



International Consulting Services

## EVALUATION REPORT

Evaluation of the ECHO  
Operations in Zimbabwe  
(2002 – 2003)

### Sector Report: **Health and Nutrition**

(essential part of the overall evaluation  
on ECHO Operations in Zimbabwe)

prepared on behalf of the:

European Commission  
Humanitarian Aid Office (ECHO)

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### List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CDC	Centre for Disease Control
CHBC	Community Home Based Care
CSB	Corn Soya Blend
CTC	Community based Therapeutic Care
DAC	Development Assistance Committee
€	Euro
EC	European Commission
ECHO	European Commission Humanitarian Aid Office
EDF	European Development Fund
EMOP	Emergency Operation Plan
EPI	Expanded Programme of Immunization
EU	European Union
GAM	Global Acute Malnutrition
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HARP	Humanitarian Assistance and Recovery Programme
HBC	Home Based Care
HFA	Height For Age
HIV-AIDS	Human Immunodeficiency Virus – Acquired Immune Deficiency Syndrome
IDP	Internally Displaced People
INGO	International Non-Governmental Organisation
LFM	Logical Framework Matrix
LFA	Logical Framework Approach
LRRD	Linking Relief, Rehabilitation and Development
MBP	Maize-Beans-Peanut Butter
MGPP	Maize-Green Leafs-vegetables-Peas-Peanut Butter
MoE	Ministry of Education
MoH	Ministry of Health
MOHCW	Ministry of Health and Child Welfare

NatPharm	National Pharmacy
NGO	Non-Governmental Organisation
NRC	Nutritional Recovery Centre
PCN	Primary Care Nurses
PMTCT	Prevention of Mother To Child Transmission of HIV
PPTCT	Prevention of Parents To Child Transmission of HIV
RSO	Regional Support Office (here: ECHO's support structure in Nairobi)
RRU	Relief and Rehabilitation Unit
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute malnutrition
SFP	Supplementary feeding Programme of children under the age of 5
TFU	Therapeutic Feeding Unit
TFC	Therapeutic Feeding Centre
UN	United Nations
UNAIDS	United Nations AIDS technical support unit
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
US \$	US-Dollar
VAC	Vulnerability Assessment Committee
VCT	Voluntary Counselling and Testing
WFH	Weight For Height
VHW	Village Health Worker
WFP	World Food Programme
WHO	World Health Organisation
ZIM \$	Zimbabwe Dollar ( 5,100 ZIM \$ = 1 Euro, during the period of the evaluation)

## **1 Executive Summary**

### **A. The Evaluation**

**Evaluated Action:** ECHO funded Operations in Zimbabwe in the Period 2002 and 2003 under the subsequent decisions have been evaluated:  
ECHO/ZWE/210/2002/01000, ECHO/TPS/210/2002/16000,  
ECHO/ZWE/210/2003/01000 and ECHO/TPS210/2003/12000  
The value of nutrition and health component, Home Based Care projects included: out of € 38.3 Mio. of total financial value of ECHO support, so far € 19.1 Mio. (or 50 %) have been dedicated to health and nutrition related operations.

**Focus of Report:** Nutrition and Health operations under the a.m. decisions (present report to be seen as essential part of the overall evaluation of the a.m. decisions)

**Dates of Evaluation:** 15<sup>th</sup> February – 09th March 2004 (Field Mission Period)

**Names of Evaluators:** Dr. Veronika Scherbaum, Nutritionist  
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### **B. Purpose and Methodology**

The evaluation team (one nutritionist, one medical doctor) collected both primary and secondary information and applied participatory methods to incorporate different views of beneficiaries and project staff members.

The methods consisted of the following:

- A desk study period in Brussels for introductory briefing, review of relevant documents and planning of the evaluation
- Introductory briefings at the RSO in Nairobi and at the Commission Services and ECHO country office in Harare
- Briefings with ECHO partners and staff of relevant national/international institutions
- Projects visited during the evaluation have been selected according to a number of criteria as pointed out in the briefing note submitted in Brussels.
- Participatory learning and action methods were applied at community level such as:
  - Participatory observation of activities
  - Trans-sectoral walks through project areas (e.g. schools, vegetable gardens)
  - Semi-structured interviews with project staff members
  - Focus group discussions with beneficiaries, mothers, school teachers and community members
- In order to increase the efficiency of the assessment within a very limited time frame the team members worked parallel in separate groups
- On-going triangulation of findings was carried out by the evaluation team members to cross-check information gained and to elaborate recommendations

- Debriefing session with ECHO partner organisations, ECHO country office staff members and the ECHO evaluation unit and the desk officer in Brussels

Projects have been visited in the following technical fields:

- Home Based Care
- Supplementary Feeding
- School Feeding
- Therapeutic feeding
- Logistics
- Co-ordination of Humanitarian Activities
- PMTCT (not funded by ECHO)

## **C. Main Conclusions**

### Relevance

C.1 The design of the health and nutrition programmes was mainly based on results of the VAC (Vulnerability Assessment Committee) assessments (2002, 2003) and on needs assessments carried out by staff of NGOs. The interventions planned in 2003 could not be based on the results of the National Nutrition Survey (February 2003) because it was released too late (at the end of 2003).

C.2 Because current nutrition and health related background information point to a comparatively higher vulnerability of children living in rural areas, the decision of ECHO to fund primarily beneficiaries living in rural areas has been appropriate to some extent.

C.3 Due to a rapidly declining economy, hyper-inflation, increasing unemployment and the consequences of HIV/AIDS, however, food security among poor people living in urban and peri-urban areas continues to be a major concern.

C.4 Looking at the data and information available on needs of the Zimbabwean population in 2002 and 2003, the areas for external support were well selected. However, after 2 years of mainly relief interventions, short-term support with longer term impact is needed in order to prevent Zimbabwean society from further social and economic deterioration.

### **Specific technical issues related to the ongoing projects in nutrition and health:**

C.5 The planning matrixes (Logical Framework) of ECHO funded projects reflect still weaknesses of implementing partners in defining clear objectives and expected results as well as objectively verifiable indicators, which are necessary for the monitoring of project implementation. Not all ECHO partners used the opportunity to initiate an external evaluation of their projects.

C.6 Current coverage of Supplementary Feeding Programmes (SFPs) does not relate to the highest prevalence of malnutrition as it was predetermined in the majority of project proposals.



C.7 Wet feeding of children under the age of five years is practised in all SFPs at community level, irrespective of the extent of malnutrition in the respective area.

C.8 Comparison of the pre-emergency levels of malnutrition and the current situation do not support the practice of blanket wet feeding of all Under-Fives.

C.9 The wet feeding using Corn Soya Blend (CSB) seems to be appropriate for school feeding programmes if there is access to adequate quantities of safe water.

C.10 In therapeutic feeding programmes more emphasis needs to be directed towards training of medical doctors, and to inclusion of areas with highest prevalence of severe acute malnutrition (SAM)

C.11 HIV/AIDS is one of the major threats for development and one of the major causes of the humanitarian crises in Zimbabwe. Other than the political crisis and mismanagement or even drought, which can be considered as short to medium term and transitional problems, HIV/AIDS severely affects social, economic and political perspectives for generations. Life expectancy at birth has declined dramatically from 62 in 1988 to 39 years in 2003; about 1.8 Million people are infected with HIV and 800,000 orphans, one third of them HIV+. Productivity of households and consequently chances for the young generation to get access to adequate social services like education and health are seriously affected by the epidemic.

C.12 Home Based Care projects funded by ECHO cover all relevant components of support to HIV/AIDS affected households. Relatively more emphasis should be put on nursing of AIDS patients in their homes as well as on preventive strategies (nutrition and health education).

#### Cost-effectiveness and efficiency

C.13 Especially in therapeutic feeding, numbers of beneficiaries have been largely overestimated.

C.14 This overestimation of numbers of beneficiaries has led to important excess stocks of therapeutic milk in the country, and consequently this instance is likely to lead to considerable losses.

C.15 Realistic calculations with respect to beneficiaries and quantities of therapeutic milk are urgently needed.

C.16 The cost per beneficiary of different feeding programmes is comparable to or even lower than those of similar projects in other countries. However, comparing these data, it is important to mention, that the social and economic crisis in Zimbabwe is not directly comparable with refugee situations or natural disasters elsewhere and that the needs of the population, their accessibility (i.e. no camp situation) and the political context are different in Zimbabwe.

C.17 ECHO-Partners are either working directly through existing voluntary organisations (i.e. national NGOs) and health care structures and their local staff, and/or using in addition international expertise to manage their projects in the field which has an influence on their cost-effectiveness.

C.18 Capacity building of health personnel did not primarily focus on training of medical doctors. As a direct consequence, ownership of feeding projects by national staff at health facility level was low and medical follow up of severely malnourished children unacceptably weak.

C.19 The applied methodology of therapeutic feeding programmes differed widely among the implementing partners. It varied from minimal to maximum input with respect to training, implementation, monitoring and evaluation. But due to the very low commitment of medical doctors the outcome with respect to case-fatality rate was comparable among the different projects.

C.20 The cost-effectiveness of therapeutic feeding could have been largely improved if experienced nutrition/health experts would have been consulted at an earlier stage.

### Effectiveness

C.21 In the field of health and nutrition, the ECHO's Humanitarian Aid Decisions principal objective (*to improve the humanitarian condition of vulnerable groups in Zimbabwe*) and specific objectives (*to reduce malnutrition levels and to prevent malnutrition among children*) have been widely achieved by the implemented interventions.

C.22 As acute malnutrition among children reflects an immediate or recent inadequacy in food intake it depends largely on short term fluctuations in food availability. The fact that wasting levels remained basically constant or have even slightly improved suggests that assistance in food security, programmes in the field of health and nutrition as well as water and sanitation have contributed to maintaining the nutritional status of children in Zimbabwe on a level well below emergency cut-off points.

C.23 Main objectives like improved school enrolments and attendance, prevention of drop-outs and prevention of deterioration of the nutritional status have been largely achieved through school feeding programmes of ECHO's implementing partners.

C.24 The effectiveness of therapeutic feeding could have been largely improved if the involvement of medical doctors during the initial phase would have received a higher priority and if local ownership of TFP would have been emphasised.

C.25 HIV/AIDS may be one of the major causes of malnutrition in those children who do not respond to treatment in the TFUs. Unfortunately, HIV-infection levels are generally not tested during admission in the medical institutions.

### Coverage

C.26 Urban areas are still not specifically targeted by ECHO funding (except therapeutic feeding in urban hospitals). On the other hand, urban population will probably need substantial support in the immediate future, as the political and economic situation won't improve rapidly.

C.27 The regions of interventions have been proposed by ECHO partners themselves mainly on the basis of the VAC assessments in 2002 and 2003 and their own needs assessment, but not according to the results of the national surveys (because they were released too late towards the end of 2003) . The necessary detailed overview to identify gaps in terms of geographical or

technical coverage is still difficult to get. Possible overlapping or areas of missing support are difficult to assess and overall co-ordination is still, after 2 years of humanitarian interventions, insufficient.

C.28 Coverage of hospital based therapeutic feeding projects is inadequate with respect to the current need. About one third of the hospitals has not yet been targeted despite the fact that 20% of these hospitals are located in areas with highest need (prevalence of SAM > 2%). In addition the coverage is low due to limited accessibility of services (geographical, social, and indirectly also financial accessibility, and time and availability of the caregiver).

C.29 For several months, Community Based Therapeutic Feeding as an additional tool has been under discussion in Zimbabwe. This approach could considerably improve the coverage of therapeutic feeding. By shortening the time of hospitalisation and bringing the services nearer to the clients.

C.30 Only a few projects funded by ECHO are providing support to vulnerable groups in resettlement areas. The needs of the populations in these areas are not yet known in detail.

#### Impact

C.31 The ongoing food aid distributions (via school feeding, supplementary feeding and the general food ration for vulnerable groups) certainly contribute to a lower prevalence of malnutrition.

C.32 The establishment of community committees for the co-ordination of all different feeding activities has further improved community cohesion and the decision-making process.

C.33 Monitoring of the impact of the interventions was not done systematically by the majority of implementing partners.

C.34 Interviews with beneficiaries and key informants revealed that ECHO funding has made a significant contribution to strengthen their coping strategies, especially in the field of HIV/AIDS and to reduce death from severe malnutrition.

#### Sustainability

C.35 Generally, community members and representatives are aware of the ECHO support in their surrounding and actively participate in the implementation of activities.

C.36 Capacity building of community members and caregivers has been achieved mainly for general hygiene behaviour. However, beneficiaries are still less well informed about the content and the nutritional value of the food distributed (i.e. CSB). This information would be useful to show, that CSB is a complete meal, that could be prepared even locally with the means already available in the majority of households (begin of the harvest season for fresh maize and beans).

C.37 Capacity building of medical personnel and caregivers at the same time can substantially increase the long term impact (prevention of death due to severe malnutrition) of all ECHO funded therapeutic feeding programmes

C.38 Despite the specific character of the protracted emergency in Zimbabwe, which calls for substantial development orientated interventions, the concepts of the majority of the projects are still dominated by their emergency relief approach.

C.39 The government of Zimbabwe has developed a number of guidelines and roll-out plans for interventions in the health and nutrition sector (e.g. guidelines for nutritional surveillance, HIV/Aids counselling, etc) which are already taken into consideration by the ECHO funded operations.

#### **D. Recommendations**

R.1 Future activities should be based on the results of very recently realised needs surveys for better targeting of areas with greatest need.

R.2 Data on nation-wide prevalence of malnutrition (Global Acute Malnutrition - GAM) do reflect large sub-national differences which need to be considered in future supplementary feeding programmes.

R.3 Vulnerable people among the urban population (as identified in the urban VAC assessment, 2003) and populations in resettlement areas and former commercial farmlands should also be targeted in future assistance programmes.

R.4 Disproportionately high levels of severe acute malnutrition (SAM) in relation to global acute malnutrition (GAM) require the continuation of therapeutic feeding programmes, especially in districts where severe malnutrition rates exceed a prevalence of 2%.

R.5 The current strategy of hospital-based therapeutic feeding needs to be urgently revised. More emphasis should be directed towards training medical doctors - who are the key decision makers in paediatric wards - in order to reduce the comparatively high case-fatality rate and to improve the commitment of medical staff members.

