Report on the Evaluation of Child Supplementary Feeding Programme Implemented from October 1999 to June 2000 in three districts in Zimbabwe

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Summary

This is a report aimed at sharing the results of an evaluation carried out at the end of the Child Supplementary Feeding Programme (CSFP). The Child Supplementary Feeding Programme was implemented in Bulilimamangwe, Umzingwane and Insiza districts of Matebeleland South Province from October 1999 to June 2000. The aim of the project was to reduce malnutrition among the under fives through target feeding. The three target districts were seriously affected by the 1998/99 drought that resulted in acute household food insecurity. The situation in these rural districts was exacerbated by the Zimbabwe economic decline of 5,1% in 2000. The CSFP programme thus aimed at providing some food supplements to vulnerable children to fill the household food security gap.

UNICEF in collaboration with three NGOs, ORAP, Red Cross and World Vision implemented Child Supplementary feeding in Insiza, Umzingwane and Bulilimamangwe districts. Key activities carried out during the reporting period included identification of the most food insecure wards in the district, pre-implementation training of Health Workers and Extension staff, social mobilisation, registration of children with moderate malnutrition, food distribution, regular monitoring and evaluation.

A total of 13,705 children under the age of five years in Bulilimamangwe, Umzingwane and Insiza were registered in the programme. The coverage of the programme among children under the age of five years in the three districts was 18%, 14%, and 3.7% for Bulilimamangwe, Umzingwane and Insiza respectively. Bulilimamangwe district had the highest coverage because it was more severely affected by drought. The programme was momentarily stopped in February and March 2000 because the districts were inaccessible due to flooding. The problem of access was followed by a shortage of diesel in the country. The project then resumed in April and end in May 2000.

UNICEF carried out an evaluation of the Child Supplementary Feeding programme in August 2000. The evaluation was undertaken in three districts, Bulilimamangwe, Umzingwane and Insiza. The aim of the evaluation was to measure the impact of the programme. The result from Focus Group Discussion with mothers indicates that the programme benefited children in these districts. Mothers reported that their children's weight improved, as shown by the Road to Health Card. Children were also reported to have started playing with other children as a result of improved health. Interviews with Health Workers revealed that attendance to Health facilities improved significantly, since these facilities were used as food holding points. The result of this improved attendance was catch-up of children on immunisations and for mothers provision of family planning services.

1.0 Introduction

The Child Supplementary Feeding Programme was implemented in Bulilimamangwe, Umzingwane and Insiza district from October 1999 to June 2000 through support from CIDA. UNICEF carried out an evaluation of the Child Supplementary Feeding programme in August 2000. The evaluation was carried out in three districts, Bulilimamangwe, Umzingwane and Insiza. The aim of the evaluation was to measure the impact of the programme, as well as to identify areas that needed improving to ensure better quality service delivery. The evaluation used Focus Group Discussions with caregivers, SWOT analysis with health workers and monitoring forms.

UNICEF implemented the Child Supplementary Feeding programme in collaboration with three Non-Governmental Organisations, ORAP, Red Cross and World Vision. The aim of the project was to reduce malnutrition among children under the age of five years through target feeding. The three districts were seriously affected by the 1998/99 drought that resulted in acute household food insecurity. The situation in these rural districts was exacerbated by the general economic decline in Zimbabwe of 5,1% that was recorded in 2000. In the same year interest rates increased sharply and inflation was reported as high as 61% in January 2000 and over 100% in 2001. Prices of basic foodstuffs such as bread increased by over 1,000% since 1990. This high inflation rate significantly eroded the purchasing power of consumers, thus making it impossible for the rural poor to cope with household food insecurity. It was therefore essential under these circumstances to urgently implement the Child Supplementary Feeding Programme in order to protect the fundamental right of children in these districts of being free from hunger.

