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**I L E U U T I**

**World Vision Relief & Development, Inc.**

**WVRD/Zimbabwe  
Final Evaluation Report  
SHAMVA CHILD SURVIVAL PROJECT  
Zimbabwe  
31 December 1995**

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory <b>Infections</b>
ANC	Ante-natal care
CBD	<b>Community</b> Based Distributors
CDD	Control of <b>Diarrhoea</b> Diseases
<b>CHS</b>	<b>Community</b> Health Sister
CIDA	<b>Canadian International Development Agency</b>
CMED	<b>Central Mechanical and Engineering Department.</b>
CSP	Child Survival Project
DDC	District Development Committee
DPI	<b>Detailed</b> Implementation Plan
DEHO	District Environmental Health Officer
DMO	District Medical Officer
DNO	<b>District Nursing Officer</b>
DPT	<b>Diphtheria/Pertussis/Tetanus</b>
EHT	Environmental Health Technician
EOP	End of Project.
EPI	<b>Expanded Program on Immunization</b>
<b>FHW</b>	Farm Health Worker
FHS	Farm Health Scheme
FP	Family Planning
HIS	Health <b>Information</b> System
HIV	<b>Human Immuno-deficiency Virus</b>
IEC	<b>Information, Education and Communicati on.</b>
IGA	<b>Income-generating</b> Activity
<b>KPC</b>	Knowledge, Practice and Coverage
MOH-CW	Ministry of Health and Child Welfare.
<b>NGO</b>	<b>Non-Governmental</b> Organization.
PHC	<b>Primary</b> Health Care
PMD	Provincial Medical Director
PNC	<b>Postnatal Care</b>
RDC	<b>Rural District Council</b>
RHC	Rural Health Center
<b>SCN</b>	State <b>Certified</b> Nurse
<b>SFPP</b>	Supplementary Food Production Program
SSS	Salt and Sugar Solution
TM	Traditional Midwife
TOT	Training of Trainers
<b>TT</b>	<b>Tetanus</b> Toxoid
<b>USAID</b>	United States Agency for International Development
VCW	Village Community Worker
<b>VIDCO</b>	Village Development Committee
<b>WADCO</b>	Ward Development Committees
<b>WCBA</b>	Women of Childbearing Age
<b>WVZ</b>	World Vision Zimbabwe

## I. BACKGROUND AND INTRODUCTION

### A. Background

From 1 October 1991 to 30 September 1995, World Vision Zimbabwe (WVZ) implemented the Shamva Child Survival Project in Shamva district, Zimbabwe. The project was funded by the United States Agency for International Development (**USAID**) Bureau for Food and Humanitarian Assistance, Office of Private Voluntary Assistance, through a PVO Child Survival Grant to World Vision Relief and Development, Inc. (WVRD). The total amount of the grant was \$652,922, of which roughly 45 percent was a match **from** WVRD. Initially, the project was intended to run for three years; but a 'no-cost' extension was received for the fourth and final year.

The goal of the project was to “strengthen and support government efforts to improve the health of children under five years and women of child bearing age” (DIP, p. 7). It was to be integrated into the existing health care system in the district under the direction of the Provincial Medical Director (**PMD**) and the District Health Executive (**DHE**) - composed of the District Medical **Officer**, District Nursing Officer @NO), District Environmental Health Officer, Pharmacist, and District Health Services Administrator. During the lifetime of the project, only the DNO was in place among the members of the DHE, with the other functions being undertaken under the guidance of junior staff

In 1995, the district had a total estimated population of 100,407 inhabitants, including subsistence farmers living in communal lands and resettlement areas, workers on commercial farms, and mine workers. The health care system included three MOH-CW Rural Health Centers (**RHCs**), two rural hospitals, three Rural District Council (RDC) clinics, two school clinics, and two mine clinics.

The project staff originally included a Harare-based project manager, plus a field team of Area Health Co-ordinator (AHC), Project Co-ordinator, two State **Certified Nurses (SCNs)** seconded by the MOH-CW, two Nurse Aides, a secretary, and two drivers, one of whom was seconded by the MOH-CW. Over the course of the project, the AHC was withdrawn from the project, the two seconded **SCNs** were replaced by WVZ **SCNs**, the MOH-CW driver was removed. At the end of the third year, the Project Co-ordinator **left** the project to continue her studies. For the final year of the project, the co-ordination of the project was largely done through the Project Co-ordinator counterpart in the MOH-CW, the Community Nursing Sister.