R.6 Future training programmes should be based on one single national treatment protocol which is currently worked out on the basis of guidelines set up by WHO (Management of severe malnutrition: a manual for physicians and other senior health workers, Geneva 1999) and Michael Golden/Yvonne Grellety (The management of acute, severe malnutrition: a suggested manual for Malawi, July 2002).

R.7 As part of quality assurance, regular supervision and monitoring of results as well as feedback should play an important role.

R.8 As motivation of health staff needs to be improved in many institutions, active participation in planning; monitoring and evaluations will contribute to empowerment and decrease dependence on external support.

R.9 Human resource development should also address the need for substitution of medical staff in case of illness, death and other causes of drop-outs.

R.10 In future Therapeutic feeding programmes, consultative assistance and follow-up by technical experts should be attempted. This is of particular importance when innovative approaches are being planned such as community-based therapeutic feeding.

R.11 As Community-based therapeutic care (CTC) might be an option to be explored in Zimbabwe, pilot projects should be planned and evaluated in both rural and urban communities.

R.12 In addition to participation of community members which should include the target group, experiences in CTC from other African countries like Malawi should be considered.

R.13 Furthermore, health-seeking-behaviour of populations should be studied; beneficial practices of Home Based Care identified and culturally adapted health and nutrition communication methods elaborated.

R.14 Appropriate nutritional information and training of caregivers/beneficiaries about infant and child feeding practices including breastfeeding promotion and healthy family diet should receive more attention in future ECHO funded projects.

R.15 In general, current preventive and therapeutic strategies should be revised and adjusted according to the guidelines of “Integrated Management of Childhood Illness (IMCI)” which is an adopted national policy.

R.16 According to the prevailing needs in Zimbabwe ECHO has to put more emphasis on funding measures contributing to the fight against the HIV/AIDS epidemic.

R.17 HIV/Aids prevention and Home Based Care of HIV/Aids patients need to be mainstreamed in all ECHO-funded projects in order to prevent further deterioration of the current economic crisis by contributing to the national programme to fight the epidemic.

R.18 Prevention of HIV-transmission from parents to the child (PMTCT) combined with voluntary counselling and testing services, supplementary food distribution for HIV+ parents and their children and access to anti-retroviral therapy (ART) are essential components. As these components need a long term financial support, ECHO need to combine its effort with other EC services like AIDCO and other donors.

R.19 The specific emergency in Zimbabwe calls for maintaining a minimum quality, availability and accessibility of social services like health. Therefore it makes sense to support – in close collaboration with DG-DEV/AIDCO – the National Drug Procurement, the Enlarged programme of Immunization and the special capacity building programme for primary care Nurses to face the alarming lack of trained paramedical staff and brain drain in the health sector.

R.20 The co-ordination of relief activities, combined with their connection to ongoing or envisaged development support, needs a sound information system. For this purpose, UNDP and the RRU will need further funding to improve their performance in providing useful data to donors and implementing partners as well as to governmental structures at central and provincial level.

R.21 ECHO partners should get more support in terms of guidance in developing their project proposals. This could be realised by additional technical expertise at ECHO Harare office or via the Regional Support Office (RSO) in Nairobi.

R.22 More exchange of information among ECHO partners working in the same field is recommended during the implementation phase and should be facilitated by the ECHO country office.

R.23 Adequate technical feedback of ECHO staff members to quarterly-, mid-term-, and evaluation reports is recommended in order to enhance the learning process at an early stage.

## **E. Lessons Learned**

LL.1 To respond adequately to the prevailing needs of the population in Zimbabwe an integrated approach with a strong link to rehabilitation and development is necessary for relevant project planning (according to national guidelines, taking development strategies of other donors and the government into account), project implementation (using existing national structures and putting more emphasis on capacity building at all levels (national, provincial and district level), using national training manuals) and project monitoring (improving national information systems).

LL.2 Combination of ECHO funding with funding from other donors will improve the effectiveness and the impact of investments.

LL.3 Investment in capacity building of implementing partners is useful, especially with the type of emergencies like the one in Zimbabwe, as most of the NGO staff are not familiar with such emergencies.

LL.4 Detailed data are necessary to identify the spectrum of needs in urban and rural areas, which asks for substantial investment in the set-up of sound information systems.

LL.5 Effective co-ordination of donors and implementing partners is a delicate task. The choice of UN organisations for the role of sector coordinating agencies in Zimbabwe is one step into the right direction. However, more guidance from donors (ECHO) seems to be needed to make that co-ordination effective.

LL.6 Food aid and feeding programmes are useful to maintain the current nutritional status and to prevent malnutrition and death among the most vulnerable groups such as children, orphans, HIV/AIDS patients and their family members, female headed households, etc.. The aspect of community participation is crucial for achieving a long-term impact of short-term interventions like emergency aid.

LL.7 A higher focus on HIV/AIDS is necessary in countries of high HIV-prevalence. The ECHO funding should directly contribute to and be oriented by the national programme against HIV/AIDS.

## 2 Introduction

This report concerns ECHO interventions in the Zimbabwean nutrition and health sector between mid 2002 and the end of 2003 following two years of drought, exponentially declining economic/food production performance and administrative chaos following a 'fast-track' resettlement programme in which previous commercial landowners and their workers were expelled from the highly productive land of Zimbabwe.

Since June 2002, ECHO has funded (in the sum of €32,934,997 through four decisions) a multi-sector programme towards the improvement of food security, recovery of water and sanitation systems and improvement of the health and nutrition status of the population.

The strictly Nutrition component comprised two Home Based Care projects, 6 school feeding projects, 5 supplementary feeding projects of under-fives and 5 hospital based therapeutic feeding centres, in the sum of €13,139,266 within four decisions.

Other Commission services have continued with the provision of such aid as could be judged as of humanitarian benefit to the population. Especially through the 8<sup>th</sup> EDF the social services (education and health) are supported in the areas of essential drug procurement, blood safety and training of a new cadre of 'primary care nurses'.

The expected output of this evaluation is a set of strategic recommendations for future funding through ECHO. The new Humanitarian Aid Decision, valid until the end of February 2005, foresees 'to save and preserve life and to provide assistance and relief to vulnerable groups in Zimbabwe'.

There are four specific objectives:

1. to assist emergency food aid operations, support logistical arrangements for these operations and support emergency agricultural and livestock rehabilitation;
2. to support emergency interventions in the water, sanitation and health sectors, including nutrition and HIV/AIDS mitigation;
3. to assist humanitarian co-ordination efforts and assistance to Internally Displaced Persons (IDPs);
4. to maintain a technical assistance capacity in the field, to assess needs, appraise project proposals and to coordinate and monitor the implementation of proposals.

The recommendations developed in this report are valid for the years ahead, given the future needs for external support in Zimbabwe.

The Terms of Reference of the evaluation assignment require that, *inter alia*, the team should consider:

- the adequacy of the management and monitoring of specific operations;
- the cost-effectiveness of specific operations;
- the relevance of the sector orientation of ECHO's financing, in view of prevailing humanitarian needs;
- the optimum added value ECHO's resources could have in the Zimbabwean context, taking into account the difficult working environment, other resources and instruments

available to the Commission in Zimbabwe, and strategies and programmes by other humanitarian donors;

- the way ECHO operations have taken into account specific cross cutting issues such as: LRRD; Gender, women and female-headed households; Elderly persons, particularly those caring for orphans and persons affected by HIV/AIDS; Children and children-headed households; IDPs, specifically the situation of displaced/dismissed farm workers; the environment; Visibility of Commission assistance both within Zimbabwe and within the international humanitarian community; Protection and human rights issues;
- the extent to which partners have sought to make the communities aware of their proposed operations and its benefits, as well as the extent to which communities have been involved in ECHO-financed operations.

The output of the mission should be the production of three documents:

- a debriefing document discussed with ECHO and ECHO partners in Harare at the end of the mission;
- a draft evaluation report presented to ECHO following completion of the fieldwork;
- a final report submitted to ECHO after incorporation of all comments.

### 3 Background information

The following background information was collected by the evaluation team during the assignment. For the later understanding of the report, its findings and recommendations, these basic health and nutrition related data are of utmost importance. Obtaining data from governmental structures like the MOHCW took some time, most of the information and documents have been sent by ECHO partners and governmental structures via e-mail after the field mission. The quality of data provided by the RRU should be improved to be useful for donors, implementing partners and governmental structures.

#### 3.1 Background information to Nutrition and Health

**Table 1: ZIMBABWE - Basic health and nutrition indicators**

Life expectancy at birth	39 years (2003)
Infant mortality rate per 1000 life birth	76 (2001)
Under-5 mortality rate per 1000 life birth*	123 (2001)
Maternal mortality rate per 100,000 life birth	700 (1995-2001)
Contraceptive prevalence	54% (1995-2001)
Total fertility rate	4,7 (2001)
Births attended by trained health personnel	73% (1995-2001)
Low birth weight (<2500g)	10% (1995-2000)
Exclusive breastfeeding (0-6 months)***	33% (1995-2001)
Breastfed with complementary food (6-9 months)	90% (1995-2001)



Still breastfeeding (20-23months)	35%	(1995-2001)
Access to safe water	83%	(2000)
Access to adequate sanitation	62%	(2000)
Consumption of iodised salt	93%	(1997-2002)
ORT use rate	50%	(1994-2000)
Percentage of infants immunized:		
Polio	75%	(2001)
Measles	68%	(2001)
HIV infections (15–49 years) 2.3 million infected, 780,000 orphans	33.7%	(2001)
Population in urban areas**	36.0%	(2001)
School enrolment (boys and girls)	80.0%	(1995-1999)
Prevalence of stunting (height for age < - 2 SD)	27%	(1995-2001)
Prevalence of underweight (weight for age < - 2 SD)	13%	(1995-2001)
Prevalence of wasting (weight for height < - 2 SD)	6%	(1995-2001)

Source: UNICEF, The state of the world's children, 2003 (Data on life expectancy taken from the 2003 - Human Development Report)

\* Beside an increasing proportion of HIV/AIDS - related death, main causes of under 5 mortality such as ARI, gastroenteritis, malnutrition, perinatal complications and tuberculosis are similar to those reported in other African countries

\*\* About 7.5 million people (2.5 in urban areas and 5.01 million in rural areas) of the population are food insecure in the 2003/04 marketing year (ZimVAC, 2003).

**\*\*\* Table 2: Additional child feeding information**

- Only 16% of infants below 4 months are exclusively breastfed
- 29% of mothers with infants < 2 months report giving water
- 52% of mothers with infants report giving other foods
- 4% of mothers reported to use infant formula
- 25% give cow's milk to their infants
- 90% of the infants have received complementary foods by the age of 5 months
- 93% of the infants are still partially breast-fed by the age of 6 to 9 months
- 26% are continued to be breast-fed up to 23 months

Source: Zimbabwe Demographic Health Survey ZDHS 1996, UNICEF 1998, FAO 2001

### 3.2 Nutrition Survey Results

**Table 3: National trends in nutritional status of children and women**

SURVEY	PERCENTAGE OF MALNOURISHED CHILDREN			WOMEN  BMI < 18.5 (%)
	WASTING ACUTE MALNUTR. < - 2 z scores WFH GAM: < - 2 z scores WFH and/or nutritional oedema	UNDERWEIGHT LOW WFA < - 2 z scores Weight/Age	STUNTING CHRONIC MALNUTR. < - 2 z scores Height/Age	
DHS (1988) MFEPD, 1989 (3-35 months)	1.3%	11.5%	29.0%	
DHS (1994) ZDHS, 1995 (3-35 months)	5.5%	15.5%	21.4%	
DHS 1999 (6-59 months)	6.0%	13.0%	27.0%	5.0%
National Micronutrient Survey, 1999	6.3%	14.9%	29.2%	6.8%
MOH/UNICEF, May 2002 (6-59 months)	6.4%	20.4%	33.0%	9.7%
VAC August 2002 ( <b>only rural areas</b> )	7.3%	24.7%	41.3%	8.6%
MOH/UNICEF February 2003 (n=41,849) (6-59 months)	4.4% 5.0% (GAM)	17.2%	26.5%	

**Table 4: Indicators used for different grades of Acute Malnutrition**

AGE GROUP	TOTAL (GLOBAL) ACUTE MALNUTRITION GAM	MODERATE ACUTE MALNUTRITION	SEVERE ACUTE MALNUTRITION SAM
CHILDREN* 6.0 – 59.9 months	< - 2 z scores WFH or 80% median WFH and/or nutritional oedema	- 3 to < - 2 z scores WFH or 70% to < 80% median WFH	< - 3 z-scores WFH or < 70% median WFH and/or nutritional oedema

### 3.3 Urban – Rural – Comparison

**Table 5: Nutritional status of children: urban – rural comparison**  
Source: National Nutrition Survey, MOH, UNICEF, February, 2003

NUTRITIONAL STATUS of children: 6-59 months Global Acute Malnutrition (GAM: at national level: 5.0%)	URBAN	RURAL
Harare (urban areas)	2.9%	
Chitungwiza (urban areas)	4.6%	
Bulawayo (urban areas)	2.6%	
Masvingo (lowest GAM of all provinces)		4.6%
Manicaland (highest GAM of all provinces)		6.6%
Umzingwane (lowest GAM of all districts)		2.8%
Mutare (highest GAM of all districts)		10.7%
Severe Acute Malnutrition (SAM: at national level: 1.4%)		
Harare (urban areas)	0.2%	
Chitungwiza (urban areas)	1.3%	
Bulawayo (urban areas)	0.8%	
Matabeleland North (lowest SAM of all provinces)		1.2%
Manicaland (highest SAM of all provinces)		2.5%
Umzingwane (lowest SAM of all districts)		0.4%
Mutasa (highest SAM of all districts)		5.0%

**Table 6: Immunization and Vitamin A coverage in children aged 12-23 months: Urban – rural comparison**  
Source: National Nutrition Survey, MOH, UNICEF, February, 2003

<b>Children fully vaccinated:</b> (at national level: 76.6%)	URBAN	RURAL
Harare (urban areas)	93.5%	
Bulawayo (urban areas)	86.1%	
Mashonaland West (lowest coverage of all provinces)		66.1%
Matabeleland South (highest coverage of all provinces)		83.6%
Kadoma (lowest coverage of all districts)		44.0%
Umzingwane (highest coverage of all districts)		94.6%
<b>Vitamin A coverage:</b> (at national level: 46.1%)		
Harare (urban areas)	93.8%	
Chitungwiza (urban areas)	82.4%	
Bulawayo (urban areas)	57.8%	

Matabeleland North (lowest coverage of all provinces)		34.5%
Mashonaland East (highest coverage of all provinces)		64.6%
Bulili South (lowest coverage of all districts)		2.8%
Umzingwane (highest coverage of all districts)		96.8%

**Table 7: CRUDE MORTALITY RATE (CMR): urban – rural comparison**  
Source: National Nutrition Survey, MOH, UNICEF, February, 2003

THE NATIONAL CRUDE MORTALITY RATE (CMR): 0.65 deaths/10,000/day = 24 deaths/10,000/year	URBAN No. deaths/ 10,000/year	RURAL No. deaths/ 10,000/year
Harare (urban areas)	11	
Chitungwiza (urban areas)	22	
Bulawayo (urban areas)	11	
Manicaland (lowest CMR of all provinces)		14
Mashonaland East (highest CMR of all provinces)		31
Gwanda (lowest CMR of all districts)		2
Murewa (highest CMR of all districts)		42

**Table 8: Urban VAC assessment**

**Results of the Urban VAC assessment**

(A livelihood questionnaire covering 5,123 households, data collected: Sep/Oct 2003)

- 51% of the households were found to be very poor, and 21% poor
- The elderly and female headed households had the lowest income
- Food insecurity increases with household size (larger households normally care for orphans too)
- The very poor consumed mostly carbohydrates (80%) followed by vegetables (16%), and very little protein and oils. About 57% of the urban population reported to have 2 or less meals a day
- As the greatest shocks that affect their livelihoods people cited inflation, followed by cost of services (school fees), unemployment and taxis, death of family members, illness and hospital bills
- Of the households that lost a member through death, about 69% were food insecure
- Of the households with at least one child dropping out of school, 85% were food insecure
- About 88% of the very poor and poor households indicated that they reduced their education expenditure to buy food
- At least 90% of the households had access to piped water and this include over 40% of the very poor. However, most households in squatter camps used water from unprotected sources.