The key activities carried out during the implementation period are, the identification of food insecure wards in the district, pre-implementation training of Health Workers and Extension staff, social mobilisation, registration of children with moderate malnutrition, food distribution, regular monitoring and the end of project evaluation. The Child Supplementary Feeding Programme was intended to specifically target only the moderately malnourished children under the age of five years in the three districts. This was done in order to encourage communities to use their coping mechanisms for feeding children, thus avoid creating dependency. It was therefore necessary to carry out some geographic targeting of the food insecure wards within each district. Geographic targeting also ensured that the programme would not be spread too thinly as this would have cost and time implications in terms of both monitoring and food distribution.

A one-day training workshop of district Health Workers and Extension staff from the targeted wards preceded implementation of Child Supplementary Feeding. The training was aimed at strengthening the capacity of these stakeholders on targeting of beneficiaries, record keeping, maintenance of stock cards, preparation of the supplementary food, and community mobilisation. The training sessions provided opportunity to share lessons learnt from implementing CSFP in other districts. Rural Health Centres (RHC) were used as food holding points at Ward and Village levels. The Health and Extension staff working in these Centres were responsible for the daily

administration of Feeding Centres. The programme administration supplies like monitoring forms, stock cards and weighing scales were distributed during the training workshop. During routine monitoring it was noted that Health workers who attended the pre-implementation training were able to properly manage the programme.

Community Social mobilisation followed immediately after the training workshop. The aim of social mobilisation was to ensure that communities are fully aware of the objectives of the Child Supplementary Feeding Project. Community leaders, Chiefs and Village Heads played an important role in mobilising communities for CSFP. Social mobilisation is one of the most crucial activities in CSFP. Social mobilisation should be strengthened if a rapid response is to be successfully launched during emergency situations. Experience with CSFP has shown that social mobilisation should first target the opinion leaders within communities. Once the opinion leaders like Chiefs, Village Heads, and Health Workers are convinced the programme will stand a good chance to succeed. It is also through social mobilisation that negotiations with communities on target feeding are carried out. Registration of children into CSFP was very poor in areas where social mobilisation was not adequately carried out. This was due to either lack of awareness of the programme or due to discontent about targeting feeding by the communities. Community members often complained that *"the non-targeted children would eventually also deteriorate"* as a result of the general food shortage. This challenge was in most cases corrected by adequately explaining to the communities the rationale for target feeding.

Children under the age of five years were brought for screening and subsequent registration into the CSFP programme for those with moderate malnutrition. All children whose weight for age fell below the 3rd percentile on the Road to Health Card were considered malnourished, and thus eligible for feeding. In some instances where extension workers were employed to carry out screening, undeserving children were registered in the programme. This was a result of extension workers giving in to pressure from the community to register all children. This problem was minimised through regular project monitoring.

After screening, a total of 13,705 children under the age of five years in Bulilimamangwe, Umzingwane and Insiza were registered in the programme. The table below shows the coverage of the programme in the three districts. Bulilimamangwe district had the highest coverage at 18%, followed by 14% and 3.7% in Umzingwane and Insiza respectively. The programme coverage was calculated from the under five child population and the number of beneficiaries attending Child Supplementary Feeding Programme.

Table 1.1 District coverage for CSFP

District	Populatiton of under 5s	Total numbers of beneficiaries	% Coverage of programme
Bulilimamangwe	9,246	42,356	18%
Umzingwane	28,177	4,000	14%
Insiza	49,898	1,850	3.7%

The aim of the Evaluation
To carry out the process and impact evaluation for Child Supplementary Feeding Program

2.0 Study Methodology

The evaluation used information collected from interviews with Health workers at Rural Health Centres, Focus Group Discussions with Mothers and use of regular monitoring forms. The sample framework is shown in table 1 below.