The key activities of the project included intensive technical training for MOH-CW and community-based health workers, supervision of facility-based staff, social mobilization and health education of mothers and communities, training of community leaders, support for **IGAs** and community self-help projects (e.g. preschool construction, nutrition gardens, latrine construction, etc.), and monthly outreach to 33 points for the provision of

immunizations, growth monitoring, distribution of **family** planning supplies, and health education on nutrition, CDD, ARI, hygiene and sanitation, family planning, and HIV/AIDS.

## **B. Evaluation team and process**

In accordance with USAID requirements, a final evaluation of the project was conducted from August 10 to 19, 1995 (a final KPC survey was also conducted from July 5 to **19, 1995**, under the direction of the PMD). Members of the evaluation team were as follows:

M. Lenneye . . . Consultant, Ziken International, **Harare**, (Team Leader and Editor)  
L. Donzwa . . . . MCH Officer, World Health Organization, Harare  
M. Netsa . . . . . Principal EHO, MOH-CW, Guruve District, Mash. Central.  
L. Mudekunya . . Senior Program **Officer**, Save the Children Fund UK, Shamva  
S. Mushapaidze . Associate Director, World Vision Zimbabwe, **Harare**  
T. Ventimiglia . . International Programs Officer, WVRD, Washington D.C.

Evaluation team members reviewed key project documents: proposal, DIP, baseline, midterm, and final KPC survey reports, mid-term evaluation report, annual reports, and FY95 quarterly reports (See Appendix 1). For field work, the team was divided into three groups of two to review the following areas:

Group 1: Communal areas, Health Centers, and Rural District Council.

Group 2: Commercial Farms, DHE, project staff, District Administrator, mines and urban areas.

Group 3: WVZ headquarters **staff**, provincial level staff, and resettlement areas.

All three groups conducted interviews with key individuals,,facilitated focus group discussions with community members, and observed the outreach team at work (See Appendix 2).

Field work was conducted **from** August 14- 17. Two days were spent synthesizing the findings and report writing. On August 19, the team debriefed-with WVZ senior **staff**, including the project manager, field operations manager, human resource manager, and finance manager/acting national director. The debriefing consisted of a presentation and discussions of main achievements, lessons learnt, and sustainability issues.

On 12 September 1995, a feedback session was held with members of Mashonaland Provincial Health Executive and Shamva District Health Executive, and the following were in attendance:

Munochiveyi, R. . . . . PMD, Mash Central, MOH-CW  
Moshi, E. . . . . . . . . . . MOH, Mash Central, MOH-CW  
Chirimumimba, G. . . . . MOH, Mash Central, MOH-CW  
Gandah, R. . . . . . . . . . . DNO Shamva District, Mash Central, MOH-CW  
Gandah, R. . . . . . . . . . . DNO Shamva District, Mash Central, MOH-CW  
Mufunani, J . . . . . . . . . . Shamva District, Mash Central, MOH-CW

Chando, E. . . . . Shamva District, Mash Central, MOH-CW  
 Dhlembeu, E. . . . . WVZ  
 Mbundure, A. . . . . **WVZ**  
 Ndlovu, T. . . . . **WVZ**  
**Donzwa**, L. . . . . consultant  
 Lenneye, M. . . . . Consultant  
 Mudekunye, L. . . . . consultant

At this meeting, the MOH-CW personnel were briefed on the evaluation, and discussions were held on strategies that could be implemented in the context of ensuring a sustainability of activities after the WVZ project is over.

## **II. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED**

### **A. Project Accomplishments**

#### **1. Objectives**

##### **The project has succeeded in:**

- Facilitation of technical training for virtually all MOH-CW staff at the rural hospitals, health centers, and health clinics in the district, as well as 111 Village Community Workers (**VHWs**), 44 Farm Health Workers (**FHWs**), over 650 traditional midwives (**TMs**), seven Community Based Distributors (Family Planning), ten Environmental Health Technicians (**EHTs**), Viage and Ward Development Committee (**VIDCO** and **WADCO**) members, and hundreds of community leaders, including traditional healers, council members, chiefs, teachers, extensions workers, and church leaders. Training and refresher training was conducted in all of the technical intervention areas on which the project was focused: EPI, CDD, nutrition, ARI, safe motherhood, HIV/AIDS and STDS, and family planning
- Maintenance of immunization coverage within Shamva district. The project supported the **MOH's** EPI outreach program, initially targeting 16 “points”, and increasing the number gradually to the current 33. Average monthly attendance at these outreach sessions increased **from** 598 in 1992 to 749 in 1993 and 872 in 1995. Although EPI coverage was not increased (according to data **from** the surveys and route information systems), all partners to the program agreed that the project’s contribution to EPI coverage was important and that the situation would have been much worse without the input of the project.
- Provision of community health education through workshops, ongoing outreach sessions, and a variety of special campaigns: male motivation campaigns, farm and school based campaigns, home-based AIDS care training, World Health Day and World AIDS Day events, etc. Topics covered the **full** range of technical interventions, and different target groups included women of child-bearing age (WCBA), adult males, teenage girls and boys,

and school children as well as the community at large in farming, communal, and resettlement areas (see Appendix 3).

