Project Brief

Nutrition Emergency Response Projects in Zimbabwe in both rural and urban domains

March 2020 to August 2022

Expanded CMAM Approach with Protection rations (food and cash)

Country/ Region:

Manicaland Province; Buhera, Chipinge & Mutare rural districts, Masvingo Province; Bikita, Gutu & Masvingo rural districts; Harare & Bulawayo metropolitan

Sector:

Nutrition Emergency Response for Early detection and Treatment (NERET) and LINKAGES

Intervention Dates:

NERET: March 2020 to April 2021

Linkages: June 2021 - May 2022

Costs:

(NERET Budget:

Euro 1,658,386.00

Direct Costs1,560,255.00

Indirect costs: 98,131.00)

Linkages Budgets

Euro 2,080,000.00

Direct Costs 1,943,925.23

Indirect costs: 136,074.77)

Statistics:

617 children received SC+ under NERET

1009 children received Cash and/or SC+ under LINKAGES according to the final reports.

Background

In 2020 Zimbabwe was impacted by multiple hazards, chief among which was drought, resulting in over half of the country's population being food insecure; 5.5 million in rural and 2.2 million in urban areas. Nearly 100,000 children under the age of 5 years were found to be suffering from acute malnutrition nationally. The wasting prevalence had already increased from 2.5% in 2018 to 3.6% in 2019. The cost of living also increased markedly as a consequence of spiraling inflation rates from 10.6% in 2018, 255% in 2019, to 557% in 2020, restricting access to many basic commodities and resulting in an increase in negative coping strategies. The situation was exacerbated by COVID-19 and gaps in community and facility based support services. In March 2020, supported by ECHO, in collaboration with the MoHCC, GOAL provided support to 210 health facilities across 6 districts (Buhera, Chipinge and Mutare Rural districts in Manicaland Province and Bikita, Gutu and Masvingo rural districts in Masvingo province) for CMAM services in conjunction with supplementary food rations (until April 2021) – called the **NERET project**. In June 2021 ECHO transitioned support to 21 urban health facilities, 4 in the suburbs of Harare Metropolitan's Kuwadzana and Waterfalls districts and the whole of the 2nd capital, Bulawayo metropolitan covering the city's 19 HFs, again supporting CMAM services but this time in conjunction with cash and supplementary food rations (until May 2022) – called the **Linkages project**.

Both NERET and Linkages projects included a package of interventions implemented at the Health Facility and Community Level. At the health facility level, the projects aimed to improve the technical capacity of health workers to deliver quality treatment to children with acute malnutrition using the expanded CMAM approach, provide inputs, and support regular and effective oversight linked to timely reporting. At the community level they promoted extensive screening to ensure early case detection via screening campaigns at public gatherings, regular outreach visits to underserved and remote communities, and the introduction and expansion of the family MUAC approach. Under NERET, GOAL trialled treatment alongside a protection ration of Super Cereal plus (SC+) porridge for all beneficiaries during their full treatment cycle and up to 3mth post-discharge, during the lean season. 12kgs of SC+ was given to each beneficiary per month between Dec '20 – March '21, taking into consideration that sharing of the SC+ would occur within the homestead, due to the stressed food security status of many HH's. This element of the project was designed as a protection ration, i) to protect the use of RUTF exclusively for the child with acute malnutrition and ii) to protect the child from relapse and promote ongoing rehabilitation upon discharge. Under Linkages, GOAL trialed cash-protection rations during treatment cycle, at $12per person per household (with up to 4 members) and SC+ protection rations upon discharge for 3 months, again using 12kgs SC+ per person per month between October 2021 to May 2022. It should be noted that there were significant delays in the issuance of cash, with most families having to wait 4-6 weeks for physical receipt of cash. The purpose of the cash and SC+ in Linkages were the same as in NERET, just trialing a different mixed modality model. This was a wholly new approach in Zimbabwe.

Methodology for evidence generation

As the inclusion of protection rations was a new approach in Zimbabwe, we wanted to assess potential outcomes in both the NERET and Linkages projects.

