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BASELINE REPORT

CYCLONE IDAI RESPONSE AND RECOVERY PROJECT IN MANICALAND PROVINCE

CHIPINGE AND CHIMANIMANI DISTRICTS

SEPTEMBER 1, 2019

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Contents

Acknowledgements.....	i
List of Figures.....	iv
Table of Figures	iv
List of Acronyms	v
1.0 Background.....	1
1.1 Goal of the project	1
1.2 Overall objective of the pilot program	1
1.3 Project main intervention Activities.....	1
1.4 Project Key Indicators	2
1.5 Purpose of the Baseline	3
3.0 Methodology	1
3.1 Study Design	1
3.2 Study population and Sample.....	1
3.3 Study timeline	1
3.4 Sampling method	1
3.5 Data collection process	1
3.6 Data collection tools	1
3.6.1 Primary data	1
3.6.2 Secondary data.....	1
3.7 Data Quality Assurance.....	2
3.8. Data analysis plan	2
3.10. Data Dissemination plan.....	2
3.11. Ethical Consideration	2
4.0. FINDINGS OF THE BASELINE.....	4
4.1. Sample demographics.....	4
4.2 Access to Clean and Safe Water	4
4.3 Access to Toilet Facilities	5
4.4 Availability of Household Hand Washing Facility	7
4.5 Number of people reached with key hygiene messages	8
4.6 What are the critical moments to wash hands?	9
4.7 Prevalence of Water Related Diseases.....	10

4.8 Coping Strategy Index	12
4.9 Additional Context Specific Coping strategies	13
4.10 Information Access about the Project	19
4.11 Preferred Feedback Mechanism	19
4.12 Gender Mainstreaming	20
5.0 Conclusions	23
5.1 Recommendations	23

List of Figures

Figure 1: Sources of Drinking Water	4
Figure 2: Households with Access to Toilet Facility	5
Figure 3: Type of toilet facility used by a household	6
Figure 4: Water Containers Used for Drinking Water.....	6
Figure 5: Availability of Hand Washing Facility.....	8
Figure 6: Methods used for water purification.....	8
Figure 7: Knowledge on 5 Critical Moments for Hand Washing.....	9
Figure 8: Hand Washing Facility Used.....	10
Figure 9: Methods of Preventing Diarrheal Diseases.....	10
Figure 11: Prevalence of Diarrheal Diseases.....	11
Figure 12: Methods Used to Prevent Diarrheal Diseases	11
Figure 13: Coping Strategy Index	13
Figure 14: Household selling assets.	14
Figure 15: Households spending their savings.....	14
Figure 16: Households who borrowed or purchased food on credit.....	15
Figure 17: Households who borrowed money from friends or relatives.....	16
Figure 18: Household who sold productive assets	16
Figure 19: Households withdrawing children from school	17
Figure 20: Household who begging for food	18
Figure 21 : Households selling female livestock	18
Figure 22: Feedback Mechanisms Preferred by Beneficiaries	20
Figure 23: Sex of Who Does Shopping at Household Level	21
Figure 24: Decision Making on Cash Utilisation.....	21
Figure 25: Income and Asset Decision Making by Sex.....	22

Table of Figures

Table 1: Project Indicators	2
Table 3: Access to Information about the Project	19
Table 4: Beneficiary Preference on Where to Report.....	19

List of Acronyms

CARE:	Care International in Zimbabwe
CfW:	Cash for Work
ECHO:	European Civil Protection and Humanitarian Aid Operation
FGDs:	Focus Group Discussions
IRC:	International Rescue Committee
KAP:	Knowledge Attitudes and Practices
KIIs:	Key Informant Interviews
MPCT:	Multipurpose Cash Transfers
SPSS:	Statistical Package for the Social Sciences

1.0 Background

CARE International in Zimbabwe and the International Rescue Committee (IRC) Consortium are currently visible in Chipinge and Chimanimani districts through support from ECHO. The consortium is currently implementing early recovery interventions which seek to address the immediate WASH and basic needs of the Cyclone Idai affected populations. The interventions are centred on a community-based integrated approach focused on building local capacities and empowering communities to regain control over their lives and become more resilient using a robust cash-based component. Targeting a total of 9 wards in Chimanimani and Chipinge districts, CARE and IRC consortium are maximizing the geographic reach and multi-sectoral coverage of the Action using a harmonized, closely coordinated, gender-sensitive consortium approach. The project is targeting households which were affected by the Cyclone Idai disaster, those whose shelter was completely or partially destroyed. Other vulnerability attributes such as elderly people, People with Disabilities, pregnant and lactating women, child headed households, and Internally Displaced People among other attributes were used for appropriate targeting.

