's request that the project cover all of Murewa District. (Table I shows the target population, area and human resources available.)

TABLE I

SUMMARY INFORMATION ABOUT TARGET POPULATION AND PROJECT AREA

AREA	Approx. Pop.	Children Below 5 Years					Total	Women in Childbearing Age							Total	Approx. No. Births	Approx. No. VHW	Approx. No. TBA	Nurse's Aids	Nurses Medical and Health Assist.	No. of Physicians
		0-11	12-23	24-35	36-47	48-59		15-19	20-24	25-29	30-34	35-39	40-44	45-49							
AREA I (Musami Start-up area)	18,000	900	810	810	810	810	3,240	1,215	945	810	585	450	350	135	4,500	720	12	90	10	3SRN 14SCN 1H/A	2
AREA II (Rest of Musami)	42,000	2,100	1,890	1,890	1,890	1,890	7,560	2,835	2,205	1,890	1,365	1,050	840	315	10,500	1,680	12	210	8	8SCN 2H/A	
AREA III *	92,000	4,140	4,140	4,140	4,140	4,140	16,560	6,210	4,830	4,140	2,990	2,300	1,840	690	23,000	3,680	106	460	18	3SRN 27SCN 6H/A	2
TOTAL	152,000	7,600	6,840	6,840	6,840	6,840	27,360	10,260	7,980	6,840	3,935	3,800	3,040	1,140	3,800	6,080	130	760	36	6SRN	4

*(Rest of Murewa District, excluding Areas 1&2)

Infant mortality rate	=	90/1000
Average birth rate	=	40/100
Average death rate	=	15/1000
Rate of natural increase	=	3/5%
Children below 5 years	=	23% of total population
Children below 1 year	=	5% of total population
Women in childbearing age	=	25% of total population

Key to Staff Columns
 SRN - State Register Nurse
 SCN - State Certified Nurse
 H/A - Health Assistant

I. 3. Health Problems Addressed by the Project

The Child Survival project addresses the health problems of WCBA and children who constitute 48 percent of the Zimbabwe population. The project is fully consistent with GOZ health policy. A 1984 Primary Health Care survey carried out by the GOZ, WHO, CIDA and SCF (UK) identified the major child health problems as measles, TB and other communicable diseases, diarrhea, malnutrition, low birth weight and pneumonia. Major maternal health problems identified were poor nutrition, complications of delivery and septic abortions.

The baseline survey carried out in Musami confirmed that the control of diarrheal diseases and the expansion of coverage of immunization for the EIP covered diseases are needed. The survey indicated that while knowledge of immunization was high in the area, full immunization coverage was only approximately 40-60 percent. Diarrheal disease is a significant problem with 90 percent of survey respondents reporting an episode of diarrhea in their children during the previous two weeks (January 1986). Eighty-three percent of the households surveyed obtained water from an unprotected source, and 75 percent of respondents had no latrines. A baseline health survey was carried out by World Vision staff to update these findings and to investigate other areas relevant to the project. The findings essentially corroborate the Musami survey.

Communicable diseases (measles, polio, TB, diphtheria, pertussis and tetanus and diarrheal diseases) are therefore the principal diseases addressed by the project. Because of the intimate interrelationship between child nutrition and child spacing and infectious diseases, the project will also address problems of inappropriate or under-nutrition and closely spaced pregnancies. This will be done primarily through health education, growth monitoring, nutrition demonstration, referral for family planning and antenatal care.

I. 4. (a) Health Intervention and Services That the Project is Providing

Immunization of under fives against six immunizable diseases. The approach is to strengthen and support the government of Zimbabwe's Expanded Immunization Program (ZEIP). The project has supported existing EIP immunization activities provided by the outreach program from St. Paul's Mission Hospital, Musami (this is the partner agency in the start-up area of the project) with transport, staff, supplies and introduction of a family registration system.

Oral Rehydration Therapy is the key focus of implementing a program to control diarrheal diseases in the project area. The approach has been through training of community health mobilizers (preschool teachers, community leaders) and retraining of various government and nongovernment extension workers. Training has included ORS preparation and nutrition education and the provision and demonstration of good water and sanitary facilities.

Other Maternal and Child Health Resources: The project works with FP workers in the community to educate women about FP and to motivate them to accept contraception. The service is provided by

the community-based pill distributor (CBPD). Specifically, the project includes the CBPDs in all training and supervision.

Training: The project applies a major emphasis on training of mothers, community leaders, supplemental training of village health workers, area health workers and Child Survival staff. The approach is to support existing training efforts and increase and accelerate community-level awareness and knowledge of Child Survival interventions. Training is done through existing or newly established health committees and in cooperation with preschool teachers, usually at the village development centers or outreach points.

Community Mobilization: To make the project community-based with full participation, the community was involved at the planning stage. The commitment of community leaders to the project was secured through social mobilization training. The community was encouraged to:

- (1) Identify its needs and problems.
- (2) Mobilize resources to support the suggested ways to solve the community's health problems.
- (3) Support the project.
- (4) Participate in the project.

As a priority development need, the community desired assistance from the Child Survival project to develop Village Development Centers called "VIDECs". This community need linked very well with the objective of introducing Child Survival and health interventions. These "VIDECs" provide an important entry point for the above-mentioned key elements to Child Survival, as well as other aspects of maternal and child health and primary health care.

The Village Development Centers are multipurpose centers serving as preschool centers, demonstration centers for health education, and sites for maternal and child health activities and other meetings and development activities. Structures at the Village Development Centers include a demonstration protected water source, a demonstration Blair toilet, a demonstration kitchen and garden, a storeroom and a simple covered meeting hall (this is especially important for immunization sessions during the rainy season). The project assisted in this effort because (1) it was responding to the community-felt needs and thus ensured community participation and sustainability; (2) it provided an excellent way to introduce, promote, implement and teach about Child Survival interventions; (3) it provided the whole community with a variety of needed health components, while also providing teaching tools for Child Survival interventions; and (4) World Vision provided for these activities out of its matching funds.

(b) Health Interventions and Services that the Project will Provide

During the first year of the project, the district and national MOH officials indicated their desire that World Vision expand into all of Murewa district, rather than concentrating resources on only a portion of the district as originally planned. Based on actual implementation experience in the area, realistic and possible interventions were determined by the project staff. In Area 1, the present interventions will be continued and expanded into Area 2, along with an expansion of antenatal care, growth monitoring and nutrition education. In Area 3, a more restricted set of interventions will be instituted. These are described below.

Interventions for Area 3:

- (1) Support of the MOH-expanded program on **immunization**, using Murewa District Hospital and its outreach program and surrounding health center as the partner agency.
- (2) Support for **Oral Rehydration Therapy**, focusing on training of mothers, VHWs and community leaders in the proper use of ORS, treatment and prevention of diarrhea.

These interventions will be primarily implemented through project-designed training workshops. The workshops will train "trainers," notably those identified as community mobilizers and leaders. Further details about interventions can be found in the Section VII titled, "Revised Work Plan." (See Table VII for a summary of Child Survival interventions by project areas.)

(c) Changes in Type and Scope of Services Since Submission of Implementation Plan and in Response to the Technical Review

The overall **type of services** has not changed since the writing of the detailed implementation plan. They remain: immunizations, ORT, nutrition promotion and training and assistance in antenatal care and FP. In response to the communities' desire, there has been additional project involvement in completion of VIDECS (as explained in the previous page).

The original plan in DIP was to train 35 new village health workers. However, the MOH would not allow new health workers to be trained outside of the GOZ system. Instead, the retraining of existing village health workers was encouraged. The project set out on an extensive training program with the 1,000 community leaders, mobilizers, village health workers, TBA, CBPD and staff participating in various training programs. (See Table VI for a more detailed explanation.)

Since the detailed implementation plan was written, there have been no significant changes in the **scope of services** provided in Areas 1 and 2. For reasons described above, Area 3 will have a modified scope of services focusing primarily on ORT and immunization.

In response to the technical review as it relates to changes in types and scopes of services, the following issues were addressed:

- (1) As recommended, the trainers and supervisors will be the same people. Supervision of village health workers will be done by the Child Survival outreach team, made up of a nurse, nurse aid, section leader and VHW.
- (2) Training will have a supervisory component as recommended. (See the following table for a detailed response to all the recommendations.)

(d) Linkages Between Existing Health Services and New Child Survival Activities

Linkages will be strengthened between existing health services and the **new Child Survival activities**. The existing health service in Area 1 are provided by St. Paul's Mission Hospital and its outreach team. This organization is designated by the MOH to serve the Musami area. Child Survival activities are already a part of these health services, but are being emphasized, increased and accelerated by the project. (See "Inputs Section" for more details.)

TABLE II

RESPONSE/ACTION TAKEN TO TECHNICAL RECOMMENDATION

Recommendations	Response/Action Taken
<p>1. The training of health workers is detailed in content, but teaching methods are not specified. Recommend that the project make use of materials on development and use of training materials, such as the Medex series, which includes methodologies for use with illiterates.</p>	<p>1. World Vision training material and curriculum have been developed. Methods of training used include group discussions, practical demonstrations, self-discovery, participatory, role plays and field visits. Materials used: real food, home toilets, etc. Posters used originated from Ministry of Health and UNICEF. Other available guides and materials will be identified and used.</p>
<p>2. Reviewers recommend that given the difficulties that VHW programs often have, the supervision of this aspect of the project be planned in detail and provisions be made for training in adequate supervisory skills.</p>	<p>2. Existing Ministry of Health programs have a health supervisory cadre trained to supervise all levels of community health mobilizers (useful particularly when project phases out). The supervisory cadre is, in turn, supervised by the health center nurse. The training programs will also focus on supervisory skills, and efforts will be made to strengthen the MOH supervisory cadre.</p>
<p>3. To the extent possible, it is recommended that trainers and supervisors be the same people since experience has shown that this facilitates retaining and supervision. If the main trainers cannot be supervisors, often the future supervisors can be given at least some of the training responsibility.</p>	<p>3. As recommended, the trainers and supervisors will be the same people. Assistance is given to the existing most supervision of VHWs by the Child Survival outreach team.</p>
<p>4. Recommend that the process of information, collection, analysis and use from the VHW to the supervisor (facilitator?) to higher levels be clarified. What decisions should be made at each level?</p>	<p>4. Village health workers detail information in the village family registration. The Child Survival team collects this for compiling, analysis and dissemination and feedback to the village worker. The monitoring and evaluation plan give further details. The system continues to be refined as experience is accumulated. A further consultation with a health statistician will be undertaken.</p>
<p>5. Recommend for the vaccine program, that in addition to vaccine quantity needed as calculated by exact number to be given, some allowance be made for wastage, interruption of resupply or increased demand beyond program guidelines in the start-up period.</p>	<p>5. The inventory for the vaccine program is maintained by St. Paul's Hospital and takes into consideration 20 percent wastage.</p>

PART II

Description of Major Actions/Activities that have Occured During the Year

September 1985 - September 1986

Inputs/Outputs

PART II

1. INPUTS

II.1 (a) Description of staff hired, job description and brief resumes

Name	Title/Position	Hired	Job Description	Brief Resume
1. S. Mushapaidze *	Project Manager	Oct. 85	Project Management, overall supervision and execution.	Nurse, mid-wife with diploma in health education. Trained in Louis Allen Management system. Fourteen years' experience in all aspects of nursing, informal education, management and communication.
2. J. Nhliziyo *	Training Officer	Mar. 86	Training/social mobilization, community organization.	Nurse, mid-wife with diploma in community health. Trained in adult learning methodologies. Ten years' experience in community health.
3. B. Chirairo *	Field/Evaluation	Feb. 86	Project site operations, community motivation, integrating Child Survival interventions with development. Aggregating field data.	BSC in engineering and post-graduate diploma in public health engineering. Four years' post-graduate experience in field work.
4. S. Chidyamatamba *	Office Secretary	Nov. 85	Office supportive services and typing.	0 Level Cambridge Certificate. One year secretarial training. Eight years' experience in office management and secretarial services.
5. G. Ngatiri (part-time)	Technical Advisor (60% man-hours)	Jan. 86	Technical support advisory services, design and planning.	Medical degree and master's in public health. Ten years' experience in community health programs in Africa.
6. M. Chigwida (part-time)	Field Director (20% man-hours)	Oct. 85	Overall direction and control.	Master's degree in divinity/administration. Twenty years' experience in administration.
7. O. Dziva	Field Finance and administration	Oct. 85	Project Finance and property control. Overall support services.	B.A. in administration and Finance. Post-graduate diploma and administration. Ten years' experience in rural health.
8. E. Tagwireyi	Health Officer (40% man-hours)	Apr. 86	Training/Social Mobilization, community organization.	Nurse, mid-wife and diploma in community health. Ten years' experience in rural health.
9. Ann Biro (part-time)	PHC Specialist	Nov. 85	"Back stopping" liaison with USAID Office. USAID documentation.	Bachelor of science in nursing and master's in public health. Two-and-a-half years' international health experience. Two-and-a-half years' nurse experience in USA.
10. Mrs. Chiradza *	Nurse Aide	Apr. 86	Immunization	Basic training in nursing. Primary School Education.
11. R. Macagba	Technical Coordinator Child Survival Program (5% man-hours)	Apr. 86	Coordination of Child Survival programs worldwide.	Surgeon and public health physician. Thirty years' experience in health administration and management.

* World Vision staff paid by the CS project.

** This percentage of time spent on the project will be increasing as Dr. Macagba fully transitions into this role.

II. 1. (b) Description of materials procured

(a) Material procured for ORT

This includes the following: salt and sugar for demonstration purposes, training charts, "diarrhea dummies" role-play demonstrations, bottles, cups and spoons for ORT demonstration.

(b) Material procured for immunization

Syringes and needles, chairs and foldable tables, immunization demonstrations charts.

(c) Materials procured for high-risk births

Training materials for traditional birth attendants.

(d) Materials bought for growth monitoring

Training and demonstration charts and books.

(e) Material procured for total project

Two field vehicles, one office vehicle, building material for facilitating building of VIDECS (immunization and training points), materials for developing an office space and residential quarter at project site, monitoring and evaluation system books, office furniture and equipment bicycles for doing sample surveys, food in all training sessions.

All above materials were purchased in Zimbabwe. All vaccines and cold chain equipment were provided from Ministry of Health.

TABLE III

Part II. 1(c) Itemization of Funds Spent by Budget Item (with the line-item - funds spent in FY86

	FY86 Field	Headquarters	Total
1. <u>Salaries</u> Project manager, training officer, field officer, secretary, nurse aid.	\$ 30,080		\$ 30,080
2. <u>Training</u> Training workshops for community mobilizers, village health workers and field staff.	3,008		3,008
3. <u>Supplies</u> Phone, telex, word processing, Xerox (headquarters), materials for demonstration toilet, protected well and roofing material (field)	41,517	994	42,511
4. <u>Equipment</u> Immunization equipment, (bicycles, needles, sterilizing equipment) office equipment for field office, for project and outreach team residence in project area.)	83,344		83,344
5. <u>Technical Consulting and Support</u> Contract with APHA year 1-4 consultation visits to Zimbabwe 30,434 and assistants backstopping. WV technical consultant 30,000 2 consultation visits to Zimbabwe headquarters by WPRO CS coordinator and visits to Zimbabwe from within Africa by CS coordinator.	60,434		60,434
6. <u>Travel</u> Trips to the project site from Harare (are 2-3 per week).	11,965	13,838	25,803
7. <u>Overhead</u> Travel for WV technical consultant from Nairobi.	0	20,700	20,700
TOTAL	\$ 230,348	\$ 35,532	\$ 265,880

II. 1. (c) Itemization Of Funds Spent By Budget Item Funds Spent In FY86

(SUMMARY)

	Field	Headquarters	Total
1. Salaries	\$ 30,080	\$	\$ 30,080
2. Training	3,008		3,008
3. Suplies	41,517	994	42,511
4. Equipment	83,344		83,344
5. Technical Consulting and Support	60,434		60,434
6. Travel	11,965	13,838	25,803
7. Overhead	0	20,700	20,700
TOTAL	\$ 230,348	\$ 35,532	\$ 265,880

TABLE IV REVISED 3-YEAR PROJECTED BUDGET

Line Item	FY86		FY87		FY88		Total		Total		Grand Proj. Totals
	Field	Head-quarters	Field	Head-quarters	Field	Head-quarters	Field	Head-quarters	USAID	WVRO Match	Field & Head-quarters AID & WVRO Match
Salaries	\$ 29,342	\$ -0-	\$ 70,252	\$ -0-	\$ 70,252	\$ -0-	\$ 169,846	\$ -0-	\$ 169,846	\$ -0-	\$ 169,846
Training	16,782	-0-	28,264	-0-	20,764	-0-	65,810	-0-	65,810	-0-	65,810
Supplies	93,000	994	28,290	940	15,000	940	136,290	2,874	39,164	100,000	139,164
Equipment	88,352	-0-	36,290	-0-	22,791	-0-	147,433	-0-	47,433	100,000	147,433
Technical Consulting	30,434	-0-	78,454	-0-	118,903	-0-	227,791	-0-	227,791	-0-	227,791
Travel	8,058	17,838	33,290	12,520	20,000	16,150	61,348	46,508	77,856	30,000	107,856
Overhead	-0-	20,700	-0-	20,700	-0-	20,700	-0-	62,100	62,100	-0-	62,100
TOTALS	\$ 265,968	\$ 39,532	\$ 274,840	\$ 34,160	\$267,710	\$ 37,790	\$ 808,518	\$ 111,482	\$ 690,000	\$230,000	\$ 920,000
GRAND TOTALS	\$ 305,500		\$ 309,000		\$ 305,500		\$920,000		\$ 920,000		\$ 920,000

Budget Narrative:

I. Significant changes in line item totals of actuals and revised projected for FY86 and FY87 Compared to proposed budget submitted to AID with original proposal.

During the first year of the implementation, the project allowed for a more realistic projected budget for the project, based on what was actually spent the first year. Following is a brief description by line item of why adjustments have been made since the original proposed budget:

Line Item	3-Year Total		Explanation for Revision
	Original Proposed Budget	Revised Budget	
Salaries	\$406,000	\$169,846	In the original proposal it was envisioned that 100 lay coordinators and 100 district coordinators would be paid \$15 per month and \$500 per month respectively for 31 months thus accounting for 195,000 of the 406,000 salary budget. Since implementation it has been found that this idea was unacceptable to the MOH. What was more appropriate was to pay salaries of the CS project staff and shift the remaining monies to the area of equipment and supplies which was higher than originally anticipated. The project feels that this is more in keeping with focusing project efforts on the actual implementation of services (see below for explanation of equipment and supplies). Salary levels increase during the second year to allow for hiring of additional project staff to implement the expansion phase. Although the WV Zimbabwe accounting staff was able to handle the accounting for the project during the first year, the project manager is now in the process of hiring an accountant solely for the CS project. The first task of this accountant will be to do an internal audit for the primary purpose of separating this CS project out of the accounting system of the other WV projects. Discussions are also under way at headquarters to assist the field in setting up special grant accounting systems for CS projects in Zimbabwe, Sudan and Senegal.
Training	\$33,000	\$65,810	This line item has increased due to an increased emphasis on training as well as an increased project population (from 75,000 to 152,000). During the first year training, particularly, community mobilization proved to be one of the most effective and far-reaching activities of the project.

Line Item	3-Year Total		Explanation for Revision
	Original Proposed Budget	Revised Budget	
Supplies	\$14,500	\$139,164	There not only appears to be a significant underestimation of this line item to begin with, but the field's definition of supplies also included items originally categorized as equipment. Another significant reason which accounts for this change is that the project decided to support the communities' request for assistance in the development of "VIDECs". This was, in essence, a new project activity not originally budgeted for, but the project felt this was a legitimate and wise use of funds as has been previously explained on page 5 of this report. Also, this is very much in keeping with the project's underlying philosophy of <u>supporting</u> existing health services. Also, WV has opted to cover 72% of all supply costs with its matching funds.
Equipment	\$56,000	\$147,433	Again on this line item there appears to be an original underestimation of this expense. Vehicles at \$10,000 per vehicle were underestimated. Equipment such as bicycles, sterilization equipment and needles were needed but not originally budgeted for. Overall there is a greater emphasis of this project on service delivery of interventions than was originally anticipated. Because WV is essentially donating many in-kind services, with the WV Zimbabwe office providing much back-up and with the use of a partner agency like St. Paul's, a much greater amount of funds are freed up for actual support of service interventions such as the procurement and provision of supplies particularly related to immunization and ORS. Again, WV has opted to cover approximately 68% of all these costs with matching funds.

Line Item	3-Year Total		Explanation for Revision
	Original Proposed Budget	Revised Budget	
Technical Consulting	\$230,000	\$227,791	<p>There is a very minimal change in this line item. However, it should be noted that some changes have been made on the use of external/international consultants. It was originally envisioned that the entire \$230,000 would be contracted out to APHA for technical assistance. However, due to an increased WV in-house technical capability and a request from the field to seek local and/or African consultants, a contract amount of 100,974 was agreed upon with APHA. In light of the first evaluation results and the felt need by the project to have assistance from APHA, particularly from Dr. S. Kessler in the area of participation in all annual evaluations as an external party, it was decided to increase the APHA budget to allow for an additional trip for Dr. Kessler to participate in the final evaluation. This brings the total APHA contract to approximately \$136,000 which covers: 3 trips to Zimbabwe during the start-up phase, 3 trips to Zimbabwe to participate as an external evaluation for the 3 annual evaluations and some general back stopping in Washington related to the trips to Zimbabwe.</p> <p>The remaining technical consulting and support budget covers part-time assistance from WV's senior technical consultant/regional Africa CS coordinator who gives approximately 60% of his time throughout the life of the project. This budget also allows for hiring of local consultants to assist with the fine tuning of the monitoring and evaluation plan and assisting with baseline surveys (many of which will be done near the end of the project in the entire Murewa district for monitoring and evaluation purposes).</p>
Travel	\$104,500	\$107,856	<p>This has a slight overall change. It is slightly higher in that travel budgets for the CS project staff to participate in workshops and training sessions outside Zimbabwe have been budgeted for in FY88.</p>

Line Item	3-Year Total		Explanation for Revision
	Original Proposed Budget	Revised Budget	
Overhead	\$76,000	\$62,100	This is a decrease of \$13,900 and was done purposefully by WVRO in order to pass additional funds to direct project activities.
TOTAL	\$920,000	\$920,000	There has been no change in the overall year project budget.

II. Status of 3-Year Financial Plan by Year

On World Vision's internal financial planning document, the following breakdown by year was budget for this CS project.

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
\$ 305,500	\$ 309,00	\$ 305,500	\$ 920,000

During the first year, a total of \$265,880 was spent shifting \$39,620 into Year 2. This is not seen as a problem to the project as most of the underspending was due to a slower than anticipated start-up phase. Now that the project is underway and beginning to expand, this additional amount will be utilized in Year 2.

III. Transfer of Funds to the Field

As can be seen from Tabel III, the monies for the project are being utilized by the field for direct project activities, with only \$35,532 being used for costs related to headquarter support and and \$230,348 being used for project/field implementation costs.

II I(d) Use of Technical Assistance

The World Vision Child Survival project has extensive use of technical Assistance for four sources:

- a. World Vision International and Regional staff.
(Dr. George Ngatiri, Dr. Rufi Macagba)
- b. The AID's PVO office and assistance provided through AID's Science and Technology Bureau.
(Dr. David F. Pyle)
- c. Consultation from experienced specialists working in Zimbabwe.
(Dr. Wayne Shirson, Mike Favin and Dr. Susi Kessler)

World Vision Relief Organization's Primary Health Care Specialist, Ann Biro RN MPH, has provided continuous liaison with AID and assistance in reporting in conformity with AID guidelines. (This has involved three visits to Zimbabwe, including participation in this evaluation visit and numerous phone calls and visits to Washington, D.C.) Dr. George Ngatiri, a senior Health Specialist from World Vision's Regional Office in Nairobi, was seconded to work with the project on a 60 percent basis to assist in developing the detailed implementation plan and to develop the monitoring and evaluation plan, and provide overall technical support.

In July, Dr. Rufi Macagba was designated International Technical Coordinator for Child Survival and made a visit to the project site to familiarize himself with the project.

Technical and administrative guidance provided by the AID PVO office has facilitated the project to meet AID's Child Survival objective. These guidelines have been transmitted through the World Vision Primary Health Care Specialist who is in frequent communication with the PVO project officers. Project staff have participated in the various workshops organized by the PVO office to provide technical assistance for project design, implementation, monitoring and evaluation.

In December 1985 the PVO office arranged for technical consultation on developing a project evaluation plan through the S and T Bureau's contract with John Snow.

American Public Health Association (APHA)

World Vision's proposal foresaw substantial technical assistance in project design, implementation and evaluation on an ongoing basis and planned a subcontract to APHA. Because of the availability of technical consultation from both AID and World Vision, the planned subcontract was modified to provide intermittent consultations and participation in all annual evaluation.

APHA support was provided by Dr. Wayne Stinson in August 1985 and again in December 1985 when the detailed implementation plan was developed.

In October 1986, Dr. Susi Kessler of APHA participated in the project annual review/evaluation and assisted the WVZ team who prepared the annual report and revised work plan.

There has been initiation of contacts to obtain technical assistance from locally available sources in Zimbabwe, in particular the university and other PVOs like OXFAM, VOICE, SCF (USA) and UNICEF.

PART II

2. OUTPUTS

**Discussion of Planning,
Implementation and Success
of Output Activities**

OUTPUTS

II. 2(a) Baseline Surveys Carried Out

A baseline survey was carried out in January/February 1986. It showed high awareness of all Child Survival elements but low competence and practice.

ORT was very poorly practiced. Only 10 percent of mothers interviewed showed competence in mixing an oral rehydration salt solution. Poor sanitation was widespread. Less than half of the population had any form of waste disposal, and only 15 percent reached the government Blair Toilet standard.

Immunization: Half of all children had completed the EPI program. Mothers were highly motivated but were discouraged by distance and irregularity of the outreach team.

Growth Monitoring: Insignificant number of children had overt malnutrition, and although most households (over 80 percent) had the growth monitoring cards, only slightly over half had more than one contact with the monitoring team. The main obstacle was distance and irregularity of service.

High-risk groups: Over half of all pregnant women delivered in hospitals and had at least one antenatal care contact.

Full survey results and questionnaire are found in annex 4.

Planning of the baseline survey was initially done in the detailed implementation plan. In January 1986 implementation was started.

Three medical students carried out the door-to-door survey in 100 households using a standard open-ended questionnaire. A random sample was chosen from the four pilot wards, with each ward having twenty-five interviews.

Although the sample size was small, the results correlate well with other statistics done by other groups and the government.

II. 2(b) Training Curriculum Developed

A curriculum was developed for training of different cadres in the community in collaboration with MOH personnel during a series of joint consultations. The content of the curriculum is as follows:

Curriculum Outline For Training of Community Leaders And Preschool Teachers:

Diarrhea

- Definition
- Causes
- Prevention
- Signs of dehydration
- Control of dehydration
- Oral Rehydration Therapy

Environmental Health

- Construction and use of Blair toilets
- Construction of protected water sources
- Use of clean water
- Improving home and village cleanliness
- Construction and use of pot racks
- Construction and use of rubbish pits

Nutrition

- Breast
- Weaning foods - food square
- Improving methods of cooking
- Nutrition gardens
- Food Hygiene

Immunization

- The six killer diseases
- Immunization schedule
- Immunization centers
- The use of the child Health Card

Health Education and Motivation

- Creation of awareness of health problems in the area
- On prevention of diseases and promotion of good health
- On child care
- Advise to pregnant mothers

Community and Social Action

- Linking the village health workers and the villagers.
- Linking the villagers and the health centers
- Initiating development project
- Educating people on working together on projects for progress
- Attending meetings
- Improving villages
- Planning and implementing projects
- Team work with other extension workers
- Confidentiality
- Coordination with other agencies
- Supervising and managing projects

Recording and reporting

- Recording and reporting diseases in the village
- Recording and reporting new-born babies
- Reporting outbreaks of diseases to staff at health centers
- Recording and reporting project's progress and limitations

Community participation is a strategy for the success of the Child Survival Program. As a consequence, the curriculum has been designed to educate and encourage full community participation in all aspects of the project.