### 3.4 Feeding Programme Coverage

**Table 9: Coverage of General food distribution and Under 5 SFPs**  
Source: National Nutrition Survey, MOH, UNICEF, February, 2003

At national level, 48.3% of households received a <i>General Food Ration</i> in the last three months	Percentage of households
Mashonaland West (lowest food ration coverage of all provinces)	25.9%
Matabeleland North (highest food ration coverage of all provinces)	69.9%
Kadoma (lowest food ration coverage of all districts)	0.1%
Nkayi (highest food ration coverage of all districts)	100%
At national level, 38.5% of children under 5 years participated in <i>Supplementary feeding programmes</i> (SFPs)	Percentage of children < 5
Mashonaland West (lowest SFP coverage of all provinces)	22.5%
Masvingo (highest SFP coverage of all provinces)	56.7%
Chikomba (lowest SFP coverage of all districts)	0.3%
Rushinga (highest SFP coverage of all districts)	89.6%

### 3.5 Interpretation of currently available background data

Infant mortality rate and Under-5 mortality rate (per 1,000 live births) has considerably increased (from 49 and 73 in 1996) to 76 and 123 in 2001 respectively whereas life expectancy has decreased from 49 years in 1996 to 39 years in 2003.

The prevalence of Global Acute Malnutrition (5% in 2003) has not changed significantly since 1995. However, the observed decline of GAM from 6.4% in 2002 to 5% in 2003 can be seen as a positive result of the massive international food aid during the last 2 years.

There are wide regional variations in the nutritional status of children (Annex XI and XIII). The last national nutrition survey (February 2003) showed that 30 districts (49%) had levels of GAM of 5% or higher (up to 10.7%) and 15 districts (25%) had levels of severe malnutrition (SAM) of 2% or higher (up to 5%) indicating an alarming situation in certain regions (Annex XI). It is important to note that provinces showing deterioration in the nutritional status had a higher HIV/AIDS prevalence than other provinces without deterioration.

For all nutritional indices the extent of malnutrition is more pronounced in rural than urban areas. Almost all rural areas have a prevalence of underweight above the national average of 17.2% whereas underweight in urban areas remains well below the national average. Immunization and vitamin A supplementation coverage is also considerably lower in rural areas.

Only 33.2% of the severely malnourished children who were detected during the national nutrition survey (2003) have been reached by SFPs. The percentage of those being treated in therapeutic feeding units is even lower. Children who were included in SFPs were more likely to

receive 2 or less meals per day at home whereas children who did not receive supplementary food were more likely to receive 3 meals per day.

The peak prevalence of malnutrition occurs in the second year of life indicating that breastfeeding and complementary feeding habits as well as caring practices play an important role along with accumulating risks of HIV/Aids and increasing food insecurity. The association between malnutrition and death of the mother or both parents is high. Malnutrition rates in children who lost their mother or both parents were 20-25% compared to 3-3.9% in children who either had both parents alive, or had lost their father only (SCF-UK, 2003).

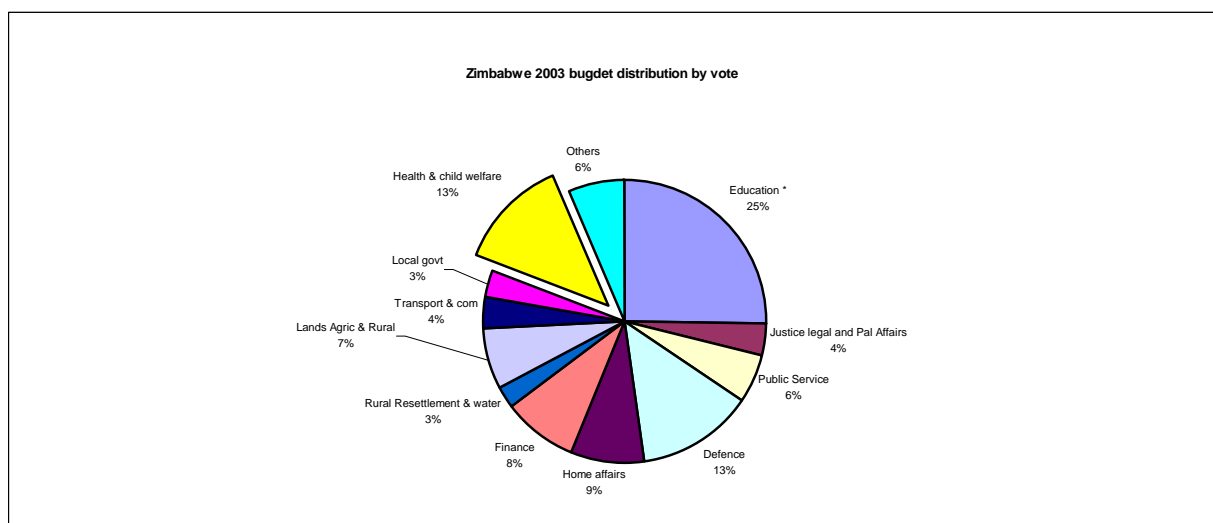
### 3.6 The Health Sector

#### National Health policy and Strategy:

According to the National Revival Plan of the MOHCW the main areas for support by the Government of Zimbabwe and the donor community in the health sector are human resources, drugs and medical supplies and the Expanded Program of Immunisation (EPI)<sup>1</sup>.

Statement of the Minister of Health: *“All activities will be geared to the survival and resuscitation of the health sector.”*

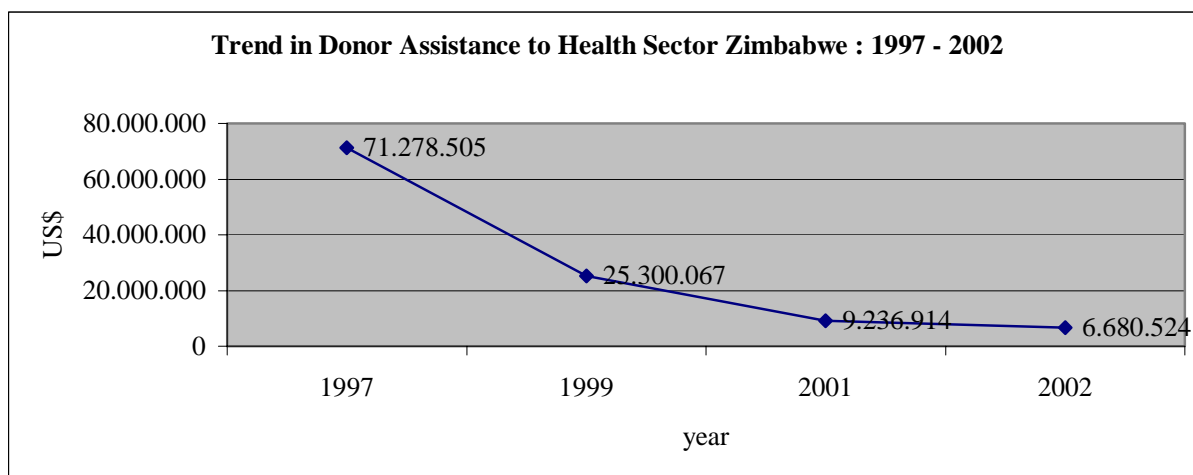
**Table 10: The budget of the MOHCW as share of the national budget in 2004**



Data received from MOHCW

<sup>1</sup> MOHCW, 2003 Revival Action Plan

**Table 11: Trend in donor assistance to the health sector in Zimbabwe**



Source: Ministry of Health (MOHCW)

The table 12 beside shows the life expectancy at birth and the infant mortality rates of countries in Southern Africa. These indicators are proxy-indicators for the social and economic development of societies.

	Gross National Income, per capita (US\$)	2003 HD Ranking (Rank of 175)	Life expectancy at birth (years)	Infant mortality (per 1,000 live births)	Adults living with HIV/AIDS
Angola	500	164	47	128	6%
Botswana	3,420	125	39	58	39%
Lesotho	550	137	39	91	31%
Malawi	160	162	44	103	15%
Mozambique	210	170	39	129	13%
Namibia	1,960	124	47	62	23%
Swaziland	1,300	133	46	89	33%
Zambia	320	163	45	69	22%
Zimbabwe	450	145	39	114	34%

The figures show, that Zimbabwe is already in a situation facing enormous problems related to the country's economy aggravated by one of the highest HIV seroprevalence rates worldwide.

Source: 2003 Human Development Report

The health sector in Zimbabwe is facing a dramatic deterioration in terms of quality and availability of services. The infrastructure of hospitals and clinics is still good. But the lack of qualified staff especially in rural areas, due to brain drain to other countries in the region, to Europe and the US as well as due to death because of HIV/AIDS, the lack of necessary financial resources for the maintenance of the cold chain for vaccines and the lack of foreign currency to procure essential drugs, reagents and equipment, have already created an alarming situation in the health sector.

In addition the country is hardly hit by the HIV/AIDS epidemic and health services are overloaded by people seeking care in hospitals and clinics.

EU is already supporting the health sector in the fields of procurement of essential drugs through the para-statal structure 'NatPharm'. The national blood transfusion service receives funding from EC as well as the capacity building programmes focussing on primary care nurses.

## **4 Additional sectors of interest for ECHO funding**

### **4.1 Human Resources development**

Due to the current harsh economic climate, Zimbabwe has been hard hit by a huge exodus of staff to other countries. In 2003, it was estimated that 55%, 40% and 92% of the posts for doctors, nurses and pharmacists respectively were vacant. In addition, the vacancies tend to be more in the rural areas than in the urban areas, creating a challenging environment also for the scaling up of ART. The MOHCW has been exploring other ways of ensuring that health facilities are staffed with competent health personnel. A Primary Care Nurse (PCN) cadre has recently been approved for training over an 18-month period, to cater for primary care facilities. Training has already started at 15 schools, with a total enrolment of 216 for the first group and 200 for the second group. One more school will be opened in July 2004. Intake per school ranges from 20 for small schools to 80 for bigger schools.

This new degree of PCNs is not recognised by other countries, which is supposed to prevent additional 'brain drain' of staff qualified in Zimbabwe. This training programme will get financial support from the EC as soon as the 9<sup>th</sup> EDF will be signed. Until signature (which might be delayed due to present political circumstances), ECHO, in close collaboration with the EC-Delegation in Harare, should provide financial support to ensure this 18 month training for PCNs.

### **4.2 Expanded Programme of Immunization (EPI)**

Recent, not yet published data show a dramatic decline of the vaccination coverage of infants, especially in rural areas. Main reasons for this are the lack of qualified staff and transport capacities with direct negative effect on outreach activities and breakdown of the cold chain and vaccines supply.

To contribute to the urgently needed support of the EPI, ECHO should add its funding instruments to the support already provided to the EPI by AIDCO and DFID. A detailed needs assessment has to be carried out immediately and in close collaboration with all partners involved in this sub-sector. Overall co-ordination of the response to the needs has to be guided by the national health sector policy.

### **4.3 Drug Procurement**

NatPharm is a parastatal procurement agency for essential drugs, which performs well. The managerial structure, supported by the Health Sector Support Programme (HSSP I and II), is operational. The EC funded drug procurement through NatPharm covers about 25% of the overall drug needs of the population and about 60% of the present overall consumption of essential drugs in the country.

ECHO should support this sub-sector by providing additional funds to enhance the import of essential drugs.

### **4.4 HIV/Aids**



The socio-economic impact of the HIV/AIDS epidemic has been mentioned above. The following objectives are guiding the national policy to fight the epidemic:

- Community Home Based Care operationalised;
- Prevention of occupational exposure and provision of Post Exposure Prophylaxis;
- HIV/AIDS programme for Health Workers;
- Awareness campaigns and events carried out and materials distributed about HIV/AIDS/STI transmission and prevention;
- Business Council on HIV/AIDS fully operational;
- Comprehensive HIV/AIDS continued care package defined;
- Phased introduction of Anti-retro-virals;
- Improve collection, distribution and utilisation of data about the HIV/AIDS epidemic;
- 2003 ANC HIV Sentinel Survey Conducted.

(UNAIDS and MOHCW, 2003)

The support to Community Home Based Care (CHBC) should be enhanced by ECHO. Funding outside ECHO is available for education of health workers how to prevent occupational exposure. Where drug procurement is still functioning, health workers living with AIDS are benefiting from possibilities for treatment of opportunistic infections. The present economical situation in Zimbabwe does not favour the involvement and engagement of the private sector in the funding of measures against the epidemic.

Mainstreaming HIV/AIDS means to introduce relevant aspects and strategies into all ECHO funded projects in order to contribute to the fight of the epidemic

Since the middle of the nineties 'anti-retroviral therapy' has developed quickly and drug combinations are now effective by prolonging life expectancy and maintaining productivity of PLWA.