- Focus Group Discussions (FGDs) were held with beneficiaries
- Key Informant Interviews (KIIs) were conducted with the district officials, health workers at clinics and Community Health workers.
- Semi-structured interviews were used to guide the FGDs and KIIs. FGDs were facilitated by 2 people, one scribing and the other asking questions to facilitate the discussions.
- The after-action reviews were conducted in the monthly health workers meetings where almost every health facility was represented.
- Qualitative data was categorised into themes.

Qualitative key findings

Overall, the respondents rated the inclusion of protection rations as 4.5/5 (5=excellent).

Results common to both NERET and Linkages (SC+ protection ration)

- Improved HH food security with added extra meal for children, though if used for the whole household due to food insecurity, it wouldn't last the whole month and access to food through cash increased.
- Improved health seeking behaviours especially in apostolic sect households for vitamin A supplementation, vaccinations and Growth Monitoring and Promotion (GMP), resulting in improved child health.
- Prevented relapse (as perceived by the caregivers).
- Increased program compliance and motivation as beneficiaries had timely CMAM successive visits and reduced work by Community Health Workers (CHWs) as fewer follow-ups were needed.
- Reduced shame and stigma of mother's with malnourished children, previously eliciting mother's lying about a child's age due to limited growth/development.
- Reduced stress to nourish children and improved dignity & peace of mind' for mothers, previously lacking as they couldn't adequately provide for their children's needs.

Results only applicable to NERET (CS+ during treatment and 3mths post-discharge)

- Helped protect RUTF consumption solely by the malnourished child.
- Reduced domestic fights due to lack of food.
- Reduced length-of-stay as reported by Key Informants resulting in less RUTF stock-outs

Results only applicable to Linkages (cash during treatment and SC+ 3mths post-discharge)

- Reduced HH food expenditure on sugar and oil, usually purchased to add to cereal staples for children.
- The provision of cash enabled HHs to buy additional, diverse foods for HH members, also used to supplement the malnourished child once stabilised and upon return of appetite due to an improving nutritional status, this supported improved weight gain.
- SC+ provided a safety net or exit strategy for curative care, where families were able to prepare for child-care post IMAM support.
- The flexibility of cash provided freedom to purchase other essential items such as soap, rent, medical expenses and pay for school fees.

Perception on ration adequacy showed that:

- Respondents recommended rations to be increased based on no. of children under five in the household.
- The cash and SC+ surpassed it's intended use as a 'protection ration' for the malnourished child, as it also acted as a supplementary food for siblings, where all HH's reported stressed food security throughout the lean season.

Homebase use of SC+ reflected that:

- Recommended preparation of 4 parts water to 1 part SC+ was repeatedly reported to be too thin and most HHs modified the method.
- Some HHs prioritized use with malnourished child, others shared with all children, others gave to lactating ♀ who reported improved milk supply, others reported use for whole family.

A recipient of super cereal plus, source: GOAL 2021


MUAC measurement during active screening, source: GOAL 2022

Quantitative key findings-NERET

- Since the start of the project (March 2020), cure rates increased by an average of 9 percentage points across health facilities, from 72% to an average of 81% (with minimum being 80% and maximum 85%). This was thought to be attributable to staff training at the outset, as since the inclusion of SC+ in December 2020, no significant change in cure rates were observed, but they were maintained at, or above 79%.
- Overall death rates from March 2020 to November 2020 averaged 4.6 per month and reduced to an average of 2.3 per month after the introduction of CS+ between December 2020 to February 2021, but trend data shows erratic fluctuations over the course of the program cycle.
- No discernable impact on non-response rates which were relatively high at 10-11%. Although GOAL staff have questioned MoHCC staff understanding of how to correctly classify non-response rates.
- Defaulter rates matched lowest levels from earlier in the year at less than 10%, but no obvious trends were observed .