The consortium is currently providing community-driven livelihoods support in four targeted wards through a Cash for Work program that was designed to rebuild community productive assets. The project is also implementing integrated WASH support interventions in 2 wards in Chipinge district and 1 ward in Chimanimani district whilst implementing the Multi-Purpose Cash Transfer project in 4 wards in Chimanimani district. The consortium conducted a baseline survey in both districts for all the interventions underway to facilitate evidence based monitoring and evaluation as well as to match targets with the expected project outcomes. The results will be used for both guiding project implementation and determining project impact by providing the datum for measurement.

1.1 Goal of the project

The overall goal of the project is to respond to the urgent needs of vulnerable populations through integrated WASH, food security and livelihoods assistance.

1.2 Overall objective of the pilot program

The objective of the project is to provide immediate access to integrated WASH and food security and livelihoods support to the cyclone-affected population

1.3 Project main intervention Activities

To address the immediate WASH, Food Security and Livelihoods (FSL) rehabilitation and recovery needs of the most vulnerable population through community based and integrated approaches focusing on building local capacity and empowering communities to regain control over their lives and becoming more resilient using a robust cash-based component. The program is to be implemented over a period of 10 months (1 May 2019 to 29 February 2020). The following are the main project activities classified per each results

Activities for Result 1: Targeted men, women, boys and girls in Manicaland have improved access to safe and dignified WASH facilities and improved hygiene practices

- Selection of community based hygiene promoters

- Hygiene promotion training - community-based hygiene promoters & hygiene promotion sessions
- Distribution of IEC material
- Assessment of boreholes to be repair and preparatory works
- Borehole repairing
- New borehole drilling & installations
- Installation of Solar piped water scheme
- Latrine construction training
- Household latrine construction
- Water quality testing and monitoring

Activities for Result 2: Targeted men, women, boys and girls in Manicaland are able to meet their basic need

- Multi-Purpose Cash Transfer (MPCT) targeting 1050 of the most affected households in Chipinge and Chimanimani districts.
- Beneficiary sensitization
- Negotiations with traders to ensure supply
- Cash distributions (MPCT)
- Post-distribution monitoring
- Cash for Work (rehabilitation of community assets)
- Complementing MPCT, IRC will support 550 HH through MPCT

1.4 Project Key Indicators

The table 1 below provides the key indicators to be tracked during the life of the project, as provided in the project proposal.

Table 1: Project Indicators

Sector Name	WASH and Food Security
Indicator 1 (ECHO)	% of target population with adequate WASH services and hygiene practices
Indicator 2 (ECHO)	% of beneficiaries (disaggregated by sex, age and diversity) reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner
Indicator 3 (ECHO)	Average Coping Strategy Index (CSI) score for the target population
Sub-sector Name	WASH
Indicator 1 (ECHO)	Number of people having access to sufficient and safe water for domestic use
Indicator 2 (ECHO)	Number of people with access to dignified, safe, clean and functional excreta disposal facilities

<i>Indicator 3 (ECHO)</i>	Number of people having regular access to soap to meet hygiene needs
<i>Indicator 4 (ECHO)</i>	Number of water point committees (WPCs) established and trained
<i>Indicator 5 (ECHO)</i>	Number of water points rehabilitated/constructed
<i>Indicator 6 (ECHO)</i>	Number of people reached with key hygiene messages
Sub-sector Name	MULTI-PURPOSE CASH TRANSFER AND CfW
<i>Indicator 1 (ECHO)</i>	Number of people enabled to meet their basic non-food item needs
<i>Indicator 2 (ECHO)</i>	Number of people enabled to meet their basic food needs
<i>Indicator 3 (ECHO)</i>	Number of people carrying out Cash for Work for community asset rehabilitation
<i>Indicator 4 (ECHO)</i>	% of project beneficiary population who receive an appropriate response

1.5 Purpose of the Baseline

The purpose of the baseline survey is to:

- Assess the livelihood status of the beneficiaries before interventions.
- Assess the pre-implementation coping strategies of the beneficiaries.
- To assess the knowledge, attitudes and practices (KAP) of the beneficiaries on WASH
- To track beneficiary pre-implementation knowledge of the project
- To assess the Client Responsiveness of the project

3.0 Methodology

3.1 Study Design

The baseline was conducted through a quantitative household survey. However, qualitative approaches were also employed through the use of key informants to gather some in-depth information especially on gender and markets. In this case, probability and non-probability sampling methods were used although the survey was predominantly probability.

