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**SAVE THE CHILDREN
ZIMBABWE FIELD OFFICE
CHILD SURVIVAL IV
FINAL EVALUATION**

**Agency for International Development
Grant #PDC-0502-A-00-5095-00**

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GLOSSARY OF ABBREVIATIONS

AID	Agency for International Development
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ARI	acute respiratory infection(s)
CFU	Commercial Farmer's Union
CL	community leader
CS	Child Survival
CSP	Child Survival Program
DDCO	District Development Committee
DIP	detailed implementation plan
DMO	District Medical Officer
DNO	District Nursing Officer
DPT	diphtheria, pertussis and tetanus vaccine
EHT	Environmental Health Technician
EOP	end of project
FHW	Farm Health Worker
GOZ	Government of Zimbabwe
HAPA	AIDS Prevention in Africa (USAID)
HIS	health information system
IA	impact area
MCCD	Ministry of Cooperatives and Community Development
MOH	Ministry of Health
MTE	mid-term evaluation
ORT	oral rehydration therapy
PMD	Provincial Medical Director
PNO	Provincial Nursing Officer
PVO	private volunteer organization
RC	Rural Council
RCH	rural health center
SCF	Save the Children Federation
TM	Traditional Midwife
USAID	United States Agency for International Development
VCW	Village Community Worker
VIDCO	Village Development Committee
WADCO	Ward Development Committee

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"PAMBERI NE UTANO!"
(Forward with Health)

I. EXECUTIVE SUMMARY

As the final evaluation team traveled through the byroads of the Eastern Highlands of Zimbabwe, we were soundly impressed by the strength of character and community spirit we encountered at each stop along the way. As we interviewed community members, community leaders and village community workers (VCWs), we were often overwhelmed by the raised fists and strong voices proclaiming in Shona the message of health promotion-"Pamberi Ne Utano!" These are the empowered! Certainly the inhabitants of the Muusha and Mutema impact areas (I.A.) have a rejuvenated sense of purpose to move forward with health. The ability to stimulate these natural instincts for the survival of children is a cardinal aspect of a program's sustainability. In addition the cadre of SCF/Zimbabwe health professionals and seconded nurses from the Ministry of Health (MOH) who implemented the project, will remain in Zimbabwe and are expected to continue in health promotion. Sustainability was the primary aim of the SCF/Zimbabwe Child Survival (CS) IV project and its major accomplishment.

As our evaluation focused on sustainability issues, we also determined some areas to improve upon in future projects. Unfortunately the MOH will not be able to continue the enumeration of individuals through the Health Information System (HIS). Most aspects of the HIS will not be sustained. There exists, however, an opportunity to broaden the scope of the HIS consistent with the expanded role of the Village Community Worker (VCW). A newly designed Home Visit Card may be piloted in one impact area to log multisectoral educational inputs at the household level. There are still a number of obstacles remaining before this reporting system can be integrated into existing MOH and Ministry of Cooperatives and Community Development (MCCD) structures. SCF/Zim is expected to continue to work for the implementation of the Home Visit Card after the End of the Project (EOP).

A second problem with the HIS as utilized in Zimbabwe is the difficulty maintaining the HIS as a management tool. After collecting the data there was limited ability to alter the CS interventions in response to the information.

The sustainability of the program for Farm Health Workers (in Mupedzanamo) did not appear to possess the strong grassroots level of support evidenced by the other two I.A.s. While the SCF/CS IV project has worked to promote the concept of the FHW in conjunction with the national

program, the actual number of farms served in the I.A. has not changed over the past six years. Even though the project did not promise to expand to other farms, the hurdles to increased coverage for this basic, beneficial program should be addressed in order to help sustain and expand the the concept to all the commercial farms of Zimbabwe. As a result of our interviews the final evaluation team was impressed with the need to work closely with the Rural Council (R.C.) and the Commercial Farmer's Union (C.F.U.) to gain acceptance of the FHW initiative.

Overall we found a well organized and competent team at work on the CS IV project in Zimbabwe. The people living in the I.A.s as well as their trainers have heard the CS message and they are motivated to respond. The project was fortunate to be able to coordinate their activities with a progressive MOH tackling many of the same issues nationwide. We sensed a strong committment from the U.S. AID Mission in Harare during our summary session in their offices. In conclusion we reinforce the recommendation of Mr. Ted Morse, U.S. AID Director, who enjoined us to publicly promote the lessons learned to assist others in Zimbabwe striving for the survival of children.

II. INTRODUCTION

This final evaluation is the product of a team effort conducted one month prior to the termination of the Save The Children--Child Survival IV project in Zimbabwe. The team of seven was actually conducting simultaneous final evaluations as the HAPA-SCF grant at the same Impact Areas in Zimbabwe expires at the same time. As much as possible the responsibilities for collecting information was shared according to individual abilities and background.

The timing of the final evaluation for the Child Survival Project resulted in a marriage of necessity with the old criteria (distributed July 5, 1990 by U.S.AID) and the fresh criteria (July 12, 1991) for final evaluations which arrived while we were in the middle of our evaluation. Just prior to our evaluation we became aware of the new guidelines for 30 cluster surveys at the time of the final evaluation. After considerable deliberation SCF\Zimbabwe determined the impracticality of performing another standard 30 cluster sample survey since their HAPA staff had just completed this type of survey in the same I.A.s. We still believe a 30 cluster sample would have resulted in the most useful information for the project as well as the MOH-District Medical Officer. Unfortunately the lead time was too short to conduct a successful survey. Considering transport, finances and the coexisting but separate needs of the AIDS evaluation, we followed the previous evaluation format. However, we made a special effort to expand upon the issue of sustainability as well as lessons learned.

The review process began with a thorough discussion of the Detailed Implementation Plan for the August, 1988 to September, 1991 CS IV grant and the Midterm Evaluation from November, 1990. The results of this discussion are listed in the table of contents as MTE Response. A randomized 100 household survey conducted 16 months ago revealed very high compliance rates for the grant objectives. The overall average compliance for the seven objectives was 84.3%. Mother's knowledge scales for four of the objectives were determined to be 93% or higher. Only the knowledge of ARI was found to be relatively low at 54%. Since there was no reasonable basis to test for a loss of knowledge, a second randomized 100 household survey would be most unlikely to reveal significant changes of value to our final evaluation. In place of a survey we did utilize data from numerous interviews and focus group discussions to corroborate the C.S. Project staff presentations.

The C.S.IV project is actually a three year extension of an original three year grant initiated in 1985. The major impetus to continue the grant to the present time was to provide for long term sustainability of the project interventions. Thus, our final evaluation comprises an

overview of the project activities as well as special emphasis on issues of sustainability and lessons learned which may be important for future endeavors.

A. COMPOSITION OF THE TEAM

The project staff assembled an evaluation team consisting of two external consultants-Dr. Eckhert for SCF/HAPA and Dr. Fazen for SCF/CS. We were joined by one representative of SCF headquarters in Westport (Nicola Gates) as well as the project director of SCF/Malawi, Mr. Stanley Jere. Other members listed below represented the MOH, World Vision and private industry in Zimbabwe.

Although much of the preparation for the final report was conducted in subgroups, we traveled together and worked well together as a team. The members of the final evaluation team were the following:

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B. EVALUATION METHODOLOGY

For the most part the evaluation team followed the outline for "Final Evaluation Guidelines for CSIII and CSII" as distributed July 5, 1990 by U.S. AID. For the category of Sustainability we followed the "1991 Final Evaluation Guidelines" published July 12, 1991. The dates for the evaluation encompassed the time period from July 8, 1991 to July 26th inclusive. A final presentation with Dr. Jerry Salole, SCF/Zimbabwe Program Director, was arranged for those team members who were available on the 29th of July, 1991.

The data for the findings were derived from structured interviews or focus group discussions with the following categories of informants:

- Provincial Medical Officers including the PMD and the PNO
- District Medical Officers including the DMO and the DNO
- Farm workers, both men and women
- Farm Health Workers

Farm managers
Rural Council, Executive Director
Village members, both men and women
Village Community Workers
Community Leaders
MCCD Ward Coordinator
Traditional Midwives
Rural Health Center Staff

In addition we conducted lengthy discussions with the Impact Area Manager and each of the three seconded nurses stationed in the I.A.s. Ms. Linile Malunga graciously accompanied us to assist with the interviews and the logistics of our travel.

We also gathered some information from the statistics presented from each I.A. as well as the MOH for Chimanimani District.

The original questionnaires are not included but may be obtained from SCF Headquarters office.

At the end of the three weeks of the evaluation process we met as a team with the representatives of the three I.A. to explain the results of the evaluation. In addition we discussed our results with the Director and staff of the US AID mission in Harare.

III. FINDINGS

A. Primary Focus and Use of Funding

The main focus of Zimbabwe CS IV project was in four areas:

1. To support and improve MOH local services-delivery through joint training, monitoring and supervision.
2. To support and deliver health outreach services from established institutions.
3. To increase community awareness of health needs and demand for health services.
4. To change health behavior through training.

Following the request from US AID and MOH at the final evaluation, SC\Zimbabwe extended the Child Survival activities to two areas (one ward in each of the two I.A.s of Muusha and Mutema). However the expansion did not include a complete set of new interventions. The CS Project simply improved upon the existing activities and did not collect impact data.

B. Organizational Development

B1. Human Resources

Though the present National CS/AIDS Coordinator only joined the Save the Children Program during the end of the first half of the grant, she has been exposed to many training sessions; especially on AIDS activities. In the three IAs the three Area Coordinators have attended several training workshops. In June 1990, two Area Coordinators for Mupedzanhamo and Mutema attended a training workshop organized by Africare in Nigeria. This visit proved to be useful.

Within the IAs the Coordinator trained the VCWs/FHWS and Traditional Midwives. The courses have assisted the staff to carry out activities successfully.

The project benefitted a great deal from visits by the SCF/Zimbabwe staff to provide adequate management and technical support to CS administrative and field staff.

B2. Use of Technical Resources

The project satisfactorily addressed most of the recommendations in the midterm evaluations and in the DIP. The effectiveness of the services provided to the communities in the three IAs can be derived from the summaries of interviews of the providers of the services such as the Rural Health Centre Staff, the area

coordinators, the VCWs/FHWs, TMs, community leaders and from beneficiaries as described in the section on results.

B3. Health Information Systems

A baseline household survey was carried out to enumerate the population. An additional 100 household random sample survey was conducted as part of the MTE. The data collected at the EOP was presented in a different format and was not directly applicable to the earlier surveys. A trend in results over the years was not available. The seconded nurses from the MOH had to be trained in the use of the HIS and because of personnel turnovers, their facility to analyze and act upon the data was hampered.

The final evaluation team did not see a significant effort to redirect resources based on the information collected by VCWs and reported to managers. However, the summary results were used to provide feedback to the project staff and community members.

C. Project Design and Implementation

C1. The CS activities at community and household level intended to improve health behavior include the training workshops and seminars. The project is also strengthened by the fact that the national health policy is progressive and well developed. The project fit well into the existing national health infrastructure. The design and implementation plan appropriately reflect the national policy, including the emphasis on universal access to health services and community participation in health promotions.

The project operates in close collaboration with MOH which enabled SCF to design the project primarily to train and supervise workers who promote services already provided by MOH. The project design and implementation plan are also strengthened by the fact that they built upon SCF's existing infrastructure in Zimbabwe and they were able to capitalize on the achievements and lessons learned in the previous CSI project. An important element of SCF's health strategy is the emphasis on intervention at household level and use of health education and training of mothers to improve key health behaviors such as service utilization.

There is clearly a strong appreciation of this approach among members of the community (men and women) and community leaders interviewed at focus group discussions and its effectiveness is evident in project's achievements. Health Education continues and will continue to be undertaken as part of community mobilization by community leaders in the impact areas.

C2. The principle interventions provided by the project address the major causes of infant and child mortality by promoting:

- a) Growth monitoring and nutrition education
- b) Immunization
- c) Oral rehydration therapy (homemade solution is promoted by Zimbabwe national policy.)
- d) Child spacing
- e) Management of ARI
- f) AIDS education
- g) Pre-natal care

As discussed before the project activities were appropriate and in line with the National Health Policy. There has been a positive impact on levels of immunization coverage; the ability of mothers to manage episodes of diarrhea at home and on outreach services providing growth monitoring. While these are clearly appropriate activities, the ability to provide funding for water and sanitation within the project has limited the effectiveness of activities designed to reduce the incidence of diarrhea in infants and children.