Quantitative key findings-Linkages

- IMAM admissions mirrored trends from the year before but with a 40% increase in case-loads (639 admissions vs 998).
- Average annual cure rates didn't change compared to the previous year (57% vs 56%). But during the intervention, prior to protection rations (June-Aug'21) there was a 30% average cure rate versus 67% average after (Sept '21-May'22), although still below the SPHERE standard of >75%. Interestingly (outside of the scope of the project) between June-Aug' '22, SC+ was layered onto the cash element during Tx as well as being provided post-discharge (per protocol) but the quantity was increased from12kg →15kg (due to remaining stocks). Results observed during this 3mth period saw a further rise in cure rates up to 89%.
- Low death rates of <5% were achieved in all bar 3 mths (5-6%).
- No positive trend observed on non-responders after the intro' of protection rations. Rates fluctuated slightly during the intervention between 0-11%, punctuated by a significant spike of 52% in July '21 (after a register clean out). Excluding this, NR averaged 5.4% compared to 7.2% year before. SPHERE target <5%. Rates fell to 1.2% in Aug' '22 after protection rations were increased.
- As per NR rates, defaulter rates fluctuated with a spike in Aug' (register clean out). Excluding this, we observed an average defaulter rate of 22%, above SPHERE standard of <15%, but a reduction on the previous year of 34%. Again this fell to 9.8% in Aug' after protection rations were increased.
- Relapses were very low throughout the year, 0 - <3 cases/mth. Rates appeared to drop after the introduction of the protection rations, with 5 cases during the 3 preceding months and only 6 cases in the 9 months after.

Recommendations

NERET

- Whist there were small gains in cure rates and a reduction in deaths, quantitative data did not demonstrate a compelling case that the inclusion of SC+ as a protection ration alone was effective in markedly improving IMAM outcomes or program compliance.
- However, multiple positive outcomes were recorded through qualitative research as a result of the inclusion of SC+ and these include protection of RUTF use solely for the malnourished child, active health seeking, program compliance, reduced HH stress & conflict and reduced length of stay.
- SOPs were needed to avoid miscommunication around protocols / supply chains need improvement / distribution locations need review / rations should be provided in one package / include monthly data verification checks.
- KIIs and after-action reviews reported a perception that improved nutrition education/counselling for key stakeholders, including influencers would likely address a tranche of malnutrition issues.
- Clear need to address wider food security problems to reduce risk of multiple forms of MN:
  - ❖ Investigate whether short-term supplementation of vulnerable groups including PLW/disabled during lean season might be a cost-effective approach to improve food & nutrition security. NB: multiple supplement options (micronut's, LNS, Fortified foods etc).
  - ❖ Compare the above with short-term cash/vouchers with impact on food & nutrition security + potential for other outcomes.
- Call for improved capacity building of MoHCC staff regarding parameters of intervention, plus improved links between nutrition interventions and other vulnerable HHs, with LLH initiatives to support 'prevention' of nutritional risk.

Linkages

- Protection rations were most successful when other HH expenses are catered for – identifying a need for MPC and supplementary feeding for high risk gps.
- Call for improved capacity building of MoHCC staff - structured / financed regular in-service training needed. Focus also on quality-of-service provision.
- Mobile public health services are needed through an outreach provision - iCCM.
- CHWs and Health Promoters need financial remuneration.
- Cash through mobile money was preferred over cash in transit (CIT), but further decentralisation was requested.
- Cash capping reduces positive impacts in larger HHs (27% of HH's are >6 people).
- Increased transfer values for cash and mixed modality cash with SC+ may yield even better results, so should be considered for future programs, especially during lean season
- IGAs needed to improve stable incomes to provide enabling environment for families to address adequate care and feeding practices. Coupled with improved nutrition SBC, targeting change makers (incl' youth), influencers and wider community.


A caregiver conducting MUAC measurement, source: GOAL 2022

Observation of an appetite test during provision of Malnutrition services at an outreach point, source: GOAL 2022

Active and passive screening during an outreach campaign, source: GOAL 2022

References/ Citations:

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