3.2 Study population and Sample

The study population was derived from Multi-Purpose Cash Transfer (MPCT), WASH and Cash for Work beneficiaries from both Chipinge and Chimanimani. The baseline study used 10% sample which is statistically representative for the generalization of findings. A total of 175 were sampled and there was 100% response rate.

3.3 Study timeline

The baseline was conducted soon after completion of beneficiary registration. The process involved designing of the baseline protocol, data collection tools, pilot-testing of tools, training the enumerators, field data collection, data entry, data cleaning, and reporting writing.

3.4 Sampling method

Modified systematic random sampling technique was used for sample selection which is widely used as a probability sampling method. The rationale for choosing this technique is its simplicity and it also gives assurance that the population is evenly sampled. A sample size of 175 households (HH) were selected for the baseline. The sample was - disaggregated as follows 105 HH for MPCT, 50 HH for WASH and 20 for CfW from both Chipinge and Chimanimani. In total, this represented 10% of the targeted households for all the three interventions.

3.5 Data collection process

Data collection was done by enumerators under the supervision of the M&E team for CARE and IRC Consortium. The enumerators were trained on the baseline survey tool and were deployed to selected wards in the respective districts of Chimanimanini and Chipinge. The questions were administered in vernacular Shona language. Eight qualitative focus group discussions with project beneficiaries were conducted, four per each district. Baseline data was also collected through key informant interviews focusing on district and ward stakeholders. KAP questions were integrated in the questionnaire.

3.6 Data collection tools

3.6.1 Primary data

The baseline assessment used a household questionnaire which was administered to communities.

3.6.2 Secondary data

A review of relevant documents from various sources was done prior to commencement of primary data collection to obtain an understanding of the context so as to inform the work, in particular, to develop relevant primary data collection tools. Some of the documents used in the

review process include previous projects PDMs and End line surveys, vulnerability assessment reports, among others.

3.7 Data Quality Assurance

- i. An intense training of data collectors (enumeration team) was conducted to ensure everyone was equipped with the right skills, understand the project objectives, and the tools.
- ii. A pre-test of the tools.
- iii. Data collection tools were linked to the project objectives and project indicators. In this vein, the idea was to have a tool that capture essential information only, and of the right size (length) to manage interviewee and interviewer fatigue hence detailed responses were elicited from the participants.
- iv. End of day debriefing sessions were conducted to review each day's data collection process and challenges.
- v. Use of kobo platform to collect data, under which data validation controls were inputted in the designing of the form so as to minimize errors.

3.8. Data analysis plan

Quantitative data was cleaned and exported to a Statistical Package for Social Sciences (SPSS) for an in-depth statistical analysis. A data analysis plan was developed and used in the data analysis phase. The data was presented in the form of frequent tables, descriptive statistics, graphs and charts.

Plans for use of data: All of the data gathered, and the reports generated in conjunction with ECHO, will be presented to different stakeholders, including the beneficiaries, financiers, implementers and government. Different methods of disseminating the results will be employed taking into consideration the different needs of data users.

3.9. Study Limitations

The major limitations centered on the long distances travelled by data collectors as the ward targeting process had to consider all affected Cyclone Idai areas. This strategy was used to ensure data is captured and reflected a true representation of the geographical and climatic differences experienced within wards and the two districts.

3.10. Data Dissemination plan

The findings and recommendations from this baseline survey are going to be shared with the IRC and CARE management and project officers before being sent to ECHO. A meeting shall be held to discuss the implications of the findings on the project implementation at consortium level. In addition, the baseline survey report will be shared with relevant district stakeholders.

3.11. Ethical Consideration

The following ethical issues were adhered to during data collection:

- i. Confidentiality
- ii. Beneficence
- iii. Respect for diversity of views

- iv. Transparency and accountability through clearly explaining the baseline process to all stakeholders.
- v. Voluntary participation based on consent – interviews were conducted upon consent of the respondent.
- vi. Do no harm approach (either emotional or physical)

4.0. FINDINGS OF THE BASELINE

4.1. Sample demographics

A total of 175 (101 males and 74 females) project participants were interviewed for the baseline with 100% response rate. The sex of the respondents interviewed were 70% females and 30% males. Females constituted 41% as the household head while 59% were male headed households. The results from the study provided baseline data reinforcing the proposed activities and expected outcomes.