The project focused its activities on proper target groups i.e, infants, 0-11 months, children whose growth is faltering and pregnant women by using the family organization system and following up the at-risk groups identified by the VCWs and FHWs. In Mutema 70% of children in the 9 to 12 month age group will receive all their primary immunizations by one year of age. Similarly in Mupedzanhamo, 66% of one year old have been fully immunized. The project ORT activities target children 0-36 months and project nutrition activities target children 0-24 months. However, the prevalence of diarrhea during the last two weeks and participation in growth monitoring activities could not be established in the absence of a 30-cluster household study.

D. Effectiveness and Impact of Services

The data collected by the VCWs and presented to the final evaluation team is described in the section on Statistics. Two of the three I.A.s were able to present the specific data requested by the final evaluation. Overall the immunization rates, tetanus coverage during pregnancy and the ability to correctly mix ORS were found to show a high degree of compliance.

E. PVO/Host Government Cooperation

Since the Child Survival Project in the three impact areas was designed to complement MOH health activities, the process of collaboration and coordination was very vital.

The involvement of MOH and other institutions in the project varied in the three areas.

The relationship of the MOH with the project was good. MOH seconded nurses became the full-time Child Survival Coordinators in all the Impact Areas. MOH staff were supervising the activities in the Impact Areas through the RHCs. All VCWs reported to the Rural Health Centres monthly to collect drugs and discuss their reports.

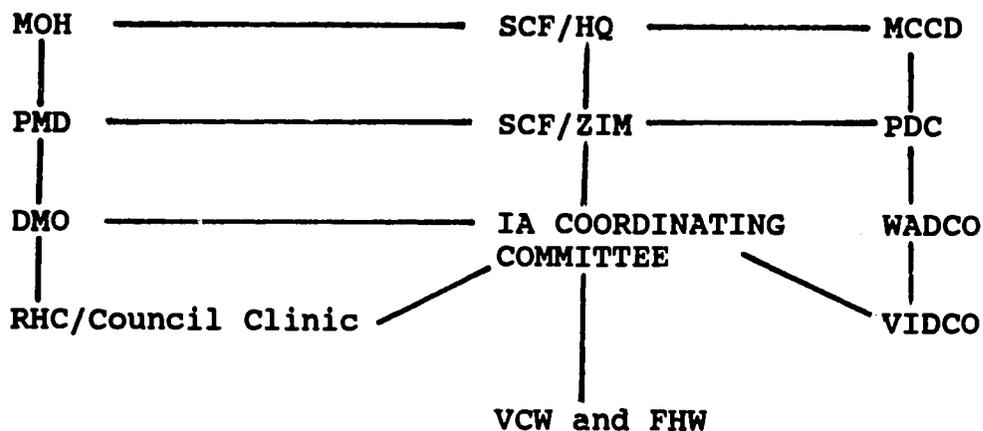
Training of FHWs and VCWs was done by MOH and SC. The Rural Health Centre staff and the Child Survival coordinators supervise the FHWs and the VCWs. The DHEs supervised all the health activities in the District including the Impact Areas. The DNOs visited the outreach centers and clinics in the Impact Areas regularly.

SC and MOH organized some workshops together for health workers, traditional midwives, VCWs and community leaders. SC staff are members of the District Health Executive which is a teaching forum in Muusha and Mutema Districts.

In all the Impact Areas the Child Survival endeavors have contributed to governmental activities in the health sector. From the focus groups we know the immunization coverages are high and communities are knowledgeable on the following health issues: the use of ORT, referral and management of ARI, usefulness of immunizations and the importance of family planning. The DMOs interviewed found it very difficult to detect an improvement in the number of children surviving in the Impact Areas compared to uncovered areas. Not much difference is found in the immunization coverages in all areas as the six killer disease have been reduced countrywide. The HIS in the I.A.s is not easily comparable with MOH data collection system. The MOH staff all agreed that the project contributed to governmental activities in the health sector although data from a household survey would be necessary to confirm the level of the effect.

The MOH did not contribute in financial terms but the MOH was involved in training the VCWs and in the process of seconding nurses. At the local level the VCWs and the FHWs formed a very important linkage. The IA Coordinating committees in Muusha and Mutema including WADCO members and chaired by the Councillor worked hand in hand with SCF in the CS activities. This committee played an important role in mobilizing the communities to mould the bricks of the SCF training programs.

**ILLUSTRATION OF SCF LINKAGES
WITH KEY HEALTH DEVELOPMENT AGENCIES**



SUSTAINABILITY QUESTIONS AND ISSUES ADDRESSED BY THE PVO CHILD SURVIVAL PROJECT FINAL EVALUATION TEAM AS STATED IN THE 1991 FINAL EVALUATION GUIDELINES

A. Sustainability Status

The organization plans to cease all survival project activities the end of August, 1991 after six years of project implementation. The initial phase of the project was started in July, 1985 and the project was extended for another 3 years to enable intensification and gradual phase over of the project to MOH and other responsible local authorities.

The major project responsibilities and control have been phased over to the local institutions such as the rural health centers under Ministry of Health for the VCWs and the District and Rural Council for the FHWs. The responsibilities and control activities include:

- (1) Taking over of the outreach centers which SCF was servicing by MOH and Rural Council Staff.
- (2) Vehicles, houses, training center and other assets in the impact areas will be handed over to the local authorities, MOH and District Councils for maintenance and sustaining project activities. However, the local authorities in Mutema are still working out the details on the best utilization of assets.
- (3) The trained community leadership is committed to supporting the project activities and the VCWs. Although in one Impact Area, Mutema, 23 out of 32 VCWs most likely will not be absorbed by MCCD. If the VCWs are not paid by the MCCD, many CS activities will be difficult to maintain with the same intensity of service. In addition, two coordinating committees chaired by the councilors who are also chairmen of the Ward Development Committees were

established in Muusha and Mutema I.A.s. The committees are charged with responsibility to make decisions and make recommendations to the local authorities for effective project implementation.

B. Sustainability Plan

B1. CS staff jointly planned with MOH staff at district level for VCW in-service training and development of the logistics for outreach health posts. The objectives and strategies of reaching the outreach posts were decided jointly by Zimbabwe and MOH personnel. All outreach posts were manned jointly by MOH and CS staff. MOH has seconded staff to CS/Zimbabwe. This is regarded as an important process for sustainability.

At community level the sustainability plan was to strengthen the community leadership and to provide support to motivate and mobilize the community to participate in the CSP activities.

Training and supervision of VCWs/FHWS was conducted by rural health clinic staff and an outreach team from the DMO. SCF/Zimbabwe was able to support a low ratio of VCWs of approximately 1 VCW to 60-70 families. Hopefully, a reduction in this ratio will not reduce the effectiveness of the program at EOP as many of the attitudes and behaviors the VCVs set out to change have already changed and the parents will continue to demand child survival services.

Recurrent costs of salaries for VCWS/FHWS and MOH supervisors as well as transportation costs (fuel, vehicle maintenance and depreciation) will be met by the local authorities (MOH and District Council) and individual farmers for FHW's wages.

B2. All aspects of the sustainability plan have been implemented although the finer details of the plan were not observed and documented such as:

(a) Which local authority will be responsible for taking over the maintenance of the vehicles and how the houses and training centres will be utilized including the dates for each activity.

(b) There could have been more collaboration at the local level with SCF/Zim staff and the project beneficiaries such as community leaders on the phase out plan and use of assets at EOP.

B3. None of the counterpart institutions made any direct financial commitment. However, commitment to take over the outreach health posts and absorb seconded staff back into MOH and payment of salaries for outreach workers represents

a substantial contribution by the MOH. MCCD has already absorbed the VCWs in Muusha and will continue to pay their salaries. Individual farmers will pay the wages for the FHWs although there are some differences in the amounts paid on each farm.

MOH was involved in the planning stage of the project so MOH is committed to continue with the activities consistent with Zimbabwe MOH programs. No new structures were set up to affect the sustainability of the project. As much as possible SCF\Zimbabwe strengthened and supported the activities of the MOH.

Failure to absorb the 25 VCWs in Mutema is due to the fact that when the VCWs were engaged at the beginning of the project, it was hoped that the VCW program would expand and possibly the VCWs would have been absorbed by MCCD. The VHW program was initially under MOH and later moved to MCCD during the project implementation.

Community Participation and Perception of Project Effectiveness

C.1 The communities represented by their leaders participated in the design and implementation of health services through the following mechanisms.

(a) Use of the existing infrastructure which address their needs at various levels.

Village Level. The various committees, health, education, agriculture, etc. at village level are involved in monitoring and improving the health status of their communities as well as motivating and mobilizing the community members to participate in the project activities.

Ward Level. A group of villages combine to form a ward which is led by WARD community leaders. Health problems which could not be solved at the village level are taken up by the ward leaders. Since the I/A operate at the Ward level, a coordinating committee was established for Muusha and Mutema to coordinate CS program activities in the I/A and the councillor who is also a chairman of the WADCO chaired the coordinating committee meetings.

District Level. A district development committee is then formed from Ward leaders and representatives including representatives of different minorities and PVOs working the area and certain policies are also formulated at this level. SCF staff, MOH officers and representatives from the wards where the I/A are operational attend the DDCO meetings.

Focus groups conducted among community leaders from the impact areas revealed that most of the respondents feel that the project activities met some of their current health needs and improved the health status of the community, e.g.,

providing immunizations to vulnerable groups, nutrition, education and ORT education.

C2. There are two functioning coordinating committees in each impact area in Muusha and Mutema. The coordinating committees are chaired by the councillors who are also the chairmen of the Ward development committee. So the coordinating committees discuss the CS and AIDS project issues as well as other development activities in the impact area. Members of the committee are democratically elected by their communities.

C3. The minutes of the last meeting between the Manicaland Provincial Health authority and SCF\Zimbabwe staff held on 15/2/91 discussed the following topics on sustainability.

- (a) Items to be handed over to Muusha I.A
- house
 - training centre
 - 1 vehicle

A list of furniture and kitchen utensils was handed over to MOH. Both the house and the training centre will be handed over at the end of July. Furniture and utensils will be handed over at the end of July. Vehicle will be handed over in August.

Staff

Seconded Nurse: will be absorbed by MOH any time as vacancy is already available.

Clerk and Driver: Clerk could be employed by Mutambara Mission Hospital. Efforts are being made to have them taken over by the Mission Hospital. Drivers could also be employed by Chimanimani District Council. The DNO was pushed to action on the issue. VCWs have already been taken over by M CCD.

Mutema I/A

House. Community wants to have this house as a clinic. The PMD, however, explained that MOH will take over the house but the purpose is yet to be discussed and finalized. The house will be handed over in August. PMD will communicate with SCF on the final suggestion for the use of the house.

Vehicle and Furniture. Vehicle, furniture and utensils will be handed over at the end of August.

Staff:

Seconded nurse. MOH seconded nurse can be absorbed at anytime.

Clerk/Driver. The DMO and DNO were trusted with the responsibility to assist the clerk and driver to get employment in public services.

VCWS. It was very unlikely that Mutema VCWS will be absorbed, so the PMD suggested that a letter be written signed by SCF, MOH and MCCD to MCCD HQ so that they consider the VCWS who are in villages where there are no VCWS employed by MCCD. SCF was asked to write the letter.

Computer. Will be handed over to PMD Manicaland.

C4. During the focus group discussions the community leaders who represented the community and were selected by the community include:

- (a) Councillors
- (b) Kraal heads
- (c) Headmasters
- (d) VIDCO chairmen
- (e) Church leaders
- (d) Party leaders

The respondents discussed project priorities for some of their current health needs e.g., providing immunizations to vulnerable groups resulting in the reduction of the immunizable diseases such as measles and whooping cough, improving the children's nutritional status through nutrition education and encouragement on food production and even small gardens at the homes. However the community leaders believe that the community needs more income to improve their economy and the general living standards.

C5. The following resources contributed by the community will help ensure the continuation of project activities once the project ends.

Manpower. The continued commitment by village leaders to support the VCWS and mobilize the community to participate in SCF activities. They support mothers who continuously attend the outreach points for education and bring children for immunization as well as prepare nutritious food for the families and use ORT when a child has diarrhea.