- Supply of essential equipment (e.g. refrigerators, scales, vaccine carriers, etc.) for all of the district health training (TV and video, video camera, over-head projector, etc.) to the district.
- Construction of two waiting mothers' shelters (one still in progress) and one pre-school shelter.
- Development of a grassroots level health information system.
- Facilitating the involvement of many health staff within the province, e.g. in the surveys.
- Focusing the Shamva district health team more on specific areas with clear objectives and work plans.
- Development, in collaboration with the MOH, of a detailed training manual as a reference for trainers and trainers of trainers. The manual covers each of the technical interventions and is intended for use throughout the district.
- Design, production, and distribution of a poster on post-natal care; two others were in the process of being produced and pre-tested at the time of the evaluation.

The objectives of the project as given in the Detailed Implementation Plan (DIP) and the level of each indicator at baseline, mid-term, and end of project (EOP) are as listed in Table 1. In interpreting these results, the following points should be **noted**:

- Different methodologies and questionnaires were used in each of the three surveys; thus, for many of the indicators, the results are not strictly comparable.
- The results shown unless indicated otherwise, are estimates based on samples with precision of +/- 10% (confidence intervals are not shown).
- Some of the indicators set were not used or were difficult to measure (e.g. WCBA receiving education on hygiene).

A table summarizing the accomplishments is shown in the following table.

**TABLE 1  
PROJECT OBJECTIVES AND ACCOMPLISHMENTS**

<b>INTER-VENTION</b>	<b>END OF PROJECT TARGET</b>	<b>BASELINE 11/91</b>	<b>MIDTERM 8/93</b>	<b>FINAL 7/95</b>
<b>Immunization</b>	95% full coverage of children 0-11 months.	84%	79%	79%
	<b>90%</b> full coverage of children 12-59 months.	84%	N/A	N/A
	85% coverage of WCBA with TT2	63%	38%	60%
	95% of mothers know the age at which measles vaccine should be <b>administered</b>	80%	73%	67%
Control of Diarrhea Diseases	95% of <b>diarrheal</b> cases in children < 5 treated at home with SSS	83%	76%	85%
	85% of WCBA able to prepare and use SSS	49%	<b>N/A</b>	52%
	95% of WCBA receive education on hygiene and <b>sanitation</b>	N/A	<b>N/A</b>	N/A
	90% of households have toilets	75%	N/A	#
	95% of households have a safe water source	<b>86%</b>	<b>N/A</b>	<b>##</b>
Nutrition	80% of children < 2 weighed monthly	59%	92%	<b>N/A</b>
	Reduce <b>from</b> 14% to 7% the children < 5 below the third percentile (W/A)	14%	5%	5%
	90% of mothers breast-feed for 24 months	<b>N/A</b>	33% <b>(3/9)</b>	28.1%
	Reduce by 50% the children 0- 11 months. not receiving supplementary foods by 4 months	N/A	N/A	N/A
	Increase <b>from</b> 21% to 50% WCBA involved in the SPPP	21%	N/A	N/A

Maternal care	95% of mothers deliver at health facilities	68%	58%	60%
	60% of mothers attend at least one PNC session (post?)	43%	N/A	<b>N/A</b>
	85% of WCBA with children d years use <b>modern</b> contraceptive method	72%	77%	77%
Acute Respiratory <b>Infection</b>	70% of WCBA know signs and symptoms of ARI ( <b>fast/difficult</b> breathing)	65%	58%	55%
	80% of mothers seek medical care for children with moderate or severe ALRI	39%	85%	<b>63%</b>
	90% of mothers provide home care for <b>children</b> with mild <b>ALRI</b>	N/A	N/A	N/A
HIV/AIDS	80% of <b>WCBA know</b> 3 modes of HIV <b>transmission.</b>	66%	N/A	*
	100% of WCBA know there is no AIDS cure	84%	<b>N/A</b>	99.5%
	50% of couples <b>use</b> condoms	17%	<b>N/A</b>	21%
Training and Social Mobilization	95% of <b>RHC staff</b> trained to train communities	N/A	N/A	**
	All <b>VIDCOs</b> have health committees	0	<b>N/A</b>	<b>N/A</b>
	At least 10 people per VIDCO trained as community mobilizers	0		4,754
	95% of VCWs and FHWs trained in data collection and <b>reporting</b>	0		***

\* The Project Consultant (as PMD) and the Provincial Health Managers decided that the most important form of transmission is Sex, and the question **was** rephrased.