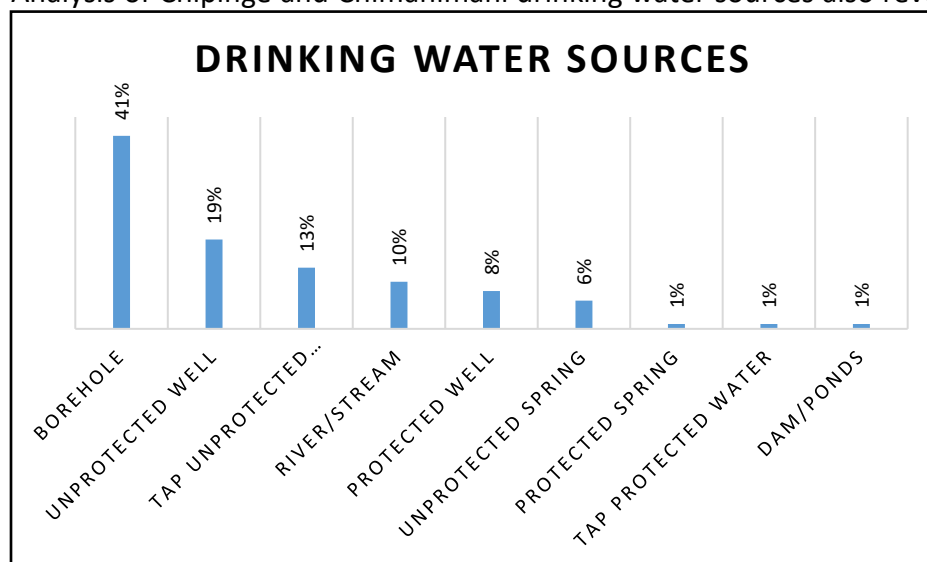
Indicator 1: Number of people having access to sufficient and safe water for domestic use

4.2 Access to Clean and Safe Water

The baseline survey also sought to assess the availability and access to clean and safe water in the targeted wards. The findings of the research revealed that, 49% of the respondents used unsafe sources for drinking water which was also evident as 13% highlighted that there was at least one member from their households who suffered from water related diseases such as cholera, typhoid and dysentery over a 21 days recall period.

The survey explored drinking water sources and realised that boreholes were currently the main drinking water sources with 41% of the respondents identifying it as their source in the two (2) districts. An in-depth analysis of this finding revealed that, the water situation is worse in Chimanimani than Chipinge as 69% of the respondents from Chipinge reported using borehole water for drinking whilst in Chimanimani it was only 25% of the sample who drink borehole water. This can be attributed to the magnitude of infrastructure distraction by Cyclone Idai which heavily affected Chimanimani. Figure 1 below depicts the different drinking water sources that are currently being used by the respondents in Chimanimani and Chipinge Districts.

Analysis of Chipinge and Chimanimani drinking water sources also revealed that the situation is



far worse in Chimanimani were 68% of the sampled population for the survey revealed that they drink unsafe water from unprotected wells (19%), unprotected taps (25%), river/streams (15%), unprotected springs (6%) and dams (1%).

Figure 1: Sources of Drinking Water

It was also prudent to understand the distance that are travelled by the sampled population to fetch drinking water. According to the SPHERE standard handbook (2004), one major indicator of community access to water is measured by the proximity to sources. The distance to fetch safe drinking water is pegged at 500 meters at most. The research findings revealed that 44% travel more than one kilometer with 18% of these traveling more than two kilometers.

Indicator 2: Number of people with access to dignified, safe, clean and functional excreta disposal facilities

4.3 Access to Toilet Facilities

Data obtained from the baseline survey established that 53% of the respondents from both districts within the sample population (n=175) have no access to safe excreta facility. Conversely, 47% had access to safe excreta disposal facility as some communities rely on next door toilet facilities. The proportion is almost similar across the two districts as illustrated on the graph in figure below. Limited access to sanitation facilities expose many people at a greater risk of contracting diarrheal diseases. Basing on the findings it can be noted that, there is a huge gap in terms of sanitation services among the people of Chipinge and Chimanimani districts particularly in cyclone affected communities.