Materials. The community will continue to contribute their labor and moulding of bricks for construction of classroom blocks, pre-school centres and for any future CSP activities which require community's labor and materials. The community leaders and the community members interviewed in focus group discussions are prepared to contribute because they have seen the benefits of CSP activities.

Money. Money has been difficult to contribute but once income producing activities are started the community is prepared to contribute money towards CS activities.

D. Institutional Sustainability - Strengthening Local Management.

D1. The VCWS (now under the MCCD) and the FHWS form a vital link between the outreach PHC staff who are under MOH at district and provincial levels and the village committees and the community for the CS project activities. The Impact Area coordinating committee in Muusha and Mutema included the WADCO members and was chaired by the councillors. This committee worked in close collaboration with SCF to promote CS activities.

The SCF coordinator attends the District and Provincial Health team meetings of MOH to present CS and other health development activities. The linkages established did not involve any financial exchanges.

D2. Besides training of CSP coordinated project staff in CSP activities, SCF staff also trained the RHC staff in the impact area on CSP activities and supervision of VCWS. The training of the RHC staff was jointly conducted by SCF personnel and MOH personnel to strengthen the program management skills of the staff in the local institutions.

D3. Ward level professionals perceive CS activities as effective although the Provincial and District level staff feel the concept of small Impact Areas creates islands of well served communities with very few members and the neighboring communities appear under served by the MOH. A program with an Impact Area focus was viewed as less than ideal. It was suggested that district based programs should be implemented in the future. Immunization coverages for the impact areas and non-impact areas were not comparable in the absence of household survey in both areas. Please note the text of the individual interviews in the section on Findings.

D4. The GOZ has the existing infrastructure for the development oriented ministries to operate at village and ward levels. The MOH has the capacity to sustain the project activities once CS funding ends. The adjustment to a lower level of funding will to some extent affect project activities as the new outreach points may cause increased workload for the outreach teams. The farmers have the capacity to pay the FHWS.

D5. As discussed before, the MCCD will not be able to immediately absorb the 23 VCWS in Mutema Impact Area and CSP activities will be definitely affected in those areas where VCWS will not be absorbed.

E. Monitoring and Evaluation of Sustainability

E1. Indicators to track sustainability

- (1) Minutes of meeting between SCF/Zimbabwe Staff and MOH.
- (2) Quarterly reports from all I/As
- (3) Demand for services by the community

E2.

(1) A need for more coordination between MOH and MCCD in the supervision of VCWs was identified. SCF/Zim should be commended for its effort to bring the two supervisors of VCWS together and have joint supervisory visits and meetings. This strategy is viewed as useful for the continuity of effective supervision of the VCWS who are now multisectoral cadres working at the village level.

(2) Adoption of the data collection system at village level by VCWs and continuation of the HIS in its present state was not viewed as a feasible approach considering the VCW workload.

(3) A system was devised to ensure continuity of the interests of both VCWs and community leaders in project intervention where the VCWs report on their activities to the community leaders on a quarterly basis.

E3. The in-country agencies who worked with the PVO on development and implementation of the mid-term evaluation and this final evaluation include

- (a) Minority of Health Zimbabwe
- (b) Redd Barna
- (c) UNICEF HARARE
- (d) WORLD VISION INTERNATIONAL (ZIMBABWE)
- (e) UNIVERSITY OF ZIMBABWE (Department of Community Medicine)

F. Calculation of Recurrent Costs.

See Project Finances description under (A.) Primary Focus and use of Funding.

G. Cost Recovery Attempts

G1.

(a) The use of existing staff and village workers have kept the project cost to a minimum. Only necessary allowances were paid by the project for seconded staff. Maximizing available resources from other sectors such as the MOH and agri-tech to supply village gardens have also contributed to reduction of costs. Workgroups and seminars on CSP and AIDS

were held in the communities and at the training centres to reduce costs and improve transportation.

(b) The role of medical and epidemiologic consultant was shifted to the PMD after the university consultant left the country. This strategy reduced the project budget and increased MOH involvement.

(c) The training budget was made known to the coordinators and they were given the responsibility to plan their own training budget. This helped the coordinators become aware of cost controls and accountability for expenses.

G3 - G6.

There were no cost recovery mechanisms planned by the PVO to offset the project expenditures. However, there are a number of projects implemented by SCF/Zimbabwe and the communities to improve their economic status and nutritional intake.

H. Income Generation

H1-H4

The project did not implement any income generating activities. The government of Zimbabwe has mandated that all families with monthly earnings below \$150 Zimbabwe dollars should not pay for health services.

G. Project Finances

At time of the midterm evaluation the summary of budgetary allocations and expenditures showed that the financial management of the project was strong.

The main focus of the project has been to a great extent educational and motivational. In the budget, training has taken 10% of the budget. This is because most training workshops were held at SCF premises. In short the whole CSP budget up to the time of evaluation still shows that it was well managed and monitored. Below is the cumulative budget as at time of the midterm evaluation.

1. Personnel	51%
2. Travel/ Auto Operation	22%
3. Training	10%
4. Other Direct Costs	10%
5. Vehicle (purchase)	6%
6. Independent Consultant	1%

	100%

CALCULATIONS OF RECURRENT COSTS

The following explanations have been given by the Finance Department of the Field Office on the above mentioned subject.

1. The budget in the DIP planned expenditure and actual expenses were compared and all the cost centres were under spent as of the time of the final evaluation.

2. Since the programme will be handed to the MOH, the sustainability of the program will be the responsibility of the GOZ. However, if the programme wanted the services of an SCF coordinator for a transition period of up to six months an amount of nearly \$10,000 US would be required to run the program jointly with MOH to avoid sudden stoppage of activities.

3. Recurrent costs are calculated on the day to day actual expenditures except predetermined costs such as staff salaries and fringe benefits.

4. Refer to #2.

From the review of the financial management as shown above the project finances appear to have once again been well expended and monitored. The balance shown in the budget analysis are subject to outstanding bills and the cost of the final evaluation. It is anticipated all funds will be expended by the end of the project.

IV. CONCLUSIONS, FINDINGS AND LESSONS LEARNED

Conclusion 1. The final evaluation team found the majority of strategies relating to sustainability outlined in the original proposal and the detailed implementation plan were pursued and considered appropriate. The following conclusions, findings and lessons learned encapsulate the results of the SCF/Zimbabwe final evaluation:

1. Strategy: Adopt certain behaviors by the members of the community to ensure the life and health of women and children.

Findings:

o Community mothers who have been trained by the project are now convinced of the need for CS interventions and will continue to seek such services after the project ends.

o Evidence of practice is seen in the example reported by the seconded nurse in the Mupedzanhamo IA. Of the 567 reported cases of children under five suffering from diarrhea, all utilized ORT and 86 % proved to be competent. Only one child under five died of diarrhea during this same reporting period.

o VCWs/FHWs, community members and community leaders believe the efforts of CS are making a difference in improving the condition of children in their areas. This is reflected in the high coverage rates documented in the HIS and reported in each IA to the final evaluation team. The HIS data, however, cannot be compared to the MOH data since the SC/HIS uses a denominator based on their household enrollment and the MOH uses a denominator based on their census data. Thus, for immunization coverage, the final evaluation team could not make direct comparisons with the MOH data. In addition the unique impact of the CS project is difficult to assess since the MOH in Zimbabwe has also made significant progress in reducing the "6 killer diseases" on a nationwide scale.

Lessons Learned:

o Continue focusing on behavioral change as an effective strategy for sustainability.

o Baseline health information should be collected for every CS project.

o Whenever possible "control" populations should be surveyed concurrently to allow for future comparisons of outcomes of specific interventions.

o Future programs should utilize the WHO 30 cluster sampling technique in the IAs and in "control" populations. This information would also be an important asset for the MOH in their health planning process.

2. Strategy: Payment of an increasing number of health workers in the villages and the farms by the MOH (since the writing of the proposal, the MCCD is now responsible for the stipends received by the VCWs and the farmers pay the FHWs).

Findings:

o VCWs and FHWs can be instructed about child survival interventions and can be effective community motivators. Please refer to results of interviews with VCWs and FHWs in the Appendix.

o All of the stipends for the VCWs in the Muusha IA are paid by the MCCD; all of the FHW stipends are paid by the farm owners. Despite much effort by the SC/CS staff and many officials in the MCCD the payment for 23 out of 40 VCW stipends will not be continued in Mutema. This is secondary to a national policy which restricts the MCCD from providing more than one VCW per village.

o The objectives of the FHW project cannot be accomplished or sustained without the financial commitment and moral support from the farm owners and managers. The health care for the farm workers is largely dependent on the individual farm owners and their collective role on the Rural Council.

o CS programs in Muusha and Mutema benefited from the continuous presence and supervision of the IA manager.

Lessons Learned:

o The MOH considers the District to be the smallest unit for health planning. Future programs to support the VCWs will need to be multisectorial in scope and cover larger populations to be consistent with MOH long term planning. This may be accomplished by providing an array of services of varying intensity throughout a District.

o When staffing a project area, it is best not to place more staff than would be designated by the MOH or other government institutions.

o An effective strategy for sustainability is identification and training of community members as para health workers.

o Early dialogue with farm owners, managers and farm organizations such as the Rural Council and the Commercial Farmer's Union is essential to identify any concerns they

may have about future projects. These concerns should be addressed promptly and resolutely in order to enlist the cooperation of all involved groups. Farm owners will be more likely to invest their resources in the health care for their workers if they are involved from the start.

o The IA manager remaining in Muusha next year should continue the dialogue with the district level MOH to encourage clinic level nurses to take over the direct supervision of the VCWs.

3. Strategy: Strengthen community participation in the health care process.

a) Improve the skill of community level workers to understand and utilize the health information system to identify their health priorities. The proposal identifies the Community Development Committees, the VCWs and community health committees as the primary groups to support such activities.

b) Support community committees composed of traditional leaders, political leaders and other community members who volunteer to lead sectorial committees. VCWs/FHWS report on their activities and on the health information they gathered so problems can be discussed and solutions reached at the community level.

Findings:

o Community leaders played an important role in supporting the efforts of the VCWs/FHWS for CS interventions during the project and expect to continue into the future.

o Although the HIS is a laudable means of family registration to provide data for staff, VCWs/FHWS, MOH and granting agencies, it will be most difficult to sustain in its present format without additional nongovernmental funding.

o The community and the multidisciplinary ministries find the Home Visit Card as the most useful component of the HIS and plan to pilot test a revised version which incorporates other sectorial interventions.

o Although a HIS workshop was held by SC for the MOH and the MCCD in order to facilitate the take over of the HIS by the MOH, the final evaluation team found that despite initial enthusiasm by the DMO, the probability of the MOH to take over the supervision of the HIS was unlikely.

Lessons Learned:

o Future HIS may need to build upon the MOH data base and expand upon it in a manner sustainable by the MOH.

- o Other SC projects should hold HIS workshops with the MOH at an early stage of the project so that sustainability of the HIS can be ensured.

- o Identify community leaders early and develop their abilities and community skills to promote and sustain health activities at the village level.

- o Project funding should be set aside to enable a one year follow up of the progress in the project areas and a review of the status of the SC HIS.

4. Strategy: Collaborate closely with the MOH through joint quarterly meetings so that the planning, monitoring and evaluation are shared with the MOH.

Findings:

- o All quarterly meetings were held with the district and often provincial level MOH and MCCD representatives. All planning, monitoring and evaluation took place jointly with the MOH staff and recently with the MCCD staff.

- o Frequent meetings between the MOH and Save the Children took place during the life of the project.

Lessons Learned:

- o It is imperative for future projects to involve the MOH, PMD and DMO in all aspects of the intended project from the inception. The purpose of the project, site selections and disposition of assets should be agreed upon from the start. Due to frequent staff turnovers at all levels in the MOH and the PVO, clearly documented agreements and understandings should be kept on file and widely distributed.

- o The optimal method for consensus on program activities should integrate the perceived needs of the community along with the granting requirements early in the project planning process.

- o In addition to the MOH, it is also important to involve other concerned organizations in the design, planning, implementation and final recommendations for change at the end of project. This is a cumbersome task, but the ultimate sustainability of CS concepts and services requires the cooperation of MCCD, Rural Council, and community leadership.

5. Strategy: Extend and improve the effectiveness of the MOH programs.

Findings:

- o The core objectives of the CS project are consistent with the MOH/MCH goals and, therefore, will be sustained by the GOZ.
- o All outreach activities were conducted jointly with the CS staff and the MOH staff.
- o Frequent staff turnovers at all levels of operation interfere with a consistent message on child survival strategies.