\*\* At least 226 health workers at the clinic level were trained in a number of health issues.

\*\*\* At least 180 persons were trained in data collections (no indication of how many were **VCWs/FHWs**).

**The main factors identified as having contributed negatively to the project are listed below:**

- Drought in 1992 and 1995.
- Population movement in and out of district.
- Frequent changes in key **staff**, combined with the use of under-qualified staff in some positions. MOH-CW staff who were manning the outreach were withdrawn and replaced with WVZ staff who were not acceptable to the province and who had serious personality conflicts with district staff resulting in the team operating independent of the district at a time when the management was supposed to have devolved from WV2 to the district.
- Lack of a WVZ project co-ordinator for the project's final 13 months. **MOH-CW** was not consulted about the removal of WVZ **staff** from the project and felt, at all levels, that this had been done without due consideration for the project and that the movements had been disruptive.
- Unavailability of one project vehicle to the district for extended periods of time. The second vehicle which was intended for supervision, critical to the project, **was** withdrawn **from** Shamva over a year ago and has only been available intermittently since then. The reasons for this are not quite clear.
- Short supply of essential medicines at district health facilities and the government stores.
- Lack of supervision at outreach points to ensure high quality of services.
- Lack of attention to the design of outreach (use of time, use of space, use of staff). The outreach team was not community oriented, and only did immunization and health education at the out-reach points only.
- Lack of effective communication between the outreach team and VCWs especially on health and development issues at outreach points. The VCWs were made to understand that the outreach team is only for immunization and growth monitoring, and not for other community-based health programs.
- Absence from outreach of several key services, including provision of TT for women, **ANC** for pregnant women, and medicines for treatment of minor illnesses (meaning community members still had to travel to clinics for these services)
- Separation of health education from services (growth monitoring without counselling, immunization without information, etc.). Furthermore, there was no linkage between what was taught at the local reality, e.g. nutrition education and food available at the

household level. Health Education methods used were limited to the lecture methods, and use of Visual Aids and other techniques was lacking - health workers were not trained in the use of participatory health education techniques.

- Lack of willingness to participate and/or contribute on the part of peri-urban populations.
- Poor communication between WVZ and the MOH-CW, and between Shamva and Harare.
- Inadequate supervision and incentives for **VCWs**. For the project, it did not **fulfil** promises on spare parts for bicycles used by **VCWs**.
- Lack of clearly **defined**, and limited set of educational messages.
- Lack of systems for monitoring training quality and impact; and too many topics may have been covered in too short a time to ensure adequate mastery of the subject. In addition, there was no feedback mechanism to the **VCWs**, community leaders and the community.
- Administrative delays resulting in the completion of only one of three planned waiting mothers' shelters, with one other in still progress, the late purchase (June 1995) of **ANC** equipment for use at out-reach, and the late initiation of environmental sanitation activities (July 1995).
- Absence of key MOH-CW district **staff** (**DMO**, **DEHO**, pharmacist, etc.) to support management.
- Lack of **funds** to support regular meetings of the District Health Team.
- No feedback to and use of data at the level of collection.
- In promoting Income Generating Activities and other community actions, technical support from other sectors was not sought, especially the expertise of Agritex, and collaboration with other Non Governmental Organization. RHC nurses were divorced from community-based health activities, and only the EHT was **left** to do the community work - and without incentives from the project. On the whole, supportive visits to the community and projects by RHCs and District Staff was lacking.
- Other problems that resulted from the **WVZ** management of the project being in Harare and the poor communication between the program partners are:
  - all **WVZ staff** commuted to Shamva from Harare for over a year, causing frequent delays to the outreach programs.

- training activities have been delayed because of undue delays in the release of funds **from** WVZ in Harare which has demoralized the district team.

- issues pertaining to procurement of supplies and equipment were not discussed between the partners resulting in distrust and frustration.

- transfer of funds between budget lines was done by WVZ without due consultation with MOH-CW staff in the Province or in Shamva district.

