WORLD VISION RELIEF AND DEVELOPMENT

FINAL EVALUATION REPORT
MUREWA CHILD SURVIVAL PROJECT
ZIMBABWE

Beginning Date: October 1, 1987
Ending Date: September 30, 1991

Submitted to:

PVO Child Survival Grant Program
Office of Private and Voluntary Cooperation
Bureau for Food for Peace and Voluntary Assistance
515 22nd Avenue, NW, Room 103C, SA-2
Washington, DC 20523

PVO Headquarters Contact:

Milton Amayun, M.D., M.P.H.
World Vision Relief & Development Inc.
919 W. Huntington Drive
Monrovia, CA 91016

December 27, 1991

WORLD VISION RELIEF & DEVELOPMENT

PART I
KNOWLEDGE-PRACTICE SURVEY
MUREWA CHILD SURVIVAL PROJECT

Submitted by
(The following staff and consultants have contributed to this report):

Ms. Regina Masangwi, Provincial Nursing Officer, Mashonaland East MOH
Ms. Monica Mukanda, District Nursing Officer, Murewa District MOH
Ms. S. Mushapaidze, Murewa CSP Manager, WV Zimbabwe
Mr. E. Dhlembeu, World Vision Zimbabwe
Dr. Partson Zvandasara (KAP Survey Team Leader), University of Zimbabwe
Dr. Virginia Canlas (Evaluation Team Leader), WVRD

September 1991

TABLE OF CONTENTS

I. INTRODUCTION

The World Vision Zimbabwe (WVZ) Child Survival Project (CSP) was initiated in October 1986 and started in the Musami area in Murewa. The project has since involved other areas throughout the Murewa District. Since its inception, the project has been evaluated yearly. The last evaluation was done in July 1990, and the evaluation team recommended extension of the program for another year.

A final evaluation was carried out from August 26 through September 6, 1991.

A. Objectives of the Field Study—The main objectives of the field study were:

1. For mothers with children 0-11 months, the survey will determine:

    a. Place of delivery during the last pregnancy.
    b. Number of tetanus toxoid vaccinations the mother received during pregnancy and the mother's knowledge of its use.
    c. Ante and postnatal clinic attendance.
    d. Source of drinking water and toilet facilities.

2. For mothers 15-49 years with children 12-23 months, the study will establish:

    a. Knowledge, Attitudes, and Practices (KAP) of mothers on family planning.
    b. Knowledge of Acute Respiratory Infection (ARI).
    c. Utilization of EPI services.
    d. Immunization coverage for children 12-23 months.

3. For mothers with children 0-59 months, the study will determine:

    a. Knowledge, Attitudes, and Practices on growth monitoring and weaning practices.
    b. Breastfeeding and feeding practices.
    c. KAP on diarrheal illnesses.
    d. Nutritional status of children under five.

The results of the final survey will be compared with the results of the 1985 baseline survey, 1988 midterm evaluation, and the 1990 end-of-project evaluation. During the time of the CSP-KAP survey, a nationwide Zimbabwe MCH evaluation survey was being launched by the MOH. The results of the survey will be incorporated into the national figures, since Murewa District was one of the districts chosen for the national survey.

B. Methodology—The format of the CSP final evaluation was modeled along the previous evaluation research protocols to facilitate comparison of the results. A household survey in a sample of randomly selected villages was carried out using three sets of structured questionnaires (see Appendix 3).

The design of the questionnaire was made in joint consultation with MOH, PMD, and DHE. The stratification of the study population was designed to study in depth the

components of the MCH program (i.e., EPI, growth monitoring, oral rehydration, and antenatal/postnatal care).

Murewa District has a total population of 169,000. The population figures of each village were recorded. Cumulative populations were calculated starting from the first listed village to the last village.

C. **Sampling**—Thirty clusters were selected from the list of the villages.

1. A sampling interval was calculated based on the formula shown below:

$$\text{Sampling interval} = \frac{\text{Estimated Murewa Population}}{\text{30 Clusters}}$$

2. The first cluster was randomly selected using a number from a bank note. The second cluster was chosen by taking a number close to 0753 + .4500 (sampling internal). The third and subsequent clusters were selected for the survey in the same way by adding the sampling interval. A list of the 30 clusters selected for the survey is in Appendix 1.

D. **Study Population**—The following number of mothers was chosen in each cluster:

1. Seven mothers and their children 0-11 months.

2. Seven mothers and their children 12-23 months.

3. Fifty mothers 15-49 years and their children aged 0-59 months (i.e., under five years).

E. **Training of Enumerators**—Fifteen enumerators, comprising State Certified Nurses (SCNs) and Environmental Health Technicians (EHTs) were trained for two days. They were taught the content and administration of the questionnaires. The questionnaires were translated into Shona, one of the country's native languages. A pilot study was undertaken in the community prior to the actual survey to standardize the administration of the questionnaire. This was followed by intense discussion among the project staff, survey team, and MOH personnel which focused mainly on addressing the problems, constraints, and solutions to overcome the problems. The enumerators worked in five groups, each group made up of three members.

F. **Field Survey**—Upon arrival to each selected area, the enumerators went to the councilor/village chairman or community leader of the area to introduce themselves formally to these people and to request permission to carry out the survey. They then went to the center of the village and spun a bottle on the ground for a starting point. They started with the houses in the direction of the spun bottle. They looked for three groups of women to be interviewed as already indicated. Questionnaires were then administered. The children were weighed and their heights were taken and recorded. The Child Health Card (CHC) was inspected to record the immunizations given to the child.

The consultants and World Vision field officers provided technical assistance and supervision. Data was collected for two weeks. A computer was used for the analysis. Frequency tables were analyzed using a Base III.

G. **Problems Encountered During the Survey**—To get the required children in each cluster, a lot of the households had to be visited. In one cluster where they were Apostolic Faith families, an unknown number of children were hidden. Three parents refused to have their children weighed. Most mothers refused to have their children weighed in the same weighing bags due to some traditional beliefs. The fear of children getting skin diseases from the same weighing bags is real, as a large number of children seen had skin rashes. Individual weighing bags provided by the mothers were used for each child.

II. SURVEY RESULTS

The results of the household survey are presented in three parts. These pertain to the three target groups in the study.

A. **Results of the Interviews With Mothers of Children 0-11 Months**—Two hundred and ten mothers were interviewed.

1. Age Distribution of Mothers

Age of Mother	Number	Percent
<20 years	38	18%
21-25	75	36%
26-30	45	21%
31-35	31	15%
36-40	17	8%
>40 years	4	2%
TOTAL	**210**	**100%**

The mothers' ages ranged from 16-42 years. The majority were young women whose age range is less than 30 years. Eighteen percent were women under 20 years old, and 57 percent were 21-30 years old. This reflects the true demographic picture of the Zimbabwean population which has a high proportion of young women in the reproductive age.

2. Educational Level of Mothers

Educational Level	Number	Percent
Less than Grade 7	49	23%
Grade 7	79	39%
Form 1-2	44	21%
Form 3-4	27	13%
Post "O" Level	5	2%
Never	5	2%
Other	1	0%
TOTAL	**210**	**100%**

The literacy rate in Zimbabwe has generally increased since independence. The high percentage (98 percent) of mothers who had elementary and higher education is a reflection of the literacy rate in the country and the youthfulness of the study population.

3. Religion of Mothers

Respondent Religion	Number	Percent
Methodist	42	20%
Apostolic Faith	66	32%
Roman Catholic	46	22%
Anglican	11	5%
Church of Christ	3	1%
Other	42	20%
TOTAL	**210**	**100%**

In Zimbabwe, the Apostolic Faith has accepted immunization to a limited degree. Thirty-two percent of the mothers in the study belong to the Apostolic Faith.

4. Child Care

Person Responsible for Child Care	Number	Percent
Mother	149	72%
Husband	2	1%
Grandparent	32	15%
Older Sibling	12	6%
Neighbors	1	0%
Friends	1	0%
Relatives	7	3%
Other	6	3%
TOTAL	**210**	**100%**

Child care is done primarily by the mother herself (72 percent). This is in concordance with the fact that 93 percent of the respondents did not work away from home. Grandparents (15 percent) and older siblings (6 percent) also share the burden of child care.

5. Water and Sanitation: Fifty-three percent of the households interviewed obtained water from an unprotected well, 3 percent from the river, and 5 percent from an unprotected spring. Thirty-eight percent of the water source was protected. This figure was less than 58.1 percent in the 1990 evaluation. Fifty-nine percent of the families were assisted to protect the water source. The assistance came from the MOH in the form of cement, pump, and bucket. Twenty percent of the families had a blair toilet, 15 percent had a pit latrine, while 60 percent did not have any toilet facilities. This figure is comparable with 68.1 percent of the families who did not have any toilet facility in the 1990 evaluation. Seventy-two percent of the families had not received any assistance to construct the toilets. For those who had received assistance, it was in the

form of cement and fly screen. The families contributed their labor and some other materials, such as bricks.

6. Antenatal Care, Delivery, and Postnatal Care

a. *Antenatal Care.* Antenatal attendance was very high (99 percent). On the average, 57 percent of the mothers had attended more than four times per pregnancy; 95 percent were satisfied with ANC they received. Only 7 percent booked when the pregnancy was less than three months. For those who booked after six months (38 percent), lack of money was given as the main reason for not going to the clinic for antenatal services during the early phase of pregnancy.

b. *Mothers' Knowledge of TT.* Fifty-seven percent of the mothers had a TT card (19 percent showed their cards to the interviewer, and 38 percent were not seen by the interviewer). Ninety percent of the women received TT during pregnancy, some 22 percent received one dose, while 48 percent and 17 percent received two and three doses, respectively. Thirty-eight percent of the mothers knew that TT protected the unborn child against neonatal tetanus.

c. *Delivery.* A high proportion of the mothers (82 percent) delivered their last child at a health center. Some of those who delivered at home (8 percent) received assistance from a trained midwife (15 percent).

d. *Postnatal Care.* Postnatal attendance was high. Seventy-three percent of the mothers attended postnatal clinics. Thirty-one percent attended the clinic at six weeks post delivery.

Fifty-eight percent of the mothers are currently using the oral contraceptive pill. These are obtained from the health centers. The CBD only provided family planning services to 20 percent of the mothers.

B. **Results of the Interviews of Mothers 15-49 Years with Children 12-23 Months**—Two hundred and ten mothers and their children took part in the study.

1. Birth Weight

Weight (kgs)	Number	Percent
<2.5	100	48%
2.5-3.4	80	38%
>3.5	30	14%
TOTAL	**210**	**100%**

Forty-eight percent of the children in the study had a low birth weight (i.e., <2.5 kgs). These were the weights recorded on the Child Health Cards (CHCs).

2. Immunization

a. *Immunization Coverage.* N = 210

Antigen	Number of Children	Percent Coverage
BCG by scar	172	82%
BCG	182	87%
Polio 1	169	80%
Polio 2	189	90%
Polio 3	173	82%
Polio 4	69	47%
DPT1	176	83%
DPT2	177	84%
DPT3	164	78%
DPT4	54	39%
Measles	182	87%
Primary course completed	168	80%

N.B. Primary Course—A child who is given BCG; Polio 1, 2, 3; DPT 1, 2, 3; and measles.

The immunization coverage for all the antigens is very high, as shown above. Eighty percent of the children surveyed had completed a primary course. Polio 4 and DPT4 is normally given as a booster at 18 months. The low uptake of these two antigens—Polio 4 (47 percent), DPT4 (39 percent)—is a reflection of an unsustained motivation of the mothers as the child gets older.

b. *Drop-Out Rate*

1) Polio drop-out rate, 2.5 percent.
2) DPT drop-out rate, 6 percent.

The exceedingly low polio and DPT drop-out rates are a reflection of the high achievement of the CS program in motivating the mothers during the first 12 months of the child.

c. *Place of Immunization*

Place of Measles Immunization	Number	Percent
Outreach	80	38%
Hospital	69	33%
Health Center	51	24%
Private/Nongovernment	4	2%
Other	2	1%
Child has no CHC	4	2%
TOTAL	**210**	**100%**

Measles has been used to demonstrate that most of the immunizations were given at the outreach points. The main strategy of the CS project has been to utilize the outreach points to bring the immunizations to the community.