Traditional Birth Attendants Training Contents

1. Describe the events of normal pregnancy.
2. Advise women on basic nutrition during pregnancy and on infant feeding.
3. List, recognize and manage--refer to Health Center--major complications of pregnancy, particularly hemorrhage, infection and toxemia.
4. List, recognize and manage--refer to Health Center--high-risk factors or pregnant women and newborns.
5. Explain the importance of referring high-risk and complicated cases promptly, use established procedures of referral.
6. Manage the normal delivery, using hygienic procedures.
7. Practice proper care of the new born, particularly cord care.
8. Use properly the contents of a simple midwifery kit.
9. Advise women on diet during lactation, breast-feeding and family planning.

The chart which follows gives details of the training activities. It also notes the training of staff under the project.

II. 2(c) TRAINING OF HEALTH WORKERS

Planning: A collaborative and multi-sectoral planning approach was used for all phases of the training, including the design, choice of the venue, decision on the period of training, of choice of the participants and facilitators. Planning representatives included the MOH, "Ag-techs" (the government's agricultural extension workers), PVOs, and persons from the community and WVZ.

Implementation: The training was again implemented in a collaborative multi-sectoral approach. Facilitators were drawn for WVZ, MOH and other PVOs well versed in the Child Survival Interventions. An informal method (participatory) of facilitation was used. Thirteen two-day sessions were held. During this time: 1,000 community mobilizers and 12 VHWs were trained on how to use the new monitoring and evaluation system; twenty-two TBAs were trained in two-day-long sessions; three CBPDs were also trained. All training was held in the project area.

Traditional Birth Attendants Training Contents

The training materials enables TBAs to competently perform the following tasks:

1. Describe the events of normal pregnancy.
2. Advise women on basic nutrition during pregnancy and on infant feeding.
3. List, recognise, manage and appropriately refer to health centers - major complications of pregnancy, particularly hemorrhage, infection, toxemia.
4. List, recognize, manage and appropriately refer to Health Centers high-risk factors or pregnant women and new borns.
5. Explain the importance of referring high-risk and complicated cases promptly, use established procedures of referral.
6. Manage the normal delivery, using hygienic procedures.
7. Practice proper care of the new born, particularly cord care.
8. Use properly the contents of a simple mid-wifery kit.
9. Advise women on diet during lactation, breast-feeding and family planning.

All abilities shown above refer to verbal or practical demonstrations.

The Success of the Curriculum and Training Programs

1. VHWs were able to understand and use the Family Registration System.

2. There was an increase in attendences at outreach centers for immunization and weighing.
3. There is marked increase in community participation in development of VIDECS.
4. The staff at St. Paul's and World Vision have noticed a marked increase in enthusiasm and participation in the communities' involvement for improved health practices.
5. There is an increase in the number of people who are able to prepare and use ORS.

For a more detailed discussion, see the following Table IV and Appendix D.

TABLE IV TRAINING OF HEALTH WORKERS

Who	Where	What	Duration	Relevance to the Program
Community Mobilizers	Wards 16-20	<p><u>Diarrhea</u></p> <ul style="list-style-type: none"> • Causes • Prevention <p><u>Environmental Health</u></p> <ul style="list-style-type: none"> • Use of toilets • Use of clean water • Use of rubbish pits <p><u>Nutrition</u></p> <ul style="list-style-type: none"> • Breast feeding • Weaning foods • Improving methods of cooking • Nutrition gardens • Food hygiene <p><u>Immunization</u></p> <ul style="list-style-type: none"> • Six killer diseases • Immunization schedule • Immunization centers • Use of Child Health Card (CHC) 	April - May August - September 86	<p>For CSP any community-based project, community participation is a prerequisite. The community should be able to identify its needs and find agreeable solutions. It should participate in planning, implementing and evaluating projects. The knowledge on basic health measures is important to be able to mobilize the community to carry out project activities in order to achieve "health for all by the year 2000." This knowledge helped the community mobilizers to plan projects implementation in line with cultural practices of the people without creating hostility.</p>
Community Mobilizers		<p><u>Health Education</u></p> <p><u>Motivation</u></p> <ul style="list-style-type: none"> • Creation of awareness of health problems in the area • Prevention of diseases • Advice to pregnant and lactating women <p><u>Community and Social Action</u></p> <ul style="list-style-type: none"> • Linking the VHW with villagers 		

TABLE IV TRAINING OF HEALTH WORKERS

Who	Where	What	Duration	Relevance to the Program
Community Mobilizers (continued)		<ul style="list-style-type: none"> • Linking the villages with health centers • Initiating health projects • Initiating development projects • Educating people on working together at projects • Improving villages projects • Team work with other extension workers • Coordination with other agencies • Supervising and managing <p><u>Recording and Reporting</u></p> <ul style="list-style-type: none"> • Recording and reporting diseases in the village • Recording and reporting newborn babies • Reporting outbreaks of diseases to staffs at H.C. • Recording and reporting projects progress and initiations • Community participation 		
Outreach Team (CSOT)	Musami	<ul style="list-style-type: none"> • How to carry out effective health education 	March 86 2 days	Health Education is a cornerstone of a successful health project. Child Survival project aims at strengthening such components of Primary Health Care in nutrition, growth monitoring, immunization, ORT, and breast feeding.

TABLE IV TRAINING OF HEALTH WORKERS (continued)

Who	Where	What	When	Relevance to the Program
Health Worker at Project Site	Musami	<ul style="list-style-type: none"> • Good weaning • Nutrition • Immunization • Growth monitoring • ORT • Water and sanitation 		For the above to be effective, the staff have to be equipped with skills and knowledge on how to impart the same to the communities they are serving.
Training Officer	Nairobi	<u>Teaching Adult Learners</u> <ul style="list-style-type: none"> • Motivating adults • Facilitation controlled and teaching • Communication skills • Adults versus children 	June 86 5 days	Child Survival program is a community project that requires full participation. Therefore, knowledge gained at this workshop helps the officer deal better with adults and other groups in the project.
Project Manager	Nairobi - Kenya	CSP orientation	August 85 3 days	Knowledge on the aims/objectives of implementation strategy of the proposal.
	Washington DC Airline Virginia - USA	Monitoring and evaluation systems	Sept. 85 5 days	Monitoring and evaluation systems are a part of the program implementation strategy. This gives the participants a sense of direction as to what is to be done to check the progress of the program and what to look for when one is assessing effectiveness of a program.
	Addis Ababa Ethiopia	<u>Community-Based Health</u> <ul style="list-style-type: none"> • Basic concept of CBHC • Model of CBHC 	Nov. 85 14 days	Child Survival program should be community-based health care project. The principles, concepts and models of CBHC will augment skills to manage the Child Survival program.
	Louis Allen Management Center	<ul style="list-style-type: none"> • Principles and practice of management • Communications skills • Motivation of own staff 	March 86 5 days	The Louis Allen management center of training in management principles of a manager and who to to manage and delegate.

TABLE IV TRAINING OF HEALTH WORKERS (continued)

Who	Where	What	Duration	When	Relevance to the Program
Project Manager	Sierra Leone Makeni, Freetown	<u>Integration of CSP into Community Development Projects</u> <ul style="list-style-type: none"> • Community development • Immunization • Village health communities • Growth monitoring, counseling, ORT • Nutrition, ORT, education • Inter-Agency collaboration • Survey preparation • Survey Analysis • Action Plans 	April 86	6 days	Health cannot be divorced from outer development activities. Sharing with other project members from other countries helped us to assess our own Child Survival project in terms of direction, pace and effectiveness.

II. 2(d) Agreements With Government of Zimbabwe on Child Survival Program

- October 1985 Introduction of project proposal to Provincial Medical Director Mashonaland Central.
- Agreement on choice of Kaitano.
- December 1985 Government of Zimbabwe requested a change of site because of World Bank involvement.
- December 1985 Consultation with ZACH and St. Paul's on new site.
- Consultation with provincial medical director, Mashonaland East on new site.
- January 1986 Agreement in principle.
- Project intended to start in two areas. Government of Zimbabwe preferred Musami with subsequent expansion to adjacent areas of the district.
- August 1986 Request from government of Zimbabwe to work in all of Murewa District. The ministry requested a detailed strategy for expansion into the remainder of the district.

Collaboration With Other Nongovernmental Organizations

- April 1986 Meeting with UNICEF on the Child Survival project proposal.
- Every month
- Monthly coordinating meetings with VOICE (Voluntary Agencies) on Primary Health Care issues.
 - Monthly meeting with Ministry of Health Expanded Program on Immunization unit.
 - Exchange of information meetings on Child Survival projects of two organizations (SCF, USA and World Vision).

Planning and Implementation

Upon formal approval of the proposal from USAID plans were developed to coordinate with the government and other organizations as summarized below:

1. Discussions with Ministry of Health at the National level to agree on location and overall project emphasis.
2. Once the area was agreed upon, discussion began with provincial and district levels for more detailed planning (as noted previously, this process was repeated upon notice from the Ministry of Health of their request for the project to relocate to Murewa District.)

3. Once in Murewa District, many discussions were held with the district and medical and nursing officer.

Success:

Despite this process taking a considerable amount of time, one positive outcome for the project has been the building of closer government ties. For example, the project has the full support of the district and medical nursing officers and they attended the WV organized community participation evaluation.

II. 2(e) Health Committees Established

In the Musami pilot area 32 villages health committees are functioning. The project activities have vitalized and strengthened these committees. The committees have been central to social mobilization in their villages. A list of villages with committees is found in Appendix B.

Planning and Implementation of health Committees

The training officer held consultative meetings with different communities to discuss the functions of health committees. At the meetings it was discussed how to revitalize these committees and how they will emphasize child survival interventions.

II. 2(f) Health Services Provided (Activities and Accomplishments)

1. Outreach team has been strengthened with:
 - a. Additional staff (nurse aids)
 - b. Vehicle (4-wheel drive) provided to transport staff to outreach immunization points (NB this has turned out to be the only means of transport as the previous vehicle provided by WV Zimbabwe, nine years ago recently "expired.")
 - c. Supplementary supplies (syringes, needles, sterilizing equipment, etc.)
 - d. 5,770 vaccine dose have been utilized by the projects.
 - e. Monitoring system designed and implemented to identify and follow up high-risk children. This system is now in 50 percent of Area I, and is being expanded into the other areas (see Annex 3).
 - f. Support has ben given to the government's training program for village health workers (VHWs) and traditional midwives. This support is achieved by refresher course in immunization techniques.
 - g. Support has been given to the Government's training program for village health workers (VHWs) and existing traditional midwives to mobilize the communities for immunization and by refresher courses in immunization techniques.

- h. Support in the way of provision of cement and door frames and assistance in community organization has been provided in the development of Village Development Centers called "VIDECs", consisting of a meeting hall, demonstration kitchen, demonstration garden, demonstration protected well, and demonstration Blair toilet. The project decided to be involved in assisting the communities in the development of these centers for the following reasons:
 - 1. These provided a definite entry for the introduction of Child Survival interventions, particularly immunizations growth monitoring and training.
 - 2. The VIDECs concept was already well-established in the project area thus the project support of VIDEC is in keeping with the project goal of strengthening and supporting what already exists.
 - 3. ^{Support of these "VIDECs" assisted} In making this Child Survival project a community based project ensured community participation and facilitated sustainability.

II. 2(g) Other Outputs

1. ORT Promotion

- a. During the first year of the project - training sessions were held stressing proper use and mixture of ORS and other child survival interventions.
- b. Over 1,000 community mobilizers were trained.
- c. 1,917 WCBA have been taught about dehydration prevention. As result of these training sessions, the following cadre of people are now promoting ORT in the community:
 - 10 nurses
 - 10 VHWs
 - 84 pre-school teachers
 - 3 CBPD
 - 300 community leaders
 - 22 traditional midwives

2. Other MCH Interventions

The project has supported existing maternal and child health/nutrition activities.

3. Nonhealth Outputs

- a. This CS project and staff has stimulated the WV Zimbabwe office to integrate CS program aspects into its other projects.
- b. A wide variety of health and non-health organizational networks are being established due to this project (i.e., ties are

being strengthened with ZACH, MOH, UNICEF, SCF(UK) and other PVOs).

- c. WV Zimbabwe has formed a health and nutrition unit which includes the Child Survival project. This has provided more infrastructure and support to all of WV's health activities and increased its health resources and improved its health information system.

PART III

Indicators of Effectiveness

III. INDICATORS OF EFFECTIVENESS

1. PVO Country Office Organization

The World Vision Zimbabwe office has established a Health and Nutrition/Child Survival unit. This unit provides technical and administrative support for Child Survival interventions. Unit staff are designated as a "Child Survival enhancement team." The team includes both staff working under the AID Child Survival grant and World Vision staff who work on other projects and who are introducing components of the strategy into other World Vision projects. The organization of the Health and Nutrition/Child Survival unit and its relationship to the World Vision Zimbabwe organization is indicated in the following organizational chart.

Staff Training

World Vision staff who have received training in Child Survival approaches include staff members from the WVI/WVRO organization headquarters, the World Vision Africa Regional office and the World Vision Zimbabwe office as well as a number of newly recruited field staff for the project. A total of five World Vision staff members have attended seven training programs in the U.S. and Africa. Table VI indicates the details of these training accomplishments identifying the individuals trained and the purpose and context of the training.

For new staff hired, please see Annex 5.

III. 2. Health Infrastructure Developments/New Services Planned

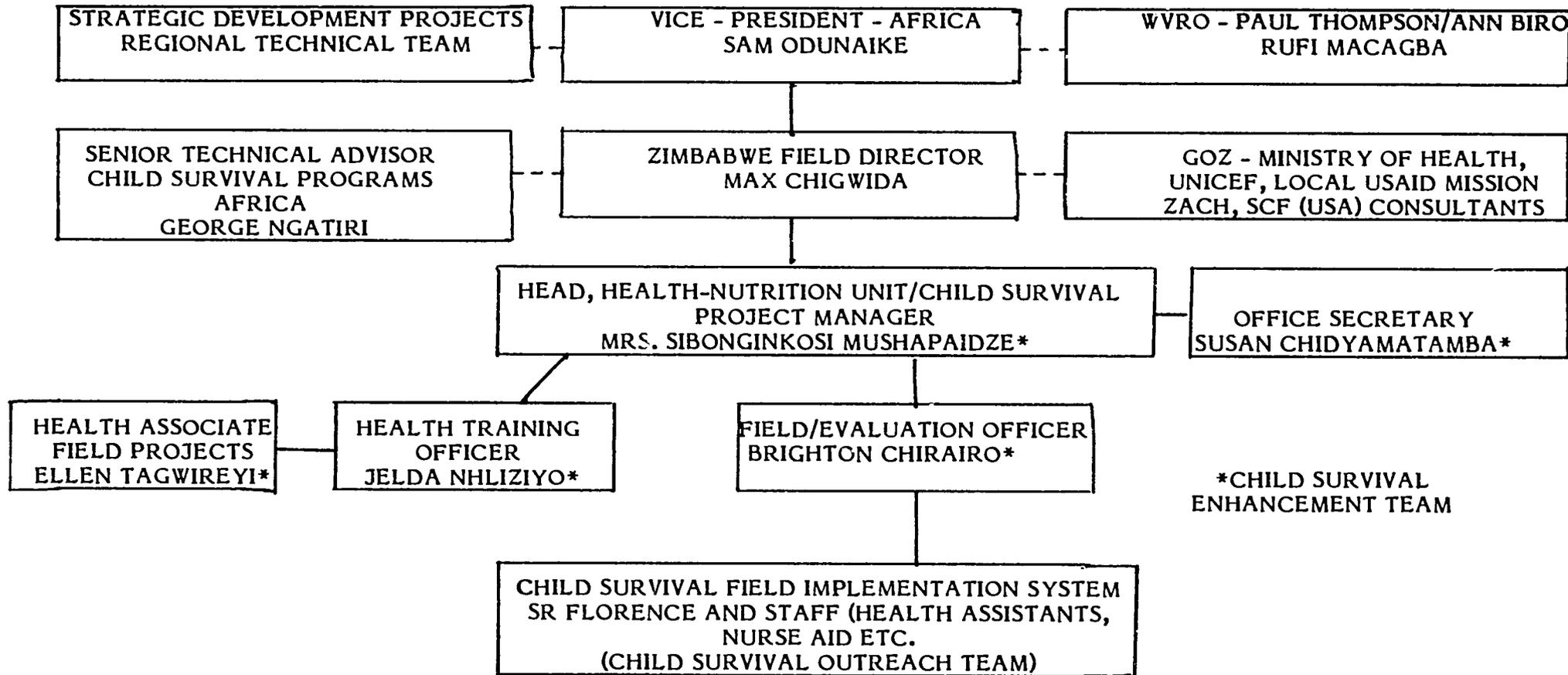
a. Outreach Team

"The Child Survival outreach team" has been designated to implement the selected Child Survival interventions at each of the 36 outreach points serving the Musami start-up area (immunizations, growth monitoring and health education). This Child Survival outreach team is staffed by government employees (nurse, driver) operating out of the St. Paul's Hospital who are responsible for the Musami area. The outreach team circulates to each of the outreach points on a monthly basis. It has been strengthened by the project that meets its schedule and through the following measures:

- Addition of a nurse aide to the team
- Provision of training and increased supervision by the project Child Survival enhancement team
- Provision of needed immunization equipment including sterilization supplies, syringes, needles
- Provision of transport for the team
- Assistance in completion of residential field quarters for the team

Table VIII

**WORLD VISION ZIMBABWE
CHILD SURVIVAL PROGRAMS
ORGANIZATIONAL CHART**



b. Child Survival Project Office

A Child Survival project office has been established at the St. Paul's Hospital which serves the Musami Area. The office has been supplied with essential furnishings.

The field office will serve as the site for:

- collection of project documentation
- collection and analysis of field reports
- continued training and supervision of outreach team
- training of other health care workers

III. 3. Community Mobilization

Training sessions have been carried out in 36 communities for community leaders to build awareness of Child Survival interventions and to make interventions an integral and central part of the community development processes. Approximately 1,000 community persons have been involved including community leaders (kraal heads, development committee members) teachers, preschool teachers and village health workers have participated in training sessions. The effectiveness of the community mobilization actions is indicated by the following developments:

- Child Survival interventions are a major objective of the 26 village development center projects which are underway. (The village development centers will be used as sites for immunizations, growth monitoring, health education, demonstration gardens, etc.)
- Child Survival objectives have become a stated objective of the health committees of 36 villages.
- Community leaders in 36 villages have agreed to assist with the family registration and demonstrated their ability to carry out this system.

III. 4. Changes in project target population

The figures below show the estimated coverage at the end of first year.

(a) Coverage (Musami pilot area)

Total population	18,000
Total under 1 in project area	900
Total completed immunization	560
Immunization coverage of under 1	62%

(b) Total number of under 5	3,240
Total number of under 5 who have completed immunization	1,917
Immunization coverage of under 5	59%

(c)	Total number of WCBA	4,500
	Total number received TT in last six months	803
	Percentage immunized in last six months	18%
(d)	Number of WCBA who have attended educational programs on ORT	1,000

Note: The immunization coverage during baseline survey was 55 percent. The monitoring and evaluation plan shows the targeted changes. It is felt that it is too early to accurately measure changes in the target population as a result of the project activities at this stage (i.e. change in health status, knowledge, practice and attitudes, etc.) except for what can actually be observed by project staff and/or by simply looking at the number of people trained.

CHILD SURVIVAL INTERVENTIONS BY PROJECT AREA

Area	Wards (Subdistricts)	Population	Health Facilities	Staff	Interventions
1 Musami	4	18,000	Hospital-1	12 VHWs 1 Driver 20 nurses, medical and health assistants	<p>CS refresher training of health staff including VHWs. Support of CS outreach team with transport, syringes, scales, staff, ORS demonstration materials, staff accommodation. Support for completion of village development center (VIDEC). Community mobilization</p> <p>Initiation of family registration. Systems at village level as tool for monitoring and management. Orient and build awareness of CS concepts in teachers, agricultural workers, other community workers.</p>
2 Greater Musami	4	42,000	4 Health Centers	12 VHWs 8 nurses medical and health assistants	
3 Rest of Murewa District	15	92,000	1 Hospital 6 Health Centers	106 VHWs 2 doctors 30 nurses 18 nurse aides	<p>As above with the exception of family registration and completion of village development centers. Where initiated by the district health team immunization campaigns will be supported by the project by assisting with transport supplies, mobilizing other sector-support and the population.</p>

PART IV

Discussion of Problems and Constraints To Implementation as Planned

IV. PROBLEMS AND CONSTRAINTS TO IMPLEMENTATION AS PLANNED

A longer than anticipated project implementation start-up period has been the main problem. Two factors necessitated major adaptations of the original project plan. Both of these constraints can be traced to insufficient participatory planning during the project formulation. The short time allowed for proposal submission resulted in a centrally U.S.-based project planning process (WVRO) which was not able to include enough Zimbabwe office input. As a result, the project design failed to consider all aspects of the local implementation context including Zimbabwe staff. The proposal therefore required substantial reformulation to be a viable long-term model in the country.

Additional participatory planning with government of Zimbabwe's Ministry of Health officials would also benefit project start-up. Four months after project initiation, a change took place in project site selection from Kaitano in Mt. Darwin District in Mashonaland Central Province to the Murewa District of Mashonaland East. This has imposed constraints and retarded the pace of project development. This change of project site resulted from the government of Zimbabwe's decision that the World Vision project would be duplicative of a planned World Bank project in the Kaitano Ward site. Unfortunately, the need for a change of project site occurred in November 1985, just prior to the arrival in Zimbabwe of a team headed by World Vision's senior technical advisor. The team included two APHA consultants and the WVRO Primary Health specialist who were to work with field staff in preparing the detailed implementation plan.

The team therefore had to concentrate on identifying a new project site and developing the detailed implementation plan before the site negotiations could be concluded. Both of these factors underscore the critical importance of a project planning process which includes all concerned parties and allows a longer time frame for preparation of project proposals.

PART V

Discussion of Project Strategies for Overcoming Constraints

V. DISCUSSION OF PROJECT STRATEGIES FOR OVERCOMING CONSTRAINTS

The following discussions indicate how World Vision coped with the short planning period. World Vision Zimbabwe rapidly mobilized staff to adapt the objectives of the Headquarters-designed Child Survival project into a "workable framework" to meet the community needs in Zimbabwe. A project site was selected in Kaitano, Mt. Darwin District--an area which is particularly in need of Child Survival interventions as indicated by an infant mortality in the range of 120-140 immunization coverage below the national average of 42 percent and high levels of childhood malnutrition. After the project site was changed at the request of most of the Zimbabwe Child Survival Team again rapidly mobilized and identified an area in need of services and recommended by the MOH.

Drawing on the working relationships developed through its long-standing community development work in Zimbabwe and its close ties to the Zimbabwe Association of Church-Related Hospitals (ZACH), the staff was able to rapidly negotiate project implementation in the Murewa district. With the assistance of consultants from APHA, John Snow (the latter provided by USAID), and WVRO, World Vision Zimbabwe staff then revised the strategy and formulated the detailed implementation and evaluation plan for the new area. The staff engaged St. Paul's Mission Hospital (a part of the government of Zimbabwe hospital network) as a partner in implementing the Child Survival activities. Although the new project site is not as deprived socio-economically and in terms of health services as the originally chosen site, it presents a number of advantages. The partnership with St. Paul's Hospital, with its four neighbouring health centers and its outreach points, provides the infrastructure needed for a Child Survival outreach work. An outreach team (part of the regular government structure) is responsible for carrying out the active interventions. The community development sensitization which has already taken place in Musami also allows the Child Survival initiative to be made an integral part of a comprehensive community development program.

PART VI

Progress and Constraints With Implementation of Monitoring and Evaluation System

VI. PROGRESS AND CONSTRAINTS WITH IMPLEMENTATION OF MONITORING AND EVALUATION SYSTEM

1. Progress The following activities and developments are positive indications of progress:

- a. Indicators and Information Objectives of System Selected. Based upon the project plan objectives, indicators were reviewed, discussed, and selected for the following areas: immunization, diarrhea disease control, nutritional improvement, and antenatal care and family planning. For project management purposes, more detailed information than the basic indicators were specified, and this data was integrated into the data to be collected.
- b. Information System Developed. A four-pronged information system was developed to collect the data required. This included information collected through the following mechanisms: 1) Family Registration Forms; 2) Government Child Health and Antenatal Cards; 3) Selective Hospital and Health Center Records and Sample Surveys; and 4) Information from Informed Sources.
- c. Information System Implemented.

At present, over half of the project families in area 1 have been registered. Data from child health and antenatal cards were noted in this process. Arrangements have been made to collect health data from nearby hospitals and health centers.

The project has made use of two baseline surveys. The first survey was performed in the Musami area in 1984 under the auspices of the MOH. The objectives of this survey were consistent with the data required by the project. Although the information was two years old, the methodology was excellent, and the information serves as a superb reference. A survey was performed by WVZ staff in 1986. A questionnaire was developed and an opportunistic sample was taken at four different sites, with each site involving 25 questionnaires. The results of the survey were essentially consistent with the 1984 MOH survey.

Information from informed sources has included routine visits with personnel from the MOH, UNICEF, and other PVOs. It has also included several visits from WVRO/WVI staff, and a consultation from APHA. A mid-term review has been planned for August/September 1987 which will involve both WV staff and available outside health personnel.

2. Constraints The major constraint of the monitoring and evaluation system has and continues to be the amount of time and coordinative/technical resources it takes to design, collect, and process the desired information.

The family registration effort is an ambitious plan which has been costly in both time and resources. It was necessary to design a system which was both acceptable to the community and the needs specified by the MOH;

this required widespread consultation. A major concern about the system was the need to ascertain that it did not overwhelm the health workers or other community members. This is a continuing concern, and the project is amenable to changing the system if field experience shows that it is overly complicated.

The project's experience with baseline surveys is that they are both expensive and time consuming. Constraints exist in terms of the time and qualified personnel available to develop the questionnaire, train personnel, and tabulate and analyze survey data. As a result of these constraints, the baseline survey effort aimed at a mix of practicality and usefulness, and the sample size was kept small (100 questionnaires total).

The mid-term review will integrate information collected from all aspects of the monitoring and evaluation system. This includes the family registration system, health center and hospital data, survey data, and both internal WV personnel and nonproject health personnel.

The system for aggregating the data to produce a useful documentation evaluation and management tool is in the process of being established and refined.

The basic instruments for the monitoring and evaluation plan are shown and described in Annex 3.

PART VII

Revised Work Plan

Describing Critical Activities

to be Carried out for Remainder of Project, Including Dates.