Table 2.1 CSFP Evaluation Sample

District	Health workers interviewed	Focus group discussions	Monitoring forms collected
Bulilimamangwe	9	1 with 3 mothers	361
Umzingwane	5	2 FGDs with 9 mothers and 6 mothers respectively	323
Insiza	3	2 FGDs with 8 mothers and 3 mothers respectively	314
Total	17	5	998

3.0 Results of the Evaluation

3.1 Results of the SWOT analysis

A total of 17 health workers from three districts (Bulilimamangwe, Umzingwane, and Insiza) were interviewed on their perception of targeted child supplementary feeding using SWOT analysis. The realisation by caregivers of the increase in weight of their children was highlighted, as the strength of targeted feeding. Another strength was the use of dry rations that prevented the stigma associated with have to queue up for wet rations. It was noted that CSFP provided an opportunity for integration with provision of other nutritional and health services to both mother and child. The practice of some households to relying exclusively on CSFP was noted as a threat to targeted feeding. The threat is that the child would miss out on receiving nourishment from household foods and thus experience limited improvement in nutrition status. A noted weakness of target feeding is that children who are not in the programme may deteriorate in nutrition status. Table 3.1 below shows pooled results of the SWOT analysis.

Table 3.1: Results of the SWOT on targeted feeding with health workers.

Strength of targeted feeding	Weaknesses of targeted	Opportunities brought by targeted CSFP	Threats of targeted feeding
• Underweight children gained weight • Prevented underweight children from further deterioration and even mortality • The timing of the project was appropriate during the most food insecure season • Dry rations used prevented stigma associated with wet feeding	• Communication for when the project would end not effective • The non-targeted children may deteriorate in weight due to general food insecurity • Mothers with more than one under 5 were sharing the food • Some mothers were also eating the porridge	• created opportunity to give nutrition education to mothers • Mobilised mothers for other health activities • Created opportunity for children to be immunised • Created opportunity for children to be treated of other illnesses (supermarket approach) • Mothers could also receive some family planning services	• Some communities were against targeted feeding • Some children were refusing other food types after getting used to the supplement. • Some family tended to rely heavily on the supplement and ignored their coping mechanisms.

3.2 Results of impact of CSFP on attendance to health facilities

As indicated in Table 3.1 above, targeted Child Supplementary Feeding using Rural Health Centres as food holding points created opportunity for both mother and child to receive health services. It was reported that mothers received family planning services, while children received vaccines and treatment for other health ailments. An analysis of health records to verify the increase in attendance of under fives at health facilities was carried out. The average number of children attending Rural Health Centres per month during the period of CSFP (October 1999 to January 2000) and a year before CSFP were compared.

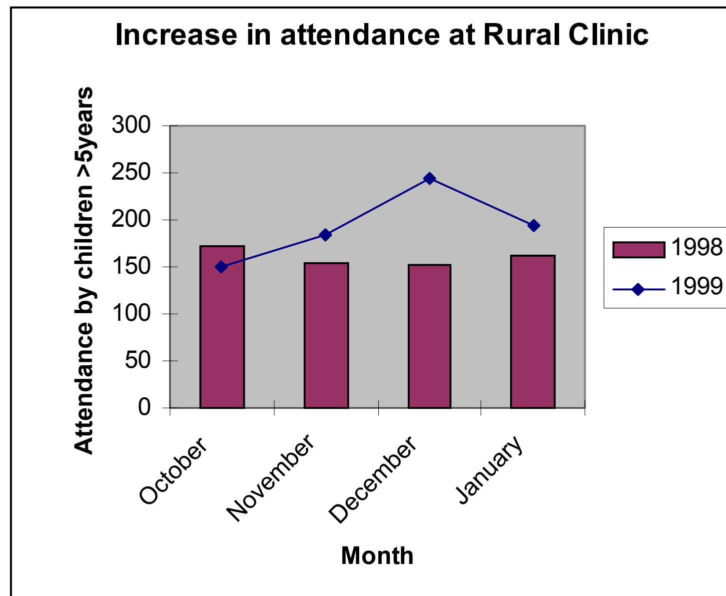

Fig 3.1 Effect of CSFP on attendance to Rural Health Centres

3.3 Results of Focus group discussions

Focus group discussions (FGDs) were held to determine the recipient's behavioural response to food distribution, the cultural acceptability of nutrimeal and the community perception of targeted feeding. A total of five FGDs were held. The FGDs consisted of mothers with children registered in the CSFP programme. The guiding question were divided into four main categories, namely:

i. Recipient's response to supplementary feeding
ii. Cultural acceptability of nutrimeal
iii. Community perception about targeting of beneficiaries
iv. Suggestions for future improvements to the project

