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:	15th February – 09th March 2004 (Field Mission Period)
Names of Evaluators:	Dr. Veronika Scherbaum, Nutritionist Dr. Alois Dörlemann, Medical Doctor

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 he 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.