VII. REVISED WORK PLAN

Experience obtained in the Musami pilot area has dictated the revision of the work plan for the remaining two years of project implementation. The revised work plan reflects the project strategy to give support to the government's immunization and diarrheal disease control programs. There will be major emphasis on training and social mobilization to facilitate the achievement of government-set targets. The work plan has been carefully designed to reflect a level of effort consistent with project and local resources, to interface with the planned district health programs, and to facilitate sustainability after project phase-out.

During the next two years, the project will expand to work in the entire Murewa district. The expansion strategy will involve supporting existing activities and services in the area and improving the potential for the project to enhance these services. From Area I where the project has worked intensively to incorporate a Child Survival approach in the community development programs of the area's four wards, the project will now begin to initiate strengthening activities in Area II which has four wards (population 42,000) and four rural health centers neighboring St. Paul's Hospital. Area III has 15 wards (population 92,000) and is serviced by the Murewa District Government Hospital and rural health centers.

In Area II the project's focus will be similar to Area I with emphasis on refresher training of health personnel and community leaders; mobilization of the population; strengthening of the Child Survival outreach team; assistance with transport and supplies; and assistance with the implementation of a community development infrastructure (VIDEC Program) as a vehicle for the Child Survival Intervention program.

In Area III (the remainder of Murewa District) the project will support the immunization and oral rehydration activities of the district health system, will assist in community health education, and will encourage mobilization of the population to utilize these services. The (VIDEC) program will not be undertaken in Area III.

Indicators of effectiveness in Area III for immunization and ORT program effort will be determined on by a sample survey in year III. Technical assistance, if necessary, will be requested for the survey. Currently, available information about the area is being used as a baseline.

See Table VII for a summary of these interventions.

WORK PLAN FY87

December 1986

31/12/86 Hire driver 31/12/86
14/12/86 Purchasing of bicycles
1-8/12/86 Immunization campaigns
1-8/12/86 Purchasing of immunization supplies

January 1987

5-9/1/87 Training of field office staff
12-16/1/87 Training of nurses and health assistants
3/1/87 Hire extra staff
8/1/87 Purchase training material

February 1987

2-3/2/86 Refresher training of VHWs and nurse's aides
17-20/2/87 Purchasing/distribution of supplies (i.e., sugar and salt)

March 1987

9-12/3/87 Refresher training of nurses and health assistants
24-25/3/86 Refresher training of VHWs and nurse's aides

April 1987

7-8/4/87 Refresher training of VHWs and nurse's aides
Refresher training of community mobilizers
(1) 20-21/4/87
(2) 23-24/4/87
(3) 27-28/4/87

May 1987

4-5/5/87 Refresher training of VHWs and nurse's aides
Training of community mobilizers
(1) 7-8/5/87
(2) 11-12/5/87
(3) 14-15/5/87
(4) 20-21/5/87

June 1987 (Estimate the number at time)

2-3/6/87 Training of VHWs and nurse's aides

2/6/87 Purchase/distribution (sugar and salt) for ORS

July 1987

7-8/7/87 Training of VHWs and nurse's aides

August 1987

3-4/8/87 Refresher training of VHWs and nurse's aides

Refresher training of community mobilizers

(1) 6-4/8/87

(2) 10-11/8/87

(3) 13-14/8/87

(4) 17-18/8/87

September 1987

(1) 31-1/9/87 Refresher training of community mobilizers

(2) 8-9/9/87

(3) 14-15/9/87

VII. REVISED WORK PLAN FOR FY87

GENERAL ACTIVITIES

ACTIVITIES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Briefing key government personnel and reviewing issues.												
Field and office staff appraisal.												
Refining budget breakdown.												
Evaluating family registration and program (mid-year evaluation).												
Purchasing/ordering capital, consumable items.												
Continuing training implementation.												
Assistance in completion of Development Centers.												
Yearly project evaluation.												
Reviewing issues with USAID, UNICEF and government personel (ORT and ZEPI units).												
Seminar for ZACH members on Child Survival strategies and development.												
USAID sponsored workshop on Child Survival and development strategies. Conceptualizing Africa-wide strategy.												

PART VIII

Headquarters Activities in Support of Child Survival Projects

VIII. HEADQUARTERS ACTIVITIES IN SUPPORT OF CHILD SURVIVAL PROJECTS IN AFRICA

1. Chronology of significant events to date:

World Vision's first USAID-funded Child Survival project in Zimbabwe launched a new focus on Child Survival programs within the organization. The organization saw an opportunity to expand its projects using Child Survival interventions. Increasing support for these types of projects was expressed by World Vision support offices all over the world, as the public (donor) seemed to respond enthusiastically to the life-saving impact of Child Survival projects.

Following is a brief historical description of accomplishments and activities that WVRO/WVI has done to support World Vision's Child Survival programs.

- | | |
|------------------|--|
| August 1985 | Three-year Child Survival grant awarded from USAID for proposal in Zimbabwe. |
| November 1985 | Public health specialist (RN MPH) hired to provide WVRO/WVI backstopping and technical support to existing projects and to develop World Vision's Child Survival strategy. |
| January 1986 | World Vision International public health physician seconded as technical advisor to World Vision Zimbabwe. |
| April 1986 | World Vision International public health physician appointed to coordinate technical support to all Child Survival and immunization programs.

Child Survival grants prepared and awarded from USAID for proposals in Senegal and Sudan. |
| May 1986 | Theme of New Zealand's "40-hour famine" fund-raising effort was Child Survival to provide for matching grants in Sudan and Senegal. |
| June 1986 | World Vision Kenya formed a Primary Health Care team, in part stimulated by the Child Survival proposal writing process done in Kenya. |
| July 1986 | WVRO public health specialist, WVI Child Survival coordinator, Africa PHC specialist attended immunization conference and NCIH conference in Washington, D.C. |
| July/August 1986 | World Vision health personnel made a goal to have PHC specialist in every field office. |
| August 1986 | World Vision International public health physician trained Child Survival staff in Senegal staff and Sudan project. |

September 1986 Senior management at WVRO/WVI and WVUS explored possibilities of developing Child Survival/child sponsorship package.

October 1986 Began searching for an administrative assistant to PHC specialist (WVRO) and WVI Child Survival coordinator.

World Vision Kenya appoints Child Survival coordinator for the country to lead the team. Funding sought for proposal project in Namelock from USAID co-financing funds.

First evaluation of Child Survival program in Zimbabwe conducted.

With the formation of a "Child Survival team" at headquarters (WVRO public health specialist, WVI public health physician and administrative assistant), the increasing enthusiasm expressed by donors and support countries, and the interest shown by field staff, WVRO anticipates expansion of its Child Survival programs all over the world--seeking support from both private and government donors.

Interest and high awareness in Child Survival has been stimulated by WVI/WVRO in every field office in Africa.

2. Long-Range Planning of Headquarters Activities in Support of Child Survival Projects

World Vision International enters the Child Survival movement with a 35-year-long history of experience related to child support and health care in Asia, Africa, and Latin America. This experience serves as a strong foundation for World Vision in understanding the appropriate role of headquarters support for child care field operations and Child Survival projects. As a general philosophy, World Vision believes that it is beneficial to decentralize project control from headquarters to the field operations while providing support as needed to the field. This thinking underlies all headquarters strategy and activities related to the support of Child Survival projects.

Headquarters' support activities of Child Survival projects fall into the following ten categories:

1. Promotion: Internal and Donor-Related
2. Staff Recruitment: Field and Headquarters
3. Advisory and Collaborative Arrangements
4. Project Development Initiative and Assistance
5. Information System Development Assistance
6. Technical Training
7. Project Management Training
8. Technical Update and Resource Center
9. Project Evaluation Assistance
10. Project Linkage With Other World Vision Development Activities.

a. Promotion: Internal and Donor-Related

Internal Promotion. Child Survival activities have been highly promoted among all levels of management at WVI and WVRO. Health and child care activities have always been a traditional cornerstone of World Vision's work. As an indication of their organization, in the past year alone top management has generated, approved, and distributed corporate statements for Primary Health Care Policy and Child Care Ministry. In recognition that many of World Vision's field operations do not presently have a health component, efforts have been made to raise field personnel's awareness of how they might participate in Child Survival efforts, especially immunization programs. Headquarters has developed leaflet and video materials on immunization and is in the process of presenting these materials to field staff. Internal company newsletters have also promoted the Child Survival efforts that World Vision is undertaking.

Donor-Related Promotion. World Vision marketing efforts have consistently heralded the special needs of children. As a by-product of a commitment to Child Survival activities, World Vision New Zealand's recent national "40-hour famine" fund-raising event concentrated on Child Survival activities to provide matching grants in Sudan and Senegal. Marketing efforts are also underway to develop a donor sponsorship package that would integrate individual child sponsorship alongside of generalized Child Survival support.

b. Staff Recruitment: Field and Headquarters

Field Recruitment. As part of a generalized strategy to strengthen and improve the quality of World Vision's primary health care and Child Survival program efforts, a corporate commitment was made to secure a Primary Health Care Specialist in each of World Vision's country field offices. This recruitment process is almost complete for each of World Vision's 43 country field offices. In addition, as desired by the field offices, WVI is facilitating an even greater strengthening of their health capabilities. For example, in Zimbabwe, Kenya, and Ethiopia, the field offices have set up Nutrition and Health Units aimed at servicing the various health projects in their respective countries.

Headquarters Recruitment. World Vision has strengthened its headquarters health capabilities by securing key health professionals to coordinate and facilitate organizational strategies and activities in primary health care and Child Survival. These include a Senior Public Health Physician (MD, MPH) with over 30 years of experience (10 with WVI) in management and public health in the developing world; a Public Health Nurse Administrator (RN, MPH) with four years of experience in nursing, public health in the developing world, and USAID grants management; and currently a search is underway to hire administrative support to this "Child Survival Team."

c. Advisory and Collaborative Arrangements

World Vision is actively pursuing organizational relationships which would be beneficial to its health and Child Survival efforts.

Currently, an advisory relationship is being formalized between the World Health Organization and World Vision, with the longer-term intent of World Vision becoming an organizational member.

A mutually beneficial relationship is also being pursued with the London School of Hygiene and Tropical Medicine. In fact, in November of 1986, a professor from the London School will be flying to Africa to assist in training World Vision health staff. Advisory relationships are also being pursued with faculty among the Medical and Public Health Schools at the University of California in Los Angeles.

Ongoing relationships exist with many organizations in the international health field. These associations are tapped upon periodically as an ongoing resource for technical support and updating, and exchange of information and experience. Organizations include: American Public Health Association, National Council for International Health, Consultancy Agencies (i.e., Management Sciences for Health, John Snow Incorporated, Pritech, Reach, Path), and other PVOs (i.e., Save the Children, CARE, ADRA, Project Concern International, Meals for Millions). Headquarters is also encouraging the field offices to establish relationships with health and development agencies in their country and regional areas.

d. Project Development Initiative and Assistance

World Vision headquarters has provided training to its field staff on health project planning and proposal writing. Guidelines have been issued for both general primary health care projects and projects related to Child Survival. Headquarters has also provided on-site technical support for the planning of health projects; this included support for the April 1986 submittal of the Senegal, Sudan, and Kenya Child Survival USAID grant proposals.

While the field staff are a significant source of generating new areas for developing health projects, headquarters staff also actively initiate opportunities in health care and Child Survival. For example, WVI is very enthusiastic about the possibility of cooperating with the Peoples Republic of China in rubella immunization work in the Quangdong Province. Discussions are currently underway, and thus far the indications are very positive.

Headquarters also initiates health opportunities by keeping abreast of available health monies from governmental and non-governmental sources. Beyond USAID monies, World Vision is actively pursuing monies from CIDA to support its immunization thrust. Monies are also being pursued from large corporate and individual sources for immunization and Child Survival projects.

e. Information System Development Assistance

One of World Vision's current priorities is the development of a field information system that will enable health personnel to better plan, manage, and evaluate their health efforts. Headquarters is presently in the process of reviewing health information systems material from its own field operations, other PVOs and health projects, and materials provided by technical consultancy agencies. Some of the prototype materials have already been developed and are being circulated among the field health staff for review, comment, and revision. It is planned that a general model of a health information system will be provided to each of the field offices in the near future. Necessarily, each field office will adapt the general system to their specific needs and the requirements of the local situation.

f. Technical Training

Each of World Vision's Child Survival teams has undergone basic orientation and training to the Child Survival process. Headquarters has facilitated and participated in this process. For example, World Vision's Senior Public Health Physician recently assisted with team identification and training sessions in Senegal and Sudan. In 1986 to date, headquarters coordinated technical health training and strategy meetings with its field personnel in Malawi and Zambia. Planned for late November 1986, headquarters coordinated an Africa regional training session to its health field personnel; the training session was in conjunction with the London School of Hygiene and Tropical Medicine. The current strategy of encouraging field staff to attend local and regional technical training sessions will be continued.

g. Project Management Training

The headquarters' health team is reviewing, adapting, and refining a general project management training module which has been widely used in World Vision field systems over the last five years. The system has proven to be enormously successful in general development training applications. The revised module aims at improving the management capacity of World Vision's health personnel in the management functions of Planning, Organizing, Leading, and Controlling.

h. Technical Update and Resource Center

A number of approaches are being followed to enhance the technical competency of both headquarters and field staff.

Headquarters health staff are staying abreast of conferences and meetings that enhance relevant knowledge and contacts. Over the last year, three of World Vision's health team members attended the vaccine symposium and Annual National Council for International Health Conference. WVRO was represented at the Annual American Public Health Association Conference, and Dr. Macagba attended the WHO Conference on Immunization in New Delhi.

To enhance field knowledge of basic technical knowledge and recent relevant developments in the public health field, headquarters has developed and distributed an annotated bibliography of maternal and child health resources which are either available directly through a distributor or headquarters.

WVI is also developing a technical update newsletter that will advise field personnel of relevant developments that aim at enhancing the quality of the field work.

i. Project Evaluation Assistance

Headquarters health staff will continue to coordinate and assist field projects in the monitoring and evaluation of their projects. In October 1986, World Vision Zimbabwe team, and the WVRO PHC specialist, with assistance from APHA, completed its first Child Survival evaluation at its Zimbabwe project. Further monitoring and evaluation assistance is planned for the mid-term and final evaluations for all the Child Survival grants.

Indirect support of the Child Survival evaluation process comes from the ongoing training and work from WVI's general Evaluation Department. Since 1981, the Evaluation Department has enhanced the evaluation capabilities of the field projects through work and training in "participatory evaluation" and "impact evaluation." A major goal is to build the field project capacity to the point where they can adequately define their own problems, generate possible solutions, and specify indicators and standards of progress. Training in World Vision's participatory and impact evaluation approaches has thus far involved approximately 12 country field offices. Although the Evaluation Department's efforts are not directly aimed at Child Survival work, the indirect effect of improved general evaluation capabilities clearly enhances the quality of Child Survival evaluation work.

WVRO is presently reviewing internal and external evaluation materials with the aim of developing a simple evaluation framework which can enhance the quality of World Vision projects receiving grant funds. When the system is complete, it is expected to complement World Vision's existing evaluation systems. It will particularly assist field projects with special needs arising from the receipt of grant funding.

j. Project Linkage With Other World Vision Development Activities

World Vision's Child Survival projects enjoy the support of linkage with the full range of development activities and resources which the organization's multi-sectoral approach to development provides. World Vision views the Child Survival activities, particularly immunization efforts, as an entry point for other health and development activities. Headquarters therefore recognizes that the full range of World Vision's technical and field development support services are a potential benefit to its Child Survival projects.

3. Description of PHC Specialist Activities to Support Child Survival projects (based in WVRO, California).

There have been four main functions of the WVRO PHC specialist over the past year:

- a. Overall contract management of the USAID-funded Child Survival project in Zimbabwe, including final preparation of all USAID required documentation.
- b. Development of three additional Child Survival proposals meeting USAID proposal requirements and application deadlines and monitoring of their start up and progress of detailed implementation plans of the two funded projects.
- c. Liaison with USAID, PVOs and other government bodies on all Child Survival-related topics; including funding, reporting requirements, administration and legislative issues.
- d. Provide direction and coordination to World Vision long-term planning for its Child Survival program, including coordination with and assistance to the following areas: internally within WVRO; to WVUS and other support country personnel, providing information and ideas for fund raising; to WVI, working closely with the recently appointed coordinator for Child Survival programs; and with various field offices and their staffs to assist them in planning and the technical aspects of Child Survival programs.

Needless to say, this has been a busy year for the WVRO PHC specialist, as an ongoing orientation process began just under one year ago. Following is a brief description of activities/accomplishments and average time spent on various areas in giving support to World Vision's Child Survival programs.

**ACTIVITIES/ACCOMPLISHMENTS IN SUPPORTING
WORLD VISION'S CHILD SURVIVAL PROGRAMS**

Activity/Accomplishment	1985			1986									
	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1. Two week orientation to new job and Zimbabwe project.													
2. Trip to Zimbabwe to coordinate writing of detailed implementation and evaluation plan.													
3. Visit to PNG office to discuss possibilities of USAID funding for already prepared CS project in PNG.													
4. Final preparation of DIP and submission to USAID on 12/31/85.													
5. Continuous monitoring and backstopping for Zimbabwe CSP, including finalization of APHA contract, clarification of CS structure internally, communication with AID and the field on various reporting/budget/project progress items/reading monthly reports/coordinating with APHA, etc.													
6. Participating in CS working group of interaction; interfacing with CS task force at AID, Congressional staff and other PVOs regarding CS funding and legislative issues.													
7. Coordination of headquarter and field preparation for CS proposal writing trip with WVI physician to five African countries (including brief visit to Zimbabwe).													
8. Visit to Washington, D.C., and five African countries with WVI physician and working with WV field staff. First draft of two proposals prepared in field.													

Activity/Accomplishment	1985			1986									
	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
9. Final preparation of two CS proposals and third one (for Senegal) at headquarters working with WVI physician and outside consultant.													
10. Visit to Washington, D.C., for CS meetings and submission of proposals.													
11. FY87 CS budget planning including meetings within WVRO, WVUS, WVI to discuss future potential of CS projects in the field for fund raising.													
12. Revision of proposals and response to AID to accept funding of Sudan and Senegal CS projects.													
13. Attended vaccine symposium at NCIH conference (also with WVI physician and WVI technical consultant to Zimbabwe) Met about Zimbabwe issues in DC and also met with AID personnel.													
4. Meetings held with LA coordinator for CS campaign and other PVO reps as to WV's support of and participation in the CS campaign in LA. Subsequent meetings had with WVUS PR division.													
15. Preparation begun for coordination of first annual progress review with the field, APHA and AID.													
16. Spent one week in DC meeting with AID, PVO personnel and APHA in preparation of Zimbabwe CS evaluation.													

Approximate time spent by PHC specialist on various activities:

	<u>To Date</u>
(1) Contract management of Zimbabwe Child Survival project (liaison with USAID, the field, APHA and WVI)	60%
(2) Development of Kenya, Sudan and Senegal and Child Survival proposals	35%
(3) Coordination/participation in headquarters activities, development of Child Survival program with nonproject related Child Survival activities.	5%
	<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 100%
	<u>Future</u>
(1) Contract management of:	
Zimbabwe	20%
Sudan	20%
Senegal	20%
(2) Development of new Child Survival Proposals	28%
(3) Development of non-Child Survival health project proposals.	10%
(4) Child Survival/office activities at WVRO.	<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 2%
	100%

This shift of time is planned primarily in light of two significant activities happening at headquarters:

- (1) Hiring of an administrative assistance to WVRO PHC specialist and WVI Child Survival coordinator, 50/50 time split respectively.
- (2) WVI Child Survival coordinator moving from "transition role" to full-time coordinator of all Child Survival projects from within WVI, with the WVI PHC specialist interfacing increasingly more with the WVI Child Survival coordinator and less directly with the field. Also, increased assistance will be coming from the field with the appointment of a regional Child Survival technical coordinator in Africa and a more established organizational definition of Child Survival projects in World Vision's overall development and organizational framework.

ANNEXES

ANNEX 1

AID Reporting Requirements

**(Health and Child Survival Project
Reporting Schedule A - FY86)**

blaw

1. PROJECT TITLE: ZIMBABWE SUPPORTED PRIMARY HEALTH CARE

2. CONTRACT/GRANT NUMBER: PDC-0505-A-00-5065-00

3. PRINCIPAL CONTRACTOR/GRANTEE: WVRO WORLD VISION RELIEF ORGANISATION

4. TYPE OF CONTRACTOR/GRANTEE: (Circle appropriate code)

University	UNC
Non-Profit: Private Voluntary Organizations	<u>PVO</u>
Non-Profit: Other (includes NGOs)	NGO
Private Sector (For Profit)	PVC
U.S. Government	USG
Multilateral Agency	MLT
Host Country: Government	HCG
Host Country: Other	HCO

5. PROJECT BEGINNING DATE: FY 85

6. PROJECT ACTIVITY COMPLETION DATE (PACD): 7/31/88

7. PROJECT STATUS: (Circle one) Proposed Ongoing Discontinued Completed

8. PROJECT REGION: (Circle one) AFR ANE LAC USA GLOBAL

9. COUNTRY: ZIMBABWE

10. HOST COUNTRY AGENT: WORLD VISION ZIMBABWE

11. GEOGRAPHICAL/POLITICAL AREA OF COUNTRY IN WHICH PROJECT OPERATES NATIONAL LEVEL:

LEVEL 1 (e.g., Province, Department): MASHONALAND EAST PROVINCE

LEVEL 2 (e.g., Sub-Province):

LEVEL 3 (e.g., District): MUREWA DISTRICT

LEVEL 4 (e.g., Town, Village): MUSAMI

12. MAP: (Indicate project site(s) or area(s))

 * - SEE ATTACHED MAP - *

FY 86SUBPROJECT NUMBER: 1

COMMENTS

13. SELECTED PROGRAM ACTIVITIES: (Circle all that apply)		COMMENTS
Institutional Development	ID	
Mass Media & Communications	MM	
Health Education	HE	
Training	TR	
Biomedical Research	BR	
Operations Research	OR	
Other Research	RS	
Social Marketing	SM	
Private Sector Involvement	PV	
Community Participation	CP	

14. PROGRAM FUNCTIONS (Life of Project Attributions):		PER CENT ATTRIBUTION	
CHILD SURVIVAL:	ORAL REHYDRATION	25 %	COMPLETE TABLES 1-1 AND 2-1
(DO NOT INCLUDE PROJECTS FUNDED FROM POPULATION ACCOUNT)	IMMUNIZATION/VACCINATION	25 %	COMPLETE TABLES 1-1 AND 3-1
	NUTRITION (e.g., Breastfeeding, Growth Monitoring, Infant/Child Feeding Practices)	25 %	COMPLETE TABLES 1-1 AND 4-1
	HIGH RISK BIRTHS (e.g., Birth Intervals, Maternal Age, High Parity)	25 %	COMPLETE TABLES 1-1 AND 5-1
	OTHER CHILD SURVIVAL (e.g., Vit A, ARI, etc.)	- %	COMPLETE TABLES 1-1 AND 6-1
	TOTAL, ALL CHILD SURVIVAL FUNCTIONS	100 %	

OTHER FUNCTIONS:	Health Care Financing	_____ %	
	Water & Sanitation	45 %	
	Health Planning/Management	_____ %	
	Health Information Systems	20 %	
	Epidemiology	_____ %	
	Medical Education	_____ %	
	Disease Control (Malaria)	_____ %	
	Disease Control (Non-Malaria)	_____ %	
	Eye Care	_____ %	
	Maternal/Child Health	25 %	
	Other Non-Child Survival	10 %	

TOTAL CHILD SURVIVAL AND OTHER PROGRAM FUNCTIONS 100%

PLEASE COMPLETE SCHEDULES "C" AND "D" ON FOLLOWING PAGES



Base 505385 (544836) 10-82

COMMENTS

15. LIFE OF PROJECT BUDGET (A.I.D. Funds): \$ 690,000

16. SOURCE OF PROJECT FUNDS:

AID:	ACCOUNT	LIFE OF PROJECT BUDGET (\$ 000)
	Health	690
	Child Survival Fund	✓
	Economic Support Fund	
	Sahel Development	
	Selected Development	
	Population	
	Education & Human Resources	
	Agriculture/Rural Development/Nutrition	
	Foreign Disaster Assistance	
	FL-480/TITLE I	
	FL-480/TITLE II	
	FL-480/TITLE III	
	TOTAL, ALL AID ACCOUNTS	\$ 690

HOST GOVERNMENT:	US \$ Equivalent	\$	} Training of VHWs Supplies - vaccines, Contraceptives, some staff salaries
OTHER FUNDING SOURCE:	Identify: WVRO	\$ 230	
ALL FUNDING SOURCES:	TOTAL FUNDS	\$ 920	

17. TRAINING: NUMBER TRAINED BY TYPE OF WORKER

	IN COUNTRY	THIRD COUNTRY	US	
Physicians	-	1	-	} Workshop in Sierra-Leone on integrating child survival activi- ties in development
Other Health Personnel (Non-Physician)	27	6	4	
Voluntary/Community Health Workers	37	-	-	
Other Community mobilizers	1000	-	-	
TOTAL	1064	7	4	

18. NUMBER OF LONG TERM ADVISORS: No. (12 Months or Longer)

AD Health Administrator	1	MA Malaria Advisor	
CM Communications Specialist		MD Physician	1
DS Demographer/Statistician		ME Medical Educator	
EC Economist		MG Management Specialist	1
EP Epidemiologist		MW Midwife	
HA Hospital Administrator		NR Nurse	1
HE Health Educator		NU Nutritionist	
HP Health Planner		SE Sanitary Engineer	
LS Logistics Specialist		OT Other (Specify)	1

CONTINUED ON OTHER SIDE

COMMENTS

19. PROJECT GOAL:

To contribute significantly to the improvement of maternal and child health and reduction of infant and child morbidity and mortality in Zimbabwe.

20. PROJECT PURPOSE:

The project strives to focus on efforts of assistance that will benefit the greatest number of people in an appropriate and sustainable manner. To strengthen and facilitate existing health services in Murewa District of Zimbabwe with the following Child Survival interventions:- 1) increase immunisation coverage in children under 5. 2) Increase use of ORT, 3) improve nutrition in children, 4) improve maternal and child health and 5) reduce high risk births.

21. PROJECT DESCRIPTION: (Include qualitative or anecdotal information)

World Vision Zimbabwe intends to implement a three year Child Survival Program in Mashonaland East Province, Murewa district, Zimbabwe by supporting and enhancing existing Ministry of Health system. It is the goal of this project to make a significant contribution to reduction of infant and child morbidity and mortality and improvement of maternal and child health by the following activities:

1. supporting and enhancing the Government of Zimbabwe's immunization program.
2. instituting an active control of diarrhoea program.
3. Nutrition promotion/growth monitoring.
4. Improvement of MCH particularly in high risk groups. Training, health education and social mobilisation play central roles in carrying out these activities.

This child survival concept of benefiting the most people with appropriate technology and cost effective interventions is very much in line with World Vision's philosophy. St. Paul's Mission hospital has been in the area since 1923 and many positive changes have been made in the area. Recently however, immunization in the outreach points had almost come to complete halt due to the only functioning immunization vehicle, named "Barnabas", breaking down. With the supply of vaccine equipment, a new vehicle, named "Timothy", additional staff and training of over 1000 community mobilizers, the World Vision Child Survival staff and staff at St. Pauls have noticed a marked improvement in attendance at immunization and growth monitoring sessions. There has also been increased community participation in the construction of "VIDECS" (Village Development Centres) which uses demonstration kitchens, latrines and latrines as effective teaching tools for Child Survival concepts. In the past six months 7 of these centres have come to completion with the key ingredient being the community itself. WV Child Survival project supplies the cement, the rest is a total community effort where money and labour are donated. The Child Survival staff have also noticed a "ripple effect" in the area spreading to members of government councils getting more involved and interested in Child Survival interventions.