Lessons Learned:

- o Working in collaboration with the MOH is an appropriate strategy for sustainability.
- o Since the MOH programs for Maternal and Child Health in Zimbabwe are promoting CS project interventions initiated six years ago, sustainability at this time could be defined in terms of acceptance of innovative aspects of the program by the community, the affected organizations and the MOH.
- o Maintain proper time for departing staff to orient new project staff.
- o Documentation of all activities and maintenance of good records of the training syllabi is important for the project.
- o Ensure proper and timely training of incoming staff.

6. Strategy: Secondment of MOH staff to key project positions.**Findings:**

- o Seconded staff positions from MOH have the potential to maintain the lessons learned within the impact areas.
- o One of the three seconded nurses has not been placed in a position which is utilizing her skills acquired during her tenure at SC.

Lessons Learned:

- o To ensure optimal use of seconded personnel, the MOH and PVO should consider the following: a) selection based on communication skills necessary to educate and motivate people in the rural areas; b) full-time seconded personnel appear to be considerably more

effective than part-time arrangements; c)
 long-term MOH position for the seconded nurse should be
 arranged in the project areas.

o Establish a written understanding with the MOH prior to
 the secondment of the nurse establishing the future
 placement of the nurse in post appropriate for her newly
 acquired skills from the project.

o SC should communicate previous agreements about the
 seconded nurses with any newly posted health person in the
 MOH at the provincial and district levels.

7. Strategy: Committee members participate in trainings.

Findings:

o The community leaders initially participated in trainings
 on their own and then were part of the refresher trainings
 of the VCWs/FHWs.

o Community leadership was found to be very positive about
 the program and expressed much appreciation to the final
 evaluation team; they feel a sense of loss because of SC's
 departure, but they feel confident that with the foundation
 built by SC they will be able to continue the work. Their
 slogan, PAMBERI NE UTANO, meaning "forward with the health
 of our children and down with all ignorance and disease"
 concluded many of the meetings with the evaluation team.

Lessons Learned:

o The optimal method for consensus on program activities
 should integrate the perceived needs of the community along
 with the granting requirements early in the project planning
 process. This can be done by integrating the community needs
 derived from a "community based needs assessment" as well as
 expectations for community health development as published
 by MOH at the Provincial level in their five year plans.

o Once a community such as Mutema becomes empowered to
 sustain the impetus for child survival, the community gains
 the leverage to decide on future priorities and activities.

8. Strategy: Minutes of the meetings and syllabi of the
 trainings will be kept by the CS staff and reviewed
 quarterly to confirm that the program is consistent with the
 initial intentions.

Findings:

- o Minutes of the quarterly meetings held jointly with the MOH, SC staff and MCCD were on record.

- o Training syllabi for the ARI, AIDS, HIS and growth monitoring were documented.

Lessons Learned:

- o The PVO should develop a mechanism for ongoing self assessment and consequent fine tuning of program objectives and interventions. This can be done by planning to utilize the HIS information on a monthly basis as a management and monitoring tool to identify early problem areas and devise adjustment in implementation programs.

9. Strategy: Share cost with the MOH in the areas of local travel, training materials, facilities, trainee per diems and village health worker supplies.

Findings:

- o Disposition and maintenance of assets procured by SC was not fully clarified within the MOH. In particular the house in Mutema has become a source of contention separating the community and the District Health Office.

- o Local travel, trainee per diems and village health worker supplies were not cost shared.

- o Training materials and facilities were shared by the CS program and the MOH.

Lessons Learned:

- o The disposition of fixed assets should be discussed early on and frequently during the life of the project in order to facilitate smooth hand over of the assets to the community or specific ministry. This is often out of the control of the project.

- o Per diems for trainings should only be provided according to MOH policy and shared by the MOH. This should be documented at the beginning of the project.

- o Transportation is a limiting factor for the MOH at the district and provincial level. Future projects should note already established MOH meetings and if MOH is amenable incorporate the CS meetings into them. Furthermore, establishing additional outreach points should only be done as per MOH policy to ensure their continuation at the EOP.

10. Strategy: Integrate more fully the health activities with the other community development activities by training the village health workers in other sectoral areas.

Findings:

o In 1985 a presidential decree placed the VHWs under the management and supervision of what is now the MCCD. Their new role as multisectoral development workers, reflected in the new title of VCW versus the VHW (Village Health Worker) brought responsibilities in agriculture, education, gardening, sewing and income generating activities in addition to health. By August, 1989 most of the VCWs were trained as multisector workers.

o The MCCD ward supervisors have not received extensive training on the delivery of health care and consequently experience some difficulties supervising the VCWs.

o The SC staff worked with both the MCCD and the MOH in order to facilitate coordination for the VCW.

Lessons Learned:

o Strengthening of the supervision of the VCW is mandatory for the future success of this useful cadre.

o Future CS programs at the community level should broaden the scope of activities consistent with improving health outcomes. For example water and sanitation projects could be supported through the VCW in cooperation with the District Development Fund (DDF) and the MOH for water and sanitation.

Conclusion 2. The majority of service delivery interventions were effective as indicated by the HIS data presented at each of the IAs to the final evaluation team. There were, however, specific interventions in the project which could be improved upon.

Findings:

o In the Mutema IA, during the sixth year of the project 3/5 deaths of children under five were reportedly due to diarrhea.

o In the Mupedzanhamo IA, during the sixth year of the project four out of the 10 deaths of children under five were reportedly due to malnutrition- a specific intervention of the project. The under five years mortality, however,

for Mupedzanhamo IA is 51 versus 90 in all of Zimbabwe, as listed in the State of the World's Children, 1991.

o Please refer to findings reported by IAs presented in the appendix for statistics.

Lessons Learned:

o Educational programs for personal and environmental hygiene should be coordinated with development of community water and sanitation programs so there is improved access to potable water and proper sanitation.

o Future CS programs should incorporate water and sanitation projects as an integral part of the activities; the cooperation with the District Development Fund and the MOH for water and sanitation projects is required. Only 52 % of the families in the Mutema IA had access to potable water.

o Future growth monitoring projects should document what interventions took place and what was the outcome following identification of children at risk.

o Cases of children who die from malnutrition should be reviewed and assessed whether the child had been previously identified as malnourished, whether they received any interventions, and if so which ones and what were the associated illnesses (this is especially relevant at this time since many children who reportedly die from malnutrition, may be dying from AIDS).

o Involvement of a university based consultant in pediatrics and epidemiology would assist the identification of cases and utilization of data collected by the VCWs.

Conclusion 3. The health situation of the farm workers and their families is particularly challenging and represents an area of much need because of their dependency on the farm owner/manager for their livelihood and standard of living. Recently the MOH has become more involved in farm worker health issues. The commitment of the 12 farm owners to pay the stipends of the FHWs in this project; however, clearly indicates a desire by the farm owners and managers to support the health training endeavors which this project pursued.

Lessons Learned:

o Undertake discussions with farm owners/managers on economic effects of poor health of workers and their families relating to productivity and the spread of contagious diseases on the farms.

- o Expand AIDS awareness and prevention programs on farms to include the owners and managers. The specter of the incipient AIDS epidemic is one of the most immediate health concerns of the farmers.
- o Expand the base of financial support of the Rural Councils for health services for farm workers.
- o Investigate the possibility of financial incentives for farmers to provide proper water, sanitation, housing, garden plots and recreation for their workers.
- o Coordinate future programs on commercial farms with the activities of the Occupational Health Division of the Ministry of Labor.
- o Utilize University of Zimbabwe social science and health care research as well as the experiences of the Save the Children (UK) to initiate future programs to improve the health of farm workers and their families.
- o Incorporate the basic concepts of the Farm Health Worker program into the training courses for new farm managers held at Black-forbes and other training centers in Zimbabwe.
- o Encourage and support the MOH and private volunteer organizations to pursue the development and expansion of improved health and living standards on commercial farms. Information gleaned from this SCF/CS project should be made widely available to assist grant writing and new programs on the farms.

Conclusion 4. The majority of the midterm evaluation recommendations were followed through and were found to be valuable by the project staff.

Findings:

- o Please refer to the Table of Contents for the attached document regarding the progress made in relation to the MTE recommendations.

Lessons Learned:

- o The MTE for CS programs helps direct the final activities for the end of the project.

APPENDICES

APPENDIX I: MTE RECOMMENDATIONS/END-OF-PROJECT ACHIEVEMENTS

The following outlines the progress made in response to the MTE recommendations.

I. MTE RECOMMENDATIONS

- Work with the GOZs National Committee on Coordination of the VCW programme (NCCVCWP) to establish a strategy and plan for community coordination, support and supervision of VCWs.
- Encourage the GOZ to profit from SC Impact Areas prior to and after the EOP to conduct operational research or test models for supervision and refresher training of the VCWs.

Achievements to date:

The MCCD has already developed a plan of supervision for the VCWs in conjunction with the MOH. This was detailed in the third annual report. Furthermore the VCWs report to the Rural Health Clinic on at least a monthly basis. A reporting form has been developed for this purpose.

Plans outlined in the Annual Report:

Refresher training courses for the VCWs in conjunction with the MOH and MCCD are planned for this fiscal year . Furthermore, in the next Quarterly meeting, we will explore with the MOH and MCCD whether they are interested in testing other models of supervision.

End of Project (EOP) accomplishments:

Refresher training courses for the VCWs/FHWs in conjunction with the MOH, MCCD and the community leaders took place on a regular basis during the final fiscal year. No other models for supervision were tried.

II. MTE RECOMMENDATION

- Develop a new DIP for the project in collaboration (or at least consultation) with both the MOH and the MCCD, once contact persons in each Ministry are identified who can work with the project staff and act as advocates for the project. Include objectives and indicators in the new DIP which reflect the project's goal of ensuring sustainability.

Response:

Our project is in its final year and rather than develop a new DIP, we are developing strategies that deal with sustainability; we have further described our plans towards

reaching our objective regarding ARI and AIDS. (Please refer to the third annual report for the details of the curriculum)

Furthermore, there are objectives which aim at training 100% of families which the present CS staff feel is unrealistic; this is based on MTE results from the household survey, CS staff field experience and the fact that the program is phasing down; the focus is on issues of sustainability and much of the remaining resources will be devoted to reaching this goal rather than only on service delivery. For instance a HIS workshop for the MOH will be held in 2/91.

The following details the revised objectives.

Objective 4a - original - 100% of families will be trained in ORT and 80% will use it correctly.

Results of MTE - 97% were trained in ORT

Revised objectives - 98% of families will be trained in ORT and 80% will use it correctly.

Objective 4b. - original - 100% of families shall be trained on the importance of hand washing and use of potable water.

Results of MTE - 93% were trained in hand washing and importance of potable water.

Revised objective - 95% of families shall be trained on the importance of hand washing and use of potable water.

Objective 6a. - original - 100% of pregnant women will be trained in the importance of proper pre-post natal care.

Results of MTE - 80% were trained in prenatal care.

Revised objective - 85% of pregnant women will be trained in the importance of proper pre-post natal care.

Objective 9 - original - 80% of families will be trained to recognize symptoms of ARI and know when and where to seek treatment.

Results of MTE - 54% of mothers had been trained and 68% knew when to seek treatment.

Revised objective - 70% of families will be trained to recognize symptoms of ARI and know when and where to seek treatment.

EOP Accomplishments

A household survey was not part of the final evaluation since the results during the midterm were so close to the stated objectives. These specific objectives were, therefore, not reevaluated at the end of the project.

III. MTE RECOMMENDATION

- Consider using SC resources after the EOP to enhance sustainability by providing a source of technical assistance, particularly in areas of information systems and supervisory systems.

Response:

At present all training workshops are facilitated jointly by MOH staff and SC staff; sharing of experiences and skills is encouraged during these workshops. Recently the MCCD has also participated in the workshops. Additionally, during a National workshop in April 1989, the MOH and MCCD outlined a joint supervisory plan. Please see third annual report for Policy Guideline and report of National workshop.

EOP accomplishments:

Workshops with the MOH, MCCD and the SC staff were held in March, 1991 and again in June, 1991. During these workshops, the home visit card was considered to be a component of the HIS which could be sustained by the MCCD and the MOH and would serve as a good supervisory tool for the VCWs. The home visit card was revised to include subjects in addition to health at the June meeting when other ministries such as agriculture and education were present. The final evaluation team unfortunately was unable to schedule a meeting with the MCCD to determine the current status of the home visit card.