- o **The** partners have not discussed the close-down of the project and neither side has a clear view of how this will happen.
- o Although the project had a full time book-keeper, the accounts are two months behind and it was difficult to extract relevant **financial** information. Computerization of the accounts was not done although computers are available in WVZ.

## **2. Unintended Effects**

### *Positive Effects*

- o PNC poster distributed to other districts in the province.
- o The community-based information system on nutrition status provided by the project enabled the District Administration to identify areas of high malnutrition and thus target the supplemental feeding program during the drought.

### *Negative Effects*

- o The MOH-CW staff essentially stopped doing outreach work, leaving it to the WV team in the 33 points which the project staff covered.
- o Differences in allowances given to WV and MOH-CW staff caused friction.

## **3. Final Evaluation.**

The final evaluation was conducted in July 1995, and the report is attached. Because of differences in methodology, in particular sampling and indicators used during the three surveys (baseline, mid-term, and final), it is not possible to carry out a comparative analysis (see Appendix 4). Nevertheless, figures from the Provincial Medical Director's Annual report for 1992-94 have been reviewed (see the following Table). A comparison of indicators for Shamva District and Provincial aggregates shows that the district has done reasonably well during the life of this project.

**Comparison of Shamva and Provincial averages, 1992-94**

<b>Indicator</b>	<b>Shamva.</b>	<b>Province.</b>
Farm Health Workers (1194)	46	235
VIPs completed ( 1994)	717	6327
Shallow Wells <b>protected</b> (1994)	16	473
Under-fives below 3rd. <b>centile</b> (1992)	11%	14%
Under-fives below 3rd. <b>centile</b> (1994)	7%	10%
Measles <b>immunization</b> ( 1992)	83%	73%
Measles immunization ( 1994)	71%	82%
BCG (1992)	82%	89%
BCG (1994)	94%	96%

An extensive program of VIPs construction and shallow wells protection is under way in three out of five districts in the province (Guruve, Mt. Darwin, and Rushinga) where the Integrated Rural Water Supply and Sanitation program is being implemented. Shamva district has not been selected for the implementation of this project.

**B. Project Expenditures - Pipeline analysis and budget comparisons**

In reviewing the attached pipeline analysis (See Appendix 5), the transfer of funds between various budget items during the implementation period has been noted. During project implementation, changes were made to the original DIP budget, and revised one prepared. From the pipeline analysis given to the **evaluation** team, there is information on how these funds were moved around; although these transfers do not produce a balanced budget between various items.

Salary costs were adjusted downwards because there were long periods when the project operated without the required **staff from WVI**. The budget for evaluation and consultancies was combined and used as one. Savings were made primarily from the evaluations, and these savings were transferred to the purchase of assets (**fridges** and other equipment for clinics, construction of Waiting Mother's shelters, etc.).

The evaluation team has been informed that the balance of just over \$50 000 in July 1995 will be used to pay for the final evaluation, to complete the building of waiting mothers' shelters, and to

repair assets so that they are handed over to Shamva District in working order.

### C. Lessons Learned

- In a project where an **NGO's** primary aim is strengthening local capacity, the absence of training in management, team building, training facilitation, etc. targeted at management levels can adversely affect the attainment of project goals. In such a program, more might be achieved if the project becomes less involved in the implementation of activities (service provision); and instead concentrate on supervision and training.
- A key activity for promoting sustainability is the development of a plan for phasing over responsibilities.
- Partnerships between government and NGOs at district level require good communication and management. If the roles of project partners, the consultant etc. are clarified at the outset, and regular management and review meetings stipulated in the DIP, the smooth project implementation might be achieved.
- The project consultant (if one is required) should not be a member of either of the partner organizations. Having the acting DMO, PMD and project consultant all in the same person can undermine objectivity in project reviews. There were instances where an independent consultant might have been able to intervene between the two partners and bring about dialogue and agreement on issues pertaining to the project - to the overall benefit of the project **beneficiaries**.
- For more effective interventions, agreements between partners about construction of buildings e.g. waiting mothers shelters should include agreement about who will provide furniture and equipment for these buildings.
- Flexibility in the use of donor funds is desirable so that the project can respond to needs as these emerge e.g. the drought and the cholera outbreak in Shamva were the most important child survival issues at that time, but they could not have been foreseen when the project was designed.
- Lack of transparency on the part of either partners can lead to mistrust and non-achievement of some project objectives and goals. Open dialogue on the use of resources, once established, can lead to the achievement of higher goals.
- Promotion of control of diarrhoeal diseases without assisting the communities in putting up the necessary water supply and sanitation facilities is a rather limited way of addressing Child Survival Interventions.
- The community should be involved in every stage of the program, from the needs assessment

to implementation. The community might then be able to contribute in the financing of certain programs e.g. nutrition projects and sanitation projects.