22. PHOTOGRAPHS INCLUDED: YES NO

NAME OF PERSON PREPARING REPORT: Mrs. Sibonginkosi Mushapaidze: Project Manager
 Dr. George Ngatiri WV Senior Technical Consultant to Project

DATE: 10-31-86

*Additional statistics attached

SUBPROJECT NUMBER: 1

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86) ESTIMATE	SOURCE/REFERENCE/COMMENTS
1-1.1	TOTAL POPULATION IN PROJECT AREA	17,433	
1-1.2	NUMBER OF CHILDREN BY AGE:		
	Total Under 12 Months	900	(Government statistics)
	Total 12 - 59 Months	3,240	
	12-23 Months	810	
	24-35 Months	810	
	36-47 Months	810	
	48-59 Months	810	
1-1.3	NUMBER OF WOMEN OF REPRODUCTIVE AGE BY AGE GROUP		
	Total 15-49	4,500	(Government statistics)
	15-19	1,215	
	20-24	945	
	25-29	810	
	30-34	585	
	35-39	450	
	40-44	360	
	45-49	135	
1-1.4	ANNUAL NUMBER OF LIVE BIRTHS	720	
1-1.5	ANNUAL NUMBER OF INFANT AND CHILD DEATHS BY AGE:	FMR = 90/1000	
	Total Under 12 Months		Unable to attain breakdown
	Total 12 - 59 Months		
	12-23 Months		
	24-35 Months		
	36-47 Months		
	48-59 Months		
1-1.6	NUMBER OF HEALTH WORKERS IN PROJECT AREA:		
	Physicians	2	st Paul's statistics
	Other Health Personnel (Non-Physician)	27	
	Voluntary/Community Health Workers	37	One physician is however part-time.
	Other Community mobilisers	1000	
1-1.7	NUMBER OF GOVERNMENT HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA		
	Hospitals	1	st. Paul's statistics
	Clinics/Health Centers	0	
	Other VIDECS	36	

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86)		SOURCE/REFERENCE/COMMENTS
		ESTIMATE		
2-1.1	NUMBER OF ORS PACKETS IMPORTED AND LOCALLY PRODUCED BY THE PROJECT, BY SIZE OF PACKET	Packet Size		NB: In Zimbabwe, it is a government policy to use salt/sugar instead of ORS sachets.
	Number Imported	0	0	
	Number Locally Produced		0	
2-1.2	COST PER PACKET TO THE PROJECT (Amount Actually Paid Plus Transportation Costs to Port of Entry)	N/A		
2-1.3	PRICE PER PACKET CHARGED TO THE CONSUMER (US \$ Equivalent)	-		
2-1.4	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH URT/ORS, BY TYPE OF WORKER	Training Target	Actually Trained	<i>project statistics</i>
	Physicians		0	
	Other Health Personnel (Non-Physicians)		27	
	Voluntary/Community Health Workers		37	
	Other		1000	
2-1.5	NUMBER OF GOVERNMENT HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS FOR ORS/ORT IN PROJECT AREA	37		
2-1.6	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA PARTICIPATING IN PROJECT ACTIVITIES TO PROVIDE ORS PACKETS			
	Public	37		
	Private			
2-1.7	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA WITH AN APPROPRIATE NUMBER OF, BUT NO FEWER THAN 10, ORS PACKETS IN INVENTORY			
	Public	37		
	Private			
2-1.8	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA WITH ORS PACKETS IN INVENTORY AND A TRAINED PERSON AVAILABLE			
	Public	37		
	Private			

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86)		SOURCE/REFERENCE/COMMENTS
		ESTIMATE		
3-1.1	NUMBER OF VACCINE DOSES PROCURED BY THE PROJECT, BY TYPE			
	Tetanus Toxoid	803		
	MEASLES	479		
	POLIO	2571		
	DPT	1833		
	BCG	1077		
3-1.2	USER FEES CHARGED FOR IMMUNIZATIONS? If so, AMOUNT Charged (US \$ Equivalent)	No	Yes	NB: All vaccines are supplied by Ministry of Health
		\$		
3-1.3	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH ABOUT OR GIVE IMMUNIZATIONS, BY TYPE OF WORKER	Training Target	Actually Trained	
	Physicians		-	
	Other Health Personnel (Non-Physician)		27	
	Voluntary/Community Health Workers		37	
	Other Community mobilizers		1000	
3-1.4	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA CAPABLE OF PROVIDING IMMUNIZATIONS			36 Village Development Centres and St. Pauls Hospital, Musami
	Public		37	
	Private			
3-1.5	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA PARTICIPATING IN PROJECT ACTIVITIES TO PROVIDE IMMUNIZATIONS			
	Public		37	
	Private			
3-1.6	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA WITH SPECIFIED VACCINES IN INVENTORY			
	MEASLES			
	Public		1	
	Private			
	POLIO			
	Public		1	

TABLE 4-1. TIER ONE INDICATORS FOR NUTRITION PROJECTS

PROJECT NUMBER: 9380505

SUBPROJECT NUMBER: 1

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86)		SOURCE/REFERENCE/COMMENTS
		ESTIMATE		
4-1.1	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH INFANT AND CHILD FEEDING PRACTICES, BY TYPE OF WORKER	Training Target	Actually Trained	
	Physicians	-----	-----	
	Other Health Personnel (Non-Physicians)	-----	37	
	Voluntary/Community Health Workers	-----	37	
	Other	-----	1000	
4-1.2	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH GROWTH MONITORING, BY TYPE OF WORKER	Training Target	Actually Trained	
	Physicians	-----	-----	
	Other Health Personnel (Non-Physicians)	-----	27	
	Voluntary/Community Health Workers	-----	37	
	Other Community mobilizers	-----	1000	
4-1.3	NUMBER AND TYPE OF PROJECT FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA WITH OPERATING SCALES	Number Targeted	Number In Place	
	Public	-----	2	
	Private	-----	-----	
4-1.4	NUMBER OF MOTHERS/MOTHER SUBSTITUTES GIVEN NUTRITION COUNSELING DURING THE REPORTING PERIOD	13 groups (171 mothers)		
4-1.5	NUMBER OF CHILDREN UNDER AGE FIVE ENROLLED IN GROWTH MONITORING PROGRAMS	1917		
4-1.6	Number of children under age 5 weighed last month	275		(September 1986)

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86)		SOURCE/REFERENCE/COMMENTS
		ESTIMATE		
5-1.1	NUMBER OF CONTRACEPTIVES PROCURED BY THE PROJECT BY TYPE OF CONTRACEPTIVE	Number		Contraceptives provided to St. Paul's hospital (Partner Agency) by Zimbabwe National Family Planning Council. Contraceptive distributors are working with child survival outreach team.
	Oral Contraceptives (# Cycles)	7,568		
	Condoms (# Units)			
	IUDs			
	Other(s) (Specify):			
5-1.2	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH ABOUT HIGH RISK BIRTHS OR GIVE FAMILY PLANNING ADVICE, BY TYPE OF WORKER	Training Target	# Actually Trained	
	Physicians			
	Other Health Personnel (Non-Physicians)	3	3	
	Voluntary/Community Health Workers			
	Other 1000 Community Mobilizers	1000	1000	
5-1.3	NUMBER OF GOVERNMENT HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS FOR CONTRACEPTIVES IN PROJECT AREA	37		
5-1.4	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA PARTICIPATING IN PROJECT ACTIVITIES TO PROVIDE CONTRACEPTIVE METHODS			
	Public	37		
	Private (Includes CRS)	1		
5-1.5	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA WITH AT LEAST FIVE UNITS OF ANY CONTRACEPTIVE SUPPLY METHOD IN INVENTORY			
	Public	37		
	Private			

ITEM NO.	INDICATOR	REPORTING PERIOD (10/1/85 - 9/30/86)		SOURCE/REFERENCE/COMMENTS
		ESTIMATE		
6-1.1	TYPE OF CHILD SURVIVAL INTERVENTION	Establishing presence of water source, good sanitation and service delivery centres.		
6-1.2	NUMBER AND TYPES OF PHARMACEUTICAL SUPPLIES PROCURED BY THE PROJECT	Number		
		0		
6-1.3	NUMBER OF HEALTH WORKERS IN PROJECT AREA TO BE TRAINED DURING REPORTING PERIOD AND NUMBER ACTUALLY TRAINED THROUGH PROJECT ACTIVITIES TO TEACH ABOUT THIS CHILD SURVIVAL INTERVENTION, BY TYPE OF WORKER	Training Target	Actually Trained	
	Physicians			
	Other Health Personnel (Non-Physicians)		27	
	Voluntary/Community Health Workers		37	
	Other Community mobilizers		1000	
6-1.4	NUMBER OF GOVERNMENT HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS FOR THIS INTERVENTION IN PROJECT AREA	1		
6-1.5	NUMBER AND TYPE OF HEALTH FACILITIES, SERVICE UNITS, OR DISTRIBUTION POINTS IN PROJECT AREA PARTICIPATING IN PROJECT ACTIVITIES			
	Public	36		
	Private			

Tables 1-5, Indicators
(from indicator sheets attached to
CS Annual Progress Report Guidelines)

ANNEX 2(a)
IMMUNIZATION

- 1.0 Input:**
- 1.1 Life of project budget by source of funds
- (a) USAID = 690,000
- (b) WVRO = 230,000
- (c) OTHERS = Community Participation
- 1.2 Estimated % of AID funds allocable to immunization activities.
= 25%
- 1.3 FY86 AID-financed obligations
= Consumable items, syringes, transport,
= training
- 1.4 Number of vaccines doses imported/locally produced by project
= 0
- 1.5 Total number of vaccine doses supplied to project by GOZ
= 77,550 April to September
- 2.0 Output:**
- 2.1 Number of projects - supported health workers in the project area and their involvement in immunization activities (see table).

Type Of	No.	Project Supported (Salaried)	Giving Immunization	Motivating/Mobilizing Immunization	Total
Nurse	14	0	14	14	14
Nurse Aides	10	1	10	10	10
Community-Based Contraceptive Distributors	3	1	0	0	3
Village Health Workers	12	0	0	12	12
Community Leaders	1,000	0	0	1,000	1,000
Others: a. Driver (Clerical Assistant) b. Rehabilitation Assistant	2	0	0	2	2
TOTAL	1,000	1	24	1,038	1,020

ORT

- 1.0 Inputs:**
- 1.1 Life of project budget = 690,000
 - 1.2 % AID budget allocated to ORT = 25%
 - 1.3 AID-financed obligations FY86 = 27,447
 - 1.4 Number of ORS packets imported/produced by project = 0
 - 1.5 Amount of salt and sugar bought by project for demonstration FY86 = 10kg
- 2.0 Outputs:** Number of health workers in project area by type and their involvement in ORT activities.

Type of Worker	No.	Supported by Project (Salaried)	Trained in ORT	Involved in Motivating/Mobilizing for ORT USE
Nurses	14	0	14	14
Nurses Aids	10	1	10	10
VHW	12	0	12	12
Community-Based Pill Distributors	3	0	3	3
Preschool Teacher	84	0	84	84
Community Leaders	1,000	0	1,000	1,000
Others: Traditional Midwives	22	0	22	22
Others: Traditional Midwives	22	0	22	22
TOTAL	1,145	1	1,145	1,145

- 3.0 Effectiveness:** Number and type of service units in project area having SS activities.

Type	No.	Having SSS for demonstration and a trained person
VIDECs	36	36
HC	0	0
HOSP	1	1
TOTAL	37	37

3.0 Effectiveness: Type of service delivery units--their role in cold chain system and utilization of vaccines (see table).

Type of Service Unit	No. In Project Area	Types of Inventory and Cold Chain	Vaccines Doses Utilized FY86					
			TT	DPT	DT	Polio	BCG	Measles
Hospital St. Paul's Musami	1	. Refrigerators . Cold Boxes . Vaccine Carriers . Ice Packs . Thermometers	203	458	197	643	269	119
Village Development Centers (VDC)		42	600	1,375	590	1,928	898	360

NB: All vaccines are mobilized from an effective cold chain maintained at the hospital distributed and utilized in VDC same day using cold boxes by an immunization mobile team.

4.0 Number and percent of WCBA reporting benefits from immunization of their children under five:

4.1 Total WCBA (Women in child bearing age) = 4,500

4.2 Total Reporting = 1,917

4.3 Percentage = 43%

5.0 Number of children (percentage in bracket) who have received project-supported immunization in FY86.

Age (Months)	TT	DT	DPT	Polio	BCG	Measles	Total
0 - 11	--	--	1,260	2,003	610	389	4,264
12 - 59	--	787	573	566	467	90	2,483
Total	--	787	1,833	2,571	1,077	479	6,747

Total number of under 1 in project area	=	<u>900</u>
Total number of under 1 who have completed immunization	=	<u>560</u>
Immunization coverage of under 1	=	<u>62%</u>
Total number of under-5 children in the project area	=	<u>3,240</u>
Total number of under-5 children completed immunization	=	<u>1,917</u>
Immunization coverage under-5	=	<u>50%</u>

Number and percent of WCBA who have received TT

Age Group	TT1	TT2	Total
15 - 49	500	303	803

Total number of WCBA in project area	=	<u>4,500</u>
Total number who received at least 1 dose TT	=	<u>803</u>
Percent immunized	=	<u>18%</u>

The calculations for immunization coverage are not very accurate because children who have completed immunizations are not recorded; hence, the calculations are not based on third DPT. There is need for a survey on immunization coverage.

INDICATORS FOR NUTRITION SURVEILLANCE

- 1.0 Inputs:**
- 1.1 Life of project budget = 690,000
 - 1.2 % AID budget allocated to nutrition activities = 25%
 - 1.3 AID-financed obligations FY86 = 27,446
 - 1.4 Number of growth monitoring instruments imported/locally produced by project and type = 0
- 2.0 Outputs:** Number of health workers in project area by type and their involvement in nutrition activities.

Type of Worker	No.	Supported by Project (Salaried)	Trained in Nutrition Activities	Involved in motivating/mobilizing for better feeding practices and surveillance
Nurses	14	0	14	14
Nurse Aids	10	1	10	10
Village Health Workers	12	0	12	12
CBD	3	0	3	3
Preschool Teacher	84	0	84	84
Community Leaders	1,000	0	1,000	1,000
Traditional Midwives	22	0	22	22
TOTAL	1,145	1	1,145	1,145

- 3.0 Effectiveness:**
- 1. Total number of service units in project area = 37
 - 2. Service units in project are involved in growth monitoring services = 37

	Last Month	Year 86 to Date	Total
Under 1 year enrolled in growth monitoring services	254	1,917	

INDICATORS FOR HIGH-RISK GROUPS (MOTHERS AND UNDER 5s)

CATEGORY

ITEM

- | | |
|---------------------|---|
| 1.0 Inputs: | 1.1 Life of project budget = 690,000 |
| | 1.2 % AID funds allocated to high-risk birth centers = 25% |
| | 1.3 AID-financed obligations FY86 = 27,447 |
| | 1.4 Number of contraceptives imported/locally produced by project and type = 0 |
| 2.0 Outputs: | Number of health workers in project area by type and activities relating to high-risk births. |

Type of Worker	No.	Supported (Salaried) by Project	Involved in contraceptive distribution	Involved in ante-natal care post-natal care, etc.	Involved in motivating/mobilizing for F.P./risk of high parity/short birth intervals, etc.
Nurse	14	0	14	2	2
Nurse Aides	10	1	10	10	10
VHW	12	0	0	12	12
Community-Based contraceptive distributors	3	0	3	3	3
Preschool teachers	84	0	0	0	84
Traditional Midwives	22	0	0	22	22
Community Leaders	1,000	1	27	49	1,000
TOTAL	1,145	0	27	49	1,145

- 3.0 Effectiveness:** Number and type of service units for contraceptive distribution in project area.

Service Unit	Total No.	Type of Contraceptive Supply	Type of Contraceptive Supply
VDC	36	Pill	6,309
Health Center	0	0	
Hospital	1	Pill	1,259
TOTAL	37	--	7,568

ANNEX 2

PVO Project Reporting Information Sheet

72a

**PVO PROJECT REPORTING INFORMATION
ON AID SUPPORTED PVO PROJECTS**

OMB No. 0412-0530
Expiration Date: 03/31/89

FOR OFFICIAL USE ONLY

PVO Type	Project Number	
Appropriation	Level	
Country Code	Fund Type	Technical Code
Project Officer	Key 1	Key 2

PROJECT INFORMATION (PRIMARY)

Name of Organization WORLD VISION RELIEF ORGANIZATION		Grant/Contract Number PDC-0505-A-PP-5065-00
Start Date (MM/DD/YY) AUGUST 1, 1985	End Date (MM/DD/YY) JULY 31, 1988	AID Project Officer's Name

AID OBLIGATION BY AID-FY (\$000)

FY	AMOUNT	FY	AMOUNT
86			
87			
88			

LOP

Activity Description

1. Supporting and enhancing the Government of Zimbabwe immunization program.
2. Instituting an active control of diarrhoea program
3. Nutrition promotion/growth monitoring
4. Improvement of MCH particularly in high risk groups. Training, health education and social mobilisation play central roles in carrying out these activities.

Status

The program is well underway after the first year of implementation with the following accomplishments:

1. Formation of a child survival team (made up of a project manager, public health specialist, health training officer, a field evaluation officer, a health associate, nurse and nurse assistant.
2. Training of 1000 community mobilizers, 22 traditional midwives, 3 community based distributors, and all child survival team staff in health and child survival strategies.
3. 7,550 vaccine doses administered in the project area
4. Completed baseline survey and monitoring and evaluation system in place (primarily by family registration.
5. Procurement of start up items such as immunization supplies, project office supplies, vehicles and some supplementary building materials.
6. Planning for expansion into a larger area.

COUNTRY INFORMATION (SECONDARY)

Country ZIMBABWE	Location in Country (Region, District, Village) Mashonaland East Province, Murewa District Musami.
PVO Representative's Name DEAN HIRSCH, DIRECTOR WVRO	Local Counterpart/Host Country Agency World Vision, Field Director, Max Chigwida, ZIMBABWE

COUNTRY FUNDING INFORMATION (\$000)

YEAR	FY86	FY87	FY88
AID \$	205,5	234	250.5
PVO \$	100	75	55
INKIND			
LOCAL	Vaccines, labour, bricks etc.		
TOTAL	305,5	309	305.5

AID 1550-11 (6-86)

(See Instructions & OMB Statement on reverse)

ANNEX 2a

Tables 1-5, Indicators

**(from indicator sheets attached to
CS Annual Progress Report Guidelines)**

ANNEX 2(a)
IMMUNIZATION

- 1.0 Input:**
- 1.1 Life of project budget by source of funds
- (a) USAID = 690,000
- (b) WVRO = 230,000
- (c) OTHERS = Community Participation
- 1.2 Estimated % of AID funds allocable to immunization activities.
= 25%
- 1.3 FY86 AID-financed obligations
= Consumable items, syringes, transport,
= training
- 1.4 Number of vaccines doses imported/locally produced by project
= 0
- 1.5 Total number of vaccine doses supplied to project by GOZ
= 77,550 April to September

- 2.0 Output:**
- 2.1 Number of projects - supported health workers in the project area and their involvement in immunization activities (see table).

Type Of	No.	Project Supported (Salaried)	Giving Immunization	Motivating/Mobilizing Immunization	Total
Nurse	14	0	14	14	14
Nurse Aides	10	1	10	10	10
Community-Based Contraceptive Distributors	3	1	0	0	3
Village Health Workers	12	0	0	12	12
Community Leaders	1,000	0	0	1,000	1,000
Others: a. Driver (Clerical Assistant) b. Rehabilitation Assistant	2	0	0	2	2
TOTAL	1,000	1	24	1,038	1,020

ORT

- 1.0 Inputs:**
- 1.1 Life of project budget = 690,000
 - 1.2 % AID budget allocated to ORT = 25%
 - 1.3 AID-financed obligations FY86 = 27,447
 - 1.4 Number of ORS packets imported/produced by project = 0
 - 1.5 Amount of salt and sugar bought by project for demonstration FY86 = 10kg
- 2.0 Outputs:** Number of health workers in project area by type and their involvement in ORT activities.

Type of Worker	No.	Supported by Project (Salaried)	Trained in ORT	Involved in Motivating/Mobilizing for ORT USE
Nurses	14	0	14	14
Nurses Aids	10	1	10	10
VHW	12	0	12	12
Community-Based Pill Distributors	3	0	3	3
Preschool Teacher	84	0	84	84
Community Leaders	1,000	0	1,000	1,000
Others: Traditional Midwives	22	0	22	22
Others: Traditional Midwives	22	0	22	22
TOTAL	1,145	1	1,145	1,145

- 3.0 Effectiveness:** Number and type of service units in project area having SS activities.

Type	No.	Having SSS for demonstration and a trained person
VIDECs	36	36
HC	0	0
HOSP	1	1
TOTAL	37	37

3.0 Effectiveness: Type of service delivery units--their role in cold chain system and utilization of vaccines (see table).

Type of Service Unit	No. In Project Area	Types of Inventory and Cold Chain	Vaccines Doses Utilized FY86					
			TT	DPT	DT	Polio	BCG	Measles
Hospital St. Paul's Musami	1	. Refrigerators . Cold Boxes . Vaccine Carriers . Ice Packs . Thermometers	203	458	197	643	269	119
Village Development Centers (VDC)		42	600	1,375	590	1,928	898	360

NB: All vaccines are mobilized from an effective cold chain maintained at the hospital distributed and utilized in VDC same day using cold boxes by an immunization mobile team.

4.0 Number and percent of WCBA reporting benefits from immunization of their children under five:

4.1 Total WCBA (Women in child bearing age) = 4,500

4.2 Total Reporting = 1,917

4.3 Percentage = 43%

5.0 Number of children (percentage in bracket) who have received project-supported immunization in FY86.

Age (Months)	TT	DT	DPT	Polio	BCG	Measles	Total
0 - 11	--	--	1,260	2,003	610	389	4,264
12 - 59	--	787	573	566	467	90	2,483
Total	--	787	1,833	2,571	1,077	479	6,747

Total number of under 1 in project area	=	<u>900</u>
Total number of under 1 who have completed immunization	=	<u>560</u>
Immunization coverage of under 1	=	<u>62%</u>
Total number of under-5 children in the project area	=	<u>3,240</u>
Total number of under-5 children completed immunization	=	<u>1,917</u>
Immunization coverage under-5	=	<u>50%</u>

Number and percent of WCBA who have received TT

Age Group	TT1	TT2	Total
15 - 49	500	303	803

Total number of WCBA in project area	=	<u>4,500</u>
Total number who received at least 1 dose TT	=	<u>803</u>
Percent immunized	=	<u>18%</u>

The calculations for immunization coverage are not very accurate because children who have completed immunizations are not recorded; hence, the calculations are not based on third DPT. There is need for a survey on immunization coverage.

INDICATORS FOR NUTRITION SURVEILLANCE

- 1.0 Inputs:**
- 1.1 Life of project budget = 690,000
 - 1.2 % AID budget allocated to nutrition activities = 25%
 - 1.3 AID-financed obligations FY86 = 27,446
 - 1.4 Number of growth monitoring instruments imported/locally produced by project and type = 0
- 2.0 Outputs:** Number of health workers in project area by type and their involvement in nutrition activities.

Type of Worker	No.	Supported by Project (Salaried)	Trained in Nutrition Activities	Involved in motivating/mobilizing for better feeding practices and surveillance
Nurses	14	0	14	14
Nurse Aids	10	1	10	10
Village Health Workers	12	0	12	12
CBD	3	0	3	3
Preschool Teacher	84	0	84	84
Community Leaders	1,000	0	1,000	1,000
Traditional Midwives	22	0	22	22
TOTAL	1,145	1	1,145	1,145

- 3.0 Effectiveness:**
- 1. Total number of service units in project area = 37
 - 2. Service units in project are involved in growth monitoring services = 37

	Last Month	Year 86 to Date	Total
Under 1 year enrolled in growth monitoring services	254	1,917	

INDICATORS FOR HIGH-RISK GROUPS (MOTHERS AND UNDER 5s)

CATEGORY

ITEM

- | | |
|---------------------|---|
| 1.0 Inputs: | 1.1 Life of project budget = 690,000 |
| | 1.2 % AID funds allocated to high-risk birth centers = 25% |
| | 1.3 AID-financed obligations FY86 = 27,447 |
| | 1.4 Number of contraceptives imported/locally produced by project and type = 0 |
| 2.0 Outputs: | Number of health workers in project area by type and activities relating to high-risk births. |

Type of Worker	No.	Supported (Salaried) by Project	Involved in contraceptive distribution	Involved in ante-natal care post-natal care, etc.	Involved in motivating/mobilizing for F.P./risk of high parity/short birth intervals, etc.
Nurse	14	0	14	2	2
Nurse Aides	10	1	10	10	10
VHW	12	0	0	12	12
Community-Based contraceptive distributors	3	0	3	3	3
Preschool teachers	84	0	0	0	84
Traditional Midwives	22	0	0	22	22
Community Leaders	1,000	1	27	49	1,000
TOTAL	1,145	0	27	49	1,145

- 3.0 Effectiveness:** Number and type of service units for contraceptive distribution in project area.

Service Unit	Total No.	Type of Contraceptive Supply	Type of Contraceptive Supply
VDC	36	Pill	6,309
Health Center	0	0	
Hospital	1	Pill	1,259
TOTAL	37	--	7,568

TABLE 1. GENERAL INDICATORS

CATEGORY	TIER ONE	TIER TWO	SPECIAL STUDIES TIER THREE
ALL PROJECTS	<ul style="list-style-type: none"> • 1. Geographic/political area in which project operates • 2. Total population in project area • 3. No. of children under 12 mos. and 12-59 mos. in project area (preferably by single years of age) • 4. No. of women of reproductive age (15-49) in project area (by 5-year age groups) • 5. Estimated annual no. of live births in project area • 6. Estimated annual no. of infant (under 12 mos.) and child (12-59 mos, preferably by single years of age) deaths in project area • 7. Total no. of health workers in project area 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •

TABLE 2. INDICATORS FOR ORT

CATEGORY	TIER ONE	TIER TWO	SPECIAL STUDIES TIER THREE
INPUTS	1. Life of project budget by source of funds	TIER 1 plus the following:	TIER 1 and TIER 2 plus the following:
	2. Estimated % of AID contribution allocable to ORS/ORT activities		
	3. Current year AID-financed obligations		
	4. No. ORS packets imported and locally produced by the project, by size of packet		
	5. Cost per packet to the project (amount actually paid plus transportation costs)		
	6. Price per packet charged to the consumer		
OUTPUTS	7. No. of project-supported health workers in project area, by type of worker		
	8. No. of health workers trained through project activities to teach ORT by type of worker		
EFFECTIVENESS	9. No. and type of service units and distribution points for ORS packets in project area	1. No. and % health workers demonstrating/reporting general and special knowledge/competence re ORT	1. Cost per treated episode
	10. No. and type of service units and distribution points in project area with at least 10 ORS packets in inventory	2. No. and % health individuals demonstrating/reporting general and special knowledge/competence re ORT	2. Cost per death averted
	11. No. and type of service units and distribution points in project area with ORS packets in inventory and a trained person available	3. No. and % of children under 60 mos. ever given ORT	3. Observational studies of effective use of ORT
	12. Total no. of service units and distribution points in project area	4. No. and % of children under 60 mos. given ORT during last diarrhea episode occurring within previous two weeks (includes measure of effective use for current and recall period)	
IMPACT			4. Mortality rate, 0-11 and 12-59 mos.
			5. Mortality due to (or associated with) severe dehydration among children 0-11 and 12-59 mos.