3. Knowledge, Attitudes, and Practices (KAP) of Acute Respiratory Tract Infection: Sixty-one percent of the children in the survey had symptoms of acute respiratory tract infection within the two weeks prior to the survey. Thirty percent of the mothers said that they would take the child to the nearest health center when the child develops signs of respiratory infection. Two percent of the mothers treated the child at home. The symptoms of ARI which were recognized by the mothers are the following: Fifty-seven percent recognized fever/hot body; 17 percent, fast/difficulty in breathing; and 13 percent, cough.

4. KAP of Family Planning: Knowledge of the family planning methods by the mothers was adequate; 48 percent of the mothers knew the pill as a family planning method, while 21 percent knew the condom as a birth control method. Eighty-two percent of the mothers had used a family planning method at some stage in their reproductive life. The popular method used was the pill (59 percent), followed by the traditional method. Most of the mothers (69 percent) wanted to space their children in two-year intervals.

Current Contraceptive Use	Number	Percent
Pill	121	58%
Condom	6	3%
Injection	2	1%
Diaphragm	12	5%
Female sterilization	6	3%
Male sterilization	7	3%
Foam/jelly	0	0%
Withdrawal	2	1%
None	21	10%
Traditional	32	15%
Other	0	0

C. **Results of the Household Interviews of Mothers with Children 0-59 Months**—Fifteen hundred mothers were interviewed.

1. Possession of a Child Health Card: Eighty-seven percent of the mothers had a CHC.

2. Growth Monitoring: Growth monitoring is done mostly during the first year, as evidenced by a high number of weight points per child in that year.

Year	% Children with 6-10 Weight Points
0-1	40%
1-2	21%
2-3	8%
3-4	3%
4-5	1%

Forty percent of the children had six to eight weight points in the first year, compared to 21 percent in the second, and 8 percent in the third year.

Thirty-seven percent of the children had the last weight point plotted on the card between 0-6 months. Twenty-five percent had the last weight point after 24 months. It is encouraging to note that 73 percent of the children had the last weight point above the third percentile.

Understanding of the Growth Curve

a. *Upward Curve*—Eighty-nine percent of the mothers recognized that an upward curve on the graph signified that the child was growing well.

b. *Flat Curve*—Fifty-five percent recognized that a flat curve meant that the child was not growing well, while 32 percent thought that the child was not gaining weight. Seventy-four percent of the mothers thought that the flat curve occurred when the child was not getting enough food to eat.

c. *Downward Curve*—Fifty-two percent recognized that the child was loosing weight. The cause for loosing weight was thought to be ill health (37 percent of the mothers) and inadequate food intake (60 percent of the mothers).

3. Breastfeeding: Twenty-nine percent of the children in the survey were still being breastfed or having mixed feeding (breastmilk and semisolids). Thirty-seven percent of the mothers stopped breastfeeding between 12 and 24 months. Breastfeeding was started within eight hours of birth by 56 percent of the mothers. A small proportion (12 percent) of the mothers had bottlefed the index child.

4. Weaning Practices: The study showed that solids were introduced early. Twelve percent of the mothers started solids in the first month, 12 percent in the second, and 29 percent in the third month.

Type of Weaning Foods	Number	Percent
Thin mealie-meal porridge	495	33%
Thin porridge with peanut butter	285	19%
Thin porridge with margarine	90	6%
Processed cereal	495	33%
Fruit	30	2%
Bananas	30	2%
Other	75	5%
TOTAL	**1,500**	**100%**

The types of weaning foods are variable depending on availability. Thirty-three percent of mothers gave the child processed cereals, while 19 percent gave thin porridge with peanut butter.

5. Management of Diarrhea: A small proportion (27 percent) of the children had diarrhea in the two weeks prior to the study. Sixty-two percent of the mothers had used a homemade oral rehydration solution (SSS) to treat the diarrhea. SSS was given with each loose stool by only 10 percent of the mothers. Seventy-two percent of the mothers appropriately took the child to the nearest health center when the diarrhea persisted for more than three days.

a.

Feeding Practices During Diarrhea	Number	Percent
More than usual	210	14%
Same as usual	165	11%
Less than usual	135	9%
Stopped breastfeeding	60	4%
Not applicable	660	44%
Other	270	18%
TOTAL	**1,500**	**100%**

N.B. Two or more responses were possible.

Only 4 percent of the mothers stopped breastfeeding during a child's diarrheal illness, and 3 percent after the episode. Most mothers continued giving fluids (67 percent) and semisolid/solids (48 percent) during and after the child's diarrheal episode.

b. Knowledge of SSS: Eighty-seven percent of the mothers had heard about SSS. The correct knowledge of the quantity of water, sugar, and salt used in the preparation of the SSS was poor. Less than 34 percent of the mothers knew correctly all the quantities of the three ingredients. In 78 percent of the households, the ingredients and the container for SSS preparation was available.

The mothers sought medical advice when the child suffering from diarrhea had the following signs and symptoms: vomiting (22 percent), sunken eyes (19 percent), diarrhea lasting three or more days (41 percent), weakness/ tiredness (49 percent), and blood in stool (23 percent).

c.

Why SSS is Given to Children	Number	Percent
Stops diarrhea	360	24%
Prevents/cures	1,065	71%
Don't know	45	3%
Other	30	2%
TOTAL	**1,500**	**100%**

A high percentage of the mothers (71 percent) correctly stated that SSS prevents or corrects dehydration of the child.

Results of the household interviews of the mothers of children aged 0-11 months. Number = 210

1. AGE OF RESPONDENT

AGE OF MOTHER	NUMBER	%
< 20 years	38	18
21-25	75	36
26-30	45	21
31-35	31	15
36-40	17	8
> 40 years	4	2
TOTAL	210	100

2. RESPONDENT'S RELIGION

	NUMBER	%
Methodist	42	20
Apostolic Faith	66	31
R/Catholic	46	22
Anglican	11	5
Church of Christ	3	1
Other	42	20
TOTAL	210	100

3. EDUCATIONAL LEVEL OF THE RESPONDENT

	NUMBER	%
Less than Grd 7	49	23
Grade 7	79	38
Form 1-2	44	21
Form 3-4	27	13
Post "O" Level	5	2
Never	5	2
Other	1	0
TOTAL	210	100

4. THE MOTHERS WHO WORK AWAY FROM HOME

	NUMBER	%
Yes	14	7
No	196	93
	0	0
	0	0
	0	0
	0	0
TOTAL	210	100

5. INCOME GENERATING ACTIVITIES

	NUMBER	%
None	29	14
Growing & Selling Agricultural products	77	37
Growing & Selling Garden products	59	28
Poultry	1	0
Crotchetting	42	20
Basketry	0	0
Other	2	1
TOTAL	210	100

6. PERSON RESPONSIBLE FOR CHILD CARE

	NUMBER	%
Mother	149	71
Husband	2	1
Grand Parent	32	15
Older Silbling	12	6
Neighbours	1	0
Friends	1	0
Relatives	7	3
Other	6	3
TOTAL	210	100

7. MAJOR SOURCE OF DRINKING WATER

	NUMBER	%
Protected Well	36	17
Borehole	42	20
Unprotected Well	111	53
Protected Spring	2	1
Unprotected Spring	11	5
River Stream	7	3
Other	1	0
TOTAL	210	100

8. ASSISTANCE TO PROTECT THE WATER SOURCE

	NUMBER	%
Yes	123	59
No	76	36
Don't Know	11	5
	0	0
	0	0
	0	0
	0	0
TOTAL	210	100

9. ORGANISATION WHICH ASSISTED TO PROTECT THE WATER SOURCE

	NUMBER	%
Health/Government	41	20
World Vision	1	0
Donor unknown	0	0
DDF	16	8
Not	152	72
Other	0	0
TOTAL	210	100

10. TYPE OF ASSISTANCE GIVEN BY THE ORGANISATION

	NUMBER	%
Cement	14	7
Cement & Pump	42	20
Pump & Bucket	44	21
Other	110	52
	0	0
TOTAL	210	100

11. TYPE OF TOILET FACILITY IN USE

	NUMBER	%
Blair toilet	42	20
Pit Latrine	32	15
None	126	60
Other	10	5
TOTAL	210	100

12. ASSISTANCE TO CONSTRUCT THE TOILET

	NUMBER	%
Yes	52	25
No	152	72
Don't Know	6	2
	0	0
TOTAL	210	99

13. THE ORGANISATION WHICH ASSISTED TO CONSTRUCT THE TOILET

	NUMBER	%
Ministry of Health	29	14
World Vision	1	0
Donor Unknown	2	1
DDF	5	2

Not	167	80
Other	6	3
TOTAL	210	100

14. TYPE OF ASSISTANCE GIVEN BY THE ORGANISATION

	NUMBER	%
Cement	15	7
Cement & Flyscrean	194	92
Other	1	0
Don't Know	0	0
	0	0
TOTAL	210	100

15. CONTRIBUTION BY THE FAMILY TO CONSTRUCT THE TOILET

	NUMBER	%
Labour	11	5
Bricks	6	3
Labour & Bricks	53	25
Other	140	67
	0	0
TOTAL	210	100

18. ANTENATAL CARE DELIVERY AND POSTNATAL CARE

	NUMBER	%
Home	38	18
Health Facility	172	82
Other	0	0
	0	0
	0	0
	0	0
	0	0
TOTAL	210	100

15

19. REASONS FOR NOT DELIVERING AT A HEALTH INSTITUTION

	NUMBER	%
Health Facility too far	12	6
Health Staff not Helpful	5	2
Prefer Delivery at Home	8	4
Cost too high	4	2
Prefer TM Delivery.	8	4
Not Applicable	172	82
Other	1	0
TOTAL	210	100

20. PERSON WHO ASSISTED THE HOME DELIVERLY

	NUMBER	%
Traditional Midwife (TM)	4	2
Trained (TM)	30	15
Self	1	0
Friends/relatives	3	1
Delivery at Health Institution	172	82
	0	0
	0	0
TOTAL	210	100

21. PERSON WHO CUT THE CORD

	NUMBER	%
Health Worker	172	82
Trained Traditional Midwife	30	15
Untrained Traditional Midwife	4	2
Yourself	1	0
Friend/Relatives	3	1
Other	0	0
TOTAL	210	100

22. SATISFICATION WITH DELIVERY AT A HEALTH CENTRE

	NUMBER	%
Yes	173	82
No	7	3
Not Applicable	30	14
	0	0
	0	0
	0	0
TOTAL	210	100

23. REASONS WHY NOT SATISFIED WITH THE DELIVERY AT A HEALTH CENTRE

	NUMBER	%
Not Applicable	204	97
Health staff	4	2
Contact with staff	0	0
Did not understand	0	0
Long waiting	0	0
Other	2	1
TOTAL	210	100

24. POSSESSION OF MOTHER's CARD

	NUMBER	%
Yes (seen by interviewer)	62	30
Yes (not seen by interviewer)	67	32
No, lost it	13	6
Other	68	32
TOTAL	210	100

25. POSSESSION OF TT CARD

	NUMBER	%
Yes (seen by interviewer)	40	19
Yes (not seen by interviewer)	79	38
No, lost it	5	2
Other	86	41
TOTAL	210	100

26. WHILE PREGNANT DID YOU RECEIVE ANY TT INJECTION

	NUMBER	%
Yes	190	90
No	14	7
Don't know	6	3
TOTAL	210	100

27. NUMBER OF TT INJECTIONS RECEIVED

	NUMBER	%
One	46	22
Two	100	48
Three	35	17
Four	2	1
Five	7	3
Did not receive	14	6
Don't know	6	3
TOTAL	210	100

28. WHAT IS TT INJECTION FOR

	NUMBER	%
1. To protect mother against tetanus	25	12
2. To protect new-borne baby against tetanus	80	38

3. To protect mother and new born baby against tetanus	33	16
4. Other	15	7
5. Don't know	57	27
	0	0
TOTAL	210	100

29. HOW MANY TT INJECTIONS DOES A PREGNANT MOTHER NEED TO PROTECT THE NEW BORNE INFANT FROM TETANUS?

	NUMBER	%
None	3	1
One	28	13
Two	59	28
Three	42	20
More than Three	23	11
Don't know	55	26
TOTAL	210	10

30. WHEN YOU WERE PREGNANT WITH YOUR YOUNGEST CHILD, DID YOU ATTEND ANC?

	NUMBER	%
Yes	207	99
No	3	1
Don't know	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
TOTAL	210	100

Results of the household interviews of the mothers aged 15 - 49 years with children aged 12 - 23 months

Weight (kgs)	Number	%
< 2.5	100	48
2.5 - 3.4	80	38
3.4	30	14
TOTAL	210	100

14. Place of Immunisation

BCG	Number	%
Outreach	19	9
Hospital	134	64
Health Centre	57	27
TOTAL	210	100

15. Place of Immunisation

Polio 1	Number	%
Outreach	84	40
Hospital	67	25
Health Centre	53	3
Private	6	3
TOTAL	210	100

16.