3.3.1 Recipient's response to supplementary feeding

One of the assumptions made in the Child Supplementary Feeding Programme was that, once distributed to households food would be acceptable and would be given to the children. It was therefore necessary to ascertain the validity of these assumptions in the evaluation. Mothers where asked to comment on how acceptable the precooked take-home dry ration of Nutrimeal was. Questions were focused on variables like ease of preparation, responses of children, and if they would have preferred any other type of supplementary food. Most mothers liked Nutrimeal because they said *"it contained all nutrients"* and that it *"caused weight gain in a few months"* (Table 3.2). The discussions were intended to find out the perception of mothers on the CSFP, and whether they followed the feeding instructions given. The results from this discussion indicated that most mothers would have preferred a larger daily ration of nutrimeal. This may have been due to the lack of general food distribution to complement the Child Supplementary Feeding Programme. All mothers responded that their children improved in nutrition and health status. This improvement was seen through increase in weight for age as shown on baby card, physical appearance of the child, improved appetite and the child being more happy and playing with others.

Table 3.2: Response to food distributions

Question	Response
Adequacy of the 3kg ration	• The majority of respondents said that the ration was not enough
Reasons why the ration was not adequate.	• The children liked it so much they gave more per day than the recommended 100grams • Children were refusing other types of food so they had to feed 3 times instead of once
Measurements for preparing the porridge	• Most mothers indicated that they knew the right measurements to prepare nutrimeal for the baby.
What did you give to other children who were not enrolled in the programme?	• Most mothers responded that it was a big problem and they had to share with other children by giving small amounts
Did you see any improvements in the health of the child?	• All mothers responded that they saw improvements in the child's health
The kind of improvement seen after giving nutrimeal.	• *"Child's weight increased"* • *"Child skin became healthy"* • *"The child was playing"*

	• *"The child was not getting sick easily" anymore* • *"Child's appetite improved"*

3.3.2 Cultural acceptability of Nutrimeal

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Table 3.3 Cultural Acceptability of nutrimeal

Questions	Responses
Was nutrimeal easy to prepare?	• All mothers mentioned that the food was easy to prepare. • There was also a comment that the porridge cooks fast.
Did the children like nutrimeal?	• All mothers responded that the children liked nutrimeal very much.
Would you have preferred any other type of food supplement?	• Most mothers preferred nutrimeal because they said it contained all nutrients. • Some mothers preferred nutrimeal because they said it caused weight gain in their children in a few months • Some mothers preferred nutrimeal because they said that 'not a single child refused it'. • A few mothers mentioned that they did not know of any other better option
What did you not like about nutrimeal?	• Most mothers said that there was nothing they did not like about nutrimeal. • One mother said that it contained too much sugar.

3.3.3 Community perception on targeting of beneficiaries.

Since challenges were reported on implementing targeted CSFP in communities it was important to get first hand information from mothers on their perception. This could be used to improve implementation of future programmes. Some mothers who were in the discussion indicated targeted feeding caused conflicts with neighbours who did not receive supplements for their children (Table 3.4). A few mothers still preferred target feeding because it helped under weight children to catch in growth.

Table 3.4 Perception of caregivers on targeted CSFP

	Responses
What do you think about target feeding?	• Mothers with more than one child under five years were forced to share the food. It was difficult to explain to small children why they were not receiving supplements, other children left out within the family would think that the mother was favouring the other child. It was mentioned that this could be avoided if all under fives were given supplementary food. • Some mothers reported that it caused conflicts between neighbours who received and those who did not receive supplementary feeds. • A few mothers felt that target feeding was good because it helped under weight children to catch up in growth.