During the last years possibilities to improve financial access to anti-retroviral treatment (HAART – Highly Active Anti-Retroviral Treatment) has become real for developing countries. The triple therapy (first line drugs) is already available for about US\$ 300 a year. But there are still many limiting factors for the implementation of ART in developing countries, such as socio-cultural (taboos, stigma, inequality of men's' and women's' rights, adherence to the treatment), technical (lack of qualified staff) and hard-ware problems (laboratory equipment, transport, etc.).

Current estimates are that about 520,000 people living with AIDS (PLWA) in Zimbabwe need anti-retroviral treatment (ART), with about 5,000 benefiting from ART at present (about 75% of these catered for by private practitioners (both specialists and general practitioners) and largely from their own means, while about 15% are treated through operational research projects financed by the government or international agencies like MSF, CDC or bilateral cooperation. All of these are largely urban-based. The experiences from these early sites should offer valuable lessons for scaling up ART in Zimbabwe.

### **Target for 3 by 5 ART Scaling Up (WHO)**

The objective of the '3 by 5 initiative' formulated by the UN-organisations is to bring 3 million people living with AIDS (PLWA) under anti-retroviral therapy by the end of the year 2005. To achieve the target for the 3 by 5 initiative of at least 50% of those in need of treatment being able to access it, there should be 260,000 PLWA on ART by the end of 2005 in Zimbabwe.

### **Entry Points for ART**

Within existing HIV/AIDS activities, and in line with the scale up plan, several well functioning HIV-related programmes already exist which could assist in rapidly enrolling patients for ART and meeting the pent-up demand.

### **PMTCT (Prevention from Mother to Child Transmission of HIV)**

In 2003, PMTCT was operational at 174 sites, though a total of 205 sites have been registered. The other 31 sites have not yet started offering Nevirapine (NVP: anti-retroviral drug) to mothers and babies for PMTCT because staff have not been fully trained. Out of the country's 58 districts, 43 have PMTCT sites. In 2003, 43,011 clients were counselled and 30,422 tested for HIV as part of PMTCT. PMTCT could thus serve to geographically spread ART coverage while also ensuring equity by getting to the vulnerable group of women and children. A policy decision has already been made to upgrade PMTCT sites to PMTCT plus, which includes ART to both parents and the siblings of the baby.

### **VCT (Voluntary Counselling and Testing on HIV)**

There are currently twenty five operational stand-alone VCT sites, six of which are rural. Eighteen of the sites are jointly operated by an NGO (PSI) and the Government, while 7 are supported by NGOs and church missions. It was estimated that in 2003, 139,000 clients were counselled & tested. VCT is also offered as part of PMTCT. In addition, all government hospitals offer VCT to patients who present at these institutions. Thus VCT could serve as an entry point for rapidly reaching the target population, particularly when clients know that if they test positive they might be eligible for ART.

### **Partners**

Several potential partners, who are already working in the health sector, were identified who might assist in the scaling up phase. The European Commission is supporting the Essential Drugs programme and the Blood Transfusion Service, while the Italian and French Cooperation, the Elizabeth Glazer Foundation and the Kapnek Trust are supporting PMTCT projects at several sites in the country. DFID is supporting the family planning programme through the Zimbabwe National Family Planning Council (ZNFPC). CDC is funding testing for HIV while USAID, through JSI and PSI, is funding aspects of the HIV programme such as VCT and delivery of commodities to outlying areas. The Red Cross is actively involved with Home Based Care.

Within the first round of the funds approved by the GFATM US\$ 2 million are specifically for ART, with a potential for applying for more funds in the 4<sup>th</sup> round. This proposal has already been technically approved by the Global Fund. But disbursement of funds will not be realised until the Zimbabwean Country Coordinating Mechanism (CCM) and the Local Fund Agent (LFA) have accepted the structure put in place for the financial management of these funds. To coordinate all these partners, a Partnership Forum for HIV/AIDS was set up in 2003 with particular focus on ART.

### **Human Resources**

Because the depleted staff complement at health facilities cannot cope with the demands of intensive counselling required for HIV clients, a new cadre of Primary Care Counsellor (PCC) has been created to relieve some of the load on doctors and nurses. Both cadres should play a crucial role in the ART roll-out and eventually make it feasible under prevailing circumstances.

With regards to the ART roll-out plan, and despite staff shortages, staff has been identified from the current establishment for training in ART. Minimum staff requirement standards for proper ART implementation at sites have been set. Some staff from the public sector have been attached to centres where ARVs are being offered e.g DART project, thus re-inforcing the use of the early sites (both NGO and research-based) as learning sites.

### **Procurement of AIDS medicines and diagnostics**

The main problem that delayed the start of ART in the public sector was the unavailability of ARV drugs due to the shortage of foreign currency to purchase drugs since initially all drugs had to be imported. There are now two local manufacturers of generic ARVs and another distributes for an Indian generic manufacturer. Before the recently introduced auction system for foreign currency, even locally produced ARVs were too expensive because of the parallel market exchange rate but now the prices are internationally competitive. All first line and alternative generic drugs have been approved and registered with the Medicines Control Authority of Zimbabwe (MCAZ). The Government Tender Board has now approved purchase from both local manufacturers and the representative of the foreign generic manufacturer. The MOHCW has placed orders with a local manufacturer of drugs for the first patients to receive ART at the initial sites in March 2004.

### **Laboratory Services**

There are two laboratories (Harare and Mpilo) that have been upgraded to perform CD4 counts, with assistance from CDC. This will be extended to other laboratories in the provinces and districts. In addition to performing CD4 counts, the National Microbiology Reference Laboratory (NMRL) at Harare hospital is now equipped to perform viral loads. Some of their staff is also trained to carry out resistance testing, though at present there is no equipment to perform them.

NatPharm is the normal supplier of reagents for haematology and chemistry tests, though hospitals can purchase directly from the private sector if NatPharm does not have them.

## **5 ECHO's Strategy**

The objectives for the Humanitarian Aid Decision ECHO/ZWE/210/2003/01000 are formulated as follows:

Principal objective: to improved humanitarian condition of vulnerable groups in Zimbabwe.

Specific Objectives of the Nutrition and Health Component are:

- to reduce malnutrition levels and to prevent malnutrition among children;
- to reduce HIV/AIDS mortality rates and to reduce growth of HIV/AIDS infection rates.

Components:

- School-, supplementary and therapeutic feeding;

- Mitigate the consequences of HIV/AIDS through enhanced prevention of mother to child transmission, HIV/AIDS awareness creation and nutritional, psychosocial, water and sanitation support to orphans and children-headed households.

Results:

- Improved access to supplementary feeding by children in food insecure districts;
- Reduced malnutrition rates and under five mortality rates attributable to malnutrition;
- Improved knowledge on management of severe malnutrition by health workers;
- Reduced malnutrition rates among school children and improved school enrolment in selected districts;
- Improved conditions for, and knowledge of, children-headed households.

The consultants considered the following aspects as specifically relevant for ECHO's nutrition and health strategy in Zimbabwe:

- Short term interventions with longer term impact;
- Coverage of food needs of vulnerable groups by general food distribution, supplementary food supply, nutritional education and training;
- Contribution to the prevention and treatment of HIV/AIDS;
- Maintenance of quality of existing social services;
- Avoidance of putting in place parallel structures;
- Combination of efforts through EDF and ECHO funds (aspect of LRRD).

## **6 Programme design and major findings**

### **6.1 Planning of Health and Nutrition Programmes**

ECHO partners proceeded differently in the process of project proposal development. On the basis of local needs assessments, available health and nutrition baseline data as well as the VAC assessments in 2002 and 2003, project proposals were designed by the ECHO partners in the field of school feeding, supplementary feeding for children below 5 years of age, therapeutic feeding in medical institutions and Home Based Care for HIV-Aids patients and their family members. In general, national guidelines relevant to the interventions have been consulted and used as guidance during proposal development because national authorities play an important role in giving permission to ECHO partners to operate in the country. The targeted beneficiaries and local stakeholders have not been consulted by all ECHO partners prior to submission of the proposal.

The ECHO assistants in Harare usually gives the partners an opportunity to improve their proposals. For health and food security related projects professional advice was provided by the concerned health expert of the Regional Support Office (RSO) in Nairobi whereas for nutrition related questions it is presumed that the implementing partner has the full expertise. After a joint

dialogue with the ECHO staff members in Brussels, the final acceptance or refusal of the proposal is decided in Brussels.

## **6.2 Intervention strategy – lessons learned**

### **Distribution of general food rations**

Strategic objective:

*“To improve food security and social well being for specific vulnerable groups like child- and female headed households, elderly, disabled, orphans, chronically ill and other beneficiaries who are classified by their own communities to be food insecure.”*

In the majority of the ECHO funded projects the distribution of a general food ration to vulnerable community members does not play a major role, except in Home Based Care programmes and in the commercial farming areas. Supplementary food rations to pregnant and lactation women have not been considered by the majority of ECHO partners.

### **Child supplementary feeding programmes (CSFP)**

#### **School feeding (primary schools)**

Strategic objective:

*“To increase school enrolment and attendance, to prevent drop-outs, to prevent a deterioration of the nutritional status.”*

For all primary school feeding programmes blanket wet feeding is the generally agreed intervention method. However, different amounts of food (100g versus 150g) have been planned by different ECHO partners for the same age group (primary school children). But during the field visit no differences could be observed in the actual portion of porridge distributed per child by different implementing partners (1 full cup for each child independently of the age of the child). The amount of food provided should be agreed upon in the nutrition working group in order to develop a coherent response among different partners working in the same field of intervention.

#### **Supplementary feeding for children under 5 years of age - at community level**

Strategic objective:

*“To cure moderately malnourished children and to prevent malnutrition”*

The SFPs were planned and implemented in partnership with the MoHCW because Rural Health Centres were used as holding points (for storage and distribution of supplies) and for programme monitoring. At the beginning health workers from the Rural Health Centres were trained who then trained Village Health Workers (VHW). The VHW then mobilised the communities to form feeding centres and to maintain monitoring records. Each feeding centre consisted of 30-50 children and was supported by a feeding committee.

Normally, the amount of the daily food supplement should be seen in relationship to the adequacy of the general food ration. But in Zimbabwe, the general food ration is given to specific vulnerable groups whereas the supplementary feeding approach of children under 5 has not been specifically targeted at community level.

At community level, **untargeted wet feeding** of all children <5 is the preferred method because mistrust in selection criteria seems to be widespread. The fact that wet feeding is more expensive and that not all wards are covered is widely accepted. In addition, untargeted wet feeding programmes have been implemented throughout the entire year without special consideration of the “hungry season”.

Blanket wet feeding (consumption of the meal on the spot) in areas with **levels of wasting > 7%** was recommended by the Nutrition Unit of the MOHCW for the following reasons:

- it ensures that all children in an identified area are fed to prevent further deterioration;
- each child receives at least one-third of its daily requirements;
- daily meetings provide an opportunity for education and psychosocial development of the children;
- it provides easy access for growth monitoring and surveillance;
- severely malnourished children can be detected earlier and referred to therapeutic feeding centres;
- it is a good opportunity to provide education for caregivers with regard to nutrition, hygiene and basic health care.

The usual arguments for blanket wet feeding are as follows:

- high prevalence of wasting;
- the security situation is poor and therefore, beneficiaries are at-risk when returning home with their dry rations;
- firewood and cooking utensils are in short supply so that it is difficult to prepare meals at home;
- due to acute food shortage of the whole family it is very unlikely that the take home ration will be given to the index child.

These arguments are not currently relevant in the prevailing situation of Zimbabwe.

Most important arguments for the advantage of **dry take-home rations** include:

- Logistical requirements are fewer and less staff is needed for the implementing partner, but larger quantities of food are needed;
- It is particularly appropriate for dispersed populations;
- It is less time consuming for the caretakers who only have to fetch the entitled ration and participate in the fortnight or monthly growth monitoring sessions;
- It keeps the responsibility for the feeding of their own children within the family;

- It carries less risk of cross-infections as large numbers of potentially sick children do not have to sit together and wait for the meals.

In most situations the advantages of take home rations outweigh those of wet feeding.

### **Supplementary feeding for children - at clinic/hospital level**

Strategic objective:

*“To cure moderately malnourished children and to prevent severe malnutrition”*

ECHO partner organisations involved in therapeutic feeding apply **targeted supplementary feeding** and distribute **dry food rations** at clinic level.

- Selection criteria for dry SFPs include weight for height <-2 to -3 z scores or weight for age below the 3rd percentile, decrease in weight for 2 consecutive weights, discharge from TFC, and special vulnerable groups (orphans, children from women/elderly headed households);
- Discharge criteria: WFH > - 2 z scores or above 3rd percentile for 2 consecutive weights, 3 months for children discharged from TFCs;

There seems to be no rational explanation why different dry rations have been planned and provided per child per day by different implementing organisation: e.g.:

- 250g CSB, 30 ml oil, 20g sugar (1280 kcal, 43 g protein)
- 300g CSB, 45 ml oil, 30g sugar (1760 kcal, 57 g protein)
- 300g CSB, 50 ml oil, (1570 kcal, 52g protein)
- 400g CSB, 40 ml oil (1857 kcal, 69 g protein)

Again, this issue should be discussed and agreed upon in the nutrition working group.

### **Therapeutic feeding – at hospital level**

Strategic objective:

*“To prevent death and to achieve rehabilitation of severely malnourished children”*

### **Training of medical personnel**

It was agreed among MoHCW, UNICEF and INGOs that there is a need to build capacity of medical staff before implementing the new treatment guidelines for severe malnutrition. Unfortunately, no consensus on the type of the protocol (WHO or Golden guidelines) was reached at the very beginning. Consequently, medical staff like matrons, nurses in charge of paediatric wards, nutritionists, paediatricians and district medical officers received different types of training (according to different protocols) in therapeutic care of severely malnourished children.

The original plan that high-level health professionals (who were trained by external consultants) would carry out the training at district level did not work due to time constraints of these professionals.

The two major ECHO implementing partners have trained a considerably high number of medical staff: 1,931 (96.8%) nurses, nutritionists and kitchen staff and **63 (3.2%) medical doctors.**

However, the number of medical doctors who participated in the training represents only a small proportion of those in need of training. In contrast, a high emphasis was put on capacity building of Village Health Workers (1,277 have been trained to recognise signs of severe malnutrition in order to improve the referral system).