Polio 2	Number	%
Outreach	75	39
Hospital	72	37
Health Centre	46	24
TOTAL	193	100

17.

Polio 3	Number	%
Outreach	94	47
Hospital	65	32
Health Centre	43	21
TOTAL	202	100

18.

DPT 1	Number	%
Outreach	86	41
Hospital	71	34
Health Centre	50	24
Private	1	0
Other	2	1
TOTAL	210	100

19.

DPT 2	Number	%
Outreach	75	38
Hospital	58	29
Health Centre	48	24
Private	3	2
Child has no card	5	3
Source not entered	11	6
TOTAL	200	100

20.

DPT 3	Number	%
Outreach	73	37
Hospital	74	38
Health Centre	43	22
Private	2	1
Other	4	2
TOTAL	196	100

21.

Measles	Number	%
Outreach	77	39
Hospital	65	33
Health Centre	47	24
Private	3	2
Other	1	1
Child has no card	3	2
TOTAL	196	100

23. <u>Why was the child not fully immunised/never had any vaccinations</u>

	Number	%
Unaware of need to immunise	80	38
Not applicable ie got primary course	79	38
Unaware of need to get 2nd or 3rd dose	46	22
Child ill	2	1
Religion	3	1
TOTAL	210	100

24. Has your child had the following during the last weeks?

	Number	%
Cough	80	38
Difficult breathing/ dyspnoea	6	3
Runny nose	41	20
None of the above	83	40
TOTAL	210	100

25. What did you do during the above illness?

	Number	%
Child had none of the above symptoms	66	31
Took child to Health Facility	63	30
Took child to Private Doctor	2	1
Took child to traditional healer	17	8
Took child to VHCW	2	1
Took child to relatives	1	0
Did not take any action	4	2
Treated child at home	47	22
Other	8	4
TOTAL	210	100

26. What are the signs and symptoms of respiratory infection that would cause you to take your child to a health facility?

	Number	%
Fast or difficult breathing	36	17
Chest in-drawing	4	2
Loss of appetite	19	9
Fever/hot body	120	57
Cough	27	13
Other	4	2
TOTAL	210	100

27. There are various ways/methods that a couple can use to avoid or delay pregnancy

	Number	%
Pill	100	48
Condom	44	21
Injection	13	6
Diaphragm	34	16
Female sterilisation	8	4
Male sterilisation	1	0
Foam/Jelly	2	1
Withdrawal	6	3
None	2	1
TOTAL	210	100

28. Have you ever used any method to delay/avoid pregnancy

	Number	%
Yes	172	82
No	38	18
TOTAL	210	100

29. If yes, which FP method(s) have you ever used?

	Number	%
Pill	123	59
Condom	6	3
Injection	2	1
Diaphragm	17	8
Female sterilisation	2	1
Withdrawal	4	2
None	8	4
Traditional	47	23
TOTAL	210	100

30. Do you want to have another child in the next two years?

	Number	%
Yes	47	22
No	145	69
Don't know	18	9
TOTAL	210	100

31. If you are not pregnant, which FP method are you using now

	Number	%
Pill	122	58
Condom	6	3
Injection	2	1
Diaphragm	10	5
Female sterilisation	6	3
Male sterilisation	6	3
Withdrawal	2	1
None	21	10
Traditional	31	15
TOTAL	210	100

32. If you are not using any method, explain why

	Number	%
Currently pregnant	15	7
Index child is still young	9	4
Not sexually active	6	3
Husband against contraception	9	4
Has menopaused	3	1
Using a method	168	80
TOTAL	210	100

33. If you are using any modern FP method, what is your regular source?

	Number	%
Ministry of Health/ Clinic	92	44
Mission/Hospital	4	2
Outreach	25	12
CBD	43	20
Other	16	8
Not applicable	30	14
TOTAL	210	100

34. Have you ever heard of a "Community Based Distributor"/ CBD?

	Number	%
Yes	142	68
No	68	32
TOTAL	210	100

35. If yes, name one task which CBD does

Task of CBD	Number	%
Distribute pills/FP commodities	99	44
Educate communities on FP	45	20
Educate and distribute FP methods	14	6
Other	15	7
Not applicable (Never heard of a CBD)	54	24

36. Have you ever been visited by a CBD?

	Number	%
Yes	84	40
No	126	60
TOTAL	210	100

37. Is there a Village Community Worker in your area?

	Number	%
Yes	154	73
No	56	27
TOTAL	210	100

38. Name one task which VCWs do in the communities they work in

	Number	%
Health educate communities	53	25
Teach home hygiene	86	41
Treat minor ailments	32	15
Don't know	29	14
Other	10	5
TOTAL	210	100

39. Have you ever been visited by a VCW?

	Number	%
Yes	120	57
No	90	43
TOTAL	210	100

40. Did she/he teach you anything?

	Number	%
Yes	129	61
No	25	12
Not applicable	56	27
TOTAL	210	100

41. If yes, what were you taught?

	Number	%
Home hygiene	65	31
Building of blair toilets	48	23
Protection of water sources	13	6
Other	21	10
Not applicable	63	30
TOTAL	210	100

42. Was her teaching beneficial to you or your family?

	Number	%
Yes	150	71
No	60	29
TOTAL	210	100

43. Explain your answer

	Number	%
Helped to prevent disease in the home	86	41
Benefitted from the health education	40	19
Other	17	8
Not applicable	67	32
TOTAL	210	100

31. TOTAL NUMBER OF ANTENATAL ATTENDANCE

	NUMBER	%
Once	5	2
Twice	15	7
Three times	22	10
Four times	31	15
More than four times	107	51
Not Applicable	10	5
Don't know	13	6
Other	7	3
TOTAL	210	100

32. GESTATION AT BOOKING

	NUMBER	%
1st 3 months	15	7
3-6 months	57	27
After 6 months from card	12	6
1st 3 months from history	11	5
Between 3-6 months from history	52	25
After 6 months from history	61	29
N/A	2	1
TOTAL	210	100

33. REASONS FOR BOOKING AFTER 6 MONTHS

	NUMBER	%
Did not know to book before 6 months	5	2
Health Facility too far	5	2
Was too busy	16	8
No money	47	23
Not Applicable	137	65
TOTAL	210	100

34. IF YOU ATTENDED ANC, WERE YOU SATISFIED WITH THE SERVICES AT THE HEALTH FACILITY?

	NUMBER	%
Yes	199	95
No	8	4
Not applicable	3	1
	0	0
	0	0
TOTAL	210	100

35. WHY UNSATISFIED WITH THE ANC SERVICES

	NUMBER	%
Not Applicable	199	95
Health staff were rude	5	2
Contact too short	0	0
Long waiting	3	1
Other	3	1
TOTAL	210	100

36. POST NATAL ATTENDENCE

	NUMBER	%
Yes	154	73
No	55	26
Don't know	1	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0

37. IF YES, HOW LONG AFTER DELIVERY?(see card)

	NUMBER	%
2 weeks from card	4	2
2-6 weeks from card	10	5
6 weeks from card	40	19
6 weeks after card	16	8
2-6 weeks from history	10	5
At 6 weeks from history	25	12
After 6 weeks from history	38	18
Not Applicable	13	6
Other	54	26
TOTAL	210	100

38. REASON FOR NOT ATTENDING PNC

	NUMBER	%
Not Applicable	156	74
Health facility too far	24	11
Not advised to attend PNC by health staff	3	1
Partner did not allow	1	0
No money	9	4
Other	9	4
Don't know	5	2
	0	0
	0	0
TOTAL	210	100

39. WERE YOU SATISFIED WITH THE SERVICE AT THE HEALTH FACILITY DURING PNC?

	NUMBER	%
Yes	204	98
No	6	3
Don't know	0	0
Not Applicable	0	0
TOTAL	210	100

40. IF YOU WERE NOT SATISFIED, WHY WAS THIS?

	NUMBER	%
Not Applicable	207	99
Rude health staff	2	1
Short contact	0	0
Did not understand	1	0.5
	0	0
	0	0
TOTAL	210	100

41. PLACE OF DELIVERY FOR THE NEXT PREGNANCY

	NUMBER	%
At home	5	2
At the local clinic	158	75
Not local clinic	25	12
Attended by TM	2	1
At church	9	4
Other	11	5
TOTAL	210	100

42. REASONS FOR THE CHOICE OF PLACE OF DELIVERY

	NUMBER	%
Expert help available	129	61
Avoid complications	51	24
Had Caesarean before	17	8
Transport problems	13	6
TOTAL	210	100

43. HAVE YOU EVER HAD A HOME DELIVERY

	NUMBER	%
Yes	87	41
No	123	59
TOTAL	210	100

44. WHO ASSISTED THE HOME DELIVERY

	NUMBER	%
Trained TM	43	20
Untrained	44	21
Not Applicable	117	56
Other	6	3
TOTAL	210	100

Results of the household interviews of mothers with children aged 0 - 59 months

3. Does the child have a child health card?

	Number	%
Yes	1242	87
Had one, but lost it	63	7
Has one, kept elsewhere	97	7
Never had one	31	2
Other	2	0
TOTAL	1500	100

4. Birth Weight (kgs)

	Number	%
<2.5	585	39
2.5 - 3.4	720	48
3.5 - 4	195	13
No card	0	0
Not recorded	0	0
TOTAL	1500	100

5. Number of weight points in the first year

Weight points	Number	%
None	315	21
1 - 5	345	23
6 - 10	600	40
>10	240	16
TOTAL	1500	100

6. Number of weight points in the second year (1-2)

Weight points	Number	%
0	570	38
1 - 5	450	30
6 - 10	315	21
> 10	165	11
TOTAL	1500	100

7. Number of weight points in the third year (2-3)

Weight points	Number	%
None	720	48
1 - 5	529	23
6 - 10	120	8
>10	135	9
TOTAL	1500	88

8. Number of weight points in the fourth year

Weight points	Number	%
None	780	52
1 - 5	195	13
6 - 10	45	3
>10	45	3
TOTAL	1500	71

9. Number of weight points in the fifth year (4-5)

Weight points	Number	%
0	975	65
1 - 5	270	18
6 - 10	15	1
> 10	240	16
TOTAL	1500	100

10. Age, in months, at last weight point

Age (months)	Number	%
0 - 6	555	37
7 - 12	270	18
13 - 18	30	2
19 - 24	255	17
25 - 30	165	11
31 - 36	135	9
37 - 40	75	5
TOTAL	1500	100

11. Position of last weight point

	Number	%
Above 3rd centile	1095	73
Below 3rd centile	150	10
On 3rd centile	105	7
Child has no CHC	150	10
TOTAL	1500	100

12. How are you feeding your child at the moment?

	Number	%
Breast feeding only	90	6
B/feeding semi-solids	345	23
Solids only	720	48
Other	345	23
TOTAL	1500	100

14. How old, in months, was this child when you stopped breast feeding altogether?

Age (months)	Number	%
Still breast feeding	840	56
12 - 18	300	20
19 - 24	255	17
>24	105	7
TOTAL	1500	100

16. Did you ever bottle feed this child?

	Number	%
Yes	180	12
No	1215	81
Don't know	105	7
TOTAL	1500	100

18. After delivery of the youngest child, when did you breast feed for the first time?

	Number	%
Immediately after birth	390	26
During 1st 3 hours	255	17
Between 8 - 7 hours	195	13
Between 8 - 24 hours	135	9
More than 24 hours	90	6
Cannot remember	240	16
Other	225	15
TOTAL	1500	100

19. How old was the child when you started weaning (ie introducing other foods in addition to breast milk)?

Months	Number	%
1	180	12
2	180	12
3	435	29
4	210	14
5	60	4
6	120	8
7	15	1
8	7	0
9	135	3
Has not started giving child any other foods	255	17
TOTAL	1500	100