3.3.4 Areas for future improvements to the project?

This question was intended to elicit ideas from mothers as to how the project could best be implemented in future. Some mothers indicated their interest in training on nutritional enhancement of complementary foods. Evidence shows that there is a wide- spread poor practice within communities of using complementary foods, which are poor in nutritional quality. This often results in growth faltering and subsequent stunting during the second year of life. The other comments are listed in Table 3.5 below.

Table 3.5 Areas of improvement for CSFP

	Response
What do you think needs to be improved about this project?	• Some mothers mentioned that the monthly supply should be increased from 3kg. • Some mothers mentioned that they needed to be trained on production of fortified complementary foods similar to nutrimeal at household level because some children would refuse white meali-meal porridge after nutrimeal is finished or after the project. • Some mothers suggested that where a household has more than one under five it would be better to feed all children. • Some mothers mentioned of the need to improve the supply pipeline for the porridge during the course of the project because delays were experienced and resulted in children deteriorating in weight. • A few mothers mentioned that they would have appreciated some milk for children below 2 years of age. • Some mothers felt that the project should be ongoing for under weight children.

3.4 Composition of Nutrimeal

The composition of Nutrimeal was revised during the course of the project using examples of supplementary foods used by UNICEF and WFP in other countries (Table

3.6). This was done to ensure an adequate supply of nutrients to children under five. During the revisions special consideration was made of the fact that Zimbabwe has a public Health problem of both Iron and Vitamin A Deficiency. The Table 7 below shows the revisions that were made.

Table 3.6: Revision of the nutritional composition of Nutrimeal/100g dry ration

Nutrient	Old Composition	New Composition based on WHO, WFP
Protein (g)	12	17.2*
Energy (kcal)	380	355*
Fat (g)	5.0	5.9*
Vitamin A (IU)	1,565	1,333
Vitamin E (mg)	*	5
Vitamin D (pg)	*	10
Vitamin B1 (mg)	0.3	0.5
Vitamin B2 (mg)	0.4	0.8
Niacin (mg NE)	4.3	9.0
Vitamin B6 (mg)	*	0.9
Folic acid (pg)	*	50
Vitamin C (mg)	*	20
Calcium (mg)	133	800
Zinc (mg)	*	10.0
Iron (mg)	3.3	12.0
Iodine (mg)	50-70	50-70

**Previously not listed on the nutritional composition of nutrimeal.*

4.0 Challenges of the evaluation

One of the challenges of this evaluation was the lack of quantitative data to measure the impact. It was expected from the onset of the study, that the evaluation would be based on monthly records of child weights. Unfortunately, the quality of the monthly records did not meet the required standard for baseline information or use in an evaluation. The ideal situation would have been to carry out a rapid nutrition assessment and then carry out another assessment to measure impact.

5.0 Lessons Learnt the CSFP project

There is need to carry out a baseline survey before implementing CSFP to enable measurement of nutrition impact. A summative evaluation should then be carried out to measure impact of the intervention. Exclusive reliance on regular monitoring data may cause problems, especially when the quality and consistence of the records is poor.
Use should be made of programme indicators like % children who recovered, % defaulters, % deaths, % transfers to health institution for therapeutic feeding. These indicators would better enable managers to reflect the quality of services provided by the CSFP. Mothers need training on how to locally enhance the nutritional value of complementary foods. This could be implemented as an activity for the on going

Community nutrition care projects. Use of Rural Health Centers as food holding points should be encouraged because it provides opportunity for children and their mothers to also receive treatment. This has been shown to improve the immunization coverage and improve provision of family planning services to mothers. UNICEF could ensure that such Health facilities have adequate supply of vitamin A capsules for children and iron/folate tablets for pregnant women. There is need for integrating training of caregiver on Early Childhood Development as part of the emergency response. It is challenging though to convince most donors that training of caregiver on childcare practices can be an activity worth undertaking during emergency situations.