### **Planning and supply of medication and therapeutic milk**

Medications (drugs, oral re-hydration solution for severely malnourished children / ReSoMal, and micronutrient supplements) needed for therapeutic care were procured and distributed in the targeted hospitals by each of the implementing partners.

Due to unrealistic planning figures and lack of co-ordination the amount of therapeutic milk purchased is estimated to be enough to treat about 18,600 severely malnourished children during the initial phase (F-75) and 25,000 during the rehabilitation phase (F-100). More than 50% of the funds allocated to this sector were covered by ECHO. UNICEF had not taken into account that the main implementing NGOs had their own sources of funding for therapeutic milk. In addition, UNICEF has accepted a transfer of excess therapeutic milk from Angola.

The reference ration of F-75 needed to treat one severely malnourished child during the initial phase is 1.5 kg per child and for F-100 it is 10 kg per child during the rehabilitation phase. One ECHO partner used up to 2.4 kg of F-75 and up to 23 kg of F-100 respectively. The long duration of stay due to the high HIV/Aids infection rate was given as an explanation of this higher usage.

For long-term planning it is recommended that only one organisation (e.g. UNICEF) should be responsible for the supply of therapeutic milk and medications.

### **HIV/AIDS and Health Projects**

All programme activities are coordinated with the National Aids Council (NAC).

### **Training of Home Based Care (HBC) facilitators and case finding of HIV/AIDS patients**

Each facilitator participated in a 4 week basic nursing course and a 10 day training in Home Based Care. Once a year, a 5 day refresher course will be offered. There are 10 clients per facilitator, and on average 2 facilitators per village. Training of facilitators focused on health and hygiene; capacity building in the field of nutrition has not yet been attempted.

About 10% of all households are affected by HIV/Aids and 247 orphans are living in the ward visited by the evaluators. Some orphans live alone but most of them stay with their uncles or



grandmother. HIV/Aids patients are diagnosed at medical institutions (clinics and district hospitals). The clinic gives a list of identified cases to the implementing partner. Registration of these clients takes considerable time (up to 2-3 months).

### **Food supply for HIV/Aids patients and their family members**

Food to registered patients and their family members is supplied on a monthly basis at the holding points (clinic or school).

A standard ration for a HIV/AIDS patients consists of:  
10.5 kg maize, 4 kg beans, 1.5 litre oil, 2 kg CSB, 1 kg sugar  
consisting of: 2443 kcal, 70g protein, 69g fat (per person per day)

A standard ration for one household member, orphans, care facilitator, etc  
10.5 kg maize, 1.8 kg beans, 0.6 litre oil, 3 kg CSB,  
consisting of: 1925 kcal, 61g protein, 40g fat (per person per day)

A standard ration for 5 household members consists of:  
50 kg maize, 11.2 kg beans, 14 kg CSB, 3.9 kg cooking oil.  
No explanation has been provided why a standard ration for 5 family members is not equal to 5 times a standard ration for one household member.

## **6.3 Monitoring and evaluation – lessons learned**

### **6.3.1 School feeding**

Monitoring of school enrolment and attendance as well as monitoring of the nutritional status of beneficiaries at sentinel sites is done on a regular basis by the school head masters and the implementing partners.

Anthropometric data of beneficiaries is collected from 10 randomly selected sentinel school sites. 10 children per grade from grade 1-4 (a total of 20 girls and 20 boys) are weighed on a monthly basis (the same day each month).

At the beginning there were problems with inaccuracy of standing scales used for weighing children who are heavier than 25 kg. Later on this was corrected and hanging scales which can weigh up to 50kg have been purchased. Nearly all ECHO partners intend to measure/monitor the nutritional status of the beneficiaries. However, only few of them were able to provide useful results of their surveillance activities.

A standard reporting format is used for identified cases of malnutrition and a follow-up is made with the child's family.

In one area, CSB with a bitter taste (procured locally) was distributed and the porridge was rejected by the school children. Quality control seems to be important in order to guarantee a well functioning feeding programme.

The achievements of school feeding programmes with regard to improved enrolments and prevention of drop-outs could have been even greater if school fees were paid for special vulnerable groups. So far, this was only attempted in special HBC programmes.

### **6.3.2 Supplementary feeding – at community level**

Monitoring indicators like record of attendance, monthly weight, age, family background, vitamin A received, and referral to hospital were recorded. Vulnerability indicators included “orphaned”, “child headed households”, and “disabled”. Regular monitoring of feeding activities was not possible by all implementing partners as there was no transport available for the district nutritionist and her assistant to carry out these visits. A national nutrition surveillance system has been implemented by the MoHCW, Food and Nutrition Council, the Statistical Office and is supported by UNICEF (10 sentinel sites in each district).

Several ECHO partners who are also involved in nutritional monitoring and surveillance share their results with MoHCW/UNICEF in order to enable early tracking of emergency needs in different parts of the country.

Community based supplementary feeding sites are supposed to include children discharged from therapeutic feeding units. In some areas there is good collaboration between different IP and a functioning referral system is in place. Currently, a referral card is being designed which should be accepted by all partners involved in food distribution projects.

### **6.3.3 Supplementary feeding – at clinic level**

Supplementary feeding programmes at clinic level (targeted dry feeding) apply the same monitoring system which is used in therapeutic feeding programmes (number of admissions, referrals, cured, defaulters, deaths) in order to enable better comparison between the two nutrition programmes organised at medical institutions.

Qualitative research methods such as focus group discussions, gender analysis, ranking and scoring activities, etc. can provide valuable information on beneficiaries’ perspectives and priorities, and should be included more often in project reports.

**Findings from focus group discussions with beneficiaries of supplementary feeding programmes (school feeding and under 5 feeding), carried out by the evaluation team during the field visits.**

- In general, children liked the taste of the CSB porridge (with the exception of one region where CSB with a bitter taste was distributed)
- Younger children were served first and received the same portion as older ones
- The CSB porridge did not reduce their access to other family meals (e.g. dinner or breakfast)
- Mothers of school children are actively involved in the preparation process (organisation of water, firewood, cooking pots, share of workload)
- Long distances to the nearest source of water and rapidly rising school fees were mentioned as major constraints
- The practice of overcooking the CSB porridge was observed. People are generally not used to the taste of soya beans. Therefore, some mothers cook the CSB for a longer period to get rid of the smell of soya
- Some mothers received training in the preparation of CSB, hygiene and the purpose of growth monitoring activities, but no information about the nutritional value of CSB and how it could be prepared locally.
- Vegetable gardens were mainly used for income generating activities
- Teachers reported a marked increase in attentiveness and participation in class since the inception of the project
- Mothers reported that their children are less likely to be sick since the beginning of the supplementary feeding

#### **6.3.4 Therapeutic feeding programmes**

Monitoring of therapeutic feeding programmes revealed that on average, less than half (46%) of the children admitted in medical institutions recover, about a quarter died (26%), another quarter defaulted (26%), and some of those who recovered/defaulted have to be readmitted or die at home. In reality, the mortality rates are even higher as, in Zimbabwe, case fatalities during the first 12 hours from admission are not registered. Follow-up home visits of those defaulted/discharged have not been performed. One ECHO partner was not able to report accurate monthly beneficiary statistics. The above mentioned results represent about 4,300 severely malnourished children of 2 major implementing partners during the last year.

41 hospitals out of 70 received training and started to implement therapeutic care. All children have been treated in existing paediatric wards which often reached the limits of their bed and caring capacity.

It was not possible to compare the current case load with that of former years because the reporting system for 'severely malnourished children' was completely different (e.g. severely malnourished children suffering from malaria or tuberculosis were reported according to their underlying disease).

During the strike of doctors and nurses in November/December 2003 the case fatality rate of severely malnourished children has increased considerably according to the statement of implementing partners.

Consented testing for HIV/Aids of severely malnourished children was not done on a regular basis and the results obtained were not shared among the medical personnel.

Due to increased training of Village Health Workers the detection and referral of children with signs of severe malnutrition has considerably improved over the last year

Not all ECHO partners have been in a position to transfer children recovering from severe malnutrition to a supplementary feeding programme (due to low coverage of SFP in certain regions).

#### **Feedback from medical doctors, nurses, nutritionists and kitchen staff**

- In the majority of paediatric wards visited the medical doctor currently in charge did not receive/attend training on the new treatment protocol of severe malnutrition (high turnover of medical staff because of routine rotation and brain drain).
- Medical staff/district nutritionists complained about the lack of coherence of different training courses and protocols applied by UNICEF, ACF, CESVI and MSF which makes transferral of medical staff extremely difficult
- Too theoretical training, introduction of the project was too fast, expectations were too high and expected too soon, facilitators role was too strong, weak communication and feedback, work was left for the facilitator, resistance to the protocol by doctors, nurses and kitchen staff
- Over the weekend and sometimes over night the therapeutic milk is not prepared (because not all staff members in the kitchen have been taught how to mix the milk) which can lead to increased mortality from hypoglycaemia in severely malnourished children
- Small baby beds are still used in several paediatric wards. This practice does not support mother and child bonding/breastfeeding and may contribute to a higher death rate due to hypothermia, especially during the night.
- The majority of severely malnourished children were below the age of 2 years indicating that inadequate breastfeeding, complementary feeding and caring practices seem to be a major cause of malnutrition in addition to reduced access to food
- More on the job training seems to be necessary as many staff members are unable to implement what they have learnt during workshops
- Village health workers have been trained how to recognize signs of severe malnutrition in order to motivate mothers to seek early treatment. The biggest constraints include lack of money for the transport, enough time to stay in the hospital for several weeks and the care of siblings left behind at home.

### **Feedback from mothers of severely malnourished children**

- Caretakers of severely malnourished children reported that they are happy to see their child quickly responding to the treatment
- The large majority of children liked to drink the therapeutic milk
- About one third of the caretakers presented the child to the traditional healer prior to admission and were offered traditional medicine
- Most mothers/caretakers received training to recognize signs of malnutrition
- Several mothers stopped breastfeeding their children a few months before they were admitted indicating that the weaning diet was inadequate (e.g maize porridge and soup)
- Mothers abruptly terminated breastfeeding of sick children (e.g. diarrhoea, fever) prior to admission
- About 20% of the caretakers were grandmothers taking care of severely malnourished orphans
- Caretakers were thankful that they received breakfast and 2 warm meals per day during their stay in the hospital
- Those mothers who had other children at home (in care of the grandmother or other relatives) wanted to go home as early as possible whereas single parent mothers or grandmothers caring for orphans did not complain about the estimated period of stay of about 3 to 4 weeks in the medical institution

### **6.3.5 HIV/AIDS – Home Based Care programme**

Reports are prepared on a monthly bases and include number of patients, male/female ratio, child headed households, orphans, amount of food distributed, training of facilitators, school fees paid and medical assistance for patients.

### **Feedback from HIV/Aids patients and their family members**

- Generally, the clients were very thankful to be included in this programme
- The food distributed lasts on average for about 2 weeks (especially in large families). Coping strategies of the other 2 weeks included: agricultural activities in their own field with the help of their children and relatives, borrowing food from neighbours or relatives
- The caregivers of the HIV/Aids patient have been well informed about the preparation of the CSB but had no adequate knowledge about the duration of the cooking period. Overcooking of CSB seems to be a widespread problem
- The facilitator comes twice a week to look after hygiene and medical needs of the patient
- Most important items for the patient include: ORS to prevent dehydration from diarrhoea, soap and washing powder to improve the hygiene conditions of a patient frequently suffering from diarrhoea, skin ointment to avoid skin infections, disinfections of sore mouth, etc.
- School fees for the youngest child are currently paid

### Focus group discussion with a HIV/Aids support group

- A group of 13 women and 3 men tested HIV positive participated in the discussion.
- The main idea is to visit each other for psychological support and to generate some income (for school fees).
- The project could be realized because the kraal head (head of community) was supportive and allocated a plot of land for a communal vegetable garden. In addition to the income gained by selling of vegetables the women produce different types of handicrafts (knitting, sewing and basket production) and try to sell it.
- All of them have already lost their partners and most of them have to care for children. The mothers have been informed about the risk of transmission by breastfeeding, but the majority of them have no financial means of buying infant formula. Consequently, many mothers apply mixed feeding which is associated with the highest risk of transmission.
- According to their own perception, the biggest problems they are currently facing seem to be lack of soap and access to adequate health care.

## 7 Relevance / appropriateness of nutrition and health-related interventions

The food-related crisis in Zimbabwe is not mainly caused by unfavourable weather conditions. It is a combination of several factors such as:

- the high prevalence of HIV and AIDS among the population with tremendous effects on the labour force and productivity;
- limited productivity of the commercial agricultural sector due to the consequences of the land reform pushed by the GOZ since 2000;
- misguided market reforms and poor governance;
- lack of foreign currency and hyperinflation;
- economic decline, shrinking manufacturing by almost 20%;
- decline in tourism revenues by 50%;
- the high unemployment rate of about 70%, especially in urban areas;
- low salary, low motivation of staff, high brain drain;
- lack of adequate rain fall during the last 2 years.

All these factors make substantial external support necessary to prevent a humanitarian disaster. The main aim of the support provided by the EC through ECHO is to ensure food security among the most vulnerable groups, access to safe water and sanitation and basic social services by maintaining the well developed social services structure of the last decades.

Available data demonstrate that there is an overall food shortage in the country and consequently a need for external support in the form of food aid. In addition, an increasing trend in the prevalence of severe malnutrition, in infant and under-five mortality rate, a reduced coverage of EPI services and increasing numbers of vulnerable groups such as single headed households, and orphans indicate that especially children are suffering from the current crisis.

Under the given political situation and socio-economic decline the choice of strategies (school feeding, supplementary feeding, therapeutic feeding and Home Based Care) seems to be appropriate in the field of health and nutrition.

According to the available background information (see chapter 3) the decision to target primarily children living in rural areas was to some extent appropriate. However, the results of a not yet officially released Urban VAC assessment (data collected in Sept/Oct 2003) indicate that future programmes should additionally consider the special needs of the urban poor, especially those who are suffering most from the consequences of HIV/Aids and the current economic crisis.

Due to the fact that the results of the national nutrition survey (data collected in Feb 03) had not been released at the time of the financing decisions in 2003, the regions chosen by the ECHO's partners do not necessarily represent the areas with the highest levels of malnutrition (GAM and/or SAM).