20. Are you giving the child any fruit juices?

	Number	%
Yes	960	64
No	420	28
Don't know	75	5
Other	52	3
TOTAL	1500	100

21. What was the first food you gave to the child?

	Number	%
Thin mealie-meal porridge	495	33
Thin porridge with peanut butter	285	19
Thin porridge with margarine	90	6
Processed cereal	495	33
Fruit juice	30	2
Bananas	30	2
Other	75	5
TOTAL	1500	100

27. Do you add any oil/margarine to your child's food?

	Number	%
Yes	1170	78
Sometimes when available	165	11
No	60	4
Child on breast	75	5
Other	15	1
TOTAL	1500	100

28. How many times per day does your child have solid/semi solid food?

Number of times	Number	%
1	165	11
2	165	11
3	615	41
4	255	17
5	81	5
6	6	0
7	1	0
8	75	5
Still on breast milk only	150	10
TOTAL	1500	100

29. Has the youngest child had diarrhoea in the last 2 weeks?

	Number	%
Yes	405	27
No	960	64
Don't know	60	4
Other	60	4
TOTAL	1500	100

30. The last time your youngest child had diarrhoea what did you do?

	Number	%
Gave SSS	930	62
Did not take action	270	18
Other	300	20
TOTAL	1500	100

31. What special action would you take if your child had diarrhoea for 3 or more days?

	Number	%
Take child to health facility	1080	72
Give child fluids	225	15
Give small feeds	15	1
Does not give fluids	5	0
Does not give food	30	2
Take child to traditional healer	8	0
Other	120	8
Don't know	15	1
TOTAL	1500	100

32. Where would you seek advice if your child had diarrhoea for 3 or more days?

	Number	%
Health Facility	1050	72
Private Doctor	60	4
Village Comm. Worker	105	7
Traditional Healer	45	3
Traditional Midwife	45	3
Relative/friends	150	10
Other	30	2
TOTAL	1500	100

33. The last time your youngest child had diarrhoea, did you give the child fluids?

	Number	%
More than usual	210	14
Same as usual	165	11
Less than usual	135	9
Stopped breast feeding	60	4
Not applicable	660	44
Other	235	17
TOTAL	1500	100

34. The last time your youngest child had diarrhoea, did you give the child fluids?

	Number	%
More than usual	690	46
Same as usual	315	21
Less than usual	165	11
Stopped giving fluids	75	5
Breast fed only	80	4
Other	195	13
TOTAL	1500	100

35. The last time your youngest child had diarrhoea, did you give the child solid/semi-solid foods?

	Number	%
More than usual	300	20
Same as usual	420	28
Less than usual	390	26
Stopped giving solids	90	6
Child is still breast feeding	105	7
Other	195	13
TOTAL	1500	100

36. After the last diarrhoeal episode, did you breast feed the child?

	Number	%
More than usual	270	18
Same as usual	315	21
Less than usual	45	3
Stopped breast feeding	45	3
Child was already off breast	600	40
Other	225	15
TOTAL	1500	100

37. After the last diarrhoeal episode, did you give the child solid/semi-solid food?

	Number	%
More than usual	450	30
Same as usual	645	43
Less than usual	135	9
Child still on breast milk only	75	5
Introduced semi-solid food	30	2
Other	165	11
TOTAL	1500	100

38. Have you heard about salt and sugar solution?

	Number	%
Yes	1305	87
No	195	13
TOTAL	1500	100

39. How much water do you use to prepare SSS?

	Number	%
750 mls	660	44
One mazoe bottleful	675	45
One cooking oil bottle	45	3
One large cocacola bottleful	45	3
Don't know	45	3
Other	30	2
TOTAL	1500	100

40. How much salt do you need to prepare SSS?

	Number	%
1/2 a teaspoon	1050	70
1/2 a levelled teaspoon	270	18
1/4 teaspoon	120	8
Don't know	60	4
Other	0	0
TOTAL	1500	100

41. How much sugar do you use to prepare SSS?

	Number	%
6 levelled teaspoons	720	48
6 teaspoons	495	33
Don't know	75	5
Other	210	14
TOTAL	1500	100

42. How often should the SSS be given to a child with diarrhoea?

	Number	%
3 times a day	285	19
As often as child will drink	945	63
With each loose bowel movement	150	10
Once per day	15	1
Don't know	60	4
Other	45	3
TOTAL	1500	100

43. What signs/symptoms would cause you to seek advice or treatment if your child has diarrhoea?

	Number	%
Vomiting	330	22
Fever/hot body	210	14
Dry mouth	37	3
Sunken eyes	285	19
Decreased urine output	0	0
Diarrhoea lasting 3 or more days	615	41
Blood in stool	345	23
Dark urine	0	0
Loss of appetite	120	8
Weakness/tiredness	735	49
Don't know	0	0
Other	0	0
TOTAL	1500	100

44. Which of the SSS ingredients are sometimes difficult to get?

	Number	%
Sugar	225	15
Salt	30	2
Water	45	3
750 mls bottle	15	1
Teaspoon	0	0
None	1170	78
TOTAL	1500	100

45. Why should SSS be given to children with diarrhoea?

	Number	%
Stops diarrhoea	360	24
Prevents/cures dehydration	1065	71
Don't know	45	3
Other	30	2
TOTAL	1500	100

46. What does a growth curve like this mean?

	Number	%
Child is growing well	1335	89
Child is not ill	120	8
Other	60	4
TOTAL	1500	100

47. What does a growth curve like this mean?

	Number	%
Child not growing	875	55
Child is ill	90	6
Child not gaining weight	480	32
Other	105	7
TOTAL	1500	100

48. What causes the growth curve in Question 47?

	Number	%
Child not getting enough to eat	1110	74
Child is ill	345	23
Other	45	3
TOTAL	1500	100

49. What does a growth curve like this mean?

	Number	%
Child not growing	390	26
Child is ill	315	21
Child is loosing weight	780	52
Other	90	6
TOTAL	1500	100

50. What causes the growth curve in Question 49?

	Number	%
Child not getting enough to eat	900	60
Child is ill	555	37
Other	60	4
TOTAL	1500	100

WORLD VISION RELIEF & DEVELOPMENT

PART II
SUSTAINABILITY ASSESSMENT REPORT
MUREWA CHILD SURVIVAL PROJECT

Submitted by
(The following staff and consultants have contributed to this report):

Ms. Regina Masangwi, Provincial Nursing Officer, Mashonaland East MOH
Ms. Monica Mukanda, District Nursing Officer, Murewa District MOH
Ms. S. Mushapaidze, Murewa CSP Manager, WV Zimbabwe
Mr. E. Dhlembeu, World Vision Zimbabwe
Dr. Paxton Zvandasara (KAP Survey Team Leader), University of Zimbabwe
Dr. Virginia Canlas (Evaluation Team Leader), WVRD

September 1991

TABLE OF CONTENTS

A. Sustainability Status

1. The Murewa Child Survival Project was completed on September 30, 1991. However, the organization plans to cease CSP activities as a time when the set objectives and targets have been achieved as agreed with the MOH. Although the funding will cease, technical assistance will continue.

2. The MOH at various levels took control of the major CS interventions and other project responsibilities from the onset of the project, while World Vision staff provided support and facilitated implementation. Training activities were jointly undertaken with the MOH officials at the provincial, district, and ward levels. These joint activities foster the Government of Zimbabwe/MOH personnel's ownership of the project.

B. Sustainability Plan

1. The project's plan for sustainability, as laid out in the Detailed Implementation Plan (DIP), annual report, or midterm evaluation report was based on the following aspects.

   a. Income-Generating Activities (IGAs) have been started recently to support health care financing. This enables the community to pay for essential child health care services. At the district level, there are a number of IGAs for women, including sewing, soap production, and crocheting. Part of the gains generated from the IGAs will be used to defray operating costs of the Child Survival (CS) activities once the financial needs of families have been addressed.

   b. The MOH will continue to provide and maintain the essential child health care services using their recurrent resources and the vehicles provided to them by the donor agency. Training and provision of equipment and supplies were all aimed at strengthening the activities provided by the MOH services to ensure sustainability after the life of the project. Commitments of human and material resources are seen as being sustainable after the end of the project.

   c. The project has worked closely with the communities in determining their health needs. The commitment of community leaders to the project is a key strategy for sustainability, which created a high-level of awareness and motivation of the community and a greater demand for health services. This was also complemented by the development of strong relationships among individuals and institutions in the project area.

2. From the inception of the project, the MOH has been actively involved in the design and planning of the project. It has provided political and material support for the project, as is suggested by the letter of support from the MOH. The communities requested assistance from the project to help establish Village Development Centers (VIDECs), which serve as an important entry point for their full participation in key CS interventions. The project has exerted much

49

effort to train community leaders and provide supplementary training to Village Community Workers (VCWs), health center personnel, and CSP staff to increase community-level awareness and knowledge of CS interventions. These high awareness levels have resulted in greater demands for EPI services than before. These last two aspects of the plan (B.1.b and c) mentioned above have been implemented successfully.

However, part of the gains generated from IGAs has been found to be utilized for basic needs of families. Parents, for instance, may prioritize paying for the school and buying food for their children. Once the financial needs of families have been addressed, gains from IGAs will be used to defray operating costs for CS activities.

3. The MOH's involvement and commitment in project design to sustain project benefits was in the form of manpower and materials, such as vaccines, needles, and training materials. The cold chain equipment and other vaccine supplies were provided by UNICEF and SIDA, respectively, and administered by the MOH staff. No financial commitments to sustain project benefits were made by any counterpart institutions. However, strong linkages and relationships with the MOH and other health sector NGOs have been established.

4. The government's MOH and other local NGO involvement in support of CSP activities in Murewa in project design, management decision, and implementation from the very beginning is the reason for keeping its commitment to the sustainability of the project.

C. Community Participation and Perception of Project Effectiveness

1. The Primary Health Care concept in Zimbabwe calls for community participation. The communities have been involved in innovative activities in the Child Survival project in all aspects since the beginning. They were involved from the planning stage to its actual project implementation. A lot of the inputs related to health needs were gathered from the communities and were utilized in addressing their needs and in the project design and planning. After the needs and problems had been identified, the communities mobilized their resources to support the CSP activities. They also participated in raising awareness of health services in the communities, thus creating a greater demand for these services to meet the current health needs of the people. They helped motivate and encourage the mother and children to promote good health through these CS interventions. They were involved in the selection and hiring of VCWs.

2. There are 27 functioning health committees in the project area. Two health committees meet two times a month; one committee holds its meeting once every two months. The majority (24) meet once a month. Committee members are representatives of their local communities. They are elected by the people in the community. They are usually the influential leaders in the community. The MOH is represented by either an SCN or an EHT. The councilor chairs the committee, which is part of his job description as village chief.

50

3. The topics or issues discussed at the last meeting of each health committee were as follows:

a. World Health Day (WHD) planning and preparation for celebration.
b. AIDS awareness campaign;
c. Construction of a Waiting Mothers' Shelter;
d. Provision of a preschool;
e. Nutrition/immunization mass campaigns to raise awareness;
f. Water and environmental sanitation;
g. Construction of Blair latrines in the communities;
h. Provision of water pump engine at the RHC and other problems related to water sources;
i. Active participation of newly elected members of the Village Health Committees; and
j. IGAs to sustain CS activities.

The Health Committee came up with the following decisions/suggestions:

a. Each community member contributed 50 cents, and each civil servant (community leader) contributed Z$2.00 to Z$3.00 for the celebration of WHD. Others contributed toward the WHD in kind. The celebration of WHD was carried out in December 1990.

b. The community started to gather all the material resources (bricks, cement) from the people to start the construction of a Waiting Mothers' Shelter.

c. Water wells have been dug for safe water. Trenches have been dug for pipes from the water source to the Rural Health centers.

d. Conducted EPI/nutrition education campaigns in the communities to increase immunization coverage and improve health of the community.

4. The majority of the community leaders perceive that the CS activities are very effective at meeting current health needs for the community. The majority feel that the CS project has improved the health status of mothers and children in their communities. This project has increased the level of awareness of health services in the community, thus creating a greater demand for health services. EPI and nutrition activities are considered as the most successful components of the project which had an impact on the health status of the communities.