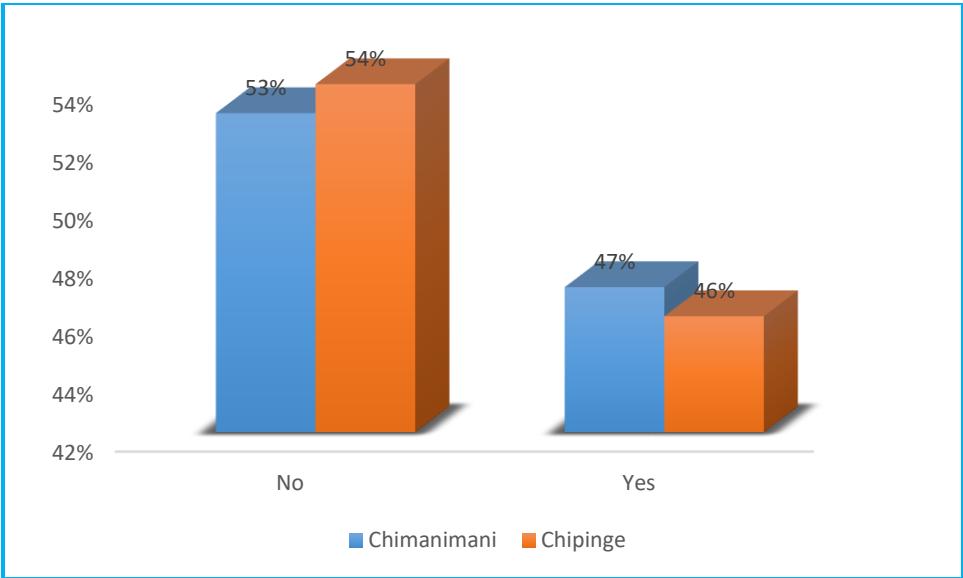


Figure 2: Households with Access to Toilet Facility

The baseline survey investigated types of toilets that the communities from the two districts were using. As illustrated on the graph in Figure 9, there is more open defecation 38% in Chipinge district than in Chimanimani that has 11% basing on the sample of 175 beneficiaries from ECHO project operational wards. Many people are using pit latrine for disposal of human excreta in Chimanimani as illustrated on the graph with a 60%. Only 5% of the respondents in Chimanimani district mentioned that they have UBVIPs. There is a higher risk of contamination due to poor and inadequate sanitation facilities within Cyclone affected households.

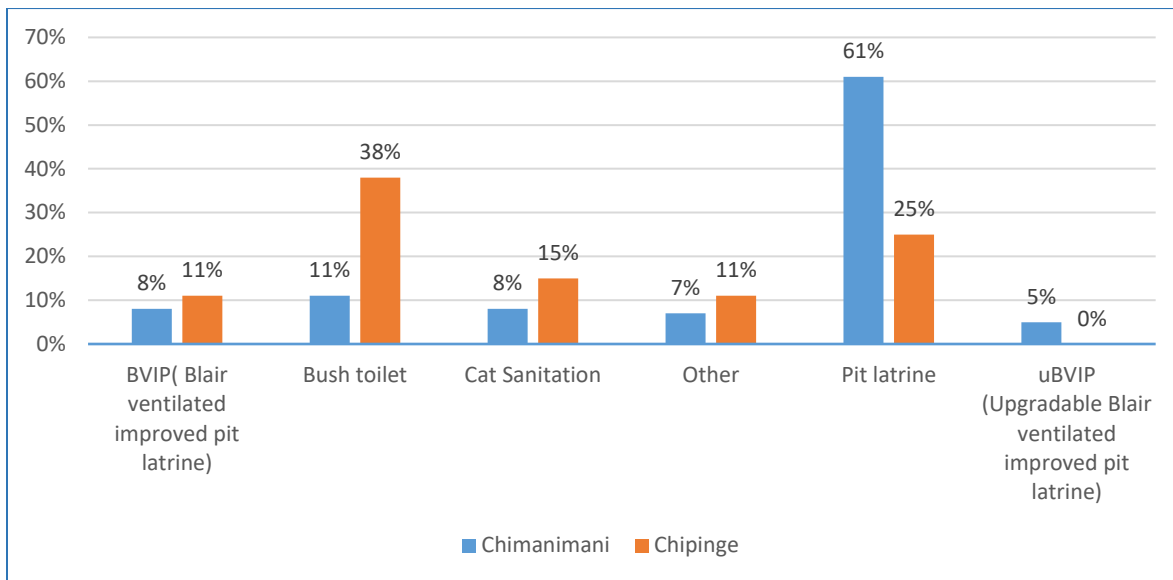


Figure 3: Type of toilet facility used by a household

The baseline study sought to establish access to clean and safe water for the cyclone affected population. WASH standards recommends the use of closed containers when fetching or transporting drinking water. The findings of the baseline depicts that, 18% of the respondents are using open containers to transport water as shown on Figure 1 below.