TABLE 3. INDICATORS FOR IMMUNIZATION

CATEGORY	TIER ONE	TIER TWO	SPECIAL STUDIES TIER THREE
INPUTS	1. Life of project budget by source of funds	TIER 1 plus the following:	TIER 1 and TIER 2 plus the following:
	2. Estimated % of AID contribution allocable to immunization activities		
	3. Current year AID-financed obligations		
	4. No. vaccine doses imported and locally produced by the project, by type		
OUTPUTS	5. No. of project-supported health workers in project area, by type of worker		
	6. No. of health workers trained through project activities to teach about or give immunizations, by type of worker		
EFFECTIVENESS	7. No. and type of service units in project area capable of providing immunizations	1. No. and % individuals reporting knowledge of health benefits immunizations, by type	1. % vaccinations resulting in full immunization/protection
	8. No. and type of service units in project area with specified vaccines in inventory	2. No. and % of individuals reporting a source of immunization available within 30 min. km?	2. Cost per protected child
	9. No. of service units in project area with effective cold chain	3. No. and % children who have received Polio 1, Polio 3, Measles, BCG, DPT 1, DPT 3 and ALL immunizations by age 1	3. Cost per death averted
	10. Total no. of service units in project area	4. No. and % children who have received Polio 1, Polio 3, Measles, BCG, DPT 1, DPT 3 and ALL immunizations by age 5 (by single years of age)	
		5. No. and % women of reproductive age (15-49) who have received two doses of tetanus toxoid (by 5 year age groups)	
IMPACT			4. No. cases neonatal tetanus per year
			5. No. cases measles per year
			6. No. cases polio per year
			7. Mortality rate among children 0-11 and 12-59 mos. (by one year age groups)
			8. Disease-specific mortality/morbidity rates (MMT, tetanus, polio and measles) 0-11 mos. and 12-59 mos. (by one year age groups)

TABLE 4. INDICATORS FOR NUTRITION

CATEGORY	TIER ONE	TIER TWO	SPECIAL STUDIES TIER THREE
INPUTS	<ul style="list-style-type: none"> 1. Life of project budget by source of funds 2. Estimated % of AID contribution allocable to nutrition activities 3. Current year AID-financed obligations 	<ul style="list-style-type: none"> TIER 1 plus the following: 	<ul style="list-style-type: none"> TIER 1 and TIER 2 plus the following:
OUTPUTS	<ul style="list-style-type: none"> 4. No. of project-supported health workers in project area, by type of worker 5. No. health workers trained through project activities to teach infant and child feeding practices, by type of worker 		
EFFECTIVENESS	<ul style="list-style-type: none"> 6. No. and type of service units in project area providing growth monitoring services 7. No. children (0-11 and 12-59 mos.) enrolled in growth monitoring programs 8. No. children (0-11 and 12-59 mos.) enrolled in growth monitoring programs weighed in last month 9. No. mothers/mother substitutes given nutrition counseling during previous 12 mos. 10. Total no. of service units in project area 	<ul style="list-style-type: none"> 1. No. and % of individuals reporting knowledge of health benefits of breastfeeding 2. No. and % children breastfed at birth, 3 mos., 6 mos. and 12 mos. 3. No. and % children bottlefed any fluid at birth, 3 mos. and 6 mos. 4. No. and % children eating semi-solids at 6 mos. 5. No. and % children identified as malnourished (less than 75-80% weight for age or alternative) 6. No. and % children identified as severely malnourished (less than 60% weight for age or alternative) 7. No. children enrolled in growth monitoring programs 	<ul style="list-style-type: none"> 1. Cost per child monitored 2. Cost per death averted
IMPACT			<ul style="list-style-type: none"> 3. Neonatal mortality rate 4. Mortality rate among children 0-11 and 12-59 mos. 5. Mortality rate among children 0-11 and 12-59 mos. due to or associated with malnutrition 6. Morbidity and mortality associated with Vitamin A deficiency among children (0-59 mos.)

TABLE 5. INDICATORS FOR HIGH RISK BIRTHS

CATEGORY	TIER ONE	TIER TWO	SPECIAL STUDIES TIER THREE
INPUTS	<ul style="list-style-type: none"> 1. Life of project budget by source of funds 2. Estimated % of AID contribution allocable to high risk birth activities 3. Current year AID-financed obligations 4. No. contraceptives imported and locally produced by the project, by type 	<ul style="list-style-type: none"> TIER 1 plus the following: 	<ul style="list-style-type: none"> TIER 1 and-TIER 2 plus the following:
OUTPUTS	<ul style="list-style-type: none"> 5. No. of project-supported health workers in project area, by type of worker 6. No. health workers trained through project activities to teach about high risk births or give family planning advice, by type of worker 		
EFFECTIVENESS	<ul style="list-style-type: none"> 7. No. and type of service units and distribution points for contraceptives in project area 8. No. and type of service units and distribution points in project area with at least 5 of any one contraceptive (supply) method in inventory 9. Total no. of service units and distribution points in project area 	<ul style="list-style-type: none"> 1. Ideal no. of yrs. between births 2. No. and % individuals reporting knowledge/awareness of health risks associated with high parity, very short birth intervals and maternal age 3. No. and % individuals reporting knowledge of/access to/availability of contraceptive information/supplies 4. No. and % of births occurring within 24 mos. of the preceding birth 5. Length of the last closed birth interval (mos.) 6. No. and % of high parity births 7. No. and % of births to women under age 20 or over age 40 8. Contraceptive prevalence rate, by age and method 9. % women who want to space their next child 	<ul style="list-style-type: none"> 1. Relationship between infant mortality and childspacing 2. Relationship between maternal morbidity and childspacing
IMPACT			

PVO Child Survival Projects -- FVA/PVC FY 1985 and 1986, and 1986 Vitamin A projects																			
PVO	AFRICA											LAC				ASIA			
	Camer	Kenya	Malaw	Mali	Niger	Nigeria	Rwanda	Seneg	Sudan	Uganda	Zimba	RIA	Boliv	Ecuad	Guate	Haici	Bangl	Indone	Pails
ADRA			85					85							85				
AFCARE						86													
AMREF	86																		
CARE				86									85			85		85	
CRS							(86)		(86)	85			85	85					
ESPERA													86						
EYECAR															86*				
FPPLAN				86									86		85				
HKI					86*							86*			86**	85	85/86*		86**
HOPE														85					
ICC															85				
IEF			85																
MHIV									85										
PCI													85/86		86			85	
SAWSO		85														85	85		85
SCF	86		86						(86)		(85)		85/86*	85			85	85	
WVRO								(86)	(86)		(85)								

86* funded for Vitamin A project

86**, primary management by Office of Nutrition; S & T/Nutrition funded Vitamin A project

Scope: 42 Child Survival projects in 17 countries (27 FY85, 15 FY86)
 AFR: 19 projects (8 FY85, 11 FY86), 10 countries, 11 PVOs
 LAC: 15 projects (11 FY85, 4 FY86), 4 countries, 8 PVOs
 ANE: 8 projects (8 FY85), 3 countries, 5 PVOs

ANNEX 3

Completed monitoring and evaluation plan

9/12

THE MONITORING AND EVALUATION PLAN

The World Vision Child Survival project at Musami utilises the following instruments as its basic tool for health and nutrition information from the beneficiaries:-

(a) Family Registration Forms

These forms, each representing a family, with children under 5 years, are bound into books. Each book is intended for a village of approximately one hundred families. Each Village Health Worker or a village leader takes care of one book or village.

(b) Monthly Project Data Sheet

The information from Family Registration sheets/books is aggregated monthly into a monthly project data sheet by the Field/Evaluation Officer.

(c) Child Health and Ante-natal Card

These cards are for the under fives and pregnant mothers. The cards are also Government of Zimbabwe standard instruments and are retained by the family. The project utilises these instruments for comparing data or for sample surveys.

(d) Hospital and Health Centre Records and Sample Surveys

From time to time as need arises the health and nutritional status of the beneficiaries is sought from existing hospital and health centre records or by instituting purpose specific sample surveys.

(e) Information From Informed Sources

Information from informed people, Ministry of Health, Central Statistical office, etc can be a very useful and cost effective method of forming baseline information for programme planning.

Objectives of the project as it relates to monitoring and evaluation plan

- I Strengthen and support Government of Zimbabwe Immunization program.
1. Seventy percent of all under ones will complete Zimbabwe Expanded Program on Immunization program by their first birthday.
 2. Eighty percent of all under fives will be completely immunised.
- II Facilitate and institute an active diarrhoea disease control program within the Ministry of Health framework.
1. Fifty percent of WCBA will demonstrate competence in oral rehydration therapy.
 2. Fifty five percent of WCBA will use salt and sugar solution as a first method to prevent dehydration when their children have diarrhoea.
 3. Ninety five percent of WCBA will know of Oral Rehydration therapy.
 4. Fifty percent of WCBA will have basic knowledge of hygiene and environmental sanitation to combat diarrhoea.

5. Thirty percent of families will have an access of a protected water source less than five kilometres radius.
6. Twenty percent of families will have a Blair toilet.

III Improve Nutritional status of the children who are under five years.

1. Seventy five percent of under two will participate regularly in weighing sessions.
2. The children under five classified as "at risk" and below the demarcating line in child health card/Family registration sheet will be reduced by fifty percent.
3. The percentage of under ones not receiving weaning foods at six months will be reduced by fifty percent.
4. Ninety percent of mothers will maintain breast-feeding for a minimum of twelve months.

IV Institute measures to improve high risk groups -

1. There will be at least a thirty percent increase of pregnant women who will at least have one ANC check up (defined as Tetanus Toxoid injection or Fe/Folic distribution, or Pregnancy counselling or fundal height measurement).
2. The number of WCBA utilizing a modern method of contraceptive will be increased by 25%.
3. Infant mortality rate will be reduced by twenty percent.
4. Child mortality rate will be reduced by twenty five percent.
5. Fifty percent of all TBA will be trained/re-trained.

EXPECTED PROGRESSION TOWARDS OBJECTIVES ACCOMPLISHMENTS

Objective No. (see obj. active Sheets)	Baseline data	Source of baseline data	FY86		FY87		FY88		Evaluation methodology	Comments
			Actual	Projected	Actual	Projected	Actual	Projected		
	1	40		55		65		70	FRS	
	2	60		65		75		80	FRS	
I	1	10		20		35		55	FRS	
	2	10		80		90		100	FRS	
	3	70		20		35		50	FRS	
	4	10		20		25		30	FRS	
	5	15		15		15		20	FRS/SS	
	6	10							FRS/SS	
II	1	40		50		65		75	FRS/SS	
	2	10		10		7.5		5	FRS/SS	
	3	10		10		7.5		5	FRS/SS	
	4	75		75		80		90	FRS/SS	
IV	1	30		40		50		60	SS/HR/FRS	
	2	30		40		50		60	SS/HR/FRS	
	3	100		90		90		85	HR/SS	
	4	50		45		35		25	SS	
	5	10		20		30		50	SS	

Key

H.R. Hospital Records
 F.R.S Family Registration System
 S.S Sample Survey done by project
 I.S. Informed source - e.g. central statistic office, MOH or other PVO survey/people

The sample survey (Baseline Survey) takes into consideration results of project survey of 100 households at Musami.

Indicators for Area III where interventions are different from Areas I and II will be appropriately modified.

II Indicators

The following Tier I and II indicators will be monitored in the World Vision project.

Number of Health Workers trained and their category

Number of WCBA trained in ORT/Nutrition/MCH and Health education

Number of WCBA taught about proper weaning habits

Number of WCBA taught about value/need for immunization

Number of families with safe water supply

Number of families with latrines, Blair/regular

Number of/percentage of mothers competent in ORT

Number of/percentage of mothers mixing ORT properly during episodes of diarrhoea.

Number of/percentage of children at twelve months with completed basic immunization (BCG, DPT, Polio, Measles).

Number of/percentage of WCBA practising contraception

Number of/percentage of pregnant mothers receiving one ANC check-up

Number of/percentage of under fives "at risk". (Below 3rd centile)

Number of/percentage of children six months receiving nutritious semi-solid foods.

Number of/percentage of infants with low birth weights

Number of/percentage of births and deaths (0-11, 12-59 months)

Number of/percentage of WCBA having too close births (interval of less than two years)

Number of/percentage of WCBA having first child before the age of 20

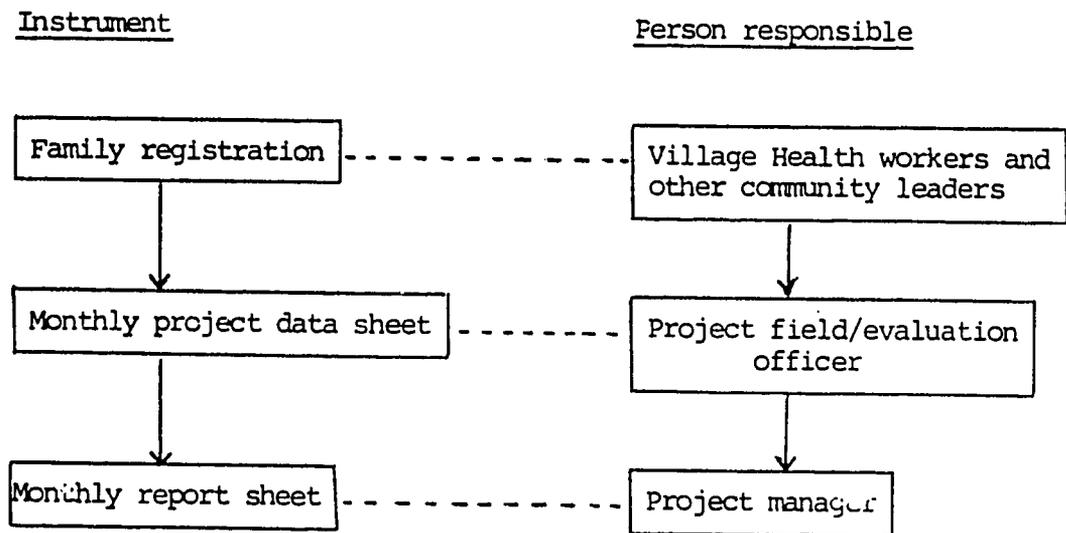
Number of/percentage of WCBA having more than six children

Number of/percentage of WCBA having children after 35 years of age.

Number of/percentage of H/H whose children below 24 months had diarrhoea in the last two weeks.

HEALTH INFORMATION AGGREGATING SYSTEM

The family registration forms will be filled in regularly by Village Health Workers with the help of other community leaders. The filling-in will be supervised jointly by Village Health Workers, supervisors and project's field officer. It will be the field officer's responsibility to aggregate the data into monthly project data and send them to the project manager for dissemination. The system will look like this.



If there is no Village Health Worker other community leaders like pre-school teachers, members of health committees, etc will fill out the registration form.

The project Field/evaluation officer will be responsible for collecting and aggregating the data.

Every month the Project Manager will include the data in a monthly report to the WZ Director. The report will interpret the data and correlate it with inputs of the programme. It will be the Project Manager's responsibility to analyse the data regularly and ascertain that the program objectives and projected milestones are being accomplished in time and effectively.

The project manager will from time to time request the field/Evaluation officer to collect data from other sources like Hospital records, statistical offices etc to satisfy expected accomplishments towards program objectives.

Evaluation

Every year there will be an annual evaluation between July and September. This evaluation shall be attended by following:-

Internal Staff

- Field Director
- Child Survival Staff
- World Vision Relief Organisation/WVRO/WVI
- Technical Assistants/consultants

External Staff

- APHA
- Ministry of Health
- WHO
- UNICEF
- Other PVOs

The purpose of this evaluation would be to generate an annual progress report and to reshape the program to attain its objectives.

SAMPLE

Extracts from Family Registration Book

HOW TO USE THIS BOOK

1. This book is for one village
2. Every sheet is for one (1) family. (defined as mother and the children under five she is responsible to feed, shelter and clothe)
3. Every child under five should be registered
4. The oldest i.e. nearest to five years should be registered first and therefore have a smaller serial number.
5. Serial numbers are registered this way:
 - a) The ward is the first two digits
 - b) The village is the alphabetical letter
 - c) The child is the last serial number e.g. 01/A/99
6. Every village shall have two books. One retained by V.H.W. and the other by Musami Child Survival Team. This may later be combined to one book.
7. Every month the book will be updated at the Village Development Centre and data generated and sent to Musami Hospital.
8. The updated report will help the V.H.W. to go to the village and monitor the children who have not been attended at the Village Development Centre and encourage them to come the following month.
9. The Village Health Worker will also monitor the diarrhoea (2) status in the community.
10. Maternal information is recorded yearly.

What is the Purpose of this book

There are several purposes to this book. The data collected will be useful in many ways to child survival team, donor agency and Musami hospital. However, the main purpose is Village Health Worker to use the book as her management and monitoring tool to have knowledge of the community. The Village Health Worker Supervisor trainer or any village leader can monitor the effectiveness of Village Health Worker using the same book.

ABBREVIATIONS USED IN THIS BOOK

C.H.C	Child Health Card
D.O.B	Date of Birth
H/C	Home or Clinic
WT	Weight
A/B	Above or Below the line
TT	Tetanus Toxoid
Y/N	Yes or No
I.S.D.	Increasing, Same, Decreasing
D.L.M.	Diarrhoea Last Month

Definitions

1. Family is the mother and the children under five she is responsible to feed and shelter for more than two months.
2. Diarrhoea is passing off three or more watery stools in 24 hours.

ANNEX 4
Baseline Survey Instrument and Analyses

ANNEX 4
BASELINE SURVEY ANALYSIS
WORLD VISION ZIMBABWE CHILD SURVIVAL PROJECT
PRELIMINARY COMMUNITY SURVEY AT MUSAMI

Introduction

The Child Survival program of World Vision Zimbabwe is a primary health care project that takes four, health low-technology interventions to maximize output at a minimal input.

The purpose of this survey was to have community's baseline data, prior to embarking on Child Survival project implementation. The data would not only serve as a basis for evaluation and monitoring, but also would serve as analytical understanding of the community facilitating knowledge and comparative basis of operation.

The project area, Musami, is located in the center of the Murewa District, 80km east of the city of Harare. The survey covered samples from four wards of Musami.

Although geographically it is relatively close to urban and prosperous commercial farms, Murewa District generally bears all the hallmarks of communal lands--poor sandy soil made worse by a combination of overgrazing, deforestation and resultant soil erosion resulting in treeless terrain with sun-scorched crops and stub-grass. The land tenure system of communal ownership does discourage heavy investment to improve the land by tree planting, land terracing, etc.

Materials and Methods

The four wards aforementioned were selected for this survey and pilot implementation of the project. Three 3rd-year medical students were trained in interviewing. They were supervised by a graduate researcher who had made an open-ended questionnaire. On an average, 25 households were randomly selected from each of the four wards. The students then interviewed the mother of the household with children below five years.

The emphasis during the interview was to be very observational and to use questions in the questionnaire as a pointer. This was to avoid leading answers and also to correlate what was being said and the home environment reality. Village health workers accompanied the medical students.

After the questionnaires were filled, they were then analyzed and results tabulated.

Results

A total of 100 households out of 4,000 (2.5%) were interviewed. The results indicate a higher-than-usual level of knowledge, attitude and practice of all four health interventions of Child Survival programs.

Some of the highlights of the results are as follows:

(1) Diarrhea and Its Management

Table I

Question	Diarrhea In The Last Two Weeks	
Response	Yes	No
%	89.9%	11.1%

Diarrhea was defined as having two or more watery stools in a day. Seasonal changes and disease outbreaks may influence the answer to this question. This research was carried out during the rainy season.

Table II

Question	Diarrhea As A Problem That Can Be Fatal	
Response	Serious, Can Kill	Not Serious
%	90.8%	9.2%

In the recent past, there hasn't been a record of deaths due to diseases like cholera, typhoid, etc., to influence the answer.

Table III

Question	Diarrhea Consequences		
Response	Dehydration	Disease	Death
%	65.7	12.4	21.0

The significant number (two-thirds) of knowledge of dehydration as a consequence does correlate with a high frequency of diarrhea (90%) in the last two weeks. 10.9% remember of their family having died due to diarrhea.

Diarrhea and Breast Feeding: Only a mere 2% of mothers stopped breast feeding when child had diarrhea. This reveals lack of hindrances or cultural influence on breast feeding during diarrhea.

Oral Salt-Sugar Solution

Question	Diarrhea Management With Home-Mix (SSS)		
Response	Knowledge	No Knowledge	Competent
%	80.5%	9.5%	10%

Only 9.5% of all mothers interviewed did not know about salt-sugar mix as a diarrhea, dehydration management method, but only 10% were competent in applying knowledge into practice. This "knowledge without practice syndrome" is not an uncommon phenomena in rural areas.

(2) Water and Sanitation

Question	Presence of Usable Toilet Facilities		
Response	Blair Latrine	Ordinary Pit Latrine	None
%	15%	26.4%	58.6%

With less than a half of this relatively well-to-do community having any waste disposal system, the problem of poor sanitation may be a major cause of diarrhea and worm infestation--only a mere 15% have the government standard (Blair) latrines.

Question	Presence of a Protected Water Source 0.5km from House	
Response	Yes	No
%	46.5%	53.5%

A protected well was defined for this purpose as one which is permanently covered so that minimal amount of contamination enters the well.

Food Availability/Feeding Habits

Question	Does Family Have Adequate Food Until Next Season	
Response	Yes	No
%	72.5%	27.5%

Only a third of families interviewed claimed to have no food stored until next harvest season. It is likely that the figure is inflated by reason of expecting to win favor.

Question	Type of Food Available	
Response	Predominantly High Protein	Predominantly Low Protein
%	45.2%	54.8%

The figures show that there is enough protein source in the community. There are no cultural or religious inhibitions to the type of food given to children or pregnant mothers.

Question	Where Was Last Child Delivered	
Response	Home	Health Facility
%	23.7%	76.3%

Unlike other developing countries, only less than 25% deliver at home. Over two-thirds of all delivering mothers therefore have had a nontraditional exposure to delivery and consequent health education.

Question	Feeding Method of the Child Below Two Years	
Response	Breast Feeding Only	Breast Feeding Plus Formula
%	81%	19%

Question	Age At Which "Other Foods" Were Added To Breast Milk	
Response	Before Six Months	After Six Months
%	91.4%	8.6%

Majority of solid foods are likely to have been introduced between four and six months.

Pregnancy and Family Planning

Question	Reason For Stopping Breast Feeding	
Response	Pregnancy	Others
%	80.6%	19.4%

Majority of mothers stopped breast feeding because they were expecting. This is typical in the country.

Over half of the people rely on agriculture for their income and less than half have an extra income (e.g., local wages) other than agriculture. Agriculture practice is usually of mixed traditional type which includes domestic animals.

Question	Type of House	
Response	Traditional (Grass Thatch)	Modern (Tiles, Asbestos, Thatch)
%	56.5%	43.5%

The percentage of those people who have extra income compares with those with modern buildings.

Question	Facilities For Children To Sleep On	
Response	Sleep on floor	Sleep on bed
%	82.1%	17.9%

Majority of the children sleep on the floor; however, the reason for this is not because of economics.

Discussion

The sample size of this study (2.5%) can be considered small. However, this limitation does not have a significant influence on figures. The sample can be said to be representative.

Due to these few obvious omissions, the result for infant mortality measurement or nutritional status are omitted. Hospital records, although available, were not analyzed to avoid error and deviation of the purpose of this report. The purpose of this study was to carry out a Child Survival-related community analysis by set questionnaire and keen observation--use the result to plan program and a basis for monitoring and evaluation.

Community's knowledge on Child Survival Interventions

From the results, it is apparent that there is high awareness on ORT management, immunization and child health care charting. However, the awareness may be only conceived and not real (no practice).

Attitudes and Practice

Although knowledge of Child Survival interventions are high, the practice is relatively low. Due to influence and close proximity to an old, established Catholic Church the attitudes towards these interventions are not negative. There are a few or no cultural inhibitions to hinder the strengthening of service deliver to improve levels of health practices.

Water and Sanitation

Less than half of the people have no form of sanitation. Only 15% have the government-required Blair toilets. This statistic compares for potable water.

Good source of uncontaminated water and a well-controlled human excreta disposal are the only long-term preventive basis for diarrhea. At the present time, these are not well serviced at Musami.

Food Availability

The community produces the right type of foods to avert any forms of protein calorie malnutrition. The usual tendency to such a stable population to exchange their foods for money to buy refined manufactured products. This can be averted by a behavioral motivation through training in mixing local foods to taste as good, if not better, than refined manufactured foodstuff.

Contraceptive Usage

Half of the women interviewed have a positive knowledge of contraceptives and over two-thirds practices any form of child spacing. Since this is Roman Catholic-predominated (78%) population, the details of family planning type could not be elucidated. However, at present there is no felt dogma emanating from the religion against family planning practice.

Recommendations and Conclusion

1. The research shows high level of awareness on all elements of Child Survival programs; however, the practice needs to be strengthened.
2. The community is very committed toward self-reliance but needs direction such as in building toilets, protecting water sources or even building nutrition center.
3. The mere fact that there is not extensive malnutrition and food scarcity is no reason to be complacent. It is a strong foundation towards better methodologies of storage and utilization of food through nutrition centers demonstration garden.
4. Training towards self-reliance, self-medication, early referral for prenatal clinic or immunization should be the major component of the project.
5. The project should run two phases:
Phase I Four wards where survey was done
and
Phase II Whole 36 service delivery centers under Musami
6. The project should have a central base at Musami--with car, office and residential base--and then strengthen the 36 centers of Musami by:
 - a. Using them innovatively as community training centers.
 - b. Motivating the community to build the 36 service delivery centers.
7. The original idea of family registration has now been piloted, and it is recommended for implementation again initially in pilot wards.

Most of these recommendations are based on the observational part of this survey, as statistic basis for such argument is both time consuming and expensive.