The following community leaders were interviewed and each represented a specific Village Development Assistance Center (VIDEC); namely, they were made up of men and women in each committee:

a. School headmaster;
b. School teachers;
c. Zinatha member (traditional healer);
d. Chairman, VIDCO;
e. Councilor in the respective community;

f. Church leader;
g. Coordinator, Ministry of Community Development and Cooperatives;
h. Traditional midwives; and
i. CBDs.

5. The community contributed in the form of human labor (manpower) and locally available materials (such as bricks, pit sand). Their strong cooperation and the trust among the individuals in the community have played a major role to promote project sustainability. These resources, in addition to the community's strong involvement in the implementation of the project, will help ensure that project activities will continue after donor funding ends.

D. Institutional Sustainability—Strengthening Local Management

1. Networking with the MOH at all levels from the inception of the CSP in Murewa has helped create a strong relationship of trust between World Vision project staff and MOH personnel. This included coordination, program sharing, institutionalization of the project, and finally a supervisory take-over by the MOH. As noted previously in this document, both the MOH and WVZ were actively involved in the planning, budgeting, and actual implementation of the project since its inception. The MOH was not limited to its decision-making power and program management. They were given full responsibility and control of the CSP. Strong linkages without financial exchange or commitment have also been established between the CSP and other NGOs or local institutions (University of Zimbabwe, UNICEF, etc.). WV staff have attended workshops and seminars sponsored by other health sector NGOs, and vice-versa.

2. The World Vision project has invested in human capital through training of MOH personnel at all levels, VHWs, and select community leaders. Emphasis has been placed in enhancing the administrative and technical skills of the core staff. This was achieved through in-service training and attendance at training seminars and workshops, in-country and internationally. Topics included CSP programming, monitoring and supervision, effective program management, and other related on-the-job training skills. The PVO strengthened the management skills of MOH staff who are expected to sustain project activities by funding monthly two-day meetings where in-service training was carried out. In addition, workshops to strengthen Ward Health Teams and Health Center Committees were held in the district. A Ward Health Team is a committee formed at ward level to act as liaison between the community and the professional people on matters pertaining to health. Refresher courses for traditional midwives were also provided during the duration of the project. The MOH has already managed to implement the project using the existing staff members to meet the technical, management, and operational needs of the project.

3. MOH key personnel (Dr. Paul Bernard, District Medical Officer; Ms. Regina Masangwi, Provincial Nursing Officer; Ms. Monica Mukanda, District Nursing Officer; Mr. Chiadavaenzi, District Environmental Health Officer) interviewed clearly perceived CS activities as very effective in meeting the health needs of the communities and in increasing awareness and greater demand for health services

57

from communities. They also felt that the CSP had a great impact on the health status of both mothers and children since the inception of the project. There has been a notable decrease in both morbidity and mortality from childhood immunizable diseases due to increased EPI coverage at the outreach points. Immunization campaigns were seen to be very effective, and the MOH personnel interviewed have mentioned that the CSP has been meeting a need which previously was not being met due to inadequate health facilities.

4. The ability of the MOH to sustain project activities is limited due to financial constraints in view of the Economic Structural Adjustment Program of the Zimbabwe government that will force all government ministries to reduce their recurrent budgets, which means that the MOH may have to prioritize its health programs because of limited financial resources. However, the MOH has the adequate skilled manpower to carry out the activities. Vehicles donated for the CSP, which eventually would be made available to the MOH, will not be used on a more regular basis when the CSP will be turned over to the MOH. The use of the vehicles will be limited as there is no money allocated for their mileage. Field visits to the impact areas and immunization outreach activities will be prioritized according to the need of the community.

   However, the MOH has initiated processes to ensure sustainability of the project despite the Structural Adjustment Program. They are as follows:

   a. Providing at least two bicycles per health center for outreach;
   b. Reallocation of outreach points to health centers;
   c. Reduction of outreach points in areas where health centers have been built;
   d. Acquiring additional manpower (SCNs and EHTs) to be deployed in the district.

   The MOH is committed to the following once the project ends:

   a. Maintaining MOH activities;
   b. Continuing to supervise and monitor CS activities.

5. The MOH will assume all the recurrent costs, but with limitations due to the effects of the Economic Structural Adjustment, in which the GOZ will allocate specific budget for each ministry in the government, all the existing project staff seconded to the outreach teams will also be absorbed by the MOH.

E. Monitoring and Evaluation of Sustainability

1. The indicators used to track sustainability are as follows:

   a. Community ownership and support—the level of awareness and demand for health services from the communities have increased. Community leaders have participated in social mobilization campaigns.

b. Creation of several outreach points for CS interventions by either the hospitals or the Rural Health Centers (number of outreach points established).

c. The number of small-scale IGAs that are functioning to support health care financing.

d. Attendance rate of children for immunization and growth monitoring activities.

e. Number of functioning cooperatives after project life.

g. Proportion of VIDECs which operate as outreach points after end of project.

2. The use of VIDECs as outreach points for CS activities and local maintenance have greatly diminished health care cost. An increased number of IGAs have been started for mothers and other women's groups to contribute to meeting the costs of health services. The community has expressed an interest, and the use of resources generated to pay for health services has become acceptable to the community.

   Project efforts in community organization have been highly successful, apparently due in large part to strong use of interpersonal communications.

   Control of diarrhea disease activities have made an impact. The number of reported cases of diarrhea in the under-fives has decreased.

3. In-country agencies which took part in the midterm and final evaluations of the WV project were as follows:

   Midterm Evaluation:

   a. Ministry of Health;
   b. UNICEF;
   c. WHO; and
   d. University of Zimbabwe.

   Final Evaluation:

   a. Ministry of Heath;
   b. University of Zimbabwe.

F. Calculation of Recurrent Costs

1. Budget revisions were made during the course of the project implementation. There has been consistent underspending each year, mostly for travel, training, and consultancy. The consultancy cost was reduced significantly after the first year because the budgeted amounts for expatriate consultancy was channeled to consultancies within the region. This reduction was also translated into a reduction of travel costs. Training costs also diminished during the course of the project duration, particularly in the fourth and fifth years of implementation at the request of the MOH at the national level to cut down on monthly coordination meetings. Expenditures for salaries increased beginning at the third

year and thereafter because of the addition of three staff seconded by the CSP to the MOH's outreach teams. However, these increases are still within budget.

Other expense categories became much higher than originally planned because of variations in costs of capital goods and services due to inflation. These items included vehicle maintenance and repair, fuel, and communications (telex, fax, telephone).

2. Mileage costs for vehicles to outreach points and expenditures incurred during monthly coordination meetings of SCNs and EHTs, which amounts to an average of U.S.$250.00/month, will be used to cover the rental fee for the conference center and food and transportation allowances for each participating SCN and EHT at the district level.

3. The project will calculate the recurrent costs based on the following factors: (a) cost of living indicators; (b) inflation and recession; (c) depreciation value; (d) wage rate (labor fees); (e) maintenance costs and repair, particularly the vehicles; (f) fuel costs for vehicles; and (g) number of outreach/field visits done.

4. The amount of money calculated by the CSP and needed to cover recurrent costs will always vary in the different outreach points in which the project operates. Costs for the monthly coordination meetings will be based on the number of SCNs and EHTs who will be called to participate and the distance between their places of residence and the meeting site. The rate of transportation (fare) will largely depend on the distance between the two; the villages where the SCNs and EHTs live are for the most part in very remote areas. The estimated costs for these monthly coordination meetings is U.S.$250.00/month.

   Given the demographic characteristic of the areas in which the CSP operates, the project staff feels it is a reasonable cost. Furthermore, the project covers the entire Musami area of the Murewa District with a total beneficiary population of 352 villages in 23 wards of the District.

   The SCNs and EHTs hold these monthly meetings to address current problems and constraints of the project activities. This is a means of increasing their knowledge level on the different CS interventions, and providing them with up-to-date information on heath-related issues and topics. They also provide the MOH personnel both in the national and provincial levels progress of CS project activities.

5. Costs which are not likely sustainable include:

   a. Maintenance of field visits to 27 outreach points due to reduced mileage allocation;
   b. Operational costs of outreach points in terms of field staff allowance;
   c. Overhead costs attributable to technical staff employed by the CS project;
   d. Some aspects of training.

55

G. Cost-Recovery Attempts

1. The project implemented various cost-reduction strategies to reduce cost and which also made the project more efficient. They are as follows:

   a. The use of VIDECs (Village Development Assistance Centers) as outreach points for CS activities and its local maintenance have greatly diminished health care costs;

   b. Income-generating activities have been started to support health care financing;

   c. For all CS activities, existing manpower resources and structures have been utilized. No new staff posts or structures have been created at project site level.

2. The following cost-recovery mechanism were implemented by the project to offset project expenditures. They were not only proved to be effective cost-cutting mechanisms, but they have also contributed to the sustainability of the project.

   a. The GOZ mandated that all families with monthly earnings below 150 Zimbabwean dollars do not pay for health services. Families with monthly income of Z$150.00 and above are required to pay Z$3.00 for adult and Z$1.00 for children during each clinic visit. Any medication prescribed during visit is included in the total service charge.

   b. Contributions from the community in terms of labor input and bricks have reduced the costs to the project of constructing the VIDECs.

   c. MOH supplies the vaccines, drugs, and equipment for the outreach clinics.

   d. MOH-sponsored training workshops for project staff and other health workers in the community.

   e. Community volunteerism in ensuring community involvement, mobilization, and participation.

   f. Ministry of Agriculture, AGRITEX, and Ministry of Community Development provided training for IGA groups on income-generation.

3. Cost-sharing and cost-cutting mechanisms were implemented and managed through the joint efforts of the MOH, Ministry of Community Development, VIDECs, CSP staff, collaborating NGOs, and other sectoral ministries. Investment made by each collaborating agency and the project staff and contributions in-kind (labor and locally available materials) from the community members in project activities has increased their identification of the project as their own. These resources contributed by the community will help ensure the continuation of activities once the project phases out.

The project health staff and their MOH counterparts were involved in supervision and monitoring of all CS interventions. It did not pose any problem in the implementation of the project activities, but it cost the project time in terms of mobilization and networking. This effort committed to management and supervision of CS activities by the project staff did not have any adverse effect in the community health services delivery, as it has become an integral part of the entire project.

4. At the district level, the dollar amount of cost-recovery obtained during the project is estimated to be minimal in the beginning because the GOZ policy on health service for the vast majority of the rural dwellers in the project areas is that they are provided free of charge if the family income is less that Z$150.00 per month. Because of this policy, the project has not incorporated cost-recovery mechanisms in the early phase of project implementation.

   The use of existing staff and village workers has kept the project cost to a minimum. Extra funds in cash were generated from gains from income-generating activities, including crocheting and sewing of chair-backs, towards the CSP. Additional contributions generated from the community were used to implement these mechanisms.

5. The communities have been involved in the design and implementation of the cost-recovery activities of the project. Through continuous dialogue and mobilization of local resources in the communities, men, women, and children in the community have helped in the cost-sharing activities of the project. A change in the attitude of the community towards sharing the cost of CSP activities, a full commitment to the project, and a strong sense of project ownership are the main reasons for the success of the CSP cost-recovery.

6. No. The result has been a better understanding of job functions, roles, and responsibilities between the project staff, MOH counterparts, the community, and other health sectors. This has strengthened the collaboration and has improved their relationships in delivering primary health care services.

H. Income Generation

1. Yes. Many IGAs were started in the project area, particularly in the Musami area. In other parts of the project area IGAs are only starting. IGA types have been found to include sewing, crocheting, baking, poultry raising, gardening, soap and vaseline making, and fence making. Most of the IGAs were started on the initiative of community members. IGA ownership is on interest group or collective cooperative basis. It has been found that women are dominant in terms of membership in IGAs with the majority of IGAs being owned and run by all-women groups.

   All IGAs that were covered by the evaluation survey were found to have been started through contributions by members. Contributions ranged from Z$2.00 to Z$23.00. Some IGAs were found to have started as far back a 1982 (e.g., sewing IGA, Ward 10), with the majority having started during the project

51

period. All IGAs, irrespective of when they started, have or are enjoying support from the project.