IV. MTE RECOMMENDATIONS

- Develop a specific strategy for improving the recognition of ARI and seeking of treatment for pneumonia. Assure that this strategy reflects the National Policy and the guidance of WHO's programme Manager's Training Course materials. Assess and assure the quality of care and availability of appropriate antibiotics in health centers before further promoting referrals.

Response:

A training curriculum for ARI in line with the National policy has been developed. Refer to the 1990 annual report for the curriculum.

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As mentioned before SCF/Zimbabwe is implementing the project jointly with the MOH, therefore, the quality of training for the MOH and SC staff is assured. The drug supply is, however, completely controlled by the MOH. The MOH does take steps to assure the availability of appropriate antibiotics in health centers.

Follow up of training in ARI for the VCWs/FHWS will be discussed in the next quarterly meeting.

EOP accomplishments:

Follow up training took place in conformity to MOH standards for ARI interventions.

V. MTE RECOMMENDATION

- Coordinate the project's efforts in health education for Prevention of AIDS with SCF new AIDS project assuring that objectives are clearly stated and activity are complementing.

Response:

From the start, SC's AIDS program planned and implemented activities jointly with MOH, and this ensured that activities have been complementary with MOH activities.

The AIDS project is supported by a HAPA (HIV and AIDS prevention in Africa) grant but its activities are completely integrated with the CS activities. A MTE of the AIDS project was conducted in 9/90. The report is attached to the ISTI form of the 1990 annual report. Within the HAPA grant a separate DIP was been developed with the following objectives:

a. 85 % of rural health center staff and MCCD officers in the 3 IAs will attend 5 days of AIDS Prevention training by August 1990.

b. All VCW/FHWS (111) in the 3 IAs. will attend 3 days of AIDS Prevention training by July 1990.

c. 100 Community leaders and all Government extension workers will attend 2 days of AIDS prevention training by August 1990.

d. Eighty percent of families trained in the 3 IAs will be able to identify the 3 major modes of HIV/AIDS transmission and 3 behaviors that prevent HIV transmission.

EOP accomplishments:

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The conclusions from the HAPA AIDS final evaluation are the following:

1. Until more acceptable methods are developed, condoms remain the best method to prevent sexual transmission of HIV. While condom use and acceptance has grown over the past 2 years, their promotion presents significant challenges for an AIDS education program. The challenge still remains to change sexual behavior.
2. An AIDS education project of 2 years' duration is insufficient to effect attitude and behavior change.
3. People will respond more effectively to AIDS education efforts which include concrete evidence of AIDS in their country and communities.
4. The effectiveness and sustainability of the HAPA project was enhanced by its high degree of integration into the existing CS health program and the MOH structure. The lessons learned from this collaboration and integration should be documented to ensure that future collaboration can be even stronger.
5. AIDS is a new disease, and as such research is needed to bring to light new information which will add to the effectiveness of AIDS education efforts.
6. VCWs/FHWs and community leaders are the two keys to providing effective community-based AIDS education. The VCWs/FHWs are the direct conduit for AIDS information to reach families while community leaders play a critical outreach role by creating awareness of and supporting the efforts of the VCWs/FHWs.
7. Chances for sustainability of the HAPA program in the commercial farming areas may be improved if the program is broadened to include all vested groups in these areas.
8. Families are concerned about and supportive of children's education on AIDS.
9. Building on pre-existing SC programs when initiating new projects is a sound idea, however, management of the

HAPA project, which required intensive effort at the family level, was hampered by the distances between the 3 project sites.

VI. MTE RECOMMENDATION

- Accelerate the development of a written plan and timetable for converting the project's capital assets (such as vehicles and buildings) to functional resources for the MOH. Include a plan specifying future uses and allocating these capital assets for conversions and maintenance.

Response:

A calendar of events for handing over assets has been discussed, but not yet developed. Once the vehicles and buildings become registered with the GOZ, they will automatically be maintained by the GOZ like other GOZ assets. However, CS funds have been put aside for repairs and renovations that may be needed at the end of the project in order to facilitate the phasing over of assets in proper running order.

EOP accomplishments:

Plans for government ministries to take over most of the assets have been made. The future of one of the buildings, however, still needs to be finalized.

VII. MTE RECOMMENDATION

- Use the remaining project period and funding to work with the MCCD and MOH (perhaps through the NCCVCWD) to adapt the health information system for reporting by supervision of VCWs.

Response:

A meeting has been arranged for the MOH, SC and MCCD staff to review the present forms and agree on the HIS that is hoped to be sustained. MOH has requested that SC hold a HIS training workshop. It is planned to take place in February 1991.

EOP accomplishments:

A workshop with the MOH, MCCD and SC took place for five days at the end of March, 1991. At the workshop, the following conclusions and actions for follow up were discussed:

1. Formation of a national committee to meet regarding revisions to the home visit card so that other sectors are represented. This process is described in the section on Lessons Learned.

2. Meet with other sectors at district level in order to review the home visit card (took place in June, 1991).

3. MCCD will first test home visit card as a supervisory tool in Muusha and then field test a revised version of the home visit card.

4. Review family enrollment and update.

5. The form (T-4) used by the MOH is a useful form for reporting the VCW activities and could be used by the VCWs in lieu of the SC form.

6. VCWs report to the rural health clinic and the health clinic will keep the registers and family enrollment. In return the staff will feedback the information to the VCWs and the Community Leaders.

VIII. MTE RECOMMENDATION

- Obtain technical assistance to increase the sustainability of the HIS by streamlining it and eliminating less useful health components, explaining alternative sources (other than VCWs/FHWs) for needed information and identifying and incorporating information needed for other sectors.

Response:

As described above the HIS is in the process of revision to meet the needs of the MCCD and the MOH. If outside technical assistance is needed, it will be considered.

IX. MTE RECOMMENDATION

Enhance the sustainability of the modified HIS that is being developed and implement a plan for dissemination of the information to VCWs, communities, ward, district, provincial and national level and other sectors agencies active in the health sector in Zimbabwe.

Response:

A district level workshop was scheduled for February, 1991. In addition, VCWs and community leaders are scheduled to have refresher courses on the HIS this year.

EOP accomplishments:

The workshop was completed in March, 1991.

X. MTE RECOMMENDATION

The project needs to reassess and shift its relationship with the impact area communities, working to enhance their self-reliance in anticipation of SCF's departure.

Response:

The community leaders have participated in AIDS workshops in the last year in Mupedzanhamo. Workshops for community leaders in Mutema and Muusha will take place by the end of the year 1990. During these workshops the role of the VCW/FHW and the HIS, for example, are emphasized. Furthermore in, Mupedzanhamo, a farming community, dialogue has already been started with the Secretary for Beatrice Rural Council. Discussions with the farmers have been about the future goals of child survival and the project's accomplishments to date.

EOP accomplishments:

Workshops were conducted in all the impact areas for the community leaders.

XI. MTE RECOMMENDATION

The projects activities in staff development and training are one of the most important hopes of achieving a sustainable impact. MTE recommended the program hasten the identification and training of the Traditional Midwives (TMs).

EOP accomplishments:

All three IAs were able to list the TMs in their areas and demonstrate the % of home births attended by trained vs untrained midwives. Training sessions were held for TMs in the final year of the project.

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APPENDIX 2: FIELD QUESTIONNAIRES**VCW/FHW FOCUS GROUP****WHAT METHODS DID YOU USE TO MOTIVATE THE PEOPLE TO PARTICIPATE IN THE VARIOUS PROGRAM ACTIVITIES?****WHAT SUGGESTIONS DO YOU HAVE TO CONTINUE YOUR ACTIVITIES IN THE FUTURE AFTER PROGRAM ENDS?****LESSONS LEARNED?***2/1*

QUESTIONS FOR HEALTH COORDINATOR IN I.A.

- 1) LEVEL AND CONSISTENCY OF TRAINING FROM CENTRAL STAFF OR OTHER STAFF(MOH)
 - 2) CONSISTENCY OF SUPERVISION AS ABOVE?
 - 3) DID C.S. INTERVENTIONS ADDRESS THE MAJOR CAUSES OF CHILD MORBIDITY AND MORTALITY?
 - 4) DO YOU SEE HEALTH BEHAVIOR CHANGING AS A RESULT OF YOUR INTERVENTIONS? LIST EXAMPLES--
 - 5) HOW DOES THE INFORMATION FROM THE HIS FLOW TO YOU AND FROM YOU?
 - 6) HOW DO YOU USE THE DATA FROM THE HIS TO MONITOR YOUR TARGET POPULATIONS AND THOSE AT RISK--FOR EXAMPLE IMMUNIZATIONS, GROWTH MONITORING, ETC AND RESPONDING TO OUTBREAKS OF DISEASES
 - 7) WHAT HAVE BEEN MAJOR DIFFICULTIES IN JOB PERFORMANCE? E.G. WERE YOU ABLE TO ADEQUATELY SUPERVISE VCWS ETC.?
- 40

8) WHAT STAFF TRAINING ACTIVITIES DID YOU CARRY OUT SINCE THE MIDTERM EVALUATION?

9) DURING THE COURSE OF YOUR PROGRAM WHAT COMMUNITY STRUCTURE HAVE YOU DEVELOPED OR STRENGTHENED WHICH WILL BE ABLE TO PERSIST AFTER EOP?

10) OTHER SUSTAINABILITY ISSUES
STAFF TURNOVER,

11) LESSONS LEARNED

SPECIFIC FOR MANAGER: CAN YOU OUTLINE HOW THE MONIES HAVE BEEN USED IN THE IMPACT AREAS FOR EACH AREA OF INTERVENTION? HOW DOES MANAGER KEEP TRACK OF EXPENSES?

FARM MANAGERS---INTERVIEWS

WHAT DO YOU SEE AS THE POSITIVE RESULTS OF THE C.S. PROJECT?

HOW CAN THESE RESULTS BE SUSTAINED?

WHAT COULD BE ADDED TO THE PROGRAM TO SUIT THE OVERALL NEEDS OF YOUR EMPLOYEES?

HOW COULD YOU (OR US) CONVINCED OTHER FARM MANAGERS TO PROVIDE FUNDING FOR THE FHW PROGRAM IN OTHER FARMS?

IS YOUR FARM ABLE TO MEET THE BASIC NEEDS OF YOUR WORKERS AND THEIR FAMILIES FOR THE FOLLOWING:

-----CLEAN WATER

-----PROPER SANITATION

-----SUFFICIENT HOUSING

-----ADEQUATE NUTRITION

CAN YOU SUGGEST SOME OTHER WAYS TO IMPROVE ON THE BASIC NEEDS OF YOUR FARMERS SUCH AS SELF HELP PROJECTS FOR BLAIR LATRINES. ETC?

COMMUNITY LEADERS---FOCUS GROUPS

DID THE C.S. PROJECT ACTIVITIES IMPROVE THE HEALTH OF YOUR COMMUNITIES? GIVE EXAMPLES

WHAT WAS YOUR ROLE IN THE PROJECT AND WHAT WILL YOU BE ABLE TO DO IN THE FUTURE (AFTER EOP)

HOW HAS THE COMMUNITY DEMONSTRATED ITS SUPPORT FOR THE PROJECT BY CONTRIBUTING RESOURCES OR OTHER ACTIVITIES

RURAL CLINIC STAFF--INTERVIEW

HOW HAVE YOU BEEN INVOLVED IN THE C.S. PROGRAM IN THE IMPACT AREA?
WITH SUPERVISION, TRAINING, RETRAINING AND OTHER SUPPORT

HAVE YOU NOTICED ANY IMPROVEMENT IN THE I.A.s COMPAIRED TO THE
OTHER AREAS IN THE CATCHMENT AREA IN SPECIFICS SUCH AS IMMUNIZATION
COVERAGE, NUTRITIONAL STATUS, REQUESTS FOR FAMILY PLANNING, ETC

HOW WILL EACH ASPECT OF THE PROGRAM BE SUSTAINED?

-----HIS

-----FULL IMMUNIZATION FOR a.INFANTS
 b.13-59 MONTH OLDS
 c.T.T. FOR ANC MOTHERS

-----TRAINING FAMILIES IN ORT AND HAND WASHING AND POTABLE WATER

-----GROWTH MONITORING OF 0-36 MONTH OLDS

-----UTILIZATION OF ANC SERVICES

-----CHILD SPACING TRAINING

-----AIDS PREVENTION TRAINING

-----ARI SYMPTOMS AND TREATMENT

WHAT WILL BE THE FUTURE ROLE OF THE VCWs?