- o The duration of the project was very short, and a project of this magnitude and importance might require a longer implementation period. At the time people's expectations and understanding was beginning to rise, they are told that the project is coming to an end - some projects were just starting e.g. the sanitation and waiting mothers shelter.

### **III PROJECT SUSTAINABILITY**

#### **A. Community Participation**

The community has contributed the following resources. bricks and labor for the construction of a pre-school, materials (bricks, stones, sand) for the construction of one of the two waiting mothers' shelters, and labor (digging pits) for the construction of latrines. Certain community members contributed significant amounts of time as **VCWs**, **FHWs**, **TMs**, etc. Mothers contributed their time attending outreach sessions. Many mothers sewed baskets in which they weigh their child. It is Government policy that those community members earning **Z\$400** or more must pay for health services and medicines, though this does not apply to the majority of community members in the district. For a period during the project, this policy was changed and all community members were paying a fee for service as well as purchasing medicines, contraceptive supplies, etc.

This level of community contribution is not sufficient to support the key recurrent costs of the project-training costs, outreach transport, repairs, salaries. Certain communities expressed their willingness to pay for services provided they are available. There is some support for reinstating cost-recovery efforts, and the belief is that this will be unavoidable in the near future. In the past, funds raised through cost-recovery have gone to the government treasury rather than staying with the MOH-CW, however, so in order to be effective a system would have to be put in place whereby funds raised would remain with the MOH-CW.

The sustainability of village-level workers is growing more and more questionable. Changes in selection criteria established by the Ministry of National **Affairs** and Employment Creation have led to the recruitment of younger, less established individuals. They are multi-sectoral (health, education, income generating activities) and essentially full-time workers, but they are poorly compensated (less than US\$ 10 per month). As a result of these two factors, in many cases the level of commitment of these workers is waning. The Ministry of National Affairs and Employment Creation in the district, which is responsible for supporting these workers, doubts that allowances will be increased. Because of resource constraints facing this ministry, the number of VCWs in the district was reduced in July 1995 from 111 to 91.

It is conceivable that because the communities' level of education of and demand for health services has been raised, they will put pressure on local authorities to continue providing services. It is also conceivable, though, that they will simply return to walking long distances to clinics.

## **B. Ability and Willingness of Counterpart Institutions to Sustain Activities**

The key institutions to take responsibility for providing the necessary financial, human and material resources to sustain project activities-primarily out-reach and training-in this district after Child Survival funding ends are the MOH-CW, Rural District Council, and FHS. All of these institutions support these activities and would **like** to have them sustained. None appear to have the resources needed to sustain them at current levels, however.

The five project outreach points in the farming areas will in all likelihood be reassigned to the FHS, which is already supervising the FHWs and providing community mobilization to these five farms. With outside resources (among them CIDA and Save the Children Fund UK), the FHS will probably be able to continue conducting outreach and initial training for health workers. The WV project was supporting refresher training, for which the FHS will have to look for additional funds.

The MOH-CW at the district level has expressed its commitment to maintaining the remaining outreach points. In terms of **staffing**, they should be in a position to do this, having increased the number of SCNs in the district from 50 at the beginning of the project to 103 currently, with no increase in the number of facilities. The project has provided sufficient cold chain growth monitoring, ANC, and other equipment to ensure the continuation of activities. However, the MOH-CW budget for **FY95/96** has been reduced in real terms, and it does not seem likely that they have the financial resources needed to sustain such activities as training and outreach at the current levels.

Presumably, training will not need to continue at current levels, given the extraordinary amount that was conducted during the project and the complete coverage in the district with this training. In order to sustain the benefits of the outreach sessions, if not current levels of activity, some creative modifications in the program will have to be made. The MOH-CW has suggested conducting two or three outreach sessions a day where only one is done now. This would likely require additional **staff**, however, as well as increased supervision and a restructuring the sessions so as to make better use of time. Other possible solutions include combining two or more current outreach points into one, conducting outreach less frequently than once per month for each point, spending nights at or near outreach points instead of returning to the hospital at the end of each day, and conducting **annual** or biannual campaigns in more remote areas.

**Rural district council** : Very much willing but lack resources. The revenue base is very low. There is need to allow RDCs retain a larger portion of the revenue they generate and send a smaller part only to central governmental.