In addition, blanket wet feeding of all children under 5 years at community level was not the most appropriate method chosen under the prevailing nutritional situation in Zimbabwe according to the opinion of the consultant. The same outcome (prevention of malnutrition) could have been achieved through dry feeding which is a less costly intervention. Potential advantages of wet feeding programmes such as nutrition education of caretakers were not fully utilised.

Although the prevalence of Global Acute Malnutrition (GAM: 5%, range: 2.6-10.7%, 2003) has been quite constant over the last 10 years, the prevalence of severe malnutrition (SAM: 1.4%, range: 0,2 – 5%) indicates an alarming situation in certain areas. 15 districts (25%) have a prevalence of SAM of equal or above 2% which is worrying. Therefore, the decision to invest in programmes considering both the prevention and treatment of severe malnutrition was appropriate and needs to be strengthened in further funding decisions.

The high prevalence of HIV and AIDS (24,6% of population according to Government of Zimbabwe and 34% according to UNAIDS data) affects the country's economy, food security, social security, health system and the caring capacity of families.

The HBC projects contribute to the alleviation of the impact of HIV and AIDS on the affected households. To face the alarming problems related to the rapidly rising number of orphans and single headed households more investment in VCT, PMTCT and ART is needed. The support of these programmes will also support maintaining the quality of social services in the health and education sector.

## **8 EFFECTIVENESS (Means to Activities)**

In the Health and Nutrition sector there are basically three different approaches/conditions which do not allow a direct cost comparison of implementing partners:

- UN-Organisations like WHO or UNICEF work exclusively through existing governmental structures based on their implementing and absorption capacity;
- International NGOs rely on their own implementing capacity and their ability to collaborate directly with local authorities and staff at community level;

- The International Red Cross is able to rely on the network of the Zimbabwean Red Cross and SCF-UK has been successful in operating within the former commercial farmlands through a local NGO called Farmer's Community Trust of Zimbabwe.

Therefore, the total cost of the interventions broken down by sector in comparison to similar projects has to take into account the different approaches and contextual differences (e.g. more emphasis on human resource development versus delivery of services).

Cost per beneficiary per month of comparable programmes (e.g. school feeding, supplementary feeding, ) are summarized in Annex VII.

The average cost per child per month of school feeding was € 2.2 with a range of € 1.3 to € 3.2 (Annex III).

The average cost per child per month of supplementary feeding was about € 1.8 with a range of € 0.7 to € 4.3 (Annex VII).

The average cost per beneficiary (admitted severely malnourished child, food for caregiver, medical staff member trained, and moderately malnourished child rehabilitated) per month of a "combined" therapeutic/supplementary feeding programme was about € 20 with a range of € 5 to € 30 (Annex XII).

While the budget of school and supplementary feeding programmes appears to be very cost-effective, the cost of therapeutic feeding programmes includes several indirect benefits (such as capacity building of medical staff, food for caregivers) which go beyond the immediate result of rehabilitating an individual child.

Unfortunately, capacity building of health personnel did not primarily focus on training of medical doctors who have the main responsibility in paediatric wards. Better training in case management could have had a considerable impact in reducing the relatively high case-fatality rate of about 20%. Successful recovery of a severely malnourished child is one of the most cost-beneficial humanitarian aid actions. Alternative approaches such as community based therapeutic care (CTC) are generally not cheaper but they can considerably increase the coverage from about 20% in TFP to about 70% in CTC (ENN, 2003).

## **9 EFFICIENCY (Activities to Results)**

### **9.1 Technical Approach**

The methodology was largely comparable for school feeding and community based supplementary feeding projects where untargeted wet feeding was applied.

The major focus was put on procurement, transport, storage and monitoring of food aid and beneficiaries, but less emphasis on community development and training of beneficiaries in nutrition and health related topics.

Clinic based supplementary feeding programmes have been designed to target moderately malnourished children (prevention of severe malnutrition) and to assist those recovering from severe malnutrition.

The applied methodology of therapeutic feeding programmes differed widely among the implementing partners. It varied from minimal to maximum input with respect to training, implementation, monitoring and evaluation.



## **9.2 Inputs**

All ECHO partners work with and through local and expatriate staff. Depending on the individual ability to delegate power and to share information, more or less external human resources are employed within different projects, which have a direct implication on project costs.

Building local capacity is the key to produce the expected results in health and nutrition. More emphasis on local capacity building could even produce better results with a longer term impact. In addition, the necessity to use existing social services (school, health services) as entry point of external aid makes training and regular supervision of local staff indispensable.

Although the technical and managerial competence of ECHO partners staff members has not been assessed systematically, the available reports and the direct observations by the evaluators in the field have guided a number of recommendations concerning the selection of local and expatriate staff:

- The high turnover of expatriate staff at the beginning of the interventions in 2002 has resulted in weak institutional memory;
- A positive and encouraging attitude of a highly qualified facilitator is of utmost importance for successful “on the job training” activities;
- Especially in medical institutions the usual staff rotation leads to the need of repeated initial as well as continuous on the job training. In addition, the high “brain drain” due to migration of qualified medical staff to other countries in the region, to Europe or the United States is challenging the training and supervision activities within each project. This situation is also reflected in the high vacancy rates of medical doctors (55%) and nurses (40%) respectively (MOHCW, 2003).

## **9.3 Outputs (Results)**

ECHO's partners working in the field of school feeding and supplementary feeding at community basis could largely achieve the proposed results within the given time frame.

In therapeutic feeding programmes the number of beneficiaries has been greatly over-estimated, and therefore, the expected outputs (number of severely malnourished children treated in medical institutions) have not been achieved from a quantitative perspective. At the same time, the hospitals' capacity for the admission of severely malnourished children is limited. In most paediatric wards the bed capacity does not allow admission of more than about 10 severely malnourished children per month.

## **9.4 Unplanned results – Lessons learned**

### **9.4.1 Wet feeding**

- Results of the National Nutrition Survey (February 2003) and personal communications with representatives of ECHO partners indicated the concern that some children who benefit from supplementary meals (wet feeding) may get less food at home (e.g. no lunch after supplementary feeding of under 5s in the morning or no dinner after a porridge at lunch time in school). This issue has not been confirmed during focus group discussions with women and school children during our field visits. One of the reasons could be the

fact that harvesting of green maize has already started (which can be seen as a major contributing factor for improved seasonal food security). On the other hand, the comment *“children who participated in CSFP were more likely to receive 2 or less meals per day at home whereas children who did not receive supplementary food were more likely to receive 3 meals (substitution)”* published in Nutrition Update (UNICEF 2003) could also partly indicate proper targeting (because the SFPs at clinic level are targeted programmes).

- One of the major problems encountered in wet feeding programmes was the long duration of cooking. Mothers have been instructed to cook the porridge for 9 minutes but they did not learn the difference in the nutritional value between CSB (as a precooked blended food with added micronutrients) and the normal maize flour. Traditionally, mothers are used to cook their maize meal porridge for a minimum of half an hour. On the other hand, the long cooking time (which decreases the nutritional value of the porridge) can not adequately be reduced under the given situation where fire wood and extremely large cooking pots are used. In addition, some mothers believe that long cooking can reduce the taste of soya and others are afraid that undercooking could lead to accusations from other mothers in case their children get sick.
- In one area cooking of porridge for school children did not take place due to distribution of CSB with a bitter taste. One of the reasons could lie in inadequate soaking of soya bean during the process of CSB production as the distributed CSB with a bitter taste had also a different colour. Ongoing quality control is of utmost importance for the success of any feeding programme.

#### **9.4.2 Therapeutic feeding**

- Nearly all therapeutic feeding centres register a high mortality rate which seems to be largely due to a combination of different factors such as lack of rooming-in, bedding-in, cold nights (leading to hypothermia), lack of provision of therapeutic milk over night and/or over weekends (hypoglycaemia), lack of breastfeeding promotion for infants and early consideration/treatment of underlying (Tb, HIV/Aids, etc.) and other infectious diseases.
- Currently there are two different therapeutic feeding protocols and training courses in use (UNICEF and WHO protocols) which have been introduced too fast due to the emergency character of the projects funded by ECHO (short term contracts, indicators based on rates and figures without consideration of individual factors). In addition, the strict application of the different protocols makes transferral of medical staff members extremely difficult.
- Despite the fact that medical doctors are key decision makers in paediatric wards, only a few of them participated in the training. However, the majority of deaths from severe malnutrition occur during the initial/stabilisation phase where the main responsibility lies in therapeutic directives of medical doctors.
- Another unfavourable factor was the usual rotation of trained medical staff. With support of the MoH, hospital matrons were requested to avoid high staff rotation in the paediatric ward to prevent further loss of trained staff.
- Provincial medical doctors were asked to support the TFU by sending a letter to kindly request the hospital staff to follow the treatment protocol and to integrate therapeutic feeding as a MoH project.
- Due to weaknesses in planning and co-ordination of the nutrition working group a large overstock of therapeutic milk products has been accumulated which will expire soon.

- The high defaulter rate can be partly explained by the intended long duration of stay in medical institutions. The majority of mothers who have other children at home (in care of the grandmother or other relatives) need to return home as soon as possible. The possibility of community based rehabilitation needs to be explored in Zimbabwe.
- There is confusion among the medical personnel with respect to wasting indicators which have been introduced by emergency staff members. In mother and child health clinics and growth monitoring programmes weight for age is commonly used as a composite index which reflects either wasting (WFH) or stunting (HFA) or a combination of both and is very useful for interpreting the growth of individual children. In contrast, weight for height (wasting) is appropriate in camp situations where access to accurate age is not available.

## **9.5 Quality of monitoring and evaluation (accountability to donors)**

In some programmes overemphasis is put on documentation and data collection as the main monitoring aspect within a project. Monitoring of processes as well as of weaknesses due to individual capacity gaps is often not emphasised at an early stage.

Each project has a budget line for evaluation. Not all ECHO partners do profit from the opportunity to get external feedback on key aspects of their project (management, administration, technical approach, integration into local structures, participation of stakeholders and beneficiaries, cross cutting issues). The quality of the submitted reports varied widely. Several ECHO partners mentioned that they would like to receive constructive feedback on their evaluation reports from ECHO staff members.

ECHO partners of TFPs suggested that quarterly reports should be submitted after four months, otherwise the data of the third month cannot be fully included. At a certain point, a monthly report was requested by ECHO - an additional amount of work which was not fully justified due to lack of adequate feedback according to the opinion of the implementing partners that were interviewed.

Feedback on the process of project implementation and the quality of interventions is mainly based on interim and final reports and project visits by ECHO staff members. Administrative and managerial recommendations have been taken into account, whilst technical issues have not always been considered properly in a timely manner.

Some of the ECHO partners have shared their results and findings with their own staff members on a regular monthly basis. Exchange of evaluation results among ECHO partners working in the same field has not yet been attempted. But, co-ordination of the TFPs and its referral system has been functioning among the major implementing partners.

## **10 EFFECTIVENESS (Results to specific objectives)**

The extent to which the ECHO funded school feeding and supplementary feeding operations have achieved the defined specific objectives (*to reduce malnutrition levels and to prevent malnutrition among children*) is partly reflected in the results of the national nutrition survey (reduction of GAM from 6.4% in May 2002 to 5% in February 2003), of regional nutrition surveys

of certain implementing partners as well as in community based surveillance of school feeding and supplementary feeding projects of children under the age of 5 years.

However, in therapeutic feeding programmes the extent to which the intervention has led to improved nutritional status and/or has prevented the death of a child depended to a large extent on the training and the motivation of the medical staff. Unfortunately, only a very low proportion of medical doctors (<4%) have been reached by the training of the new treatment guidelines for severe malnutrition. In addition, due to high work loads in the clinics, low salaries and low purchasing power, the overall motivation of the medical staff was felt to be generally low. Other reasons why therapeutic feeding in medical institutions has not been very successful, include risk factors for hypothermia (lack of co-sleeping) and hypoglycaemia (lack of provision of therapeutic milk during the night and during weekends), and the presumed (mainly untested) high prevalence of HIV/Aids.

How much severely malnourished children and their caregivers have really benefited from the services provided depended also on the quality of care and nutrition education skills of medical staff as well as the availability of time mothers can spend in the medical institutions.

## **11 COVERAGE**

There is no comprehensive and easy way to capture an overview of all humanitarian projects in the country. Possible overlapping or areas of missing support are difficult to assess and overall co-ordination is still, after 2 years of humanitarian interventions, insufficient.

It has not been possible to draw a complete picture of all interventions targeting the needs of the population in nutrition and health. RRU is not yet able to collect all necessary data and information to facilitate effective co-ordination. This is mainly due to problems of access to project data from all implementing agencies and to data to be provided by the government of Zimbabwe. Available overview of coverage of school feeding programmes (collected by WFP and RRU – Annex IV, V, VI), and of supplementary feeding programmes (collected by RRU) is presented in Annex VIII.

With respect to therapeutic feeding there is a good overview (Annex XIV) about hospitals whose medical staff received a training (n=39) compared to those who did not yet receive a training (n=30). In 7 hospitals without prior training the prevalence of severe malnutrition is => than 2% (range 2 to 4.5%). The medical doctors and other staff members of these hospitals should receive priority in any future training activities. Nearly all hospitals (except 2) whose staff members participated in training implemented the new treatment guidelines for severe malnutrition. An overview of coverage of TFPs is presented in Annex XV (provided by RRU).

To improve the coverage caregivers were reimbursed for their transportation costs and received food during their stay in the medical institutions. In addition, there was training of village health workers to recognize signs of severe malnutrition in order to make early referrals. To invite traditional healers to join the training course was also one appropriate option of achieving a better coverage and early referral of severely malnourished children.

Beneficiaries of supplementary feeding programmes regarded the coverage of the general food ration as inadequate because in their opinion only highly vulnerable groups received food aid.

## **12 IMPACT**

The wider planned outcomes – improved humanitarian condition of vulnerable groups in Zimbabwe have been achieved by the ECHO funded interventions in the field of nutrition and health. The ongoing food aid distributions (via school feeding, supplementary feeding and the general food ration for vulnerable groups) certainly contribute to a lower prevalence of malnutrition.

Access to services (e.g. schools, medical institutions, Home Based Care) has improved for vulnerable groups due to ECHO support during the last years. The ECHO partners attempted to improve the impact of the TFP by increasing coverage and expanding the programme to the community level (e.g. training of VHW in recognizing signs of severe malnutrition to achieve earlier referral). However, a higher involvement of medical doctors at hospital level could have contributed to a considerable reduction in case-fatality during the initial phase.