CHILD SURVIVAL/SOCIO-ECONOMIC SURVEY

NAME OF INTERVIEWER: AZ DATE: 29-01-86

PROVINCE: SINSH LEST DISTRICT: MUREWA

COUNCIL: MUREWA KUSATANA WARD: 18

VILLAGE: TABIKIRA

1. NAME OF PERSON: CHARI 2. SIZE OF HOUSEHOLD: 4

3. SIZE OF FAMILY: 4

<u>ALIVE:</u>	<u>YEAR BORN:</u>
1. <u>WILLIAM</u>	<u>1967</u>
2. <u>SIMONASIE</u>	<u>1967</u>
3. <u>WALTER</u>	<u>1981</u>
4. <u>VIRGINIA</u>	<u>1936</u>
5. _____	_____

<u>DEAD:</u>	<u>YEAR BORN:</u>
1. _____	<u>1968</u>
2. _____	<u>1969</u> <u>1956</u>
3. _____	<u>1963</u>
4. _____	<u>1960</u>

4.	<u>EDUCATION:</u>	<u>OCCUPATION:</u>
1. Household:	_____	_____
2. FATHER:	<u>PRIMARY</u>	<u>BUILDER</u>
3. MOTHER:	<u>GT</u>	<u>HOUSEWIFE</u>
4. CHILDREN: 1.	<u>F4</u>	<u>awaiting results</u>
2.	<u>F4</u>	<u>"</u>
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

7. MAJOR SOURCE OF INCOME:
1. AGRICULTURE
 2. LIVESTOCK
 3. LOCAL WAGE EMPLOYMENT
 4. FROM HOUSEHOLD MEMBERS
 5. PENSION & INSURANCE
 6. WELFARE
 7. OTHERS
 8. AVERAGE MONTHLY INCOME: \$130

8. NUMBER OF:
1. CATTLE: _____
 2. GOATS: _____
 3. SHEEP: _____
 4. OTHERS: 6 PIGS

9. MAIN DWELLING TYPE:
1. THATCH ON TRADITIONAL BRICK/DOORS
 2. TIN _____ ASBESTOS ON BRICK
 3. MIXED DESIGN
 4. OTHERS

10. FLOORING FOR CRT DRESS:
1. BLANKETS SPREAD ON FLOOR
 2. BLANKETS SPREAD ON TOP OF MAT
 3. BED

11. RELIGION:
1. METHODIST
 2. ROMAN CATHOLIC
 3. ANGLICAN
 4. HINDOSTANI
 5. TRADITIONAL
 6. OTHERS

12. SOCIAL ACTIVITIES:
1. CLUBS
 2. PARTY LEADERSHIP
 3. FAMILY PLANNING
 4. OTHER

HEALTH

1. O.R.T: - DIARRHOEA

10. Has any of your children had diarrhoea the last 2 weeks:
YES/NO

Comment:

11. Death from diarrhoea of any member of the family before the age of five : YES/NO

Comment:

12. Normally what is the consequence of diarrhoea? 1. Dehydration
2. Infection
3. Death
4. Other

13. Treatment administered and sort:

- (a) Hospitalisation
- (b) Traditional
- (c) Prayer
- (d) None

14. Do you consider diarrhoea to be a severity disease? YES/NO

- (a) Nuisance
- (b) Serious
- (c) Fatal
- (d) Problem

Comment:

AS SEEN A MILD DISEASE

15. What is the effect of breast feeding on diarrhoea?

- (a) Can cause it
- (b) Can remedy it
- (c) No effect
- (d) Don't know

Comment:

DISCUSS ABOUT CAUSALITY

16. Do you know anything about O.R.T. sugar, salt solution?

(a) Attitudes: EFFICACIOUS IF DONE PROPERLY

(b) Applications: ADMINISTERED WHEN NEEDED BY CHILD OR EVERY 2 HRS

Comment:

17. Do you advise mothers to continue breastfeeding during diarrhoea?

YES

YES			NO		
VHW	HA/MA	COMM. SISTER	VHW	HA/MA	COMM. SISTER

18. Toilet facilities

1. Flush toilet
2. Household vented pit latrine
3. Communal latrine
4. None - WUSH
5. Other

19. Which household member do not use the latrine? If so why?

1. All use
 2. Men
 3. Women
 4. Grandparents
 5. Others
- MEN | WOMEN 2/1

20. Where do you usually dispose your waste?

1. Latrine
2. Rubbish pit
3. Courtyard
4. Garden
5. Bin
6. Other

21. Where do children usually wash their bodies?

1. River
2. Bathroom
3. Toilet
4. Courtyard
5. Inside
6. Other

Water

22. Usual water source used for:

- | | |
|--------------------------|----------------|
| 1. Drinking and domestic | PROTECTED WELL |
| 2. Washing clothes | _____ |
| 3. Watering gardens | RAIN |
| 4. Beer brewing | PROTECTED WELL |

23. Usual water source, is it protected?

Yes

24. Distance of this source from one point

1. Less than 5m
2. 6 - 30m
3. 101 - 500m
4. 501 - 1km
5. 1 - 3km
6. More than 5km

25. Is household satisfied with existing domestic water use? Yes/No Comment CHEMICAL PURIFICATION

Nutrition

26. Adequate food storage until the next season? Yes FERTILISE AVAILABLE.

27. Types of food available
MANGO, GROUND-NUTS, ROUND NUTS

28. Type of food normally given to children? Investigate
MILK + VEGETABLE BUTTER, EGG,
BREAD + TEA

29. Are there any kinds of nutritious foods which are not meant for the children but only for elders? If so which ones?
NO

30. Adequate food in stores within the locality?
STATE COOP
MISERABLE SITUATION

31. Is food distribution locally adequate?

32. Place mode of birth HOSPITAL
1. Health education (nutrition) ADEQUATE
2. Traditional education USEFUL

33. Methods of feeding other than breast-feeding.
PERIODIC

34. Times and ages of feeding solid foods.
6/12 TWICE A DAY

35. Age of weaning.
5 YRS

36. Reason for weaning (literally) kurumura
①. Pregnancy
2. Diarrhoea
3. Others - ILL-HEALTH

Health

37. Nutrition

Nutritional status of child

Height	Weight	Reasons
NORMAL	Normal	

38. What is the food situation like in dry months?

SADZA, MILK, FRESH VEG

DRY FEED OCCASIONALLY

39. Do you practice family planning? Yes/No If so how?

S.P.

40. Do you have access to supplementary feeding schemes?

NEGATIVE - INADEQUATE FOOD SUPPLY

Immunization

Awareness and attitudes USEFUL

41. Are there any reasons for dropping out?

NO

HEALTH : GENERAL

42. How far is it to the nearest clinic

1,2

43. What are the opinions of Medical Health Workers?

a. Nursing officer

b. Health assistant

44. Do you have access to Health Workers?

VHW VISITS INADEQUATE , INFREQUENT
HOSPITAL STAFF UNSATISFACTORY

45. Examination of hospital records.

ANNEX 5

Personnel job descriptions and resumes

II. (a) Description of staff hired, job description and brief resumes

Name	Title/Position	Date Hired	Job Description	Brief Resume
1. S. Mushapaidze *	Project Manager	Oct. 85	Project Management, overall supervision and execution.	Nurse, Mid-wife with diploma in Health Education. Trained in Louis Allen Management system. Fourteen years experience in all aspects of nursing, non-formal education, management and communication.
2. J. Nhliziyo *	Training Officer	Mar. 86	Training/social mobilization, community organization.	Nurse, mid-wife with diploma in community health. Trained in adult learning methodologies. Ten years experience in community health.
3. B. Chirairo *	Field/Evaluation	Feb. 86	Project site operations, community motivation, integrating Child Survival interventions with development. Aggregating field data.	BSC in engineering and post-graduate diploma in Public Health Engineering. Four years post-graduate experience in field work.
4. S. Chidyamatamba *	Office Secretary	Nov. 85	Office supportive services and typing.	O Level Cambridge Certificate. One year secretarial training. Eight years experience in office management and secretarial services.
5. G. Ngatiri (part-time)	Technical Advisor (60% man hours)	Jan. 86	Technical support advisory services, design and planning.	Medical degree and Masters in Public Health. Ten years experience in community health programs in Africa.
6. G. Chigwida (part-time)	Field Director (20% man hours)	Oct. 85	Overall direction and control.	Masters degree in Divinity/Administration. Twenty years experience in Administration.
7. O. Dziva	Field Finance and Administration	Oct. 85	Project Finance and property control. Overall support services.	B.A. in Administration and Finance. Post-graduate diploma and Administration. Ten years experience in rural health.
8. E. Tagwireyi	Health Officer (40% man hours)	Apr. 86	Training/Social Mobilization, community organization.	Nurse, mid-wife and diploma in community health. Ten years experience in rural health.
9. Ann Biro (part-time)	PHC Specialist	Nov. 85	"Back stopping" liaison with USAID Office. USAID documentation.	Bachelor of nursing and Masters in Public Health. Two-and-a-half years international health experience. Two-and-a-half years nurse experience in USA.
10. Mrs. Chiradza *	Nurse Aide	Apr. 86	Immunization	Basic training in nursing. Primary School Education.
11. R. Macagba	Technical Coordinator Child Survival Program (5% man-hours)	Apr. 86	Coordination of Child Survival programs worldwide.	Surgeon and Public Health physician. Thirty years experience in Health Administration and management.

* World Vision people paid by project.

ANNEX 6

Photos



New immunization outreach vehicle (called Timothy) getting ready to go out to do an immunization session.



Original immunization outreach vehicle Barnabas, which "expired" just prior to the Child Survival start-up.



Happy mom, skeptical child in Musami.



A life-saving immunization being given by the Child Survival Nurse.



Training Session for mothers being conducted by Child Survival nurse.



Child Survival field officer assisting in a monthly growth-monitoring session in Musami, Zimbabwe.



Beginnings of the building of a demonstration Blair toilet.



Child Survival training officers conducting a training session for village health workers in Musami.



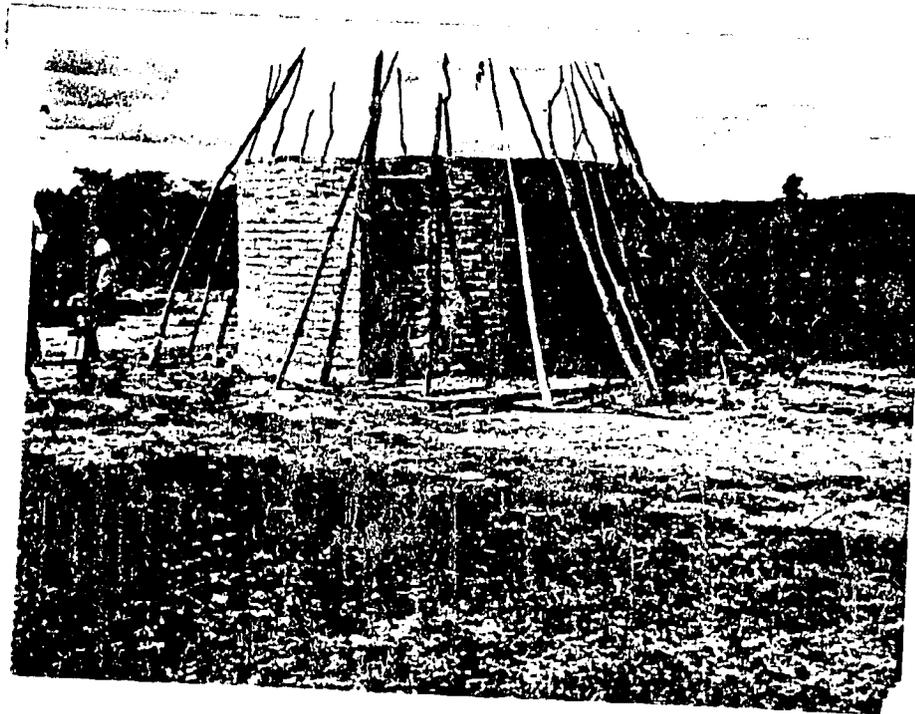
Some beneficiaries of the Child Survival project in Musami, Zimbabwe.



Typical landscape of the project area.



Community donating labor to construct a meeting hall/immunizations center.



Typical demonstration kitchen and garden built by the community as part of the Village Development Center (VIDEC)

APPENDICES

- A - Project Map
- B - Health Committees Established
- C - Response to Technical Recommendations
- D - Training Report
- E - Headquarters Approved Child Survival Project Proposal Form and Report of WVI Child Survival Coordinator
- F - Chronology of WV Zimbabwe Child Survival Project
- G - Original AID Annual Report Guidelines
- H - WV Child Survival Strategy Paper
- I - WV Child Survival Press Kit Contents

Health Committee Established

In every village development center one to three villages have formed a village health committee. There are 32 village health committees established so far. These are:

1. Benzi
2. Shamu
3. Diza
4. Mukurazhizha
5. Seki 1
6. Seki 2
7. Mhembere
8. Kuveya
9. Pfende
10. Manomano
11. Matete
12. Chigombe
13. Gwazvo
14. Zengenene
15. Mushinga
16. Toropito
17. Makumana
18. Dombodzvuku
19. Darare
20. Chidiya
21. Chitsaga
22. Murenge
23. Manjonjo
24. Mabika
25. Hurwi
26. Zvareva
27. Goto
29. Shamba muto
30. Chigwada
31. Chanetsa
32. Pakati

RESPONSE/ACTION TAKEN TO TECHNICAL RECOMMENDATION

Recommendations	Response/Action Taken
<p>1. The training of health workers is detailed in content, but teaching methods are not specified. Recommend that the project make use of materials on development and use of training materials, such as the Medex series, which includes methodologies for use with illiterates.</p>	<p>1. World Vision training material and curriculum have been developed. Methods of training used include group discussions, practical demonstrations, self-discovery, participatory, role plays and field visits. Materials used real food, home toilets, Posters used originated from Ministry of Health and UNICEF. Other available guides and materials will be identified and used.</p>
<p>2. Reviewers recommend that given the difficulties that VWH programs often have the supervision that this aspect of the project be planned in detail and provisions be made for training in adequate supervisory skills.</p>	<p>2. Existing Ministry of Health programs have a health supervisory cadre trained to supervise all levels of community health mobilizers (useful particularly when project phases out). The supervisory cadre is, in turn, supervised by the health center nurse. The training programs will also focus on supervisory</p>
<p>3. To the extent possible, it is recommended that trainers and supervisors be the same people since experience has shown that this facilitates retaining and supervision. If the main trainers cannot be supervisors, often the future supervisors can be given at least some of the training responsibility.</p>	<p>3. As recommended, the trainers and supervisors will be the same people. Assistance is given to the existing most supervision of VHWs by the Child Survival outreach team.</p>
<p>4. Recommend that the process of information, collection, analysis and use from the VHW to the supervisor (facilitator?) to higher levels to be clarified. What decisions should be made at each level?</p>	<p>4. Village health workers detail information in the village family registration. The Child Survival team collects this for compiling, analysis and dissemination and feedback to the village worker. The monitoring and evaluation plan gives further experience is accumulated. A further consultation with a health statistician will be undertaken.</p>
<p>5. Recommend for the vaccine program, that in addition to vaccine quantity needed as calculated by exact number to be given, that some allowance be made for wastage, interruption of resupply or increased demand beyond program guidelines in the start-up period.</p>	<p>5. The inventory for the vaccine program is maintained by St. Pauls' Hospital and taken into consideration of 20 percent wastage.</p>

WORLD VISION INTERNATIONAL
P.O. BOX 2420
HARARE, ZIMBABWE.



DATE: 27th May, 1986
TO: S. Mushapaidze
FROM: J. Nhliziyo
SUBJECT: REPORT ON CHILD SURVIVAL TRAINING FOR COMMUNITY HEALTH
MOBILIZERS IN MUSAMI

Introduction

The Child Survival Programme was initiated to speed up primary health care. It aims to continuously improve and maintain the health status of the community. Training the community to identify its needs, devise and carry out activities to achieve "Health for all by the year 2000" was recommended as an important strategy to be used in achieving the above goal.

In preparation for the implementation of the training for community mobilizers, consultative and planning meetings were held with different categories of people in order to achieve smooth implementation.

The initial meeting was held with the Musami Hospital Executive. The objectives of the training programme which are as follows were discussed:-

Training objectives

- a) To impart knowledge on community participation in programmes, programme planning and implementation.
- b) To conscientize the community mobilizers on their health needs and how to solve their health problems.
- c) To impart knowledge on basic health interventions like nutrition, water and sanitation, immunization, causes, prevention and treatment of diarrhoeal diseases.
- d) To motivate the mobilizer so that he is able to impart acquired knowledge on health to other people in the community.

The next meeting was with the Hospital Health committee members who are also representative of the community of the Musami catchment area on health issues. The training content was discussed. Suggestions on who was to attend the training sessions were made.

The members decided to go and hold meetings with their respective communities to discuss the training programme.

A meeting was later held with the Musami hospital executive, the hospital health committee members and the village health workers. This was a report back meeting on the previous consultative meeting. All the members reported favourable responses to the programme. They also made recommendations on the venues and periods of training for participants for different areas. They also suggested that the community leaders be trained as the community mobilizers. These leaders include kraalheads, vidco chairman, pre-school chairman and supervisors, nutrition co-ordinators, party leaders and all other grassroot workers.

A meeting was also held with the District Nursing Officer, Musami Hospital matron, the Provincial Nursing Officer, the Provincial Health Inspector and the acting Provincial Medical Director to update them on progress of the programme so far and to seek advice on the training programme.

The final meeting was held with the District Nursing Officer, the district community sister, the matron of Musami and the World Vision training officer to draw up the training programme and content.

Before and after every meeting, consultation was done with the Project Manager to ensure quality in the training programme.

Planning of the seminars

A meeting was held between Ministry of Health representatives, Musami Hospital executive and World Vision Staff to draw up a training programme and content. This was done in order to draw a training content which is in line with Government Health policy. The facilitators were also decided at this meeting.

Consultation was also done with the Provincial Health Education Officer and the Provincial Nutritionist on the training content.

The period of training venues and training content were designed in line with the recommendations of the community leaders.

Initially, six training sessions each lasting for 2 days were decided on. The participants were drawn from six different areas in the four pilot wards.

Methodology of facilitation

Basing on the relevance of the chinese proverb, "Hear and forget, see and remember, do and understand" the non-formal approach of education was used in order for everybody to contribute to the training.

Most of the training was in form of:

- Small group discussions
- Question and answer sessions
- Films were shown where possible.

- Practical demonstrations
- Role plays
- Field visits

Evaluation

This was done by participants in small groups answering the following questions:

- a) What had they learnt at the seminar?
- b) What hindered learning?
- c) What helped learning?
- d) What are the important tasks that they were going to carry out?
- e) What was not covered at the workshop as per participants' expectations?
- f) Future plans for other courses

They expressed their new found ability to plan and implement programmes. They now knew where to direct different communication to the right people. This was the first chance for different leaders to meet so they learnt the importance of working as a team. They learnt how to prevent and treat diarrhoea, how to prepare a balanced diet for a pregnant mother to the diet of an elderly person with special emphasis on breast feeding and weaning. They also learnt the importance of water and sanitation and immunization in preventing diseases and promoting health.

Musami nutrition village on 14-5-86 to 15-5-86

What helped in learning?

Film shows because they saw what other people were doing in their areas and they actual saw people carrying out activities to promote health.

Posters because they enhanced what had been discussed. -Pamphlets because the people would revise what they had learnt. -Small group discussions because everybody had a chance to air their views and contribute.

What hindered learning

Some participants showed lack of understanding of the course objectives. They spent most of the time arguing unnecessarily.

What are the important tasks that should be done after the workshop

Put into practice what they had learnt i.e. use of clean water and proper sanitation, proper hygienic practices, good nutrition, ensure that all the children are immunized. They were also going to impart the knowledge they had acquired to the people in the community. Planning and implementation of any projects will be done by leaders together.

What areas were not covered at the workshop which should have been covered?

The salaries of pre-school teachers were not discussed.

Plans for other courses

They needed a follow up workshop to find out what had been put into practice and what had not been done. This will also help to iron out problems which the community will have faced. They also wish to have yearly workshops to keep them up to date on how to prevent diseases in their community. At the subsequent workshops more members of the apostolic faith sect should be involved.

Zorizzozo School on 16th April to 17th April, 1986

What did we learn?

They learnt unity of all leaders and community workers. The duties of different community leaders were also explained and this will help the people when channelling any issues. The knowledge gained on the importance of water and sanitation, nutrition, immunization diarrhoeal diseases and oral rehydration therapy will help in promoting the health of the family and its economy too.

Programme planning and implementation session helped solving a lot of problems they were facing in building pre-school centres.

What helped in learning?

Film shows and posters because some of them cannot read or write but they could see and hear what other people were doing for their communities. - Group discussions because they had a chance to share their views with other people from their communities rather than being told what to do. - The attitudes of the facilitators because they were cheerful, relaxed and knowledgeable. They took time to explain all issues that arose.

What hindered learning?

Unnecessary arguments and lack of respect for some community leaders who were also participants.

What are the important tasks that should be done after the workshop?

Leaders will ensure that all people use clean water and proper sanitation. Encourage planning and implementing of projects by all leaders and their people together. Impart knowledge on health interventions to other people. Encourage the Apostolic faith members to have their children immunized and be cleansed with their holy water. The use of the right people for any developmental project will be practised.

Future plans for other courses

Follow up workshops to assess the progress in prevention of diseases and developmental projects. These workshops will also help people who still have health problems in their communities to find solutions. Yearly follow up workshops would be appreciated.

Musami Nutrition village (2) 21-04-86 - 22-04-86

What did we learn?

We learnt that unity among leaders is a very important pre-requisite of development. Community participation helps people to regard programmes as their own not the donor agency's property. This will help the people to maintain the property well. The people have also learnt how to recognise their health needs and how to solve their health problems especially in prevention and treatment of diarrhoeal diseases and use of oral rehydration therapy. The importance of immunisation and use of clean water and good sanitation was also learnt.

What hindered learning?

There was no hinderance to learning.

What helped in learning?

The use of films and posters helped as motivating aids because people could see what happens in other places and these helped re-enforcing the knowledge acquired during discussions.

The type of facilitation e.g. group discussions and role plays encouraged everybody to contribute towards what was being taught.

The food eaten at the training sessions helped both as a visual aid on good nutrition and as a motivating factor on basic human needs.

What areas were not covered in the workshop which participants expected to be discussed?

The sessions on child spacing were too short.

Future plans for other courses

Follow up workshops to assess progress in health interventions and other community development programmes. At these workshops new and previous participants should be brought together to ensure a continuity in health interventions. This will also serve to evaluate the previous training sessions.

Chemhondoro School 25-04-86 - 26-04-86

What did we learn?

Food - the type of food eaten, the way it was cooked and presented has been a very good example to follow in our homes because it was nutritious and clean.

The importance of community participation and co-ordination among the leaders was correctly over-emphasized. The knowledge on prevention and treatment of diarrhoeal diseases by use of clean water, good sanitation and use of Oral Rehydration therapy will relieve many people of the burden of travelling long distances to Hospitals.

Nutrition education was also learnt with emphasis on diet in pregnancy, breast feeding, weaning and the food square on available foods.

What helped learning?

The method of facilitation which involved participants all the time. They allowed the participants to contribute what they already knew. The big posters were a reminder to the participants that they were attending a health seminar and that stopped people from wondering away from the seminar.

The practical demonstrations especially on preparation of oral rehydration solution and the locally available foods that constitute a balanced diet made it easy for people to go and do it at home.

What hindered learning?

Nothing hindered learning.

What are the important tasks to go and do after the workshop?

To report back to the others on what was learnt especially on health interventions.

To show by examples on use of clean water and proper Blair toilet, good personal, food and home hygiene and having all children immunized. Encourage proper co-ordination among leaders.

Plan and implement programmes together, all leaders and the people.

Plans for future courses

Arrange a workshop for the remaining community leaders and the Apostolic Sect which do not believe in immunization or sending their people to hospital.

Hold a follow up workshop yearly to assess what has been implemented and what has not and also to solve problems that might have arisen.

More mothers to be involved in future workshops since they do most of the work in the home like cleanliness of the home, prepare food for the family members. They also take the children for immunization.

Gezi School on 5th May, 1986 to 6th May, 1986

What did we learn?

The importance of working together in order to achieve success in development goals from planning to implementing. We learnt that most health problems can be prevented e.g. bilharzia, diarrhoea, malnutrition, polio, tuberculosis, diphtheria, tetanus, pertussis and measles. We also learnt how to prevent and treat the above health problems. Community participation was discussed as this helps people to regard any programme as their own and this helps to make a project viable when the community remains alone to carry on with the programme.

What helped us in learning?

The venue:- There was no noise to distract the participants because the school is away from the villages. The facilitators were very knowledgeable. Group discussions helped to make many people air their views so sharing of ideas was wide.

The pamphlets issued helped us to revise what had been taught. The presence of the kraalheads helped to make final resolutions on the tasks to be carried out at home. The practical demonstration on the preparation of the oral rehydration solution were easy to follow.

What hindered learning?

Some of the participants made unnecessary arguments.

What are the important tasks that are to be done after the workshop?

The participants as leaders of the community are going to show what they learnt by building toilets in their homes and using protected water supplies. They are going to ensure unity of all leaders in the community. They are also going to teach others the health interventions they were taught.

All community development programmes are going to be speeded because the participants felt they had acquired better knowledge on planning and implementing projects.

Plans for future courses

Participants wish to have follow up workshops to evaluate progress on what had been learnt. The workshops will also help to solve problems that might be met in implementing what had been learnt. This will also help to update the participants with information that they might have forgotten. At the follow up workshops, new participants should also be invited so that many people can be involved in preventing diseases and promoting health.

Nyamutumbu Agritex Training Centre 8-05-86 to 0-05-86

What did we learn?

The sessions on health topics were an eye opener because we are now able to prevent and even treat some diseases like diarrhoea and malnutrition.

Unity among community leaders will help in developing our communities. The role of the community leaders and other workers has helped us to know where to take the different problems faced.

What helped in learning?

The food eaten made everybody relaxed and attentive because it was exemplary on content and cleanliness. All the topics discussed were relevant to our needs and course expectations. The facilitators allowed everybody to contribute to the discussions. The pamphlets issued helped to reenforce what had been discussed. Everybody tested the prepared sugar and salt treatment for diarrhoea.

What hindered learning?

There was no hinderance to learning.

What are the tasks to be done after the workshop?

The participants who have no toilets and protected water sources have decided to go and build the toilets and protected wells but hope to get material support for those who have not got especially cement. They are also going to impart knowledge on health interventions to people who had remained at home. All leaders are going to unite when planning and implementing any community programmes. Since all the participants were community leaders, they were going to encourage people to have their children immunized, build blair toilets, boil water or use water from a protected source and have nutrition garden or community gardens and village development centres.

Plans for future courses

Follow up courses to evaluate what had been implemented. Train new people especially the Apostolic Sect members who do not believe in any hospital treatment.

Include facilitators from Ministry of Labour and Social Services for them to solve matters on government social assistance.

Recommendations

- a) Training of community leaders should be an on going strategy because they seem to isolate themselves from different development projects by identifying the projects as belonging to individuals and not the communities.
- b) The importance of involving the local staff in training should be put in the forefront in order to ensure continuity when the programme's life span ends.
- c) Continuous close liason and co-ordination with the ministries involved in the programme area helps in smooth implementation of the program. This way we give more meaning to what is called a joint effort and partnership programme.
- d) The training program should be designed in line with recommended health education policy of the Ministry of Health to ensure uniformity of information disseminated by different workers in all areas.
- e) More people in the same areas should be trained since the services are delivered voluntarily. This helps in the event that one worker becomes inactive or leaves the area, the others will always remain carrying on the task or responsibility. This also instils competition among the mobilizers.
- f) Training should be a regular activity, considering the short period of training and the volume of knowledge and information about health to be learnt.

This also helps the mobilizers to learn to put value and importance to all their endeavours.

The partnership that was shown in the training sessions and willingness to improve the health status of their communities was educative to the facilitators. Information collected will help the facilitators when they plan the next sessions. The organization provided material support and invited facilitators and the participants provided people to prepare food, venues and made the atmosphere congenial to learning.