To sustain the outreach activities the second vehicle should be repaired as a matter of urgency and returned to the project for its intended purpose. The experience of Save the Children Fund (UK) in working with the Farm Health Scheme has been that the rural councils in four districts of Mashonaland Central have run outreach services to the commercial farms in collaboration with the MOH-CW. The outreach vehicles are owned by the RDCs and MOH-CW provides funds to

them for mileage. The experience with the Farm **Health** Scheme is that the outreach is much better maintained when the vehicles are controlled by the councils than when the vehicles are maintained by CMED. Thus, some vehicles have been retrieved **from CMED** by MOH-CW and handed over to the councils. The Shamva RC used funds of its own to purchase a second hand Land Rover for the FHS when the vehicle that was donated for outreach broke down. The capacity of the amalgamated RDCs is as yet untested but it is government policy to decentralize health to the RDCs.

Both vehicles could be handed over to the RDC with a clear agreement that they will be used for outreach activities in Shamva. The project house could also be handed over to the RDC to rent out with agreement that the rent accruing to the RDC **from** the house would be used to supplement the MOH-CW grant for mileage for the vehicles.

To sustain training initiatives in the district, training for key personnel in training methodologies should **be** arranged before the end of the project.

**Health Center:** Services at static facilities with continue to be offered, however the community based activities will crumble. The bicycles have not been put to good use.

**Other Government Departments:** These were under utilized and in some cases were not involved at although they were able and willing to participate. It is difficult to involve them now when there are no resources to enable them to participate. It is difficult to involve them now when there are no resources to enable them to participate more actively.

**The community:** It is able to sustain some of the activities ifinvolved from the very beginning. Some communities are willing to help in sustaining the project but have never been approached by project implementors to contribute in what ever way.

**C. Sustainability Plan, Objectives, Steps Taken, and Outcomes**

<b>Goal</b>	<b>End of Project Objectives</b>	<b>Steps Taken to date.</b>	<b>Outcomes</b>
1. CSP activities will be integrated into existing health system in the line with MOH-CW's <b>MCH/FP</b> programs.	(1) District health team to manage project.	Training courses held, and health education campaigns mounted in the <b>district</b> .	<ul style="list-style-type: none"> <li>- 226 health workers trained.</li> <li>- 2,700 <b>TMs</b> trained.</li> <li>- 3,300 <b>teenagers</b> reached with HIV/AIDS education.</li> <li>- 4,700 persons on commercial farms trained.</li> </ul>
	(2) MOH-C W will allocate resources throughmmal channels to support CSP activities.	Provision of equipment.	Functioning cold chain assured by supply of fiidges, and health centers and clinics equipped.
2. community Participation will be promotedinsupport of CSP activities.	<b>(1) Community self-help</b> projects will be promoted.	Communities mobilized to make contributions.	A Pre-school and two Waiting Mothers' shelters built.
	(2) organized groups will be encouraged to undertake <b>IGAs</b> .	Support of <b>IGAs</b> and their mea&a-strained.	Three <b>IGAs</b> <b>currently</b> functioning.
	(3) Increase <b>community</b> knowledge.	Training communities and their leaders for mobilization.	over 4,700 <b>community</b> leaders trained; increased attendance at EPI out-reach points.
3. cost-recovery activities will be <b>supported/implement</b> cd.	Sustainability of project activities assured.	Mobilizing government and community agencies.	Discussions initiated with Ministry of Health.

**Note:** Full details of training outputs are given in Appendix C

# Appendices

## Appendix A

## APPENDIX A

### KEY DOCUMENTS CONSULTED

Munochiveyi, R. (1995) “Shamva Child Survival Project WVI: Field Survey Fii Report”, Bindura.

PMD ( 1993) *Mashonaland Central Annual Report*, 1993 and 1992, Bindura.

PMD (1995) *Mashonaiand Central Annual Report*, 1993 and 1994, Bindura.

World Vision Relief & Development Inc. (1992) “DIP Shamva District Child Survival Project Zimbabwe”, Washington.

World Vision Zimbabwe (n.d.) “General guidelines for ward-level health workers trainers”, Harare.

\_\_\_\_ (1995) “Shamva child survival project audit report”, March 1995.

\_\_\_\_ (1993) “Mid-term evaluation Shamva Child Survival Project Zimbabwe”

## Appendix B

**APPENDIX B**  
**LIST OF EVALUATION INTERVIEWS**

**Team 1 (Netsa/Mushapaidze)**

Team Members: **Bakire**, Ms. SCN Chidembo.  
Musariri, Ms. SCN, Bushu.  
Zendera, Mr. RDC (Executive Officer).