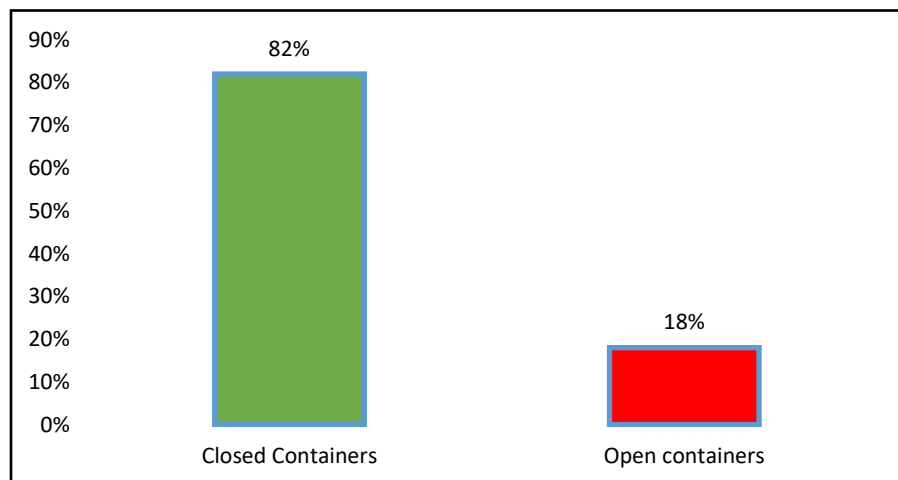


Figure 4: Water Containers Used for Drinking Water

Building on the findings in the chart in fig 2 above, it can be realized that the majority of the population in both Chipinge and Chimanimani districts are aware of the proper handling and storage of water but there is still need to ensure everyone is aware of proper handling and storage of drinking water through

hygiene promotion in the project targeted areas.

The survey solicited information on how frequently communities clean containers used for fetching and storing water. The survey data revealed that 68% of the respondents (n=175) were cleaning each time before storing water while 28% was doing it daily. There was 2% who indicated that they clean household water storage containers once a week and another 2% were not sure on how frequently they clean their water storage containers. The intervention should

increase awareness and ensure that all the targeted communities are exercising good hygiene practices. Figure 2 presents frequency of cleaning water containers at household level.

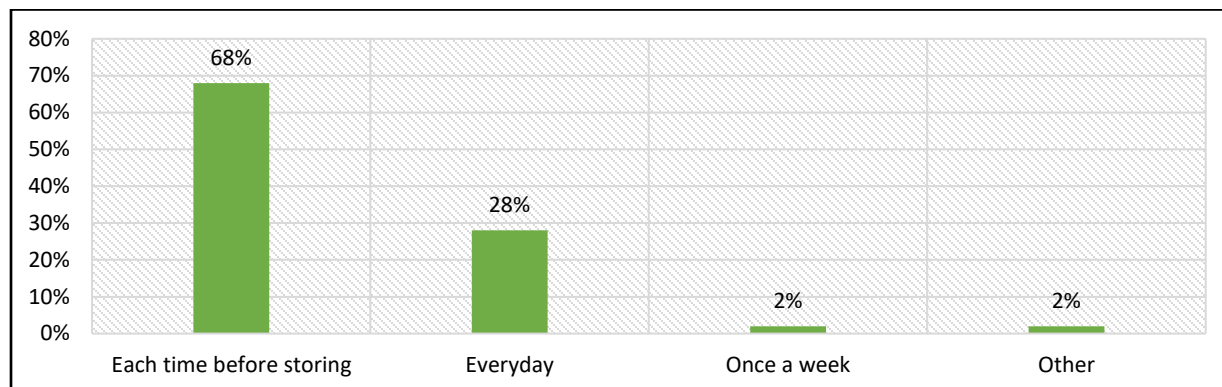


Figure 2: Frequency of cleaning water containers at household level

Indicator 3: Percentage of target population with adequate WASH services and hygiene practices

This indicator is based on averaging 2 sub-indicators:

i. Percentage of population considering that their basic WASH needs are met;