The demand for assistance to start IGAs is very high in the project area, particularly outside Musami. It has been found that most communities would like to start IGAs of the type given above, as well as welding, carpentry, piggery, and grinding mills. Many of these communities were, at the time of the evaluation, looking to World Vision for assistance, who, they maintain, has promised them assistance in starting IGAs. Some communities were found to have done the preparatory work (e.g., construction of chicken runs) and are waiting for take-off, which is only possible with assistance, which they claim World Vision has promised them.

2. The small revenues of the IGAs are going to groups and individuals, mostly women, who participate in the IGAs. The IGAs' revenues are pooled together with household income from other sources and used to meet family needs, including those relating to health. It is not possible, according to the evaluation survey, to give the proportion of revenue from IGAs that families direct to health activities. It was found that because of the difficult circumstances of the families participating in IGAs, the most pressing needs (which could be an ill child, school uniforms or fees, etc.) are given priority. The families are not in the luxury position of being able to budget their meager incomes beforehand. In general, however, it was found that over two-thirds of income is spent on health-related activities.

   A number of IGAs were found to be contributing directly (and not through revenues) to health activities of families and communities. Such IGAs include soap and vaseline making and sewing, as they relate to personal hygiene. Other examples are gardening, poultry raising, and baking, which relate to food and nutrition.

3. Although the survey found two cases of IGAs that had folded, the general conclusion is that the IGAs in the project area are achieving some success. The following indicators can be used:

   a. Some IGAs have provided revenues, though small, for distribution among circle members.

   b. Some IGAs (e.g., sewing, baking, soap making) are providing, or have the potential to provide, products at lower prices to community members without having to travel long distances to service centers.

   c. IGAs promote group cohesion.

   d. IGAs have contributed to enhancing the status of women who no longer have to rely on their husbands for everything. IGAs were found to be dominated by women.

   e. IGAs provide for interaction and collective approach to common problems.

58

The main coptributing factor to the achievement of some success of IGAs was found to be that they are initiated and owned by community members. The participants were found to contribute some money, their time, and labor to establish IGAs and, hence, they become committed to them.

Many IGAs were, however, found to be experiencing some constraints. These include:

a. Limited initial capital (e.g., one sewing machine to a group of 11 women)

b. Supply side constraints (e.g., tallow and candles for soap and vaseline making, respectively).

c. Power market outlets (e.g., a group of women has been waiting for more than a year to open a market for crocheting products in Canada with the assistance of World Vision. Without this assistance, the group would have nowhere to market their produce).

d. Lack of economics of scale of the IGAs.

These constraints are evidence of need of material and technical support by IGAs, particularly those that are only starting in much of the project area.

4. In areas where the IGAs have been established, communities are grateful for the assistance they have received from World Vision and government ministries and departments, including those of Health, Community, and Cooperative Development, AGRITEX. Assistance from some of these government agencies has been in the form of IGA-related training. In many parts of the project area, IGAs are only starting. Communities therein maintain that World Vision has promised some assistance and would like to see that promise honored.

CSP services were free of charge to all. Where communities were to contribute, it was mostly through local resources such as time, labor, and materials (e.g., bricks). These did not require any monetary expenditure. The IGAs did not create problems in project service equity.

54

APPENDIX TO INCOME-GENERATION SECTION

Income-Generation Activities in Bandakamwe I Area

	Area
Chimani Poultry and Gardening	Njenje
Chara—Chimwe Poultry and Hodidog	Chisaga
Bandakamwe Green Growers	Bandakamwe
Nhaurwa Dovi	Chingwanda
Hazviuye Ugere Bakery	Makuwaza
Kunanaira Bakery	Chihumbiri
Chidawaya Taguta Gardening	Chidawaya
Ngundu Fish Farming	Ngundu
Wadzanai Poultry	Chitsanga
Kunfumaishungu Poultry	Chitsanga
Chadenga Poultry	Chadenga
Magabuzi Dovi	Chimani
Chinembiri Bakery	Chinhoi
Kumboyedza Bakery	Chigwanda

Ex Officials	
AGRITEX	Mr. E. Maganga
VCW	Mrs. Placidia Njenje
Councillor	Mr. Parcevel Chapaguta
Health Assistant	Mr. Matigona

Musami Hospital and Mr. Mudembe helps us on Immunization Program

Address:	Pakiti School P.O. Box 137 Murewa
Hospital	Musami
Clinic	Kadzere
Headmaster	Mr. E. Rugai

Bandakamwe I Income-Generation Activities (continued)

No. of Members		Types of IGAs	Money in Bank Books
Female	Male		
16		Chimani Poultry and Gardening	$1,050.00
20	10	Chara—Chimwe Poultry	650.00
		Bandakamwe Green Growers	
15		Nhaurwa Dovi Chingwanda	500.00
12		Kumboedza	
14		Hazviuye Ugere	
15		Kunanaira	100.00
		Chidawaya Gardening	
		Ngundu Fish Farming	
16		Wadzanai Poultry	90.00
10	2	Kupfumaishungu Poultry	450.00
11	3	Chadenga Poultry and Fish Farming	200.00
11		Magabuzi Dovi and Poultry	55.00
16		Chinembiri Bakery	100.00

WORLD VISION RELIEF & DEVELOPMENT

PART III
END-OF-PROJECT PIPELINE ANALYSIS
MUREWA CHILD SURVIVAL PROJECT

December 1991

62

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./ZIMBABWE MUREWA CHILD SURVIVAL
#PDC-0505-A-00-5065-00

FIELD	Actual Expenditures To Date (8/01/90 to 9/30/91)			Projected Expenditures Against* Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (8/01/90 to 9/30/91)		
COST ELEMENTS	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Supplies	1,000	8,041	9,041	2,500	(3,843)	(1,343)	3,500	4,198	7,698
B. Equipment	0	10,954	10,954	0	(1,007)	(1,007)	0	9,947	9,947
C. Services/Consultants	17,577	3,695	21,272	(3,377)	5,000	1,623	14,200	8,695	22,895
SUB-TOTAL I	18,577	22,690	41,267	(877)	150	(727)	17,700	22,840	40,540
II. EVALUATION/SUB-TOTAL II	0	0	0	0	0	0	0	0	0
III.INDIRECT COSTS									
Overhead on Field (%)	13,135	8,253	21,388	12,865	2,658	15,523	26,000	10,911	36,911
SUB-TOTAL III	13,135	8,253	21,388	12,865	2,658	15,523	26,000	10,911	36,911
IV. OTHER PROGRAM COSTS									
A. Personnel	21,582	11,383	32,965	(294)	0	(294)	21,288	11,383	32,671
B. Travel/Per diem	12,738	10,476	23,214	254	(2,436)	(2,182)	12,992	8,040	21,032
C. Other Direct Costs	12,779	7,671	20,450	65,472	14,566	80,038	78,251	22,237	100,488
SUB-TOTAL IV	47,099	29,530	76,629	65,432	12,130	77,562	112,531	41,660	154,191
TOTAL FIELD	78,811	60,473	139,284	77,420	14,938	92,358	156,231	75,411	231,642

*Note: An extension has been requested to spend the remaining funds under this grant.
Certain other documentation remains to be submitted for the granting of this extension.

63

APPENDIX 1

List of Clusters surveyed

Cluster Number	Name of Village	Ward
1	Mavangwe Gukurahundi Manita	6
2	Chizunzu Chivhinga Sengu	7
3	Soka Vengesa Gwangwadza	8
4	Mapanga Kapungu Munomure	9
5	Chidawaya Hukuimwe Sande Njenje	9
6	Gatsi Jonga	10
7	Gandazha Marozva	10
8	Dandara 1 Dandara 2	11
9	Shambahweta Goso Jaji	11
10	Shambare 1 Shambare 2 Tanda 1 Tanda 2 Tanda 3	12
11	Mavhura Chipori Mavura Nemukunyu	13
12	Nheweyembwa Mwenge Masaka	14

13	Kambarami 1		15
	Kambarami 2		
14	Nyamutumbu		16
	Gatsi		
	Machrakaire		
15	Zihundi		17
	Mhembere 1		
	Mhembere 2		
	Mhembere 3		
16	Pjende		17
	Nzungu		
	Musekiwa		
	Munyakure		
17	Gonzo		18
	Chingombe		
	Tabikira		
18	Gwazvo		19
	Muchemwa		
	Manjonjo		
19	Choto 1		20
	Choto 2		
	Choto 3		
	Toropito		
20	Muza 1		20
	Muza 2		
	Muzembe 1		
	Muzembe 2		
21	Chitaukwe		21
	Utsiwegota		
	Chirimuuta		
	Kondo		
	Ruze		
22	Makore		22
	Chigumadzi		
	Ngoroshe		
23	Chakanyuka		23
	Chitongo		
24	Parirenyatwa	1	23
		2	
		4	
		6	
		7	

25	Tsambati Dzivarasekwa	1
26	Chirimudombo Kunzurisisa Gomure	2
27	Muchengetahondo Kuberekana Chaminuka Mudzimundiringe	3
28	Mupudzabuhnu Chikoro Songwa Kudzanai	4
29	Chayamarombo Muzunza	5
30	Chibanda Kwayedza Magamba	5

Group Leaders

1. Mr Murahwa
   Mr Makotore
   Ms Jonga

2. Ms Valley
   Mr Karonga
   Mr Chivanda

3. Mr Mubaiwa
   Mr Tsodzo
   Ms Wire

4. Mr Mkondwa
   Ms Mufandaedza
   Mr Matigonda

5. Mr Chidavaenzi
   Ms Chagwedera
   Mr Sithole

APPENDIX 3

- SURVEY QUESTIONNAIRES

END OF PROJECT EVALUATION OF THE WORLD-VISION ZIMBABWE CHILD SURVIVAL PROJECT IN MREWA DISTRICT, MASHONALAND EAST PROVINCE.
AUGUST - SEPTEMBER 1991.

QUESTIONNAIRE A - EPI AND FAMILY PLANNING

7 PER CLUSTER

QUESTIONNAIRE TO BE ADMINISTERED TO MOTHERS AGED 15 - 49 YEARS WITH CHILDREN AGED 0 - 11 MONTHS ie UNDER 1 YEAR.

IDENTIFICATION.

CLUSTER NUMBER:_ _

NAME OF WARD:.....

NAME OF VILLAGE:.....

DATE OF INTERVIEW (DD/MM/1991):_ _ / _ _/1991.

FULL NAME OF RESPONDENT:.....

FULL NAME OF HEAD OF HOUSEHOLD:.....

Name Of Interviewer:.....

Designation Of Interviewer:.....

Signature of Team Leader:.....

END OF PROJECT EVALUATION OF THE WORLD-VISION ZIMBABWE CHILD SURVIVAL PROJECT IN MREWA DISTRICT, MASHONALAND EAST PROVINCE.

AUGUST - SEPTEMBER 1991.

QUESTIONNAIRE C
COMPLETE SEVEN QUESTIONNAIRES PER CLUSTER

QUESTIONNAIRE TO BE ADMINISTERED TO MOTHERS OF CHILDREN AGED 0 - 11 MONTHS.

IDENTIFICATION.

CLUSTER NUMBER:_ _

NAME OF WARD:.....

NAME OF VILLAGE:.....

DATE OF INTERVIEW (DD/MM/1991):_ _ / _ _/1991.

FULL NAME OF RESPONDENT:.....

FULL NAME OF HEAD OF HOUSEHOLD:.....

Name Of Interviewer:.....

Designation Of Interviewer:.....

Signature of Team Leader:.....

SECTION 1. RESPONDENT'S BACKGROUND AND HOUSEHOLD QUESTIONS.

QUESTIONNAIRE TO BE ADMINISTERED TO MOTHERS WITH CHILDREN AGED 0 - 11 MONTHS.