The establishment of community committees for the co-ordination of all different feeding activities has further improved community cohesion and the decision making process. Effective communications with higher government levels was difficult to achieve but the relations at district and local level were reported to be good.

Better co-ordination among ECHOs implementing partners and the sector specific working groups could have contributed to an even larger impact.

Monitoring of the impact of the interventions was not done systematically by the majority of implementing partners. However, interviews with beneficiaries and key informants revealed that ECHO funding has made a significant contribution to strengthen their coping strategies, especially in the field of HIV/AIDS and to reduce death from severe malnutrition.

## **13 SUSTAINABILITY**

### **13.1 Community participation**

In general, community members are informed and welcome the ECHO funded interventions in the field of nutrition and health.

Registration of beneficiaries for general food distributions is a comprehensive process and requires active community participation of village committees, community leaders and public meetings. Due to the fear of politicisation of food aid there are also transparent community control mechanisms in place including complaints committees.

On the other hand, there was no adequate beneficiary involvement in the design of supplementary feeding programmes. In the opinion of ECHO partners, alternative feeding methods (e.g. benefits of dry versus wet feeding) could not be discussed with the potential beneficiaries as the GOZ strongly advocated wet feeding.

In school feeding and supplementary feeding projects community members and representatives are actively involved in the implementation process (supply of firewood, cooking pots, plates for meals, share of workload among women, etc.).

Women received instructions on how to prepare the CSB porridge but no information was shared about the nutritional value of the porridge. The majority of the women wished to learn more about food preservation methods and the nutritional value of highly recommended food combinations (e.g. cereals, legumes, nuts, vegetables) in order to become independent from food aid in the long run.

With respect to TFP, local power-structures, status systems and local beliefs were not adequately taken into consideration by all implementing partners (e.g. to train medical doctors prior to other staff members, to invite local healers to training sessions).

Caregivers of severely malnourished children stated that they would like to learn more about the benefits of exclusive breastfeeding, appropriate complementary feeding, how to recognize early signs of malnutrition and adequate care for a sick child.

Community members of HIV affected households are assisted by Home Based Care facilitators. Especially for single parents the HIV/Aids support group is of utmost importance as it provides psychological assistance and the possibility to participate in income generating activities.

## **13.2 Connectedness**

Although community participation and involvement of local leaders in the identification and planning of the ECHO funded projects have not always been prioritised, feeding projects and Home Based Care projects rely to a large extent on local implementing structures such as health facilities, schools or local NGOs.

With respect to therapeutic feeding, the projects have been implemented as a relief programme but in reality it addressed an endemic problem with a clear potential for an escalation due to the rapidly deteriorating social and economical living conditions in Zimbabwe. Local ownership of objectives and achievements of therapeutic feeding programmes is not yet strong enough as the medical personnel was not adequately consulted during the planning period and felt overburdened during the implementation phase.

Despite the specific character of the protracted emergency in Zimbabwe, which calls for substantial development orientated interventions, the concepts of the majority of the projects are still dominated by their emergency relief approach. A combination of emergency interventions and activities to support development is needed.

## **13.3 Coherence**

The Government of Zimbabwe has developed a number of guidelines and roll-out plans for interventions in the health and nutrition sector (e.g. guidelines for nutritional surveillance, HIV/Aids counselling, etc) which are largely taken into consideration by the ECHO funded operations.

By the end of March 2004, uniform national guidelines for therapeutic feeding in district hospitals will be elaborated. However, guidelines should be used for informed decisions, but not as a dogma.

UN-Organisations are the leading agencies for different sectors to ensure that project concepts adhere to already existing standards, rules and regulations. However, effective co-ordination via the different thematic working groups is still rare. Coherence becomes an important issue especially when humanitarian actors have limited access to certain regions (e.g. former commercial farming areas are supported by SCF-UK via a local NGO called Farm Community Trust of Zimbabwe).

Because of the centralized structure of the GOZ it is important that the framework which the government sets in the field of health and nutrition must include advocacy from the local and NGO level.

## **14 CROSS CUTTING ISSUES**

### **14.1 Focus on both – curative and preventive activities (LRRD)**

The humanitarian disaster in Zimbabwe has been effectively prevented by the emergency aid provided by ECHO and other donors. To slow down further the rapid deterioration of social services and poverty in Zimbabwe, rehabilitation and development orientated measures are needed and ECHO funding should support such project concepts instead of just trying to fill the gaps.

ECHO does not give much guidance in proposal development and partners are often not aware of the importance ECHO puts on the link between relief, rehabilitation and development.

Current data from different needs assessments and nutrition surveys indicate that the time has come for more emphasis on preventive measures to face the needs in the field of nutrition and health of the most vulnerable population groups.

There is an ongoing discussion among donors on the cost and appropriateness of the current therapeutic feeding programmes in medical institutions in Zimbabwe. In the form of 2 pilot projects (one in a rural area and one in an urban setting) it should be explored if community based rehabilitation of malnourished children is a feasible alternative in Zimbabwe.

The specific situation in Zimbabwe would still allow emphasising co-funding of development measures in addition to the relief interventions. The ECHO funding should contribute to the prevention of further rapid deterioration of social services. This is in line with the view of other donors, and meets the strategy of other EC programmes in the country.

### **14.2 Gender**

In general, there was no special effort of implementing partners to increase the participation of women in decision making processes. The head of community support groups was usually a man and even the organisation of women cooking the porridge of supplementary feeding programmes was supervised by a male community member. In addition, there was no analysis by the implementing partners of the impact of wet feeding programmes on the workload of women.

Women are targeted through assistance to female headed households by general food distribution and HBC activities. Traditionally women have the role to care for their children and their husband. Especially in HIV/AIDS affected households women need more attention from the projects funded by ECHO as men (in Zimbabwe) are culturally not obliged to care for their sick wives and children.

Especially in rural areas, women are reluctant to be tested for HIV/Aids because they will be chased out of the house by their husbands, if tested positive. Early treatment of HIV/AIDS positive mothers and prevention of transmission of HIV infection from mother to child is both very important as the loss of a mother is very crucial to infant/young child survival.

Food insecure female headed households are more likely to apply harmful coping strategies, such as prostitution or spending days without eating. Girls and orphaned children are marginally more likely to be removed from school than boys and non-orphans respectively (ZimVAC 2003).

### **14.3 Children, orphans, elderly, disabled**

General food distribution is targeting especially children of very poor households, orphans and women and elderly people when head of household. The list of beneficiaries is established by community members according to 15 different criteria. A specific dilemma relates to the inability of children to raise their individual concerns due to their frequent invisibility in community structures.

Primary school children receive a CSB porridge at lunch time and children < 5 years do get a supplementary CSB porridge at about 10 am in the morning in areas where such programmes are implemented. Orphans are usually looked after by close relatives such as uncle or grandmother.

The current HIV/AIDS pandemic will directly (linkage between infection and malnutrition) and indirectly (lack of caring capacity) increase the prevalence of malnutrition among children. The nutritional status is usually worse among children who are orphaned. Recently, orphan-headed households are begun to be targeted by HBC facilitators in certain areas.

27% of households who lost an adult to chronic illness, removed a primary school aged child from school (between 6 and 14 years) in the last year, compared to 16% of households who did not have a death from chronic illness (ZimVAC 2003).

### **14.4 IDPs and displaced farmers**

Currently, “Internally Displaced People”, are not necessarily a specific target group of ECHO funding. The approximate number of IDPs in Zimbabwe is not known at present. The bulk of migrating people within Zimbabwe appear to look for better economic opportunities.

Access for international staff to resettlement and former commercial farm areas is still limited. Reliable and comprehensive figures on prevailing needs in health and education, water and sanitation and food security are not yet available. ECHO is currently funding a school feeding project of one IP under a subcontract of a local NGO (FCTZ) in the commercial farming areas. In addition, special vulnerable families (single parent households, orphans, and families who suffer



from the consequences of the commercial land reform that has ended their employment) receive supplementary food rations on a monthly basis.

## **14.5 HIV/AIDS**

In a medium time frame, HIV/AIDS is the major threat to development of Zimbabwean society. As a cross cutting issue it should be integrated in all components of each project financed by ECHO.

Even the projects with a closer focus on logistical aspects like food distribution and transport of food should include substantial information and education on HIV/AIDS for the beneficiaries and for the project staff. These activities should be orientated by the national guidelines to fight HIV/AIDS. Thus mainstreaming HIV/AIDS is an essential strategy for sustaining ECHO funded measures.

## **14.6 Protection and human rights**

Advocacy regarding adequate nutrition as a human right is essential. Vulnerable groups like children, women and persons with disabilities should be particularly targeted by ECHO funded interventions. Several public meetings are necessary to maximise the transparency of the selection and registration processes.

Channelling complaints and suggestions related to food-aid operations in Zimbabwe should be done in an independent and child friendly manner. Much emphasis is put on monitoring activities to prevent the politicisation of food aid.

## **14.7 Visibility**

Visibility of ECHO funding is present everywhere. In certain settings the emphasis on visibility expressed by stickers on each item financed by ECHO can be counterproductive: i.e. in public health facilities, where ownership of local staff is crucial for the continuity of services and the success of the programme. Some of the therapeutic feeding projects financed by ECHO are seen by the local staff as purely ECHO initiatives and the involvement of local staff is difficult to achieve. This attitude of local staff is partly caused by the division between 'hospital owned' and 'ECHO funded' items, and the inequality in salaries and working conditions for local, governmental staff and staff hired by ECHO partners

# **15 RECOMMENDATIONS**

## **15.1 Recommendations at strategic level**

- Measures with respect to nutrition and health, funded by ECHO should as far as possible be adjusted to existing national policies, strategies and structures.
- On the basis of the National Nutrition Survey (2003) and the ongoing nutritional surveillance, ECHO should support school feeding and supplementary feeding

programmes of implementing partners who choose to work in areas with highest levels of GAM (Annex II) and lowest level of current coverage. In view of the findings of the Urban VAC assessment (2003) targeted supplementary feeding programmes should also be supported in urban and peri-urban areas.

- National authorities, lead agencies and their humanitarian working groups should be consulted before submission of proposals. For each of the respective regions an optimal feeding approach (blanket dry, blanket wet ration, targeted wet etc.) should be agreed upon in the nutrition working group. As a profound understanding of living conditions and felt needs of community members is essential, their active participation in planning, monitoring and evaluation of programs is needed. Communities themselves could even be capable of deciding upon the appropriate type of feeding within their specific context.
- Currently, a good overview about all hospitals in relationship to prevalence of SAM, training and implementation status of therapeutic care (see annex XIV) exists. In future, new ECHO commitments should take this information into consideration and give priority to training of medical doctors and nursing staff in areas with a high prevalence of SAM (e.g. >2%). The maximum funding period has to be allocated especially for medical institutions where human resource development with long-term effects is aimed for in contrast to projects where delivery of goods is the main objective.
- Capacity building in therapeutic care of severely malnourished children should be incorporated into training curricula of medical students and nurses.
- The complexity of underlying problems demands more development orientated programmes in the field of nutrition and health. A conceptual model with emphasis on capacity building and support to social services is needed for dealing with the protracted crisis in Zimbabwe.

## **15.2 Proposed additional areas of ECHO funding**

### **15.2.1 HIV/AIDS**

- Introduction of Support to PMTCT programmes into the ECHO funding portfolio.
  - PMTCT+: ARV for mothers and fathers
  - Nutritional support for mothers and children
- Support the feeding of children of HIV+ mothers after cessation of breast feeding (4 to 8 months after delivery, replacement feeding)
- Co-financing of ART (8<sup>th</sup> and 9<sup>th</sup> EDF: ARV / ECHO: technical assistance to set up the decentralized structure)
  - ARV through EDF
  - TA and Equipment through ECHO (short term action - long term impact)
  - Support of monitoring and supervision systems at community level (village health workers, volunteers/facilitators)
- Home Based Care:
  - intensification of training of facilitators on nutrition, basic paramedical care
  - promotion of support groups

- continuation of food supply for HIV/AIDS affected households
- connection of HBC facilitators with village health workers

#### **15.2.2 Availability and accessibility of Essential Drugs**

- Identification of problems related to the regular procurement and availability of essential drugs at health facility level
- Support of free access to drugs for HIV+ individuals to treat opportunistic infections

#### **15.2.3 Training of Health staff**

- Contribution to the training programme of Community Care Nurses (in total it is a 18 months training programme)
- Continuous and short term training on the job to avoid absence from work and non-application of knowledge and competency

#### **15.2.4 Blood Safety**

- Financial support by DFID and EU up to 04.2005
- A needs assessment will be necessary, in order to be able to identify possible areas of support.

#### **15.2.5 EPI**

- Financial support by UNICEF, DFID and EU up to 07.2005
- There is an urgent need for support to the cold chain and the procurement of vaccines (the cold chain has collapsed and availability of vaccination services at district and community level has become very low). The MoH will communicate health services indicators that will be analysed for designing a comprehensive picture of the actual situation.

#### **15.2.6 Community-based therapeutic care (CTC) or Outpatient therapeutic care (OTC)**

This concept has not yet been introduced in Zimbabwe, but experience from other African countries, e.g. Malawi, does exist. For complicated cases of severe malnutrition the initial treatment phase has to take place in a medical institution. As the CTC concept has its own advantages and shortcomings in different contexts, a pilot phase with respect to different treatment approaches in urban as well as in rural communities is recommended:

- Community based therapeutic care (CTC) approach in rural areas
- NRC<sup>2</sup>/day care centre (OTC) attached to hospitals in urban areas

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<sup>2</sup> A nutritional recovery centre is the first referral unit for the therapeutic feeding units and both are hospital based. A NRC in a hospital is functioning like a day care centre.

### **15.3 Recommendations at management level**

- ECHO should more intensively assist partners in terms of technical support during the planning and implementation of projects. Furthermore, regular feedback on mid-term reports and evaluations of nutrition and HIV/Aids programmes is required.
- Exchange of evaluation reports among ECHO's partners working in the same field is recommended in order to promote inter-agency learning.
- Co-ordination meetings between ECHO and its partner should be held on a regular basis in order to be timely informed about delays and/or modifications during the implementation period.
- Additional technical support by the RSO and/or by the country office in Harare to ECHO partners during elaboration of project proposals, at least intermittently, should be guaranteed.