OPENENDED SUGGESTIONS TO US AND LESSONS LEARNED

TIME PERMITTING: PLEASE DESCRIBE COLD CHAIN MAINTENANCE AND OUT
REACH SCHEDULE.

DO YOU USE A HIGH RISK REGISTER?

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FOCUS GROUPS OF VILLAGERS OR FARM WORKERS 10 MEN SEPARATE FROM 10
WOMEN

WHAT DO YOU NEED MOST TO IMPROVE YOUR LIVING STANDARDS?

CAN YOU EACH GIVE US ONE WAY THE CHILD SURVIVAL PROGRAM HELPED YOUR
FAMILY

NOW THAT THE PROGRAM IS CHANGING HOW CAN YOU HELP TO CONTINUE TO
BRING THOSE ASPECTS MENTIONED ABOVE TO YOUR FAMILIES?---INTERVIEWER
--BE SPECIFIC ABOUT EACH INTERVENTION MENTIONED ABOVE IN QUESTION#1

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Questions for Central Staff:

1) What was major focus and describe final % of funding for each C.S. activities. (services vs training and support)

2) How has C.S. intensified the MOH program for Child survival in the I.A.s?

3) Involvement and collaboration of other agencies (HEAD OFFICE-SCF, MOH, NGOs, AID, UNICEF, MOH at Provincial and Dist levels) for: give specific answers---

PLANNING AND DESIGN

FUNDING

STAFF SHARING

SHARING TRAINING

SHARING SUPERVISION

4) Staff evaluations -- how performed?

5) What are plans for sustainability and which have been implemented? (How to use unused assets-vehicles etc and money)

Income generation

how to sustain the concepts of children surviving?

6) What will happen to VCW and FHW allowance after EOP?

7) Have you been able to identify high risk sub groups of the I.A. Population?

8) What methods do you use to cut costs and increase productivity?

9) What lessons have you learned?

INTERVIEWS WITH DNOs AND DMOs

WHAT WAS YOUR INVOLVEMENT IN THE CHILD SURVIVAL PROJECT ---

INITIATION AND DESIGN

TRAINING

SUPERVISION

STAFFING

YOUR FUTURE ROLE AND FUTURE FOR THE CHWs/FHws

HOW WILL YOU UTILIZE THE SECUNDED NURSES

DO YOU HAVE PLANS TO UTILIZE THE H.I.S. ?

SPECIFICALLY, WILL YOU USE THE HOME VISIT CARD?

WHICH ASSETS OF THE C.S.PROJECT WOULD BE MOST USEFUL TO YOU?

HOW WILL YOU MAINTAIN THE VEHICLES, COMPUTERS, ETC

AS YOU ASSESS THE DATA FROM THE C.S.-- I.A.s DO YOU DETECT AN IMPROVEMENT IN NUMBERS OF CHILDREN SURVIVING COMPAREDD TO UNCOVERED AREAS ?

WHAT COMMITMENT ARE YOU WILLING TO INVEST TO CONTINUE THE C.S. PROGRAM ?

FINANCIAL--

MATERIAL--

HUMAN RESOURCES--

PLEASE GIVE EXAMPLES OF SOME LESSONS LEARNED-----THANK YOU ! !

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FOCUS GROUP FOR TRADITIONAL MIDWIVES

1) WHAT ASPECTS OF MCH WERE COVERED DURING YOUR TRAINING?

2) WHAT SPECIFICALLY HAS CHANGED IN YOUR PRACTICE AFTER TRAINING?

3) WHAT ARE YOUR SUGGESTIONS FOR IMPROVING YOUR WORK?

4) DID THE TRAINING BENEFIT YOU IN ANY WAY AND IF SO IN WHAT WAYS?

INTERVIEWS WITH VCWs AND FHWS

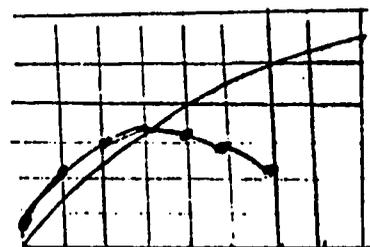
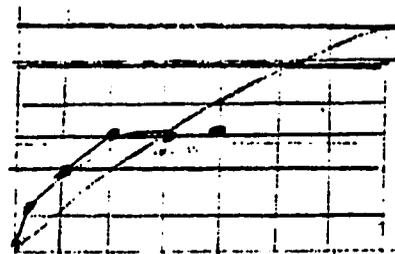
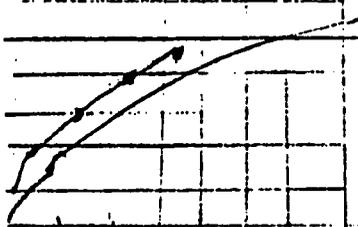
WHEN DO YOU REFER CHILD TO CLINIC WHO HAS RESPIRATORY PROBLEM?

WHAT DO YOU TELL MOTHERS TO DO FOR CHILD WITH DIARRHEA?

PLEASE LIST THE SIX IMMUNIZABLE DISEASES

WHAT IS BCG IMMUNIZATION USED FOR?

GRAPHS--PLEASE LABEL EACH GRAPH WITH LETTER DESCRIBING THE GRAPH
NORMAL GROWTH=A
PREMATURE INFANT GROWTH=B
GROWTH FLATERING=C
SEVERE MALNUTRITION=D



WHAT ARE THE MAIN TOPICS YOU TEACH PARENTS?

APPENDIX 3: INTERVIEW RESULTS

Focus Group - Community Leaders

1) The community leaders in all the I/As said the SCF\CS greatly improved the health of their communities.

The examples given were:

a) Fewer children dying from immunizable diseases because children are being immunized. It is rare to see children with tetanus or measles.

b) The environmental health of the I/As has improved. More toilets, pot racks and rubbish pits were built during the project.

c) Child care has improved and has helped in reducing deaths and child illnesses. Growth monitoring, nutrition and use of ORT has improved the child health in the I/As.

2) The role of community leader in CSP was to mobilize the community on CS interventions, i.e., encourage parent to take children for immunizations and growth monitoring. CL also encourage people to build Blair toilets, pot racks, and to produce food to feed their children, e.g., have gardens at home. The community leaders said that their role will continue after EOP. They will talk about CS activities during their meetings.

Mupedzanhamo: Community Leaders Interviews

1. From the answers given during the interviews the farm community leaders expressed their appreciation for the CS activities in the communities on their farm locations such as improvement in hygiene, immunization coverage, water supply and reduction in cases of diarrhea in children. Most FHWs now teach other women about AIDS and other diseases.

In summary the leaders who came from farms where there are FHWs support these ladies very strongly but they require an authority to help them continue. In this way they will realize that they are a golden link in the chain that eventually ends at the offices of the Ministry of Health Headquarters.

Interviews with DNOs and DMOs

Group interviews were conducted in the three Districts with the CS Projects. The DMO for Mupedzanhamo was unavailable so only the DNO was interviewed.

1. Involvement in the Child Survival Project

a. Initiation and Design: In Mupedzanhamo and Mutema the MOH could have been more involved in the program start up as stated by the DNOs for Seke and Chipinge Districts. In Muusha the DNO was actively involved.

b. Training: In all the three IAs, MOH was involved in the training of FHWs/VCWs. In Chimanimani EHT meetings were also used as a teaching forum for health workers. In Mutema some workshops were planned together by SCF and MOH.

c. Supervision: The clinic staff and the Area Coordinators supervise the FHWs/VCWs. The DNO supervises the clinic staff and the Area Coordinators.

d. Staffing: MOH seconded nurses to the IAs in the three districts became the Area Coordinators. In all the districts an Environmental Health Technician (EHT) was attached to the IA.

2. Utilization of the HIS

Generally it was felt that the HIS was useful and accurate but very difficult if not impossible to sustain in its present form because:

a. Enrollment of families is not possible in the entire district due to lack of manpower.

b. The Home Visit Card is multisectoral and needs MCCD to implement it. The DMO for Chipinge was also unclear on how the information on the card was going to leave the home and be utilized by the rural health clinics and then the DMO.

3. Maintenance of Assets

The maintenance of vehicles was not a problems in all IAs. In Chimanimani the vehicle will be maintained by the District Council. In Chipinge the Hospital Advisory Board will take over maintenance of the vehicle. In Mupedzanhamo the vehicle will be handed over to Central Mechanical Equipment Department which maintains all government vehicles. The computer would be handed over to PMD Manicaland who then decides on where it is kept. There was a suggestion from the DMO to give it to Chimanimani District for use. The other small items like sphygmomanometers and scales will be used by the Rural Health Centres to support the Programme.

4. From the data collected from the IAs it was difficult for DMO/DNO to conclude that more children survived compared to uncovered areas. The immunization coverages were high in the IAs and in the uncovered areas. The knowledge of people in the IAs on

use of ORT has improved and participation in immunizations is high. The House in Mutema brought a lot of controversy between MOH and the community who wanted it as a clinic. The location is not appropriate for a clinic because it is only 6 kms from the nearest clinic. The training centre in Muusha will remain a training centre but the community wants to use it as a clinic. According to MOH criteria for a static clinic this location is not a priority. The Environmental Health Technician will continue to use the f 15 house at the school.

5. Commitment to invest to continue the CS program.

All the IAs are committed to continue this program. It is an ongoing program in the MOH and they are prepared to prove human resources just like what they are doing in other areas. The I.A.s will not be treated in a special manner and the activities will be sustained at the level allowed by MOH resources. All the Districts will get some money from the Ministry of Maternal and Child Health for specific activities they continue to maintain.

6. How seconded nurse will be used.

In Chimanimani the nurse will be stationed at a rural hospital but will continue to support the CS activities. The nurse from Mutema will go back to the PMDs offices in Mutema and may not be able to continue supporting these activities. In Mupedzanhamo the nurse will be going to a hospital where the Farm Health Workers are trained and she might use her knowledge and skills to continue supporting the program.

Individual Interviews with Farm Health Workers

11 farm health workers from Mupedzanhamo I.A. were interviewed individually. All of them knew when to refer a child with respiratory problems to the clinic. A variety of other answers such as when the child has hot body, difficulty in breathing, indrawn chest, fast breathing, refusing food, grunting and rib recession were given. The farm workers then advised the mothers on home remedies which have been found to be helpful.

Diarrhea

All the 11 farm workers interviewed knew what to tell the mothers of a child with diarrhea. The advice on homemade salt and sugar solution will be given and then the correct recipe for the ORS was also given.

6 level teaspoons sugar
1/2 level teaspoon salt
750 mls boiled, cooled water

The mother is also advised on how to give the child the solution after each bout of diarrhea and to continue with breastfeeding of the child. They also advise giving other fluids and soft diet foods such as porridge. Other farm health workers emphasize the need for hygiene (handwashing, cleaning of utensils) during the preparation of ORS and others would demonstrate to make sure mother understands. The mother is advised to prepare fresh solution on a daily basis and if the diarrhea persists for 3 days, the FHWS refer the child to the clinic.

Immunizations

The farm workers were asked to list the 6 immunizable diseases and all the 11 farm workers interviewed listed all the 6 immunizable diseases correctly. When they were asked what BCG immunization is used for, 10 out of 11 got the answer right.

Growth Monitoring/Nutrition

Growth charts (graphs) describing the following were presented to each farm worker:

- a) Normal growth
- b) Premature infant growth
- c) Severe malnutrition

The farmworkers were asked to identify the graph which describes each of the above growth curves 2 a) 10 out of 11 got the answers correct (b) 1 out of 11 got the answers wrong.

Main Topics Taught by Farmworkers

- (1) Immunizations
- (2) Nutrition (food square) weaning/food producer

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- (3) Teach pregnant mothers to visit ANC for check-ups and TT
- (4) Preparation of oral rehydration solution and ORT.
- (5) Environmental/Hygiene Health:
 - a) use of rubbish pits
 - b) Use of pot racks
 - c) Construction of
 - d) Cleanliness and general home hygiene
 - e) Family Planning
 - f) Acute respiratory infections
 - g) Prevention of diseases such as malaria and diarrhea
 - h) AIDS: transmission, prevention, use of condoms
 - i) General child care and home hygiene
 - j) Growth monitoring and also impart knowledge to the mothers on the different growth curves and what to do if a child loses weight.