RESPONDING MOTHER'S NUMBER	1	2	3	4	5	6	7
1. Age of respondent (Completed years)							
2. Respondent's Religion: 1 Methodist 2 Apostolic Faith 3 Roman Catholic 4 Anglican 5 Church of Christ 6 Other (Specify)							
3. What was the highest educational level you attained? 1 Less than Grade 7 2 Grade 7 3 Form 1 - 2 4 Form 3 - 4 5 Post "O" Level 6 Never went to school 7 Other (Specify)							

RESPONDING MOTHER'S NUMBER	1	2	3	4	5	6	7
4. Do you work away from home? (Munoshanda here?) 1 Yes 2 No							
5. What income generating activities are you involved in? 1 None 2 Growing & selling agricultural products 3 Growing and selling garden produce 4 Poultry 5 Crotcheting 6 Basketry 7 Other (Specify)							
6. Who takes care of the youngest child when you are away from home? 1 Mother takes child with her 2 Husband 3 Grand parent 4 Older siblings 5 Neighbours 6 Friends 7 Relatives (Specify) ..... 8 Other (Specify)							

RESPONDING MOTHER'S NUMBER	1	2	3	4	5	6	7
7. What is your major source of drinking water? 1 Protected well (lined & has lid lifting devise) 2 Borehole 3 Unprotected well 4 Protected spring 5 Unprotected spring 6 River/stream 7 Other (Specify)							
8. If protected, did you receive any assistance to protect the water source? 1 Yes 2 No 3 Don't know							
9. If Yes, who helped you? 1 Ministry of Health/Govt of Zimbabwe 2 World Vision 3 Donor unknown 4 DDF 5 Not applicable 6 Other (Specify)							

RESPONDING MOTHER'S NUMBER	1	2	3	4	5	6	7
10. What assistance or materials did you get? 1 Cement 2 Cement & pump 3 Pump & bucket 4 Other (Specify)							
11. What type of toilet facility do you have? 1 Blair toilet 2 Pit latrine 3 None 4 Other (Specify)							
12. Did you receive any assistance in constructing the toilet? 1 Yes 2 No 3 Don't know							
13. If Yes, who assisted you? 1 Min of Health or Govt of Zimbabwe 2 World Vision 3 Donor unknown 4 DDF 5 Not applicable 6 Other (Specify)							

RESPONDING MOTHER'S NUMBER	1	2	3	4	5	6	7
14. What assistance did you get? 1 Cement 2 Cement & fly-screen 3 Other (Specify) ..... 4 Don't know							
15. What did your family contribute? 1 Labour 2 Bricks 3 Labour & bricks 4 Other (Specify)							

Please fill in the table below for each mother of children aged under 1 year ie <u>0 - 11 months</u>.

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
Name of child							
16. Date of birth of child (DD/MM/YY							
17. Relation-ship of respondent to child: 1 Mother 2 Grandmother 3 Aunt 4 Older sibling 5 Other (Specify).....							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
18. Where was the child born: 1 Home 2 Health Facility 3 Other (Specify).....							
19. If not a health facility delivery, why was this? 1 Health facility too far 2 Health staff not helpful 3 Prefer delivery at home 4 Cost too high 5 Prefer TM delivery 6 Not applicable 7 Other (Specify)							
20. If you had a home delivery, who assisted you? 1 Traditional Midwife (TM) 2 Trained TM 3 Self 4 Friend/relative 3 Other (Specify).....							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
21. When you delivered your youngest child, who cut and tied the cord? 1 Health Worker (Nurse/Doctor) 2 Trained Traditional Midwife (TTM) 3 Untrained Traditional Midwife (UTM) 4 Yourself 5 Family member 6 Friend/Relative 7 Other (Specify)..... 8 Don't know							
22. If you delivered at a Health Facility, were you satisfied with the services? 1 Yes 2 No 3 Not applicable							
23. If you were not satisfied, why was this? 1 Not applicable 2 Health staff were rude 3 Contact with staff too short 4 Did not understand health worker 5 Long waiting time 6 Other (Specify)							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
24. Does the mother have a Mother's Card? 1 Yes (seen by interviewer) 2 Yes (not seen by interviewer) 3 No, lost it 4 No, never had it 5 Other (Specify).....							
25. Does the mother have a Tetanus Toxoid (TT) Card? 1 Yes (seen by interviewer) 2 Yes (not seen by interviewer) 3 No, lost it 4 No, never had it 5 Other (Specify).....							
26. While you pregnant with, did you receive any Tetanus Toxoid injections? 1 Yes 2 No 3 Don't know							
27. If Yes, how many injections did you get? 0 Not applicable __ Write number 99 Don't know							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
28. What is the Tetanus Toxoid injection for? 1 To protect mother against Tetanus 2 To protect new-borne baby against Tetanus 3 To protect mother & new-born against Tetanus 4 Other (Specify) ..... 5 Don't know							
29. How many Tetanus Toxoid injections does a pregnant mother need to protect the new borne infant from tetanus? 1 None 2 One 3 Two 4 Three 5 More than 3 6 Don't know							
30. When you were pregnant with your youngest child, did you attend ANC? 1 Yes 2 No 3 Don't know							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
31. If Yes, How many times? 1 Once 2 Twice 3 Three times 4 Four times 5 More than four times 5 Not applicable 6 Don't know 7 Other (Specify)							
32. At what gestation did you book for ANC (see card)? 1 In the first three months from card 2 Between 3 - 6 months from card 3 After 6 months from card 4 In the first three months from history 5 Between 3 - 6 months from history 6 After 6 months from history 7 Not applicable 8 Don't know							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
33. If you booked after 6 months why was this so? 1 Did not know had to book before 6 months 2 Health Facility too far 3 Was too busy 4 No money 5 Other (Specify) ..... 6 Don't know							
34. If you attended ANC, were you satisfied with the services at the Health Facility? 1 Yes 2 No 3 Not applicable							
35. If you were not satisfied, why was this? 1 Not applicable 2 Health staff were rude 3 Contact with staff too short 4 Did not understand health worker 5 Long waiting time 6 Other (Specify)							
36. Did you attend Post natal after the delivery of your child? 1 Yes 2 No 3 Don't know							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
37. If Yes, how long after delivery? (See Card) 1 Under 2 weeks from card 2 2 - 6 weeks from card 3 At 6 weeks from card 4 After 6 weeks from card 5 Under 2 weeks from history 6 2 - 6 weeks from history 7 At 6 weeks from history 8 After 6 weeks from history 9 Not applicable 0 Other (Specify)							
38. If you did not attend Post Natal Care, why? 1 Not applicable 2 Health facility too far 3 Not advised to attend PNC by health staff 4 Partner did not allow 5 No money 6 Other (Specify) ..... 7 Don't know							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
39. Were you satisfied with the service at the Health Facility during PNC? 1 Yes 2 No 3 Don't know 4 Not applicable							
40. If you were not satisfied, why was this? 1 Not applicable 2 Health staff were rude 3 Contact with staff too short 4 Did not understand health worker 5 Long waiting time 6 Other (Specify)							
41. For your next pregnancy, where would you like to deliver? 1 At home 2 At the local clinic 2 Not at the local clinic 3 Attended by a TM 4 At Church (For Apostolic Faith) 5 Other (Specify)							

NUMBER OF MOTHER IN CLUSTER	1	2	3	4	5	6	7
42. Explain your choice (Sei madaro?) 1 Expert help available 2 Avoid complications 3 Had Caesarian Section before 4 Transport problems 5 Other (Specify)							
43. Have you ever had a home delivery? 1 Yes 2 No							
44. If Yes, who assisted you? 1 Trained TM 2 Untrained TM 3 Not applicable 4 Other (Specify)							

SECTION 1. EPI QUESTIONS PERTAINING TO CHILDREN AGED 12 - 23 MONTHS.

CHILD NUMBER	1	2	3	4	5	6	7
Name of child							
1. Date of birth (DD/MM/YY)							
2. Birth-weight (Kg)							
3. Whether the child has a BCG scar (examine the top of right shoulder): 1 Yes 2 No							

CHILD NUMBER	1	2	3	4	5	6	7
From CHC: Whether child is immunised against the following (Enter date given) Codes: Enter DATE if on card Enter HISTORY if mother says child got vaccine, but not on card Enter TICK if there is a tick on card Enter 0/ZERO if no vaccine was given							
4. BCG (DD/MM/YY)							
5. Polio 1 (DD/MM/YY)							
6. Polio 2 (DD/MM/YY)							
7. Polio 3 (DD/MM/YY)							
8. Polio 4 (DD/MM/YY)							
9. DPT 1 (DD/MM/YY)							
10. DPT 2 (DD/MM/YY)							
11. DPT 3 (DD/MM/YY)							
12. DPT 4 (DD/MM/YY)							
13. Measles (DD/MM/YY)							

Write, in the Table below, where the following vaccines were given using the codes given:

1 Outreach
2 Hospital
3 Health Centre
4 Private/Non Government
5 Other (Specify).....
6 Child has no card
7 Source not entered

Child number	1	2	3	4	5	6	7
14. BCG							
15. Polio 1							
16. Polio 2							
17. Polio 3							
18. DPT 1							
19. DPT 2							
20. DPT 3							
21. MEASLES							
22. Immunization Status: 1 Child got full primary Course 2 Child got part of Primary Course 3 Not immunized							

CHILD NUMBER	1	2	3	4	5	6	7
23. Why was the child not fully immunised/never had any vaccinations 1 Unaware of need to immunise 2 Not applicable (ie got Primary Course) 3 Unaware of need to get second or 3rd dose 4 Place & or time of immunisation unknown 5 Fear of side-reactions 6 Wrong ideas about contra-indications 7 Other (Specify) ..... 8 Postponed until another time 9 No faith in immunisation 10 Rumours 11 Other (Specify) ..... 12 Place of immunisation too far 13 Time of immunisation inconvenient 14 Vaccinator absent							

CHILD NUMBER	1	2	3	4	5	6	7
15 Vaccine not available 16 Mother too busy 17 Family plroblem, including illness of mother 18 Child ill - not brought 19 Child ill, brought but not given immunisation 20 Long waiting time 21 Religion 22 Other (Specify)							
24. Has your child had the follcwing during the last two weeks? (Read cut the illnesses. More than one answer allowed) 1 Cough 2 Difficult breathing/dyspnoea (kunetsekana pakufema/kuzarirwa/kufemera pamusoro) 3 Runny nose 4 None of the above							

CHILD NUMBER	1	2	3	4	5	6	7
25. What did you do during the above illness? (Do not Prompt. More than one answer allowed) 1 Child had none of the above symptoms 2 Took child to Health Facility 3 Took child to Private Doctor 4 Took child to Traditional Healer 5 Took child to Village Health/Community Worker 6 Took child to relatives (Specify)..... 7 Did not take any action 8 Treated child at home 9 Other (Specify).....							

CHILD NUMBER	1	2	3	4	5	6	7[8]
26. What are the signs and symptoms of respiratory infection that would cause you to take your child to a health facility? (Do not prompt. More than one answer allowed). (Ndezvipi zviratidzo zvinoita kuti muende nemwana wenyu kuchipatara kana aine dziwa/chipfuva kana kuti chikosoro?) 1 Fast or difficult breathing 2 Chest in-drawing 3 Loss of appetite 4 Fever/hot body 5 Cough 6 Other (Specify).....							
27. There are various ways/methods that a couple can use to avoid or delay pregnancy. Which ways have you heard about? 1 Pill 2 Condom 3 Injection 4 Diaphragm 5 Female sterilisation 6 Male sterilisation 7 Foam/Jelly 8 Withdrawal 9 None 10 Traditional 11 Other (Specify).....							

CHILD NUMBER	1	2	3	4	5	6	7 [9]
28. Have you ever used any method to delay/avoid pregnancy? 1 Yes 2 No							
29. If Yes, which FP method(s) have you ever used? (More than one answer possible) 1 Pill 2 Condom 3 Injection 4 Diaphragm 5 Female sterilisation 6 Male sterilisation 7 Foam/Jelly 8 Withdrawal 9 None 10 Traditional 11 Other (Specify).....							
30. Do you want to have another child in the next two years? 1 Yes 2 No 3 Don't know							

CHILD NUMBER	1	2	3	4	5	6	7[10]
31. If you are not pregnant, which FP method are you using now? 1 Pill 2 Condom 3 Injection 4 Diaphragm 5 Female sterilisation 6 Male sterilisation 7 Foam/Jelly 8 Withdrawal 9 None 10 Traditional 11 Other (Specify).....							
32. If you are not using any method, explain why. 1 Currently pregnant 2 Index child is still young 3 Not sexually active 4 Husband against contraception 5 Has menopaused 6 Other (Specify).....							