St. Pauls Musami (1) 14-04-86 to 15-04-86 (Participants List)

Mr. F. Matete	Chairman Musami Health Committee
Mrs. Machengo	Health Committee Member
Mrs. Diza	Health Committee Member
Mr. Gatoma	Health Committee Member
Mr. Masivadzawo	Health Committee Member
Mrs. Makumi	Health Committee Member
Mrs. Mutsago	Health Committee Member
Mr. L. Bumhi	Health Committee Member
Mrs. Mhembere	Village Health Worker
Mrs. Mandere	Village Health Worker
Mrs. Kamhara	Village Health Worker
Mrs. Jani	Village Health Worker
Mrs. Makombe	Village Health Worker
Mrs. Zongororo	Village Health Worker
Mrs. Chirenda	Village Health Worker
Mrs. Mhonyera	Village Health Worker
Mrs. Chisungo	Village Health Worker
Mrs. Jemwa	Village Health Worker
Mrs. Tomu	Community Based Pill Distributor
Mrs. Maupfu	Village Health Worker
Mrs. Mutichakwa	Village Health Worker
Mrs. Chigumba	Nutrition promoter
Mr. Jonas	Councillor
Mr. Mhembere	District Party chairman
Mrs. Nhau	Community Development Worker

St. Pauls Musami from 21-04-86 to 22-04-86

Participants list

F. Matete	Health Committee Chairman
E. Jonasi	Councillor
A. Mazivinga	Branch chairman
J. Marufu	Village Chairman
K. Chiradza	Branch Chairman
F.J. Yana	Kraalhead
Otilia Dhana	Pre-school teacher
G. Garikayi	Pre-school chairman
E. Chiyangwa	Kraalhead
S. Makuchuruka	Village Chairman
S. Mangwenzi	Vidco chairman
E. Mhembere	Vidco chairman
D.A. jena	Pre-school chairman
J. BAngo	Kraalhead
S. Tombe	Village Committee Member

N. Kuripisa	Village Committee Member
D. Mushake	Mushake village chairman
M. Ngwerume	Village chairman
Mrs. Tomu	Village chairman
S. Tegwe	Pre-school teacher
S. Pahurwi	Kraalhead
S. Tigere	Branch chairman
C. Maudere	Village Health Worker
A. Mhembere	Village health Worker
N. Mhere	Village chairman
K. Mushake	Kraalhead
W. Chiradza	Village chairman
J. Muchagoneyi	Pre-school chairman

Zorizozzo from 16-05-86 to 17-06-86

Participants List

V. Chari	Sabhuku Matete
N. Gwara	Sabhuku Zinhumwe
B. Chirenda	Village Health Worker
Elifigio	Pre-school supervisor
Mrs. Gabriel	Vidco chairlady
F. Midoamo	Pre-school supervisor
C.G. Magomo	Pre-school chairman
Mrs. Nyandoro	Village chairman
Beatrice	Preschool teacher
Mrs. R. Chiradza	Branch chairman
C. Gomo	Vidco chairman
Mrs. Shoriwa	Pre-school teacher
C. Tagarira	Village chairman
Mrs. Mupedza	Pre-school teacher
Finias	Village chairman
Mr. Muyengwa	Kraalhead
Mrs. J. Sandi	Nutrition Promoter
C. Chigumba	Village Health Worker
E. Jonasi	Councillor
F. Matete	Health Committee chairman
M. Juru	Councillor
Mrs. Majuru	Chairlady
S. Muchagoneyi	Village chairman
Mrs. Tangwanda	Pre-school supervisor
Mrs. Mushamba	Vidco Chairlady
Mr. Chiradza	Kraalhead
L.M. Goma	Vidco chairman

Chemhondoro from 25th - 26-05-86

Mr. Svenhe	Kraalhead
A. Musungambwa	Pre-school supervisor
K. Mukakanhanga	Chairman village
E. Chinyerere	Village chairwoman
T. Mare	Vidco chairman
M. Fukure	Pre-school supervisor
S. Guveya	Kraalhead

J. Marufu	Kraalhead
R. Mutatarara	Vidco chairman
S. Muchapondwa	Kraalhead
E. Mhembere	District chairman
C. Bika	Village Chairman
M. Masawi	Village chairman
J. Nhau	Kraalhead
V. Mandongwi	Pre-school chairman
A. Makurira	Pre-school supervisor
B. Nyikadzino	Health Committee member
Mrs Chigoya	Pre-school chairwoman
S. Chigurenwira	Pre-school supervisor
M. Pfende	Pre-school chairwoman
E. Nyikadzino	Pre-school chairwoman
F. Jokonya	Village chairwoman
R. Mukakanya	Kraalhead
A. Tafirenyika	Pre-school supervisor
R. Bure	Pre-school supervisor
T. Jemwa	Village Health Worker
J. Jani	Village Health Worker
S. Marange	Pre-school supervisor
G. Muza	Vidco chairman
R. Jani	Village chairman
C. Mabika	Kraalhead
J. Magaya	Pre-school chairman
L. Pfende	Pre-school chairman
G. Matope	Vidco chairman
S. Njokoza	Village chairman

Gezi School from 5-05-86 to 6-05-86

Participants list

A. Makuni	Musami health Committee member/ Village Health Worker
M. Kaseke	Pre-school teacher
B. Chihoko	Chairman pre-school
E. Mhembere	Musami District chairman
A. Madzikanda	Pre-school Chairman
E. Jonasi	Councillor
Jeke	Village chairman
C. Muroyiwa	Pre-school teacher
C. Mashamba	Pre-school chairman
Mrs. Makwasha	Pre-school teacher
Robert Gandiwa	Vidco chairman
Mrs. Ngara	Pre-school chairman
Kukora Gezi	Kraalhead
Chenharo	Village chairman
E. Mutandwa	Village chairman
M. Madzikanda	Village chairman
M. Mtandwa	Kraalhead
M. Mteswa	Treasurer
P. Munemo	Kraalhead
F. Gaadza	Kraalhead
Chigaramasimbe	Village chairman
S. Nyoni	Village Police
C. Ganda	Group chairman

E.M. Nyatiyaro	Village Chairman
V. Chaora	Kraalhead
M. Hore	State certified Nurse Child Spacing District coordinator Child Spacing
Mrs. Nhau	Community Development Worker

Nyamutumba Village 8-05-86 to 9-05-86

A. Hore	Mrewa health Chairman/Councillor
Stephania	District Chairman
W.M. Makore	Branch chairman
Z. Gatsi	Village chairman
Masango	Kraalhead
Duweti	Village chairman
Pennish Chiwanza	Village Health Worker
Chedende Chiwanya	Village Chairman
Chidyamudungwe	Village Chairman
Isaac Shamba	Village chairman
Margaret School	Pre-school teacher
Maud Zingunde	Pre-school teacher
Maximus Mavhurume	Village chairman
Gatahwa Kufa	Kufa village chairman
B. Mhembere	Pre-school teacher
Stanley Muyondo	Pre-school chairman
M. Chami	Kraalhead
M. Makwasha	Pre-school chairman
L. Chakanetsa	Pre-school chairman
L. Kadzere	Branch and Vidco chairman
R. Shamu	Chairlady vidco
M. Makachaire	Pre-school teacher
P. Munanga	Village chairman
M. Mabvuwane	Kraalhead
M. Diza	Pre-school mistress
E. Neuso	Pre-school mistress
M. Makore	Kraalhead
A. Chaikosa	Village Health Worker
G. Diza	Village Chairman
L. Gatora	Village Chairman
J. Nyamutumbu	Vidco Chairman
L. Diza	Branch chairman
E. Masawi	Village chairman
Mrs. Hunidzarira	Vidco Secretary
L. Bumhe	Village Health Worker
M. Bere	Village chairman
E. Dizah	Village Health Worker
F. Matete	Musami Health Committee Chairman

Facilitators

Mrs. J. Nhliziyo	Child Survival Health Training Officer World Vision
Mrs. E. Tagwireyi	Health Associate World Vision
Mrs. N. Hove	District Nursing Officer, Murewa
Mrs. Donzwa	Community Nursing Sister Murewa District
Sister F. Chipango	Matron Musami Hospital
Mr. C. Mudengezi	Administrator Musami Hospital
Mrs. Chingombe	Village health Worker Trainer Murewa District

Mr. Nyamutawera	Cadec Training Officer
Mrs. Hore	Nursing Officer Child Spacing Council Mashonaland East
Mr. Hore	District Health Committee Chairman Murewa
Mr. Nzuma	National Supervisor for Community based Pill distributor

Training Programme

Day 1

0830	Opening Prayer
0845-0900	Introduction of Participants
0900	Opening Speech
1030	Objectives of the course
0930-1000	Participants expectations
1000-1030	Tea
1030-1200	The Roles of: Councillors Village/Ward/District Development Committees Village Health Workers Health Assistant Community Development Workers Community Based Family Planning Distributors
1200-1300	Nutrition - Nutrition in Pregnancy - Breast Feeding - Weaning - The food square
1300-1400	Lunch
1400-1500	Community Participation in Projects planning and implementation
1500-1515	Tea
1515-1630	Expanded Programme on Immunisation
1630-1800	Break
1800-1900	Supper
1900-2000	Film on Water and Sanitation Mental Health
2000	Closing Prayer

Day 2

0800-0815	Opening Prayer
0815-0900	Hygiene - Personal - Food - The Home
0900-1000	Water and Sanitation
1000-1030	Tea
1030-1200	Diarrhoeal diseases Oral Rehydration Therapy
1200-1300	Growth Monitoring
1400-1600	Visit a Village Development Centre/Immuniza- tion Session
1600-1700	Evaluation
1700	Closing Prayer

God is not unjust, he will not forget your work and the love you have shown as you have helped his people and continue to help them.

WVI IMMUNIZATION AND
CHILD SURVIVAL
PROGRAM COORDINATION

PERSON RESPONSIBLE Rufi Macagba
APPROVAL BY _____
DATE 1 June 1986

OBJECTIVE:

"To expand WVI's involvement in immunization and child survival efforts in the field."

GOALS FOR FY87:

1. To have at least four proposals for area-wide immunization projects in the field, and have at least three new proposals for child survival projects.
2. To publish a resource booklet for immunization and child survival projects.
3. To develop and field test a prototype training course in immunization and child survival concepts and methods that can be adapted to the requirements of each country for the training of community health workers or VHWs in these projects.
4. To develop prototype illustrated health education/training booklets on (a) oral rehydration, (b) immunization, and (c) child nutrition, aimed at the home and community levels in developing countries.
5. To conduct an annual evaluation of each immunization or child survival project.
6. To print and distribute prototype illustrated health education/training booklet on oral rehydration aimed at the home and community levels in developing countries.
7. To visit at least four field or program offices each quarter in coordination with the appropriate RVP staff, to promote the program, assist in the development of proposals for large projects, evaluate the status of existing projects, and provide technical guidance as required.
8. To attend at least one international conference on child survival and/or immunization.
9. To implement the training course in project planning, implementing and evaluating immunization and child survival projects for the training of project managers and staff.

ARM6528.Q

- 4.0 State the Plan of Action using the same numbers for goals stated on the first page of IA153 (PPF) and from the Goal Changes section of the Ongoing Project Budget Form (IA243). Under each goal summarize 2 or 3 major activities intended to achieve each goal for the current year.

GOALS/MAJOR ACTIVITIES FOR FY-87

1. Four immunization and three child survival project proposals:
 - a. Obtain latest project proposal guidelines from funding agencies.
 - b. Inform the field in collaboration with RVPs.
 - c. Assist interested field offices in writing project proposals.
2. Resource booklet for immunization and child survival projects:
 - a. Get someone to do research on useful resources for these projects.
 - b. Produce final manuscript and duplicate for field use.
3. Prototype training course on immunization and child survival concepts and methods:
 - a. Design prototype training course.
 - b. Field test and implement with WVI health advisers in the field.
4. Prototype illustrated health education/training booklets on oral rehydration, immunization and child nutrition.
 - a. Do research on available material in field countries.
 - b. Develop, field test, refine and print prototype booklets.
5. Annual evaluation of each immunization and child survival project:
 - a. Develop monthly/quarterly reporting system for each project.
 - b. Compile monthly/quarterly reports.
 - c. Arrange for annual evaluations to be done by WVI regional advisers in PHC.
6. Training course in health program management:
 - a. Field test and refine course.
 - b. Implement course in field countries with major projects in immunization or child survival.
7. Staff Development:
 - a. Attend at least one major international conference on immunization or child survival.

9/11

ON-GOING PROJECT BUDGET FORM FOR FY 87

Please complete Project Budget form (IA125) on reverse side.

COUNTRY U.S.A.	PROJECT NUMBER GEN-31-531998	PROJECT NAME WVI IMMUNIZATION AND CHILD SURVIVAL PROGRAM COORDINATION	PREPARED BY RUFU MACAGBA	DATE 7-14-86
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FINANCIAL HISTORY AND FUTURE PLANS:

Type or Source of Funding	Act. Expend. for Prior FY's	Projected Expenditures for FY <u>86</u>	Requested Budget for FY <u>87</u>	Est. Budget for FY <u>88</u>	Est. Budget for FY ___	Est. Budget — Remaining Years	Total Project Budget
From World Vision		\$2,000	\$95,120	\$104,700			\$201,820
From Non-World Vision Sources		10,400	10,000	12,000			32,400
Total		\$12,400	\$105,120	\$116,700			\$234,220
Number of Children-in-Program							

GOAL CHANGES (Additions, deletions, or revisions to project goals. Explanation of changes from previously submitted budget amounts or termination dates.)

(See attached goals sheet)

WORLD VISION INTERNATIONAL
PROJECT APPROVAL SYSTEM

LHI

Project Budget Form

COUNTRY U.S.A.	PROJECT NUMBER GEN-31-531998	PROJECT NAME WVI IMMUNIZATION AND CHILD SURVIVAL PROGRAM COORDINATION	PREPARED BY RUFU MACAGBA	DATE 7-14-86
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INCOME:

		FISCAL YEAR <u>87</u>				
A/C NO	DESCRIPTION	QUARTER I	QUARTER II	QUARTER III	QUARTER IV	TOTAL
700	Income - World Vision					
710	Income - Other Partners					
720	Income - Local					
	TOTAL INCOME					

EXPENDITURES:

		FISCAL YEAR <u>87</u>				
A/C NO	DESCRIPTION	QUARTER I	QUARTER II	QUARTER III	QUARTER IV	TOTAL
	Travel	\$4,500	\$4,500	\$4,500	\$4,500	\$18,000
	Training materials production	2,500	2,500	2,500	2,500	10,000
	Training materials purchases	1,500	1,500	1,500	1,500	6,000
	Supplies and misc.	300	300	300	300	1,200
	International Office Support	14,980	14,980	14,980	14,980	59,920
	Expense to Revolving Loan					
	TOTAL EXPENDITURE	\$23,780	\$23,780	\$23,780	\$23,780	\$95,120

SUPPLEMENTARY PROJECT UPDATE FORM

COUNTRY <u>U.S.A.</u>	PROJECT NUMBER	PROJECT NAME WVI IMMUNIZATION AND CHILD SURVIVAL PROGRAM COORDINATION
NAME OF PRIMARY PARTNER AGENCY		DENOMINATION OF PRIMARY PARTNER AGENCY
PUBLICITY SENSITIVITY <u>X</u> None ____ Medium, check before use* ____ High, no publicity*		NUMBER OF DIRECT BENEFICIARIES Adults _____ Children _____ Total _____
PROJECT ELIGIBLE FOR SPECIAL FUNDING ____ Yes (Relief, Dev., E/L only) ____ No*		NUMBER OF PAID PROJECT STAFF <u>1</u> Expatriates ____ Nationals
		OTHER WVI PROJECTS IN SAME COMMUNITY

1.0 Check all current descriptors regardless of project type. (If Family or Community Development [110 or 111] is checked, also do Dev. Subtype in Column 3. These are all 11 sponsorship projects.)

<input type="checkbox"/> SPONSORSHIP	<input type="checkbox"/> RELIEF	<input checked="" type="checkbox"/> DEVELOPMENT	<input type="checkbox"/> EV/LDRSHIP DEV
<input type="checkbox"/> School (101) <input type="checkbox"/> Day Care Center (102) <input type="checkbox"/> Baby Home (103) <input type="checkbox"/> Orphanage (104) <input type="checkbox"/> Handicap Related (105) <input type="checkbox"/> Leprosy Related (106) <input type="checkbox"/> TB Related (107) <input type="checkbox"/> Family-to-Family (108) <input type="checkbox"/> Family Development (110) <input type="checkbox"/> Community Development (111)	<input type="checkbox"/> Emergency Relief (201) <input type="checkbox"/> Rehabilitation (202) <input type="checkbox"/> Refugee Related (203) <input type="checkbox"/> Natural Disaster (204) <input type="checkbox"/> War Related (205) <input type="checkbox"/> Urban Relief (230)	<input checked="" type="checkbox"/> Single Activity (301) <input checked="" type="checkbox"/> Multiple Activity (302) <input checked="" type="checkbox"/> Macro or Regional (303) <input type="checkbox"/> One-time Grant (304) <input checked="" type="checkbox"/> Family Based (305) <input checked="" type="checkbox"/> Community Based (306) <input checked="" type="checkbox"/> Proj Staff Training (307) PRINCIPAL DEVELOPMENT SUBTYPES <input checked="" type="checkbox"/> Health/Nutr/Food Plan (351) <input type="checkbox"/> Agricul Improvement (352) <input type="checkbox"/> Land Reogenor/Water (353) <input type="checkbox"/> Employ/Income Gener (354) <input type="checkbox"/> Educ/Irng/Literacy (355) <input type="checkbox"/> Christian Nurture (356) <input checked="" type="checkbox"/> Large Scale (375) <input type="checkbox"/> Urban Dev (380)	<input type="checkbox"/> Scholarship (401) <input type="checkbox"/> Church Lay Irng (402) <input type="checkbox"/> Child Evangelism (403) <input type="checkbox"/> Pastor/Evang Irng (404) <input type="checkbox"/> Scripture Distrib (405) <input type="checkbox"/> Survey/Research (406) <input type="checkbox"/> Prison Ministry (407) <input type="checkbox"/> Crusade Evangelism (408) <input type="checkbox"/> Management Irng (409) <input type="checkbox"/> Project Stf Irng (410) <input type="checkbox"/> Unreached Peoples (411) <input type="checkbox"/> Seminar/Conference (412) <input type="checkbox"/> One-time Grant (413)

2.0 Significant information about the education, technical skills, experience and employment status of the project manager.

Project manager is Dr. Rufi Macagba, who has served as WVI's health care delivery systems adviser since 1975.

3.0 Please itemize the major expense items contained in the budget categories of salaries, supplies and capital expenditures on the revised annual budget (Ongoing Project Budget Form IA125). Please include amounts and estimated costs.

FY '87

Travel.....	\$18,000
Training materials production.....	10,000
Training materials purchases.....	6,000
International Office Support.....	59,920

150

WORLD VISION

MEMO

Date: September 24, 1986

To: Bryant Myers

From: Ruffi Macagba

Subject: Progress report on Immunization and Child Survival Program

Bryant, here is my latest progress report on the program. I appreciate your continuing support and encouragement.

Sincerely,

Ruffi

cc: (Last two pages)

PROGRESS REPORT ON WVI IMMUNIZATION/CHILD SURVIVAL PROGRAM

By Rufi Macagba, Program Coordinator

September 23, 1986

IMMUNIZATION PROGRAM

1. **FURTHER PROGRESS IN CANADIAN FUNDING:** Linda Tripp of WV Canada recently announced that the Canadian Public Health Association (CPHA) expects to be ready to accept project proposals from Commonwealth countries in October, 1986. Steve Houston of WV Canada has been given the responsibility for interacting with CPHA and preparing the final form of project proposals before submitting them to CPHA.

2. **STATUS OF WV IMMUNIZATION PROJECT PROPOSALS:** WV ZAMBIA has submitted its refined project proposal for the Southern Province, which has been forwarded to WV Canada. It will be shown informally to CPHA for suggestions on content and format before it is finalized and submitted. WV GHANA indicated by telex that its refined proposal for the Western Region is being finalized and will soon be on its way to the I.O.

WV TANZANIA has recently hired new health staff and will be visited by Rufi Macagba after the Africa Regional Strategy Conference in November to provide any assistance that may be needed in refining their immunization project proposal for the Shinyanga District. By that time, we hope to have the project proposal guidelines from CPHA.

3. STATUS OF IMMUNIZATION EFFORTS IN PROJECT COMMUNITIES:

A. **AFRICA REGION:** WV ETHIOPIA has expressed interest in collaboration with WHO in a training program on Logistics and Cold Chain Management. WV TANZANIA has a nurse/midwife going around in a mobile clinic to immunize the children in WV projects. WV ZIMBABWE has a plan to have a mass immunization campaign among the children in its Child Survival Project area during the first quarter of FY 87.

WV MALAWI has communicated its desire to the Ministry of Health to seek to strengthen the Expanded Programme on Immunisation by motivating communities in one of its Development Areas to increase the number of immunised children. WV GHANA continues its program to immunize the children in all its project communities and has deployed an experienced public health nurse in each Region in the country, to follow through on this program.

B. **ASIA REGION:** WV INDIA has included immunization as a goal in the great majority of its new PPFs for FY87.

C. **LATIN AMERICA REGION:** As stated in the last progress report, the Field Directors of the Region made a decision to include immunization of the children in WV project communities in their new operations and management plans.

In response, WV CHILE reported in a memo to the RVP that as a result of a survey made to study the matter of vaccination of children in WV projects, it has reached the conclusion that "more than 85% of the children are up-to-date in this respect. The remainder are being controlled now so as to complete the necessary vaccinations." It is hoped that more field offices will also find out for themselves how many percent of the children are immunized and will then make a decision on what to do about it.

4. LINKAGE WITH WHO ON IMMUNIZATION: A plan of action for collaboration proposed by Rufi Macagba after a visit to Geneva has been approved by the Director of WHO's Expanded Programme for Immunization (EPI). This includes invitations to international WHO conferences on immunization and child survival, two-way exchange of training materials, and training in Logistics and Cold Chain Management by WHO staff for WV and MOH staff in requesting field countries. One result is that Rufi Macagba will be attending the WHO Global Advisory Group Meeting on EPI in New Delhi this October. Coordination with WHO's office for collaboration with NGOs has also been established.

5. SPECIAL WV PROMOTIONAL VIDEO ON IMMUNIZATION: Don Maynard's group is in the final stages of completing this special video aimed at promoting field office participation in immunization programs.

CHILD SURVIVAL

1. WV ZIMBABWE CS PROJECT: The first annual internal evaluation of this project will be conducted this October by Ann Biro, RN, MPH of WVRO and Dr. Susie Kessler, APHA Executive Director, as a result of a contract made by WVRO and APHA during the early months of this project. The first monthly technical report of the project arrived for the month of August, showing useful statistical information for the month and year-to-date on project inputs, outputs, effectiveness and impact. Dr. George Ngatiri serves as special adviser to this project. The first annual report to USAID is due in October, 1986.

2. WV SUDAN CS PROJECT: This AID-funded CS project will begin this October. Two experienced public health nurses (one from the U.S. and one from Europe) and an African nutritionist are already on board. The search is still on for a project manager. Dr. Rufi Macagba and Dr. Alemu Mammo are scheduled to visit the project staff from Nov. 28-31, to help develop a detailed implementation and evaluation plan, and a technical reporting system for the project.

3. WV SENEGAL CS PROJECT: This is the other AID-funded CS project beginning this October. Its project manager will be Dr. Milton Amayun who has an MPH from Harvard and extensive WV field experience in Asia, Latin America and Africa (currently with WV Ethiopia). An experienced public health trained man, Mr. Jean M'Baitoloum from Tchad has been seconded by the WV Dakar office to be available as another key person in this project. The search is still on for a contract person as public health nurse for the project. Dr. Rufi Macagba is scheduled to visit this project on November 13-19 for the same purpose as the visit to Sudan.

4. LINKAGE WITH LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE: WV Britain has agreed to pay the fees and expenses of two trips to Africa by Dr. Andrew Tomkins of the Department of Human Nutrition to prepare for and conduct a Field Office-based prototype trainer training workshop on nutrition monitoring

and improvement, an essential part of child health and survival. Dr. Alemu Mammo is coordinating Dr. Tomkins' trips and will be submitting a formal proposal on the proposed workshop to the RVP for Africa.

To conserve WV funds, the workshop will be conducted in a field country for field office and project staff. Other field offices and regions would be invited to send observers at their own expense. These observers will bring home the experience and the materials from the workshop, for implementation in their own areas.

5. INCREASING WV PARTNERSHIP INTEREST IN RAISING FUNDS FOR CS PROGRAMS: Peter McNee of WV NEW ZEALAND and Ian Curtis of WV Australia have expressed a strong interest in obtaining copies of available promotional materials on child survival for use in their respective support countries. Bruce Brander of the I.O. has been requested to write promotional materials on immunization and child survival for use by the Partnership. WV US is interested in a direct mail campaign to raise funds for WV projects on immunization.

cc:

INTERNATIONAL OFFICE:

Hal Barber
Ed Dayton
Manfred Grellert
Reda Hanna
Dean Hirsch
Graeme Irvine
Sam Odunaike
Russ Kerr
Ron Maines
Jack Kenyon
Dayton Roberts
Dick Watson
FDD Executive Staff

FDO: Mulatu Belachew and Alemu Mammo, Africa FDO

LSD: Bob Ainsworth/Julian Pitchford
Milton Amayun, Louga CS Project
Tony Atkins, Nairobi
Loc Le Chou, Louga WU Team
George Ngatiri, Zimbabwe

SUPPORT OFFICES: Through Cheryl Stock (Support Office distribution)

WVRO: Paul Thompson
Ann Biro

WVI PHC NETWORK:

Africa:

Ms. Helena Eversole and health team, WU/Ethiopia
Dr. Joe Riverson and health team, WU/Ghana
Ms. Joyce Githaiga and health team, WU/Kenya
Mrs. Rose Namarika and associate, WU/Malawi
Mrs. Florence Manning and health team, WU/Tanzania
Mrs. Paitha Sikazwe, WU/Zambia
Mrs. Bongi Mushapaidze and health team, WU/Zimbabwe

Asia:

PHC Coordinator, WU Bangladesh
PHC Coordinator, WU India
Ms. Corry Tilaar, WU Indonesia
Dr. Young Ae Chae, WU Korea
PHC Coordinator, WU Philippines
PHC Coordinator, WU South Pacific
PHC Coordinator, WU Sri Lanka
PHC Coordinator, WU Taiwan
PHC Coordinator, WU Thailand

Latin America:

PHC Coordinator, WV Bolivia
PHC Coordinator, WV Brazil
Dr. Lee Huhn, WV Chile
PHC Coordinator, WV Colombia
PHC Coordinator, WV El Salvador
PHC Coordinator, WV Haiti
PHC Coordinator, WV Dominican Republic
Dr. Anette Fortin and health team, WV/Guatemala
PHC Coordinator, WV Mexico

APPENDIX F
CHRONOLOGY OF WORLD VISION ZIMBABWE CHILD SURVIVAL PROJECT

DATES	ACTIVITY
Jan/Feb 1985	Proposal written in WVRO.
Aug/Sept 1985	Contract effective and signed WVZ/WVRO with assistance from APHA. Wrote "workable framework."
October 1985	Project manager and evaluation officer assigned to project.
September 1985	Wayne Stinson (APHA) and John Ahrens (WVRO) to Zimbabwe and worked with George Ngatiri (WVI) and WV Zimbabwe to redesign project. Project and Kaitano ward selected. "Workable framework design."
September 1985	WV Zimbabwe (Max Chigwida, Flora Gwazemba, Bongi Mushapaidze) and John Ahrens (WVRO) attended monitoring and Evaluation workshop in Airlee, Virginia, sponsored by USAID.
September 1985 to November 1985	WVZ selection of project site by project manager. World Vision technical advisor worked out details of approval by MOH project manager. Evaluation officer and technical advisor collected data and did baseline survey in Kaitano.
November 1985	MOH (Provincial Medical Officer) asked WV to change project site from Kaitano to St. Paul's, Murewa District, due to World Bank project in Kaitano.
Early December	Visit by AB, MF, WS and GN to write detailed implementation plan. Wrote DIP and confirmed selection of Musami Pilot Area.
January 1986	Negotiations took place with government of Zimbabwe regarding project hiring of field/evaluation officer, Brighton Chirairo.
February 1986	Baseline survey in Musami by project staff.
March 1986	Training officer, Jelda Nhliziyo, hired.
April 1986	Refined Implementation Plan written in field by project staff and World Vision senior technical consultant.