Focus Group Discussions were held with the following:

Village Community Workers in Bushu  
Women at an Out-reach point for EPI at Madziwa and Chidembo  
Participants at **IGAs** (Piggery, Sewing, and Poultry)

**Team 2 (Donzwa/Ventimiglia)**

The evaluation included interviews with the project **staff** and with the following:

*District Health Executive*

Ms. R. T. Gandah, District Nursing Officer  
Ms. J. **Mufunani**, Community Nursing Sister/District Project Co-ordinator  
Ms. E. Chando, Shamva Hospital Clinical **Officer**  
Mr. N. Masvosva, Senior Environmental **Health** Technician/Acting DEHO

*Others*

Ms. E. N. Jones, District Administrator  
Ms. Chaza, Nurse In-Charge, Madziwa Mine Clinic  
Ms. Maregerere, Farm Health Scheme Supervisor  
Farm Manager, Bamboo Creek Farm  
**FHW**, Bamboo Creek Farm  
**FHW**, Ilton Farm  
Mr. Manyonga, Provincial Education Officer  
Mr. Nyamuziwha, District Education Officer  
Mr. C. T. Chimbindi, District Education Officer  
Mr. Makombe, District Head, Ministry of National Affairs  
Mr. Kagodora, Senior Clerk, Ministry of National Affairs

The outreach point near **Chidembo Clinic** was visited and observed. Focus **group** discussions with mothers at Bamboo Creek and Ilton farms were conducted.

**Team 3 (Mudekunye/Lenneiye).**

**WVZ:**

Mr A. Mbundure	Ass. Director, Finance & Acting Director
Mr E. Dhlembeu	Ass. Director, Field Ministries
<b>Mrs</b> S. Mushapaidze	Ass. Director, Technical Services
Mr, J. Thabethe	Ass. Director, HRD & Admin
Mr. T. Ndlovu	Project Manager
Mr R. Musunzwa	Internal Auditor
Mr Makanda	Head Driver

**MOH-CW:**

Dr R. Munochiveyi	PMD
Dr E. Moshi	<b>MOH-CW (MCH/FP)</b>
Mr Abureni	Provincial Health Education officer
Ms L Adams	Provincial Nutritionist

**Resettlement Area:**

Nurse Aide	Mupfhudzi Clinic
Mr Maveneke	Councillor, Mupfhudzi
Councillor,	Chidumbwe
v c w,	Chidumbwe
Group of mothers	Gato village, <b>Mupfurudzi</b>

## Appendix C

**APPENDIX C**  
**TRAINING ACTIVITIES 1992-95**

<b>Cadre trained</b>	<b>Activity</b>	<b>No. trained</b>	<b>Sub-totals</b>
Apostolic <b>faith</b> training	MCHPHC	350	350
Awareness campaigns in schools	<b>HIV/AIDS</b>	2,031	2,031
Builders training	<b>VIP construction</b>	18	18
Business Community	<b>MCH/PHC</b>	21	21
Commercial sex workers	HIV/AIDS	112	112
Community leaders	MCHPHC	289	
	MCWPHC	500	
	Cholera	418	
	MCWPHC	609	
	<b>MCH/PHC</b>	640	
	HBV Training	640	
	<b>MCH/PHC</b>	1,658	4,754
<b>Community</b> theater groups	Theater skills.	6	6
Community members	HIV/AIDS	800	800
Data collectors	HIS	180	180
Extension workers	MCHPHC	34	34

Farm health workers	FP	24	24
Farmingcommunity	<b>HIV/AIDS</b>	2,500	
	HIV/AIDS	1,359	
	MCHIPHC	800	4,659
Health workers	HIV/AIDS	45	
	Cholaa	75	
	IEC	23	
	Safe motherh~	46	
	TB management	37	226
	Income Generating Activities	Busness Man.	27
Male motivation campaigns	FP	2,500	2,500
Nutrition gardens (ccmmilies)	Nutrition	56	56
Secoudary schools	HIV/AIDS	7	7
Teenage boys and girls	HIV/AIDS	1,600	
	HIV/AIDS	1,750	3,350
Traditional Midwives (TMs)	Refresher	130	
	Initial	105	
	Initial	55	

	Retresher	560	
	<b>Initial/TMs</b>	500	
	<b>ARI/CDD</b>	1,340	2,690
	<b>MCH/PHC</b>	26	26
Trainers of trainers ( <b>Nurses/EHT</b> )	TOT	46	46
Water <b>sub-committees</b>	<b>MCH/PHC</b>	189	189
Women	FP	80	80