A high level of knowledge of the different CS interventions was achieved during the course of the program and the suggested strategies to support the FHWs will strengthen and sustain the project activities.

OVERALL RESULTS OF INDIVIDUAL INTERVIEWS WITH 43 FHWS/VCWS COVERING THEIR RESPONSES TO THE ABOVE QUESTIONS.

TABLE LISTS THE % WITH CORRECT ANSWERS FROM EACH I.A.

	MUPEDZANHAMO	MUUSHA	MUTEMA
ARI AND CDD	62%	79%	71%
EPI	91%	75%	94%
G.M. AND ANC	82%	88%	75%
TOTAL	78%	81%	80%

(CDD = control of diarrheal diseases and G.M.= growth monitoring. EPI =expanded program of immunizations and ANC = antenatal care.)

From this table it was obvious to the evaluation team and to the FHWS\VCWS (presented at the summary session) that all were well trained in the important CS interventions. This chart provided positive feedback and encouragement to the trainers and the village workers in each I.A.

Summary Focus Group VCW - CS/DATA

Focus Group VCW's

- (1) The VCWs used a variety of methods to motivate people to participate in the project activities.

- Demonstration and return demonstrations in the preparation of ORT;
- Home visits and education them at home using the home visit card;
- Drama especially at well baby clinics;
- Use of charts because some people learn better from seeing than from hearing only;
- They used to ask participants to draw, e.g., a dehydrated child and then discuss around the drawing;
- Invite people to the VCW's garden so that she works together with them to establish their own gardens;
- Demonstrations on how to cook different foods;
- Ask other VCW to help with difficult families.

(2) Suggestions to continue their activities.

- All the VCW should be kept on the payroll;
- Save the Children should try and get another donor to continue the work;
- SCF should stay a bit longer in the area to reinforce the good teaching that has been done;
- Some VCWs will continue with what they were doing even if they are not paid.

Summary on Traditional Midwives Focus Group Discussion

Three focus group discussions were conducted with the traditional midwives (TMs) who went through an upgrading exercise. A total of 27 traditional midwives participated in the focus group discussions.

Q1. What aspects of MCH were covered during your training?

1) TMS were taught not to deliver primgravidas, unbooked mothers, those with previous caesarian sections and those with high blood pressure and grand multiparous women. The modern midwives, during the training of traditional midwives agreed with using a "red X mark". This is a mark on the ANC cards which identifies mothers at risk and hence they should not be delivered by a TM. TMS were taught to insist on

seeing the ANC to make sure that the pregnant woman is not at risk.

2) TMs were taught not to use ash or cowdung on the umbilicus and to use a new razor blade to cut the cord.

3) To keep the delivery kit ready all the time with clean equipment such as plastic paper and old ironed sheets, new razor blade, spirit and cord ties.

4) Hygienic aspects were emphasized during the training, especially hand washing and keeping short fingernails. After delivery the VCW should be advised about the delivery and the mother is advised about well baby clinics for the baby to be immunized and weighed.

5) TMs were also taught about who to refer, such as those with ante-partum and post partum hemorrhages.

6) To identify cephalo-pelvic-disproportion on inspection and were also taught how to palpate.

7) TMs also advise pregnant women on TT and good nutrition and supervise the women to take tablets that are given at the ANC - iron and multivitamin tablets. They also advise against wearing tight clothes and high healed shoes.

8) They were also taught to advise their clients to ask their husbands to use condoms during the pregnancy to avoid infections.

9) Advise women to go to post natal clinics, personal hygiene, post natally as well as child spacing using condoms and pills.

10) Child with diarrhea should be given salt sugar solution.

Q2. What specifically has changed in your practice after training?

- 1) They learned how to use razor blades and to tie the cord with clean strips.
- 2) Avoid usage of cow dung - now using spirit on the naval.
- 3) They refer is the mother has prolonged labor and TMs go along with the mother to the hospital.
- 4) Now they use clean utensils. TMs also use plastic bags and clean cloth under the mother instead of sand to contain the birth fluids.
- 5) After mother's delivery the TMs now refer mother to hospital for baby to have BCG and be weighed.
- 6) TMs now stress spacing the children.
- 7) They advise the mothers on good nutrition for the children as they never used to talk about kwashiorkor before.
- 8) Primagravidas are now accompanied to hospital as they realize the significance of referral where necessary.

Q.3. What are your suggestions for improving your work?

- 1) Continued collaboration with the ANC.
- 2) TMs would like supplies of gloves, new razor blades, tying cords and methylated spirit from the clinics.
- 3) Clinics should provide cloth for delivery purposes and soap to wash hands and hand washing basin.
- 4) TMs suggest payment from the government for the services they rendered since some of their clients are too poor to pay even in kind.
- 5) Will continue to encourage pregnant women to go to the ante-natal clinic and stress on checking the ANC card before delivery to ensure that client attend ANC.
- 6) Use of gloves was stressed to avoid catching AIDS in case one has a wound and delivers with bare hands.

Q4. Did the training benefit you in any way and if so what ways?

- 1) Use of cow dung and ashes on the cord, as well as use of dirty razor blades to cut cord was causing tetanus but now it is not happening because of the information gained through teaching.
- 2) Training enabled close collaboration of TMs with X and the RHC staff.
- 3) TMs can now identify twin pregnancy and also differentiate a normal position or lie from an abnormal one.
- 4) They have learned the dangers of a breech presentation and prolapsed cord.
- 5) TMs are not aware of placenta previa, retained placenta and post partum hemorrhage, although the belief that post partum hemorrhage is caused by a mother who sees the blood at delivery still exists and their eyes are covered.
- 6) Small babies and premature babies are taken to the hospital immediately.
- 7) To resuscitate the baby they lift the baby's head down and pet the back and when needed they place the baby again on their chest to warm the baby up. The baby is never up on the ground or the spirits will come and take it away (i.e., it will be hypothermic). They also use clean cloth to wipe out any mucus obstructing the mouth.

Conclusion

The TIM upgrading exercise started by MOH and supported by SCF by provision of funds for training and refresher courses was useful in improving the MCH care by TMs and increasing the chances of survival for the newborn children.

The widespread fear of contracting AIDS is discouraging TMs from delivering their clients and they are no longer as keen to do home deliveries. This may result in untrained TMs continuing to deliver using the antiquated methods.

Interviews With RHC Staff

Individual interviews were conducted with 6 RHC staff from 4 RHCs in Muusha and Mutema Impact Areas. The 6 RHC staff interviewed are involved in the CSP activities in

various ways (a) Teaching VCWs on how to educate mothers on CSP interventions, (b) Supervision of VCWs through the months, (c) Teaching mothers on nutrition and growth monitoring, (d) Support and supervision of VCWs by follow-up visits to their homes, (e) joining the Zimbabwe's outreach team for immunizations.

The Rural Health Center staff have noticed improvements in the following CSP activities: (a) attendance at outreach points were better than in other non-impact areas, (b) knowledge on ORT is better than outside the impact area, (c) during the quarterly meetings it was highly agreed that immunization coverage is higher and nutrition status of children improved and infant mortality rate is lower in the I.A.s. On family planning, some staff members felt that response on family planning was very poor both in I/A and non I/A villages. The community is not interested in oral contraceptives or the use of condoms although about 50% of the population are aware of the modern methods of family planning.

On the issue of sustainability, MOH RHC staff think the HIS will be very difficult to sustain with SCF/HIS format but they will use MOH forms to collect data at village level.

Immunizations: With the help of VCWS who encourage mothers to attend immunization sessions and ANCS, mothers will continue to bring their children for immunizations. The MOH will take over the outreach points to help sustain the project but without the encouragement of VCWS, the coverage may be affected.

Training families in ORT and hand washing/potable water by clinic staff and VCWS at the clinics, in the homes or at outreach points. VCWS will continue home visits to monitor the health practices.

Growth Monitoring of 0-36 month olds

Growth monitoring of the 0-36 month olds will continue at both RHC and outreach points.

AIDS Prevention Training

AIDS education will continue at outreach points and clinics and the training centers will be used for AIDS workshops and seminars although it won't be as intense as when the project was operational and not everyone will be covered.

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Future Role of VCW

Those absorbed by MCCD will continue their work as before but for those who will not be absorbed, they will get demoralized and find something else to do or they might continue with the hope of being absorbed in the future.

Lessons Learned

Most of the RHC staff have had beneficial experiences and learned a lot on AIDS and CSP activities from workshops held by SCF. One feels that they have learned how to prioritize activities and implement programs which are beneficial to the rural community.

Mupedzanhamo Impact Area

Summary of Interviews with Farm Managers

Managers from four farms were interviewed using a questionnaire with similar questions on CSP in farms which had FHWs. Analysis of their responses are summarized as follows:

Question #1

All the managers were quite positive on the impact of SC on the health status of the farm employees and their families. They gave examples such as:

The FHWs teaching mothers about immunizations, child feeding, ORT, dispensing of simple drugs, general cleanliness of the compounds and ability to seek to refer cases to nearest health centers by the FHWs.

Question #2

On this question three of the four managers had very definite ideas about what they intended to do in order to sustain the activities of the FHWs in Child Survival, e.g.,

Putting their resources together to build another clinic from whence the FHWs would operate and collect their supplies;

- continue paying the monthly allowances to FHWs;
- Employ qualified clinic staff who would support the FHWs. The FHWs would collect their drugs from the clinic instead of the farm owner.

Question #3

Three managers think that the CS activities can be maintained by either:

- Extend the program to provide static clinics from whence the services will operate to the farms;
- The FHWs must be assisted in carrying out their activities by the management;
- The Ministry of Health should continue providing new information on health programs which can keep the FHWs up to date and help the employees adequately.

Question #4

Two out of three managers who have been in the farms longer said that this could be done by:

- Discussion among farm managers and convince others about advantages and use of FHWs.
- Since each farm has its own management policy, farms with FHWs can organize field days and displays at which managers from farms not participating in FHW program can be invited.

Question #5

Out of three managers, two responded positively to three of the four subquestions, thus they believe their workers have access to: -clean water; - proper sanitation; sufficient housing.

On adequate nutrition almost all farms do not provide rations but make available in farm store various foodstuffs for sale.

Question #6

Though the managers differ in approach to methods of improving the welfare of their farm employees, they all agree on the importance of providing basic needs of the employees and their families such as:

- Potable - from boreholes or piped water;
- Toilet - Blair toilets for every house;
- Housing - well ventilated houses
- The MOH should takeover the supervisory role of the FHWs which was done by Save the Children;
- The FHWs should be supported and their allowances increased.

Though managers priority to increase production and make a profit, they also agree that only healthy workers can increase production. The FHW program enhanced by SCF/CS program has helped not only the workers families but members and relatives of the managers themselves have also benefitted.

**Mupedzanhamo Impact Area
Farm Manager Interviews: Farms with No FHWS**

Two farm managers from farms which never participated in the FHW program were also interviewed and both SCP and AIDS questions were asked.

The farmer from Edinburgh farm heard about Save the Children Federation activities in the farming areas, but he took no direct part nor did his manager.

The farmer from Rusimbiro farm also said that he heard about the activities of SCF but he really did not know what they were doing.

On specific questions about Child Survival and AIDS, the two farmers appear to be very concerned with the health of their farm employees. They were particularly concerned with the outbreak of AIDS and they thought some of their employees may have suffered from AIDS and some may have died.

These farmers have heard about the FHW program and the work the ladies do in the teaching of farm families about immunizations and AIDS, but their FHWS left years ago and were not replaced. From the responses to the questions, the managers require more information on what the FHWS do and one would easily conclude that at the end of the day they would support the program and the FHWS.

Focus Groups - Men and Women

1) What do the men and women in the I/As need most to improve their living standards?

Money
Jobs
Income generating projects
Improvement in home hygiene
Good prices for their produce, e.g., eggs, tomatoes, maize and ground nuts.
More hospitals
Piped water, toilets and good accommodations.

2) How has the Child Survival Program helped their families?

Children are immunized and they are getting mild measles and children are no longer suffering from Pertussis;
Most families in Muusha and Mutema now have backyard gardens;

Mothers no longer go to rural health centres with simple diarrhea; they treat it at home;

Clean water and building of Blair toilets has helped to reduce diseases.

Family planning was of great help to some families;

Preschools have also helped.