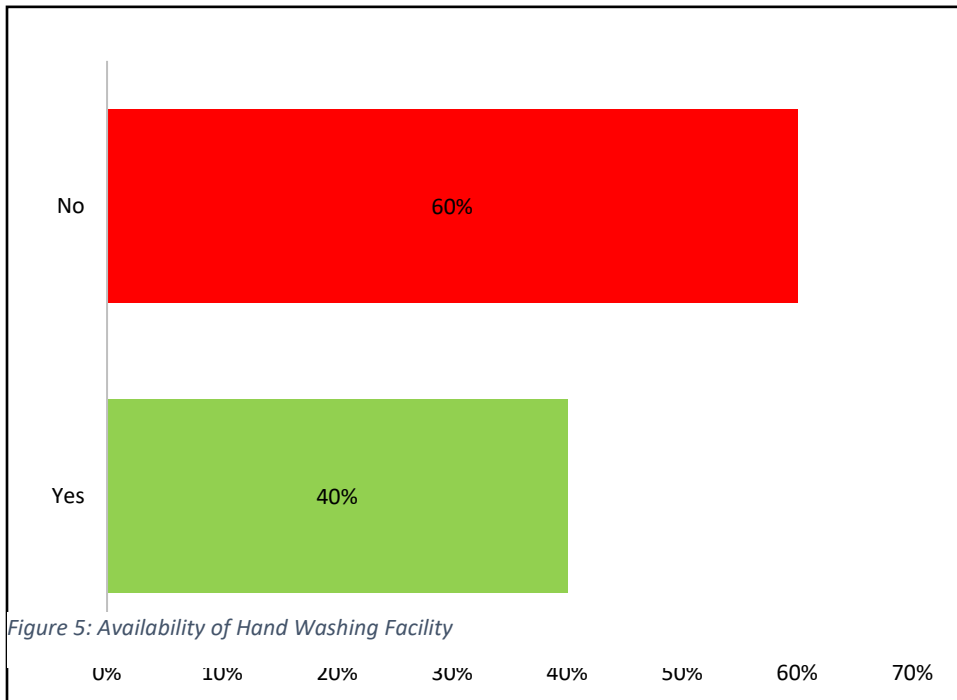
At baseline, there was a small proportion of respondents (48%) who indicated that their basic WASH needs were being met. Hand washing facilities such as tippy-taps and ablution facilities were lost during cyclone.

ii. Percentage of population with adequate hygiene practices (according to SPHERE standards on appropriate use and regular maintenance of facilities and on hand washing).

This sub indicator is based SPHERE standards with particular focus on existence of handy washing facility at household level and community knowledge on critical moments for hand washing. This will be presented separately below:

4.4 Availability of Household Hand Washing Facility

Households with hand washing facilities at their homestead in both districts Chimanmani and Chipinge were low and the survey revealed that 60% did not have the facility while 40% had one. It baseline survey reviewed that communities are reluctant to put up the hand washing facility. This is attributed to limited awareness on the need and potential risks that are associated with poor hygiene practices. The project will put more emphasis on health and hygiene promotion messaging and practices. Figure 5 below is a graphical presentation on the household with hand washing facilities.



Out of the 40% with hand washing facility it was also of interest to establish the most commonly used type of facility. The findings of the survey depicts that, 'tippy tap' system was common in both district with 38% of households in Chipinge using the facility and 24% for Chimanimani. A small proportion 8% indicated that they used bucket system.

Figure 5: Availability of Hand Washing Facility

4.5 Number of people reached with key hygiene messages

The baseline survey data revealed that 60% of the respondents mentioned chlorination as one of the methods used to purify water. 40% of the respondents mentioned boiling whilst 14% mentioned filtration. Basing on these findings presented below on figure 24, it can be noted that the bulk of the respondents are aware of most common water purification methods