April to June 1986 Child Survival activities were in progress at Musami. Immunization monthly training of 60 community mobilizers and leaders.

April 1986 Sierra Leone AID-sponsored conference integrating Child Survival into development projects (G. Ngatiri and S. Mushapaidze).

May 1986 Training officer to Nairobi for workshop on training of trainers.
Discussions with government of Zimbabwe and decision to expand to Murewa district.

June 1986 Training officer and health officer to Zambia for training community-based health care workshop on how to design community-based health programs.

July/August 1986 Continued Musami activities, particularly facilitating in establishment of VIDECS.

September 1986 Prepared for annual review and annual report (AB, GN, SK and Zimbabwe project staff).

October 1986 Team came to Zimbabwe to carry out annual review and to prepare annual progress reports Area II work plan.

CHILD SURVIVAL PROJECT ANNUAL REPORT
GUIDELINES

Project Description: Summary (5 pages maximum)

1. Statement of Project Objectives

Please indicate if objectives have changed from implementation plan statements and/or A.I.D. technical review recommendations.

2. Identification of Target Groups

Describe Target Group - Age, Numbers, Location, other important characteristics.

(Please indicate any changes in target group, i.e., number, age, focus from your implementation plan description.

3. Identify Health Problems that Your Project Will Specifically Address.

First year baseline survey and studies should help specify these problems in greater detail.

4. Describe briefly the health interventions and services that your project is providing (will provide). Indicate any changes in types, scopes of services since submission of implementation plan and/or in response to A.I.D. technical review recommendations.

If Child Survival activities have been added to ongoing health projects, please discuss the linkages between the existing health services and the new CS activities.

II. Describe major actions/activities that have occurred during the year September 1985-September 1986 including:

1. Inputs:

- a) Description of staff hired - job description and resumes to be included;
- b) Description of materials procured, ORT packets, vehicles, cold chain equipment, etc.; and sources, i.e. UNICEF.
- c) Itemization of funds spent by budget item. Differentiate headquarters and field expenditures.
- d) Use of Technical Assistance.

2. Outputs:

Examples

- a) Baseline surveys carried out; (Please include survey instrument and analysis as annexes);
- b) Training curriculums developed;
- c) Training of health workers;
- d) Agreements with governments; collaborative efforts with other organizations, etc.;
- e) Health Committees established;
- f) Health services provided.

Please discuss planning, implementation, and success of these activities.

III. Indicators of Effectiveness

During year one, what are your critical indicators of project progress and effectiveness. It is likely that most projects will be reporting on Examples 1 and 2 type indicators.

Examples

1. Changes in PVO country organization or infrastructure to support Child Survival program, i.e. new staff hired, staff training, new outreach strategy, etc.
2. Changes in the health infrastructure, i.e. new services provided, new community health workers selected, new MIS in place.
3. Changes in the Community or Geographical area, i.e. number of communities with growth monitoring programs; Number of communities with health committees.
4. Changes in your Target Population,
 - a) Coverage - i.e. number and percentage of target population receiving immunizations; number of mothers attending education sessions, etc.;
 - b) Knowledge, attitude and practices - i.e., Number of mothers who know how to mix ORT;
 - c) Health Status, i.e.; Decrease in malnutrition, etc.

- IV. Discussion of Problems and/or constraints to implementation as planned.
- V. Discussions of project strategies for overcoming constraints.
- VI. Discussion of progress and constraints with implementation of monitoring and evaluation systems. Please include discussion of baseline surveys - data collection, analysis and uses and plans for mid-term evaluations.
- VII. Revised work plan describing critical activities to be carried out for remainder of project, including dates.
- VIII. Discuss Headquarter activities in support of Child Survival projects , i.e. new organization CS initiatives, technical support to field, Reporting System, etc.

- Annex 1 AID Reporting Requirements.
- Annex 2 PVO Project Reporting Information Sheet
- Annex 3 Completed monitoring/evaluation plan, specifying data to be collected.
- Annex 4 Baseline survey instrument and analyses.
- Annex 5 Personnel job descriptions and resumes.
- Annex 6 Photos or slides (optional)

3 copies
Pls
one to Anne ✓
Rufi
Jack C.

APPENDIX H



MEMO

ZIMBABWE OFFICE

WORLD VISION INTERNATIONAL
P.O. BOX 2420
HARARE, ZIMBABWE.

DATE: 20th October, 1986

TO: John Howell

Mulatu Belachew
Paul Thompson
Max Chigwida

FROM: George Ngatiri *George Ngatiri*

SUBJECT: CHILD SURVIVAL STRATEGY

Kindly find enclosed Child Survival strategy for inclusion in the Africa strategy meeting.

I realise that this document is late but I think it would be good to be included in the programme.

Thanks and blessings.

CHILD SURVIVAL AND DEVELOPMENT PROGRAMMES STRATEGY FOR AFRICA

PAPER PRESENTED IN PARTIAL FULFILMENT OF AFRICA HEALTH STRATEGY

George Ngatiri
with assistance
of SDP Team
NOVEMBER 1986

THE CHILD SURVIVAL REVOLUTION

1.0 INTRODUCTION

During 1983 the term "Child Survival" entered the lexicon of the aid industry. The term promotes a strategy towards an objective and predicated upon a philosophy of development each of which corresponds closely to the philosophy, key objective, specific objective for child-care/child sponsorship and field operational capabilities of World Vision.

This brief paper is an attempt to introduce Child Survival and promote consideration of its adoption within the development strategy of World Vision. It also stimulates Child Survival being integrated into Child Sponsorship where children benefitting from Child Survival project can actually have a picture and case history for sponsors.

2.0 HISTORY OF HEALTH CARE IN TWO-THIRDS WORLD: AN OVERVIEW

Colonial health services were widely characterised by adherence to contemporary Western models. Curative services for the advantaged and preventative programs for certain economically-significant infectious diseases were augmented by Christian missions serving mainly the rural poor.

Economic development models of the immediate post-independence decades not uncommonly reinforced prior trends. However, in the last 1960's and early 1970's burgeoning impoverished populations, urban drift, deteriorating infrastructures and related factors demanded radical policy re-appraisal.

Diverse experimental efforts re-discovered the effectiveness of approaches promoted long before by some missionaries, colonial administrators and others.

An ambitious global objective of "Health for all by the year 2000" (HF A2,000) linked to a set of 8 integrated strategies collectively entitled the Primary Health Care (PHC) Plan was adopted in principle by many agencies and governments in 1978. This was incorporated as the health policy of many nations of the Two-Thirds World in subsequent years. Insofar as there is today dissatisfaction with PHC, that arises mainly from issues of implementation rather than of concept. These issues include:-

- (a) program imposition unrelated to community process
- (b) insufficiency of management and technical resources
- (c) ineffective efforts to retain resource allocation for curative and referral services.

Faltering progress in national PHC Programs, and receding prospect of achieving HFA 2,000, have encouraged the search for complementary strategies to PHC; most notably measures of strategic potential impact, of high cost-benefit ratio to those most in need, simple to manage and supportive of the development process in each community. During the 1980's key complementary strategies have included:-

- (a) encouraging traditional health practices by recognising and adapting the role of traditional practitioners and herbal medicinals
- (b) the Child-to-Child and Health Scouts program assisting older siblings to identify and simply correct common ailments of infants.

162

(c) A PHC off-shoot movement fostering emphasis on Community-based health Care (CBHC) engaging motivational and functional social communication techniques to foster indigenous community action towards community health objectives, initiated and directed by them.

(d) the Child Survival and development Revolution.

3.0 THE CHILD SURVIVAL AND DEVELOPMENT CONCEPT

Since 1982 UNICEF has adopted as a major programming objective the testing and dissemination of certain results of research of the previous decade into measures impacting child health, and nutrition. Selective field testing and vigorous economic and impact analyses have resulted in a prioritisation of those learnings. In turn a concept has been developed; since 1983 this has been known as the Child Survival Concept and its program of implementation worldwide as the Child Survival and Development Revolution.

In abbreviated paraphrase the concept statement declares that a rapid and very significant reduction in child morbidity and mortality may be achieved in the Two-Thirds World by four simple and relatively low-cost measures (summarised as GOBI)

- Growth monitoring to detect early signs of readily correctable infant malnutrition;
- Oral rehydration by mothers of infants with diarrhoea;
- Breast feeding encouraged in order to promote infant nutrition, maternal bonding and birth spacing. (a measure commonly achieved in an African context as an integral part of growth monitoring, or may actually be of low priority in rural areas where breast feeding is universal).

1/60

- Immunisation against 6 common fatal infectious diseases of infants and children.
- High Risk births - the idea of preventing births at too young or too old age or too close or too many or poor past obstetric history.

The concept is intended to complement PHC. Standard implementation protocols, presently in experimental stage, assume a national PHC program is in place.

The absence of effective local commitment to PHC would likely make necessary some adjustments in local Child Survival Project design.

4.0 CHILD SURVIVAL PROGRAMS

Various models are being promoted. None is more comprehensive than the Child Survival Action Program (CSAP) developed during 1985 by USAID. CSAP design, implementation and evaluation guidelines are documented and form the basis of a WV project in Zimbabwe which have been evaluated in October 1986 after one year of implementation. Great progress on this project has been made and documented by the findings of the evaluation.

Certain technical variants of Child Survival program have been widely discussed in 1985. These include:-

- low birth weight (LBW) proposed use of traditional birth attendants to initiate growth monitoring at birth, identify LBW infants and institute corrective action to mother and infants.
- family planning (FP) - attempts to integrate FP strategies with growth monitoring.
- extend immunisations to include tetanus prophylaxis to all women of child bearing age.
- Child Survival concept as an entry to all community development strategies, social mobilisation and functional social communication,

methodology for problem identification, cause and effect inter-relationship and community problem prioritization.

5.0 KEY CHARACTERISTICS OF CHILD SURVIVAL PROGRAMS

5.1.0 Operational Characteristics

- (a) host governments are already or readily convinced
- (b) implementation exclusively employs appropriate technology of low complexity
- (c) participation of mothers is commonly readily secured
- (d) all participants and project level staff are community members (national regulations may determine the seniority of vaccinators)
- (e) some results are immediate (e.g. oral rehydration) and evident to the community
- (f) most objectives are readily quantifiable

5.1.1 The following characteristics may diminish the developmental impact of the program:-

- (a) community opinion (e.g. older men accustomed to traditional health care strategies) may not perceive the program as addressing priority needs.
- (b) Approximately 50% of the adult population will have no direct need for the program (men, and women outside child-bearing age etc)
- (c) essential contact with mothers is not great (say 3 - 8 contacts in the life of each child).
- (d) Host government bureaucratic inertia may delay donor agency time framing.

16/11

5.2.0 Marketing characteristics

- concept becoming widely recognised and well documented worldwide
- generally favoured by governments (host and donor)
- child-oriented
- life-saving
- readily susceptible to cost benefit analysis in terms of cost per child saved
- early onset of visible programming components

5.3.0 Developmental Perspectives

Preliminary indicators are that child survival programming can be an effective stimulant to the development process, and thus represent a very favourable entry strategy not only into community health, but into the full spectrum of development programming.

5.4.0 Forecasting

Some of the observed or predicted trends arising from child survival programming are:-

- (a) Growth monitoring demonstrates the occurrence of malnutrition and may contribute to developing felt-needs which stimulate the development of agriculture and marketing.
- (b) Oral rehydration opens the way to enhanced community understanding of the consequences of water pollution and stimulate development of potable water resources and better sanitation
- (c) Breast feeding promotes birth spacing, often the locally preferred approach to family planning and maternal bonding.
- (e) Immunisation creates an environment for expanding understanding of the "germ theory" of diseases and then stimulating development towards environmental sanitation including the sectors of housing and refuse disposal and personal hygiene.

6.0 OBSERVATIONS ON THE PLACE OF CHILD SURVIVAL IN WORLD VISION

- 6.1 Child survival programs may prove to be relatively readily marketable, and implemented with only modest difficulty.
- 6.2 The approach may be applied most readily in Field Countries where necessary relationships are established.
- 6.3 Short-term application of a CSAP not integrated or leading into broader community development may generate short-term benefits of significance yet without sustained impact.
- 6.4 CSAP show promise of being an uncommonly effective means of entering communities with a view to establish more long-term and more broadly-based World Vision ministry.
- 6.5 CSAP appears readily adaptable to application in regions populated in advance by numerous WV childcare and CD projects. In such situations CSAP introduces a basis for developing a sustained elevation in standards of child health.
- 6.6 Pursuit of the Child Survival approach may represent one very worthwhile next step in the process of formulating policy in the entire health sector of WV ministry.
- 6.7 The unlimiting concept of starting with the most hurting, winning confidence yet yielding maximum quick results in return - opens a community and local government leaders much more readily.

WORLD VISION ZIMBABWE CSAP Lessons Learnt

This section of the paper gathers experiences gained in the only operational WV Africa child survival project in Zimbabwe and puts them in World Vision operational concepts, perspectives and standards that can be applied in all WV child survival planning and implementation.

The Evaluation report of the child survival project is available on request from the Field Director - World Vision Zimbabwe.

.7.0 KEY OBJECTIVE

World Vision will manage the planning, implementation, monitoring and evaluation of community-sustaining, child survival and development projects in Africa which will improve the overall quality of life for disadvantaged communities by applying at least the four child survival low technology health interventions.

8.0 KEY STANDARDS

8.1 WV Internal Management

World Vision will have established internal systems to manage financial, technical, personnel, logistical and information resources so as to achieve these most effective and efficient health intervention to lower infant and child mortality and morbidity rates.

8.2 Planning

World Vision will have developed and implemented a planning module which will utilize health professional expertise and high levels of community participation.

8.3 Implementation

WV will have implemented programs according to plans in a manner which incorporates high levels of technical input, community participation and managerial competence.

8.4 Monitoring and Evaluation

WV will have developed key standards for any child survival programmes which will be used to determine project performance and adjust design and direction accordingly.

8.5 Infant Mortality/Morbidity Rate/Child Mortality/Morbidity Rate

The communities will have achieved an improved quality of life in terms of reduced no. of children dying or getting sick/pscho-social awareness and skills, in specified areas of prescribed health interventions.

8.6 Target Beneficiaries

WV, together with identified beneficiaries, will have planned and implemented the child survival project(s) for the benefit of the communities whom committment to directing and managing their own development, destiny should be instilled.

8.7 Community-Based Management And Training

The communities will have gained the necessary technical and management skills and will have taken on responsibility for the management, staffing, and maintenance of child survival activities.

8.8 Sound Technical Assistance

WV will have established a set of technical standards which will govern the performance of all technical inputs to ensure the technical quality and appropriateness of all health interventions applied. WV will have established a directory of experienced in country Christian technical professionals to facilitate in planning and implementing this child survival project. The staff could be part time or full time.

8.9 Environment Sanitation

WV will have assisted communities to improve and maintain a sanitary environment that is self-sustaining.

9.0 ASSUMPTIONS, DEFINITIONS AND PECULIARITIES

9.1 Child survival and development programmes is nothing new nor is it exclusive to health interventions.

- 9.2 WV is committed to community based child survival and development whereby recognition and destiny with facilitation that people have the potential to find their own solutions.
- 9.3 Community based child survival and development means that action is taken by the community to address felt and expressed needs of that community.
- 9.4 Community based child survival and development must arise from and be controlled by the community itself and WV will only enhance with financial and technical resources.
- 9.5 WV is involved in the community-based Child Survival and development process as facilitators working with the community in reflection and analysis resulting in prioritizing and conducting activities to improve community conditions.
- 9.6 Child Survival and development projects have the following peculiarities:-
- (i) Size The project will cost more than a normal field office project and serve a larger population.
 - (ii) Complexity The project will be technically complex requiring the input of technically sophisticated skills in disciplines of health e.g. Immunisation/Diarrhoea control, water and sanitation, engineering, population dynamics etc.
 - (iii) Duration The project will be in operation for at least five years.
 - (iv) Funding The funding will normally be above or within the project office budget and will generally be funded by a single donor or a combination of a few donors. The donor(s) will often want some personal involvement in the project and host government commitment.

- (v) Scope The project will often cover a larger geographical scope - i.e. a valley , a district or a region, numerous villages and a larger number of people as beneficiaries.
- (vi) Service The project offers to communities opportunities to engage in self sustaining longterm health development which are characterised by community based management and training and improvement of physical environment.
- (iiv) Mode of Operation Projects will be planned, implemented, monitored and evaluated by WV staff, donor agency, host government or specified outside agency.
- (viii.) Integration Child survival programming could easily be integrated within the project communities already existing even in child sponsorship areas.
- (ix) Child Survival componets Each of the components of child survival can be implemented separately e.g. Immunisation

10.0 ORGANISATION AND MANAGEMENT STANDARDS

- 10.1 Because of the technical complexity of such projects, child survival management, although falling under the Field Director, will be specialised.
- 10.2 In WV field country the costs involved in project identification and design (planning) will be carried by a special cost centre appearing in the VP Africa's budget.

- 10.3 All CSAD will be incorporated into the 5 year country strategy. The responsibility for this task rests with Field Director receiving input from the design team.
- 10.4 The Child Survival budget will be above or within FO/PO budget, will fit within the FO/PO budgetting cycle, and will be a self contained financial plan including costs of logistic, management, and operations that will not be subjected to support office fund raising pressures nor will it drain field office financial commitments.
- 10.5 Child Survival manager has the managerial responsibility of implementing the child survival reporting directly to the Field Director. This Project Manager is appointed by the Africa VP with advise from FO/PO director and consultancy team leader.
- 10.6 Child survival projects will be provided with management and technical staff as needed such that FO/PO staff are not over burdened or distracted from their project commitments.
- 10.7 Child survival planning and monitoring would be undertaken by the technical consulting team headed by the Regional Technical Team leader. This team falls directly under the VP for Africa. The team leader is appointed by the Africa VP and reports to him. The terms of reference for the planning and monitoring of a particular team is under FO/PO director.
- 10.8 The technical team appointed to undertake the planning and monitoring of a particular project will be appointed by the Regional Technical team leader. The majority of these individuals would be WV consultants but would sometimes includes some external consultants. It would be necessary to include at least one PO/FO representative on this team. The team would report to the Field Director.

- 10.9 Child Survival Projects will be evaluated against WV country project design standards and development position paper. The evaluation team comprising of international senior technical staff will advise the Project Manager and the Field Director and report to the Africa V.P. through technical team leader.
- 10.10 Child survival staff would be recruited, selected appointed and remunerated on the same basis as FO/PO staff but the actual personnel decisions are made by the Field Director in consultation with the Technical team leader.
- 10.11 The existence of expertise relevant to child survival work in other WV entities in Africa as a whole should be noted and utilised through establishing a mechanism to define the strategy which will draw on the existing knowledge and experience.
- 10.12 Where a child survival programme is established and there is no FO/PO, the Project Manager reports directly to the VP Africa through the Technical team leader.
- 10.13 Child Survival office will be located in or near the community which it is designed to serve.
- 10.14 The Project Manager has full responsibility and authority for operations, finances, personnel and logistics relating to her/his project.

CHILD SURVIVAL

GOBI: AN OASIS OF LIFE

If the word Gobi brings anything to mind at all it would have to be one of the world's largest deserts, half a million square miles void of life or hope--a huge, prostrate expanse of death in central Asia.

But when it comes to child survival, GOBI stands for just the opposite--an acronym for life--a chance to save as many as half of the 1,700 children around the world who will die of illness and malnutrition this hour; the 40,000 who will die today; the more than 15 million who will die this year.

GROWTH MONITORING

Below normal growth tendencies are pinpointed long before malnutrition sets in by comparing weight and height on a growth chart every month. Cost of the chart is just 10 cents. At this early stage, a child's nutritional health can be improved, even when food and money are in short supply, through the recommendations of community health workers.

ORAL REHYDRATION THERAPY

Dehydration from diarrhea is the number one killer of young children in the world today, claiming five million victims a year. At this point, an average of only 15 percent of the world's families know about oral rehydration therapy (ORT), a ten-cent packet of pre-mixed salts or homemade solution, that is saving half a million children a year.

BREAST FEEDING

During the first six months of life, mother's milk provides the best possible nutrition coupled with a high degree of natural immunity against common childhood infections, and all for free. In poor communities, bottle-fed infants are 2 to 3 more times likely to die in infancy than their breast-fed counterparts. This is due to the ingestion of inferior artificial substitutes overdiluted with unclean water in unsterile containers.

IMMUNIZATION

Three and a half million children die each year from vaccine-preventable diseases with millions more crippled or malnourished as a result. At a cost of just \$5 per child they can be completely immunized against the six diseases that threaten them most--measles, whooping cough, tetanus, polio, tuberculosis and diphtheria. At present, an average of just 10 percent of the children in the developing world are vaccinated, but more than 40 countries have joined the United Nations campaign for universal immunization by 1990.

WHAT WORLD VISION IS DOING

World Vision has only recently entered the field of child survival projects, even though children and their sponsorship have been this organization's credo since its inception in 1950.

Three projects are currently operational: the Primary Health Care Project (Sudan), the Louga Child Survival Project (Senegal) and the Zimbabwe Child Survival Program (Zimbabwe). Of these, the Zimbabwe project is the first of these efforts for World Vision.

The purpose of the Zimbabwe Project is to support existing health services by introducing, expanding and accelerating child survival interventions so as to reduce child morbidity and mortality. The project focuses on immunization, control of diarrhea and improved nutrition. The 3-year project encompasses the entire district of Meurewa and will benefit approximately 152,000 people. Funding is provided through a cost-sharing grant from USAID totaling \$920,000. USAID pays \$690,000 and World Vision supplies the remaining \$230,000.

The start-up area is located in Mashonaland East, one of eight provinces of Zimbabwe. It is based in St. Paul's Mission Hospital, World Vision's partner agency, in Musami, 70 kilometers east of Harare, the capital of Zimbabwe.

The target group for the project is children under 5 years old and their mothers. Immunization is focused on children 18 months old and under. Approximately 4,000 families in the project area have children under 5 years old; approximately 1,100 children are born each year.

All families in the project area will be registered enabling project staff to identify members of the target group who are not fully immunized, not having their growth monitored or who have inadequate knowledge of oral rehydration. High-risk children will be identified through monthly observation and growth monitoring at outreach points. At each of the 46 outreach points, children and mothers receive immunizations, children are weighed and health instruction is given. High-risk children are followed up by home visits.

Oral rehydration therapy will be accomplished through the use of home mix, as required by the Ministry of Health. ORT instruction will be given to mothers by volunteers at the village level and by nurses at the hospital and health centers. Such advice will be afforded both in the home (10 to 15 households a day) and at special outreach clinics.

At the end of the 3-year program the nutritional status of the under-5 age group is expected to be significantly changed. The percentage of children "at risk" will be reduced by 50 percent and infant and child mortality rates will be decreased by 20 percent. In addition, 35 percent of families will have access to a safe source of water.

No doubt these percentages look impressive. Yet, in the final analysis, it's not percentages that will benefit, but people; families; individual men, women and children. That's what World Vision is all about: names, not numbers.

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FOR IMMEDIATE RELEASE

Contact: Public Relations

November 1986

Extension: 2516

WORLD VISION: A KNEE-HIGH VIEW OF THINGS

If World Vision were ever looking for another name to call itself, at the top of the list would have to be Child Vision.

In 1948 China, a missionary thrust an orphan girl into the arms of a young evangelist and asked, "What are you going to do for this child?" The child was named White Jade. The man was Dr. Bob Pierce. And his answer was an organization that last year helped over 415,000 children through programs around the globe: World Vision.

From Dr. Pierce's trip came the film "China Challenge" in 1949. Now people stateside could see what he had seen. They began asking how they might help the "White Jades" of the world. Before too long it became evident that an organization was needed to handle the contributions that resulted.

On September 22, 1950, just 3 months after the Korean War broke out, incorporation papers were signed for the Christian service organization to be called "World Vision." Bob Pierce became the first president, Paul Myers vice president and Dr. Frank Phillips executive secretary.

Dr. Phillips said, "The purpose of World Vision is to meet emergency needs in crisis areas of the world. We do this principally by working through national churches and existing missions to make our funds do the most possible good...where the need is the greatest."

The films "38th Parallel," "The Flame" and "New China Challenge" followed. Billy Graham was so taken with World Vision's work that he canceled his order for a new 1950 Bel Aire Chevrolet and gave the money instead to Bob Pierce to help the work in Korea. In 1952, Dr. Graham visited World Vision orphanages and hospitals in Korea with Dr. Pierce.

The end of the Korean War in 1953 brought World Vision many additional responsibilities and opportunities including a clinic in Calcutta for starving children and the construction of a Boy's Home on the island of Formosa. The childcare program had grown to 751 sponsored orphans.

By 1956, the number of children sponsored had increased by more than ten-fold. Thereafter, the organization and its ability to meet the challenges of the day grew miraculously.

Today, World Vision can look back on 35 years of meeting the needs of hurting children. In 1986, the organization committed approximately \$114 million to more than 4,000 childcare, relief and rehabilitation, and development projects. This afforded an estimated 6 million children and their families with food, clothing, health care and education in 84 countries throughout the world.

Senator Mark Hatfield recently noted, "World Vision presents a model of economic efficiency in identifying the needs of the world and in meeting those needs in a cost-efficient manner."

And those needs are legion. In developing nations today, infant deaths average 114 per 1,000 live births, compared to 11 per 1,000 live births in the United States. Some 1,700 children die every hour; 40,000 die every day; and more than 15 million die every year from measles, tetanus, malnutrition and dehydration due to diarrhea.

Twenty-nine of every 30 childhood deaths are in developing countries. Approximately 5 million of these die on the continent of Africa each year, and most of those deaths could be prevented.

Africa's need for a revolution in Child Survival is greater than ever before and, given present advances in knowledge, is also more possible than ever before. Several simple, inexpensive, effective techniques can save millions of children's lives--oral rehydration therapy (\$.10 per dose) to combat dehydration, immunization (\$5 per child) to protect children from the six major diseases, growth monitoring (\$.10 per chart) to determine the advent of malnutrition before it sets in, and breast-feeding (free). Half of those children presently dying could be saved through these measures.

According to World Bank studies, investments in basic health care and primary education not only save lives, but can lead to significant increases in productivity and economic growth. A long-term study in India, for example, found that adults who were malnourished in childhood have a 30 percent lower work capacity than those with a healthy early childhood.

That's why World Vision is helping to reduce the number of children lost to preventable diseases through Child Survival projects in Senegal, Sudan and Zimbabwe. In addition, Child Survival aspects are an integral part of most World Vision projects throughout the rest of Africa as well as Asia and Latin America. Each project is shaped by both the innovation and expertise that has given World Vision the reputation for effective development projects around the world. Last year, World Vision committed more than \$10.5 million to just such projects in Africa alone--every one based in the community, for the community and by the community.

No doubt some people would say that a knee-high view of life was too low to really matter; too inconsequential for today's sophisticated world. But at World Vision it's our perspective. That's because we believe that unless someone starts looking at things from a child's viewpoint, they may never live long enough to see things from ours.

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