### **15.4 Recommendations at operational level**

#### **15.4.1 School feeding**

- To improve the water supply in school compounds
- To raise awareness among mothers about the nutritional value of CSB in order to achieve a shorter cooking time.
- To develop and evaluate affordable and culturally appropriate alternative recipes which can be easily prepared at household level (e.g. combinations of maize, beans, groundnuts, etc. see annex IX and X) in order to reduce dependency on external support.
- To assist in establishing vegetable gardens for training purposes and distribution of seedlings (e.g. fruit trees, etc.)
- To assist in training of teachers in nutrition and health related topics

#### **15.4.2 Supplementary feeding**

- The quantities of food supplied by the different wet and dry feeding approaches should be discussed and agreed upon in the nutrition co-ordination meetings
- Higher emphasis should be given to the following training topics of caregivers in the community
  - promotion of exclusive breastfeeding during the first 6 months of life
  - timely introduction of adequate complementary feeding
  - appropriate care of sick children including home-based management of diarrhoea
  - recognition of early signs of severe malnutrition and prompt referral to a medical institution
- To promote well known local food combinations such as Mutakura (a mixture of grain, groundnuts and cow beans) or Nhopi (a mixture of pumpkin, peanut butter and cowpeas) for adequate complementary feeding and the concept of a healthy family diet

- The supplementary feeding programme as a short term intervention is based on assessment of wasting (weight for height measurements). This anthropometric method which is introduced as a parallel assessment system is not superior to the already existing measurement of weight for age applied at clinic/hospital level. Thus emergency staff should not try to replace the latter one.
- Specific follow up strategies should be elaborated with respect to vulnerable groups like children with disabilities, HIV/AIDS, socially disadvantaged families etc.
- Ready to use therapeutic food (RUTF) or a dry food ration should be given to malnourished children who cannot stay in the hospital until full recovery (e.g. defaulters) and who are not covered by a community-based SFP.
- Long term nutritional training is needed to increase the diversity of the family meals. Production and consumption of more legumes/pulses to increase the protein content of the local maize-based diet should be emphasised in rural and urban areas.
- Opportunities to promote more vegetable gardens should always be linked with nutrition education about a healthy family diet.

#### 15.4.3 Therapeutic feeding

- Hospitals located in areas with a high prevalence of SAM (>2%) should be given priority in training medical personnel in therapeutic care of severe malnutrition.
- In the current stage, through support of MoH, medical doctors should be primarily targeted to receive training in the new treatment approaches of severe malnutrition. Supportive staff of implementing partners should train on request those physicians, nurses and kitchen staff in the form of in-service training. The individual supportive and encouraging qualification of such a trainer is of utmost importance.
- MoH needs to agree on one treatment protocol and a specific training curriculum as soon as possible. Regular supervision and continuous on the job-training of health staff is needed during the first year of introduction of new treatment guidelines. Positive feedback is needed to enhance motivation of health staff. Transparency with respect to suspected causes of mortality, obstacles and limitations of severely malnourished children would be beneficial as part of quality assurance.
- In the opinion of the evaluators case fatality rates could be reduced by:
  - continuous feeding (including feeding at night and during weekends) which also will reduce the risk of life-threatening hypoglycaemia
  - provision of bedding-in to reduce the risk of hypothermia by co-sleeping
  - prompt treatment of concomitant infectious diseases
  - introduction of ART for HIV-positive children
  - increased motivation of staff by participative concepts and empowerment
- Qualitative assessment methods such as focus group discussions with caregivers are a valuable tool to explore specific causes of malnutrition in order to elaborate appropriate preventive strategies.

- TFPs should focus on capacity building of caregivers during their stay in the medical institutions regarding prevention of malnutrition. This training should include the following topics:
  - early recognition of signs of malnutrition and early referral to treatment
  - culturally appropriate feeding and care practices including promotion of exclusive breastfeeding, adequate and timely introduction of complementary food, long duration of breastfeeding, care of a sick child, etc.
- Cooperation with local healers and traditional birth attendants should be attempted and referral systems established. Potential beneficial practices should be explored and strengthened.
- Mothers who cannot stay in the hospital until full recovery of their child due to certain constraints should receive ready-to-use therapeutic food (RUTF) and be followed-up closely. This approach to provide the mother with the RUTF (to be given to the child at home) will reduce the current high defaulter rate.
- The current existing excess stock of therapeutic milk powder has to be used appropriately (e.g. mixed with cereal flour and offered as enriched porridge for chronically ill patients) before the shelf life expires.

#### **15.4.4 Home Based Care (HBC) for HIV/Aids patients and family members**

- To include ARV treatment into the Home Based Care programmes (co-funding approach)
- To continue to offer food to HIV/Aids affected households
- To recommend the formation of more support groups
- To include practical information about the contents of different types of food groups and minimum combinations recommended during times of food shortage
- To employ at least one nutritionist for the training and supervision of the HBC facilitators
- Village health committees need to be informed and involved in all HIV/AIDS activities
- There is a national strategy to prevent PMTCT of HIV which needs to be taken into consideration

With regard to breastfeeding counselling of HIV-infected mothers the following facts have to be taken into consideration:

- Although breastfeeding is associated with an additional risk of HIV transmission from mother to child as compared to non-breastfeeding it is not advisable to recommend bottle feeding (due to increased risk of dying from diarrhoea) for the large majority of infants.
- Exclusive breastfeeding during the first 6 months of life carries greater benefits than mixed feeding. However, to minimize HIV transmission risk, breastfeeding should be discontinued as soon as feasible, taking into account local circumstances and the risks of replacement feeding. In untreated women who continue breastfeeding after the first year, the absolute risk of transmission through breastfeeding is 10-20%.
- During the transition period between exclusive breastfeeding and complete cessation of breastfeeding there are concerns about increased risk of HIV transmission with mixed feeding. To keep the period of transition as short as possible may reduce the risk. Shortening the transition period, however, may have negative nutritional and

psychological consequences for the infant, and expose the mother to the risk of breast pathology (mastitis, breast milk stasis). Therefore, appropriate breastfeeding counselling in order to guarantee exclusive breastfeeding during the first 6 months and to offer replacement food in adequate amounts to avoid malnutrition in the early weaned infant is of utmost importance.

- When HIV-infected mothers choose not to breastfeed or stop breastfeeding a few months later, they should be provided with individual counselling and nutrition support for at least the first 2 years of the child's life to ensure adequate replacement feeding.

## **ANNEXES**



## **Annex I: Persons Met and Schedule of the Mission**

### **January 2004**

Monday, 26	Travel to Brussels, ECHO briefing Paul Koulen, ECHO Desk Officer – Zimbabwe Montse Pantaleoni, ECHO Evaluation Sector Martine Vanackere, ECHO Evaluation Sector
Tuesday, 27	ECHO briefing, DG DEV briefing in Brussels Steffen Stenberg, Head of Unit, ECHO 1 Philippe Darmuzey, Head of Unit (Southern Africa) DG DEV Joan Pijuan-Canadell, DG DEV Desk Officer- Zimbabwe Val Flynn, ECHO Security
Wednesday, 28	AIDCO F5 briefing in Brussels Xavier Guillou, Desk Officer – Zimbabwe Jose Valente, AIDCO (health) Alain Sancerni, AIDCO (education)
Thursday, 29	ALNAP briefing in Brussels Tony Beck, ALNAP Consultant John Mitchell, ALNAP Co-ordinator Review of documents and presentation of the briefing note Beatrice Miège, ECHO NGO Sector Peter Billing, ECHO – Head of Strategic Planning Sector Hermann Spitz – ECHO 1
Friday, 30	Travel back to Germany

### **February 2004**

Sunday, 15	Flight to Nairobi
Monday, 16	ECHO Nairobi briefing Johan Heffinck, ECHO Regional Support Office Co-ordinator Enric Freixa, ECHO RSO, Medical Co-ordinator
Tuesday, 17	Alessandro de Matteis, ECHO RSO, Food Security Adviser Enric Freixa, ECHO RSO, Medical Co-ordinator
Wednesday, 18	Flight Nairobi – Harare Beatriz Torres-Trejo, ECHO Harare support office secretary Clodagh O'Brien, EC Delegation, Charge d' Affaires Patrick Phipps, EC Delegation, Food Aid/Food Security
Thursday, 19	Festo Kavishe, UNICEF Representative Nicolina Kobali-Drysdale, UNICEF, Nutritionist Victor Angelo, UNDP and Humanitarian Aid Co-ordinator Vincent K. Lelai, RRU – Co-ordinator Ruth Butao Ayoade, RRU – Recovery Programme Officer George Olesh, RRU – Deputy Co-ordinator Kevin Farrell, WFP – Country Representative Diane Prioux De Baudimont, WFP - Logistical Support Project Sophie Chotard, WFP – Monitoring & Nutrition Unit Dr. Mulugeta, WHO Dr. Drysdale, WHO Dr. Panganai Dhliwayo, WHO
Friday, 20	Karl Dehne, UNAIDS – Country Co-ordinator

Mrs. Chanzi, MOHCW – Relief and Rehabilitation Unit  
Lizbeth Kallestrup, EC-Delegation, Health Advisor

*Briefing meeting with representatives of ECHO partner organisations:*

Vincent Lelai and Ruth Butao, RRU/UNDP  
Alberto Mendez, WFP  
Nikolina Drysdale and Ron Powels, UNICEF  
Peter Pichler, World Vision  
Emma Frame, JOHANNITER  
Camillo Risoli, CESVI  
Jochen Hertle, GAA  
Christopher Bowley, SCF  
Poul Brandrup, GOAL  
Paul Prinsen Geerlings, MEDAIR  
Christina de Nicolás Izquierdo, ACF  
B. Makunike and S. Maphosa, WHO  
Erik Peterson, DRC  
SHEMELES Mekonnen, OXFAM

Aadrian Sullivan, ECHO – Country office

Saturday, 21                      Lars Peter Nissen, DRC  
Debriefing with John Wilding

Sunday, 21                        Karine Coudert, CESVI

**Project visits (field mission): Monday, 23 February to Tuesday 2 March**

Date	Location and Activities
Monday, 23.02.2004	<p><b>Harare</b> ACF-Office Harare Hospital: TFU - discussion with responsible medical doctors and nurses, ward round, discussion with ACF staff Chitungwiza Hospital: TFU – discussion with responsible nursing staff, ward round, structured interview with individual care givers, discussion with ACF staff Meeting at Medair-Office in Harare</p> <p><b>Mudzi</b> Visit of the Medair Field Office and store building</p>
Tuesday, 24.02.2004	<p><b>Mudzi</b> Visit of 3 school feeding programmes supported by Medair (Macinda, Chindoko and Nyamukoho Primary School) Discussion with 3 teachers and community representatives Focus group discussions with 26 cooking women/mothers (in 3 groups), focus group discussions with about 90 school children (in 3 groups – boys and girls in separate groups) Discussion with Medair staff members</p>
Wednesday, 25.02.2004	<p><b>Rusape</b> Goal Office and discussion on project organisation and management Visits of Under-five feeding projects and CSB stores Visit to a health Centre (holding point) Visit to a SFP at hospital level Visit to a SFP at community level Focus group discussions with about 18 cooking women/mothers and grandmothers Discussion with community representatives</p> <p>ACF: TFP Visit to the TFU at Rusape Hospital Ward round, Structured interviews with individual mothers/caregivers Discussion with ACF staff Summary discussion with Goal and ACF staff Visit of the Goal food store</p>

Thursday, 26.02.2004	<b>Kwekwe</b> Kwekwe Hospital: TFU and PMTCT unit Ward round, Focus group discussion with 8 mothers/caregivers Discussion with medical and paramedical staff Discussion with CESVI staff <b>Silobela</b> Hospital: TFU and PMTCT unit Ward round Structured interviews with individual mothers/caregivers Focus group discussion with 7 care givers Structured interview with 4 SFP staff members Discussion with medical and paramedical staff
Friday, 27.03.2004	<b>Bulawayo</b> Discussion with DRC staff Field visit to different Home Based Care activities Discussion with nursing staff at clinic level Focus group discussion with 10 ZRC volunteers Discussion with AIV/AIDS patients and household members in different assisted, HIV/AIDS affected households Visit of a HIV/AIDS support group and focus group discussion with about 15 members of the group (3 men, 13 women) Summary discussion with DRC members and ZRC volunteers
Saturday, 28.02.2004	<b>St. Lukes Hospital</b> Discussion with the paediatrician
Monday, 01.03.2004	<b>St. Lukes Hospital</b> Discussion with responsible nurses and medical doctors TFU ward round Structured interviews with 5 individual mothers/caregivers Summary discussion with the hospital management
Tuesday, 02.03.2004	<b>Harare</b> Michael Jordan, Chris Bowley, Chris Mclvor, SCF - UK Planning of the field visit to a resettlement area

Wednesday, 03  
Lizbeth Kallestrup, EC Delegation, Health Advisor  
Peter Halpert, USAID – Director Office of Health  
Camillo Risoli, CESVI team members

Thursday, 04  
Jeffrey Tshabalala, GTZ financial advisor MOHCW, HSSP-EU  
Patricia Darikwa, EU-HSSP, Health Programme Manager  
Agnes Mahomva, MOHCW, national PMTCT technical co-ordinator  
Aadrian Sullivan and Jose Tamarit, ECHO office Harare  
Celestine Kumire, NatPharm  
Mrs. Mosca, EC Delegation in Zimbabwe

Friday, 05  
Jan Hendrik van Thiel, Counsellor German Embassy in Zimbabwe

*Debriefing meeting with representatives of ECHO implementing partners:*

Ruth Butao, RRU/UNDP  
Diane Prioux de Baudimont, WFP  
Ron Powels, UNICEF  
Camillo Risoli and Karine Coudert, CESVI  
Alberto Porro, COSV  
Christopher Bowley, SCF  
Michael Jordan, SCF-UK/FCTZ  
Padraig O'Rourke and Bridget Churawa, GOAL  
Paul Prinsen Geerlings, MEDAIR  
Christina de Nicolás Izquierdo and Gloria Kusenererwa, ACF  
Alexander Chimbaru, WHO  
Sophie Brandt, DRC  
Gopika Dass, DANChurch AID

	Lizbeth Kallestrup, EC Delegation, Health Advisor Pierre Luc Vanhaeverbeke, EC Delegation
Saturday, 06	Davis Dhlakama, MOHCW – Technical Director of Medical Services Gloria Kusemererwa, ACF Christina de Nicolás Izquierdo, ACF Eoin Sinnott, WFP – School feeding co-ordinator AEDES
Monday, 07	Flight back to Germany