CHILD NUMBER	1	2	3	4	5	6	7 [11]
33. If you are using any modern FP method, what is your regular source? 1 Ministry of Health / Clinic 2 Mission Hospital 3 Outreach 4 CBD 5 Other (Specify) ..... 6 Not applicable (ie not using a modern method)							
34. Have you ever heard of a "Community Based Distributor"/CBD? 1 Yes 2 No							
35. If Yes, name <u>one</u> task which the CBD does. 1 Distribute pills/FP commodities 2 Educate communities on FP 3 Educate and distribute FP methods 4 Other (Specify)..... 5 Not applicable (Never heard of a CBD)							

CHILD NUMBER	1	2	3	4	5	6	7 [12]
36. Have you ever been visited by a CBD? 1 Yes 2 No							
37. Is there a Village Community Worker in your area? 1 Yes 2 No							
38. Name <u>one</u> task which VCWs do in the communities they work in? 1 Health educate communities 2 Teach home hygiene 3 Treat minor ailments 4 Don't know 5 Other (Specify).....							
39. Have you ever been visited by a VCW? 1 Yes 2 No							
40. Did she/he teach you anything? 1 Yes 2 No 3 Not applicable (has never been visited)							

CHILD NUMBER	1	2	3	4	5	6	7 [13]
41. If Yes, what were you taught? 1 Home hygiene 2 Building of blair toilets 3 Protection of water sources 4 Other (Specify)..... ..... 5 Not applicable							
42. Was her teaching beneficial to you or your family? 1 Yes 2 No							
43. Explain your answer. (Sei madaro?) 1 Helped to prevent diseases in the home 2 Benefitted from the health education 3 Other (Specify)..... ..... 4 Not applicable (ie not beneficial)							

END OF PROJECT EVALUATION OF THE WORLD-VISION ZIMBABWE CHILD SURVIVAL PROJECT IN MREWA DISTRICT, MASHONALAND EAST PROVINCE.
AUGUST - SEPTEMBER 1991.

QUESTIONNAIRE B - GROWTH MONITORING

FILL IN 50 QUESTIONNAIRES PER CLUSTER

HOUSEHOLD LEVEL QUESTIONNAIRE TO BE ADMINISTERED TO MOTHERS WITH CHILDREN AGED 0 - 59 MONTHS ie UNDER FIVES.

IDENTIFICATION.

CLUSTER NUMBER:_ _

NAME OF WARD:.....

NAME OF VILLAGE:.....

DATE OF INTERVIEW (DD/MM/1991):_ _ / _ _/1991.

FULL NAME OF RESPONDENT:.....

FULL NAME OF HEAD OF HOUSEHOLD:.....

Name Of Interviewer:.....

Designation Of Interviewer:.....

Signature of Team Leader:.....

SECTION 1.

QUESTIONS ON GROWTH MONITORING.

SECTION 1.

QUESTIONS PERTAINING TO CHILDREN 0 - 59 months ie under fives.

Please fill in the table below for each mother of children aged under 5 years ie 0 - 59 months.

Components	Child Number						
	1	2	3	4	5	6	7
1. Date of birth (DD/MM/YY)							
2. Sex of child 1 Male 2 Female							
3. Does the child have a child health card? 1 Yes 2 Had one, but lost it 3 has one, but kept elsewhere 4 Never had one 5. Other (Specify)							
4. Birth weight (Record from card) _ ._ Record birth weight 0 No card 9 Not recorded							
5. Number of weight points in the first year (0-1)							

Components	Child Number 1	2	3	4	5	6	7
6. Number of weight points in the second year (1-2)							
7. Number of weight points in the third year (2-3)							
8. Number of weight points in the fourth year (3-4)							
9. Number of weight points in the fifth year (4-5)							
10. Age, in months, at last weight point (Record the age on the left of the weight point)							
11. Position of last weight point: 1 Above the third centile 2 Below third centile 3 On the third centile 4 Child has no CHC							
12. How are you feeding your child at the moment? (Muri kumupei mwana chekudya?) 1 Breast feeding only 2 Breast feeding & semi-solids 3 Solids only 4 Other (Specify)							

Components	Child Number 1	2	3	4	5	6	7
13. If not breast feeding at the moment, was the child ever breast fed? 1 Yes 2 No 3 Child still breast feeding							
14. How old, in months, was this child when you stopped breast feeding altogether? __ Write months 0 – Still breast feeding 99 Never breast fed 999 Don't know							
15. If the child was never breast fed, explain why? 1 Child was breast fed 2 Child still breast feeding 3 Mother was ill 4 Mother died at birth 4 Don't know 5 Other (Specify)							
16. Did you ever bottle feed this child? 1 Yes 2 No 3 Don't know							

Components	Child Number 1	2	3	4	5	6	7
17. What milk other than breast milk are you giving your child at the moment? 1 None 2 Fresh cows milk 3 Infant formula 4 Other (Specify)							
18. After delivery of the youngest child, when did you breast feed for the first time? 1 Immediately after birth 2 During the first three hours after delivery 3 Between 4 -7 hours after delivery 4 Between 8 - 24 hours after 5 More than 24 hours after delivery 6 Cannot remeber 7 Other (Specify)							
19. How old was the child when you started weaning (ie introducing other foods in addition to breast milk?) _ Write months 0 Has not started giving child any other foods 9 Don't know							

Components	Child Number 1	2	3	4	5	6	7
20. Are you giving the child any fruit juices? 1 Yes 2 No 3 Don't know 4 Other (Specify)							
21. What was the first food you gave to the child? 1 Thin mealie meal porridge 2 Thin porridge with peanut butter 3 Thin porridge with margarine 4 Processed cereal (eg Cerelac, Pronutro) 5 Fruit juice 6 Bananas 7 Other (Specify)							
22. What did you give your child to eat yesterday morning?							
23. What did you give your child to eat yesterday mid-morning?							
24. What did you give your child to eat for yesterday's lunch?							
25. What did you give your child to eat yesterday mid-afternoon?							

Components	Child Number 1	2	3	4	5	6	7
26. What did you give your child to eat for yesterday's supper?							
27. Do you add any oil/margarine to your child's food? 1 Yes 2 Sometimes (When available) 3 No 4 Child still on breast milk only 5 Other (Specify)							
28. How many times per day does your child have solid/semi solid food? 99 Still on breast milk only							
29. Has the youngest child had diarrhoea in the last 2 weeks? (Mwana akambochaya mumasvondo maviri apfuura here?) 1 Yes 2 No 3 Don't know 4 Other (Specify)							
30. The last time your youngest child had diarrhoea what did you do? 1 Gave SSS 2 Did not take any action 3 Other (Specify)							

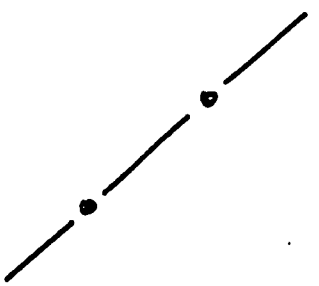
Components	Child Number 1	2	3	4	5	6	7
31. What special action would you take if your child had diarrhoea for 3 or more days? (DO NOT PROMPT) 1 Take child to Health Facility 2 Give the child more fluids than usual 3 Give the child smaller but more frequent feeds 4 Does not give any fluids 5 Does not give any food 6 Take child to traditional healer 7 Other (Specify) ..... 8 Don't know							
32. Where would you seek advice if your child had diarrhoea for 3 or more days? 1 Health Facility 2 Private Doctor 3 Village/Community Health Worker 4 Traditional Healer 5 Traditional Midwife 6 Relative/friends 7 Other (Specify)							

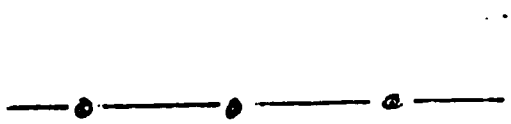
Components	Child Number 1	2	3	4	5	6	7
33. The last time your youngest child had diarrhoea, did you breast feed (Read out the answers to mother): 1 More than usual 2 Same as usual 3 Less than usual 4 Stopped breast feeding completely 5 Not applicable (child was already off the breast) 6 Other (Specify)							
34. The last time your youngest child had diarrhoea, did you give the child fluids (Read out the answers to mother): 1 More than usual 2 Same as usual 3 Less than usual 4 Stopped giving fluids completely 5 Breast fed only 6 Other (Specify)							
35. The last time your youngest child had diarrhoea, did you give the child solid/semi solid foods (Read out the answers to mother): 1 More than usual 2 Same as usual 3 Less than usual 4 Stopped giving solids completely 5 Child is still breast feeding only 6 Other (Specify)							

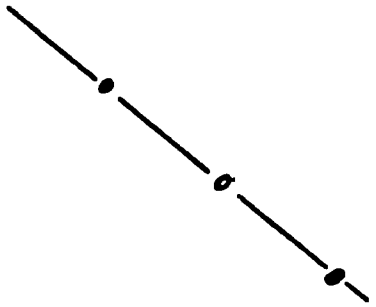
Components	Child Number 1	2	3	4	5	6	7
36. After the last diarrhoeal episode, did you breast feed the child (Read out the answers to mother): 1 More than usual 2 Same as usual 3 Less than usual 4 Stopped breast feeding completely 5 Child was already off the breast 6 Other (Specify)							
37. After the last diarrhoeal episode, did you give the child solid/semi solid food (Read out the answers to mother): 1 More than usual 2 Same as usual 3 Less than usual 4 Child still on breast milk only 5 Introduced semi-solid food 6 Other (Specify)							
38. Have you heard about Salt and sugar solution? 1 Yes 2 No							

Components	Child Number 1	2	3	4	5	6	7
39. How much water do you use to prepare SSS? (DO NOT PROMPT) 1 750 mls 2 One Mazoe bottleful 3 One cooking oil bottleful 4 One large cocacola bottleful 5 Don't know 6 Other (Specify)							
40. How much salt do you need to prepare SSS? (DO NOT PROMPT) 1 1/2 a teaspoon 2 1/2 a levelled teaspoon 3 1/4 teaspoon 4 Don't know 5 Other (Specify)							
41. How much sugar do you use to prepare SSS? (DO NOT PROMPT) 1 6 levelled teaspoons 2 6 teaspoons 3 Don't know 4 Other (Specify)							

Components	Child Number 1	2	3	4	5	6	7
42. How often should the SSS be given to a child with diarrhoea? (DO NOT PROMPT) 1 3 times a day 2 As often as the child will drink 3 With each loose bowel movement 4 Once per day 5 Don't know 6 Other (Specify)							
43. What signs/symptoms would cause you to seek advice or treatment if your child has diarrhoea? (It is possible to have more than one answer) (Ngatitii mwana aita manyoka, mungazotsvaka rubatsiro maonei kana kuti zvaita sei) (DO NOT PROMPT) 1 Vomiting 2 Fever/hot body 3 Dry mouth 4 Sunken eyes 5 Decreased urine output 6 Diarrhoes lasting 3 or more days 7 Blood in stool 8 Dark urine 9 Loss of appetite 10 Weakness/tiredness 11 Don't know 12 Other (Specify)							

Components	Child Number 1	2	3	4	5	6	7
44. Which of the SSS ingredients are sometimes difficult to get? 1 Sugar 2 Salt 3 Water 4 750 mls bottle 5 Teaspoon 6 None							
45. Why should SSS be given to children with diarrhoea? 1 Stops diarrhoea 2 Prevents/cures dehydration 3 Don't know 4 Other (Specify).....							
46. What does a growth curve like this mean? (SHOW MOTHER GROWTH CURVE ON CHC)  1 Means child is growing well 2 Means child is not ill 3 Other (Specify)							

Components	Child Number 1	2	3	4	5	6	7
47. What does a growth curve like this mean? (SHOW MOTHER GROWTH CURVE ON CHC)  1 Means child is not growing well 2 Means child is ill 3 Child is not gaining weight 4 Other (Specify)							
48. What causes the growth curve in Question 47? 1 Child not getting enough to eat 2 Child is ill 3 Other (Specify)							

Components	Child Number 1	2	3	4	5	6	7
49. What does a growth curve like this mean? (SHOW MOTHER GROWTH CURVE ON CHC)  1 Means child is not growing 2 Means child is ill 3 Means child is loosing weight 4 Other (Specify)							
50. What causes the growth curve in Question 49? 1 Child not getting enough to eat 2 Child is ill 3 Other (Specify)							
51. Do you think the Child Health Card is useful? 1 Yes 2 No 3 Don't know							
52 Today's weight (Kgs)							
53. Today's height (Cms)							