3) The CS activities can continue after EOP because:

Families will continue to work with VCW and all the relevant departments;

MOH should take over all the CS activities in the I/As;

Those educated will continue to educate others;

VCWs will be given a platform at meetings so that they reinforce what they will have taught;

Mothers will continue to have their children immunized and use the ORT;

Those who have internalized what Save the Children has taught them will continue to teach others.

6/1

**APPENDIX 4: DATA FROM THE HEALTH INFORMATION SYSTEM
FOR EACH IMPACT AREA**

DATA FROM MUUSHA I.A. OFFICE PRESENTED BY JERRY MATANDANDHLE

Data usually listed for three wards only since the fourth ward was deemphasized and new areas to the East were added after the Second Annual evaluation as recommended by US AID and MOH.

	POPULATION		FAMILIES
	MALES	FEMALES	
CHIKWAKWA	2352	2306	504
MHAKWE	2019	2016	477
SHINJA	1620	1762	403
TOTALS	5991	6084	1384

TOTAL POPULATION= 12,075

TOTAL POPULATION OF THE INITIAL IMPACT AREA OF 4 WARDS=17,980
WITH A TOTAL OF 2245 FAMILIES. CENSUS DATA IS NOT
AVAILABLE FOR THE ADDED AREAS OF COVERAGE.

Population data based on a house to house survey conducted in April, 1991.

BIRTHS RECORDED FOR PAST 12 MONTHS = 250 (DUE TO UNDER REPORTING OF 50-70 BIRTHS IN PAST 4 MONTHS, THE BEST ESTIMATE FOR THE NUMBER OF BIRTHS IS 300 TO 320)

CRUDE BIRTH RATE = 20.7 (ADJUSTED FOR UNDER REPORTING-- THE BEST ESTIMATE FOR CRUDE BIRTH RATE IS 24.8 TO 26.5)

FROM REPORTED DELIVERIES BY VCWs, 61% OF BIRTHS OCCUR IN THE CLINICS AND 39% IN THE HOME.

INFANT MORTALITY RATE= 68/1000 LIVE BIRTHS

NEONATAL MORTALITY RATE= 8/1000 LIVE BIRTHS

UNDER FIVE MORTALITY RATE = 19.6/(CHECK POPN DENOMINATOR)

Data on births and deaths based on monthly reports submitted by the VCWs to the I.A. Health Coordinator.

MUUSHA IMPACT AREA

UNDER FIVE DEATHS

CAUSE OF DEATH	# 0to12 MONTHS	#13to59MONTHS	TOTAL
A.R.I.	7	6	13
DIARRHEA	4	5	9
MALNUTRITION	2	4	6
TETANUS	0	2	2
ACCIDENTS	1	1	2
MENINGITIS	0	1	1
MEASLES	0	1	1
MALARIA	0	0	0
UNKOWN	1	2	3
OTHERS	2	2	4
TOTALS	17	24	41

Data submitted to I.A. Office by VCWs based on their assessment of cause of death as a result of a home visit after death. Their assessment was checked by the I.A. nurse coordinator to verify cause of death based on home revisit and hospital or clinic records as available. (Program to specifically train VCWs on the verbal autopsy technique was not available to the VCWs.) Two cases of Tetanus were unimmunized by history. One case diagnosed at Mutare Hospital and the other after death by nurse who elicited symptoms from family of Apostolic faith. AIDS as a cause of death was not specifically diagnosed since many children do not have serology done and if done, the reports take months to be returned.

Oral Rehydration Therapy assessed by the VCWs at the time of acute diarrhea during a household visit. For 141 cases under 5 years old, all mothers were able to describe the correct use of the ORT solution.

ENVIRONMENTAL FACTORS FOR MUUSHA IMPACT AREA

	CHIKWAKWA	MHAKWE	SHINJA	TOTAL
BLAIR TOILET	81	201	122	404 (29%)
DEEP WELLS	19	18	10	47 (3%)
BOREHOLES	5	5	3	13 (1%)
RUBBISH PITS	369	428	220	1017 (73%)
POT RACKS	387	442	334	1163 (84%)
Number of Families	504	477	403	1384

At the present time a total of 782 families (57% of total) have access to potable water from the 47 deep wells and the 13 bore holes.

GROWTH MONITORING--MUUSHA

Overall 10.5 % of 4136 weighings were noted to be below the Road To Health card 3rd percent line. However these observations are based on both impact and non-impact area populations measured at MOH clinics and recorded on tally sheets. Unfortunately, the distribution of low weights between the two areas can not be determined from available data.

During the past 6 months (January '91 to June '91) in the Impact Area, 55% of children 0 to 12 months were weighed 3 times. In the 13 to 23 months age group, 67% were weighed 3 times in the past 6 months. In the 24 to 59 month age group only 29% were weighed 3 times in the same period. Data collected by nurses at the immunization points.

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EXPANDED PROGRAM ON IMMUNIZATIONS--MUUSHA

	TOTAL 0 TO 12 MONTHS	TOTAL TO 23 MONTHS
B.C.G.	99%	99%
D.P.T. #1	78%	97%
D.P.T. #2	63%	91%
D.P.T. #3	45%	83%
POLIO #1	78%	97%
POLIO #2	64%	91%
POLIO #3	45%	83%
MEASLES (9-12 MONTH ONLY)	56%	70%
PRIMARY COURSE COMPLETED	56%	62%

**POPULATION DATA
FOR MUUSHA IMPACT
AREA-----3 WARDS**

	MALES	FEMALES	TOTAL	% OF TOTAL BY AGE GROUP
0-12 MONTH	108	125	233	2%
13-23MONTH	101	113	214	2%
24-59MONTH	478	535	1013	8%
5-13 YEARS	1511	1478	2999	25%
14-49YEARS	3163	3243	6406	53%
50+ YEARS	630	581	1211	10%
TOTALS	5991	6075	12076	100%

MUTEMA INFORMATION PRESENTED BY GERRY MATANDAUDHLE, IMPACT AREA
 MANAGER, AND NONIAH TEMBERERE, I.A. HEALTH COORDINATOR.
 17-7-91

MUTEMA IS A RELATIVELY MORE COMPACT AREA COMPRISING TWO WARDS.
 CHISUNGO IS LOCATED ALONG THE SAVE RIVER AND HAS CHLORINATED
 PIPED WATER FROM A WATER PROJECT BUILT BY THE SMITH REGIME TO
 SEQUESTER THE TRIBAL PEOPLES AWAY FROM THE FIGHTING AREAS AND
 DENY FOOD TO THE REBEL FORCES. AFTER INDEPENDENCE MANY PEOPLE
 REMAINED IN THE IRRIGATED AREA. THIS AREA TODAY CONTINUES TO
 HAVE RELATIVELY GREATER SUPPLIES OF VEGETABLES AND OTHER FOODS
 ALTHOUGH THE MALNUTRITION RATES ARE HIGHER FOR THEIR CHILDREN.
 BANGWE IS A VERY DRY ROCKY SOILED AREA OF COMMUNAL LANDS JUST
 NORTH AND EAST OF CHISUNGO.

POPULATION--2 WARDS

AGE GROUP	MALES	FEMALES	TOTAL
0-12 MONTHS	221	211	432 (3%)
13-23 MONTHS	220	219	439 (3%)
24-59 MONTHS	773	768	1541 (10%)
5-13 YEARS	1929	2017	3946 (26%)
14-49 YEARS	3700	3795	7495 (49%)
50 + YEARS	622	779	1401 (9%)
TOTALS	7465	7789	15254 (100%)

IMMUNIZATION DATA MUTEMA I.A.

	0-12 MONTHS	13-59 MONTHS
B.C.G.	410	1820
D.P.T. #1	396	1770
D.P.T. #3	386	1650
POLIO #1	394	1770
POLIO #3	382	1650
MEASLES (9-12 MO ONLY)	135	1421
PRIMARY COURSE COMPLETED	129	1379
TOTAL CHILDREN	432	1980

NOTE 441 LIVE BIRTHS RECORDED DURING THE PAST 12 MONTHS AND 432 INFANTS WERE ENUMERATED IN CENSUS.

DPT#1 COVERAGE BASED ON LIVE BIRTHS = 90%
 DPT#3 " " " " = 88%
 OPV#1 " " " " = 89%
 OPV#3 " " " " = 87%
 MEASLES " " " " = 31% (Note: of 169 children eligible to receive Measles in the 9-12 month age group, 135 received Measles Immunization at the appropriate time for an 80% age specific compliance rate.)

DPT DROP OUT RATE = 2% FROM DPT#1 TO DPT#3
 OPV " " " = 3% FROM OPV#1 TO OPV#3

FOR ALL CHILDREN 9 TO 12 MONTHS, 70% HAVE PRIMARY COURSE OF ALL IMMUNIZATIONS COMPLETED BY ONE YEAR OF AGE.

Tetanus coverage during pregnancy--June,90 to June,91
 281 Pregnancies reported
 101 TT1 only
 163 TT1 and TT2
 17 Did not receive any Tetanus Toxoid
 TT2 COVERAGE = 163/281 = 58 %

BCG COVERAGE:

INFANTS 0-12 MONTHS WITH BCG / # LIVE BIRTHS = 410/441 = 93 %

INFANT MORTALITY RATE = 11 PER 1000 LIVE BIRTHS (NOTE: This rate considered too low by the I.A. Staff due to selective under reporting of infant deaths by the VCWs.)

MUTEMA I.A.

OUTREACH POINTS:

The C.S. project started with 8 outreach immunization points but added three additional points outside the I.A. after urging by MOH.

Five of the 11 outreach points were originally MOH run and will be assumed by Chipinge District Medical Office. Three of the remaining six will be closed and three will represent new outreach points to be maintained by outreach from fixed clinics. S.C.F. is in the process of purchasing 6 to 7 new bicycles to facilitate these outreach efforts.

During the past year mothers of children with diarrhea were questioned by the VCWs about the proper mixing of the Oral Rehydration Solution recommended in Zimbabwe. On a month to month basis between 69% and 89% of mothers were mixing the formula properly.

Growth Monitoring.

5% of infants (0-12 months) measured below the 3% line on the Road To Health Card during the past 12 months.

10% of children (13-59 months) measured below the line during the past year. The highest rates of 14% noted in the Tongogora and Goko areas.

ENVIRONMENTAL FACTORS

	CHISUNGO WARD	BANGWE WARD
TOTAL # FAMILIES	1342	1396
BLAIR TOILETS	341	249
PIT LATRINES	138	287
RUBBISH PITS	698	814
POT RACKS	805	585
BORE HOLES	8	16
DEEP WELLS	NONE	NONE
# OF FAMILIES WITH ACCESS TO POTABLE WATER	748	732

HEALTH INFORMATION DATA FROM MUPEDZANHAMO I.A.

There are 22 commercial farms in the I.A. and the 12 with an active FHW make up the data base for this report.

Total Population = 8,494

0-12 months = 139
13-23 mo. = 152
24-59 mo. = 432
TOTAL <5YR = 723

Births recorded in the past 12 months = 169

17% of births are home deliveries attended by Traditional Midwives.

Crude Birth Rate = 20/1000 total population

CAUSES OF DEATH <5 YEARS OLD

Malnutrition=4
Diarrhea =1
ARI =1
Meningitis =1
Poisoning =1
Neonatal =2
TOTAL =10 (5 of total deaths in the 0-12 month age group)

INFANT MORTALITY RATE = 5/169 = 30/1000 Live Births

NEONATAL MORTALITY RATE = 2/169 = 12/1000 Live Births

UNDER FIVE YEARS MORTALITY = 10/723 = 14/1000 Children <5YR

IMMUNIZATIONS-----FOR INFANTS 0-12 MONTHS

DPT #1 97%
DPT #2 46%

OPV N/A

BCG 97%

MEASLES 24% OF TOTAL (Note 77% of 9-12 month age group were immunized for Measles.)

TT2 COMPLETED BY PREGNANT WOMEN DURING PAST YR = 51%

DPT DROP OUT RATE = 28 %

MUPEDZANHAMO DATA CONTINUED

GROWTH MONITORING

4% of 0-12 month old infants measured below the 3% on the Road To Health Card during the past year.

5% of the 13-59 month old children measured below the line in the past year.

ORS Compliance

During the past year 567 mothers of children with diarrhea were questioned about the proper mixing of the Oral Rehydration Solution. 487 or 86% were found to be in compliance.