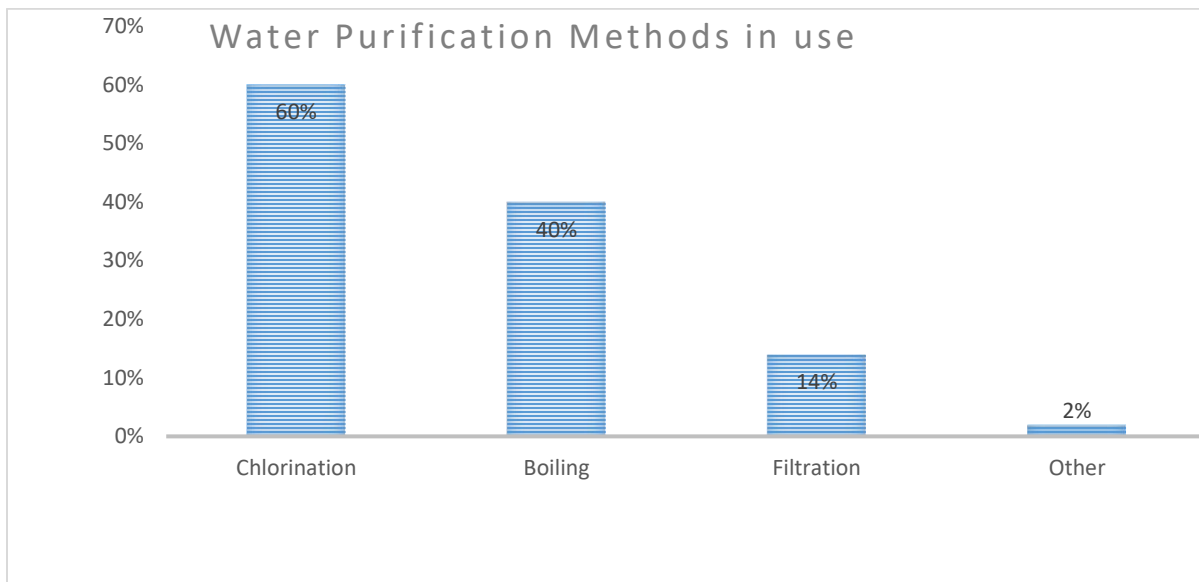


Figure 6: Methods used for water purification

4.6 What are the critical moments to wash hands?

Responses from the survey depicts that an average of the great population within the sample n=175 were familiar about only 2 out of 5 critical moments for hand washing with most of them mentioning hand washing after using the toilet and before eating. Over and above, only 20% of the respondents managed to mention all the 5 critical moments for hand washing whilst 79% could not mention all the five critical moments for hand washing. Hand washing behavior is not fully comprehended by many people as indicated on the chart. Behavior change, counselling and communication process may help in ensuring that people adopt and practice the behavior holistically.

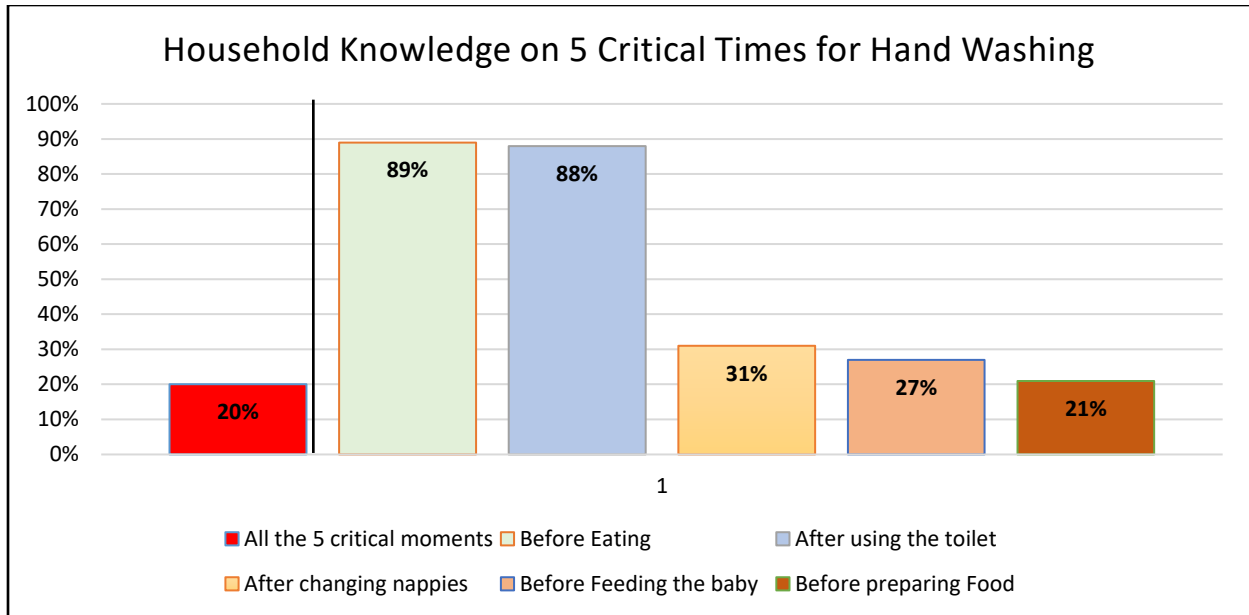


Figure 7: Knowledge on 5 Critical Moments for Hand Washing

Data from the survey indicated that the majority of the respondents (71%) used soap and ash for hand washing. Moreover, 29% of the same population sample indicated that they use water only for hand washing. Using water only for hand washing is not sufficient for improved health and hygiene.

The findings points out to the needs to for improved health and hygiene promotion. The figure 8 below show the hand washing system used by the sampled households.

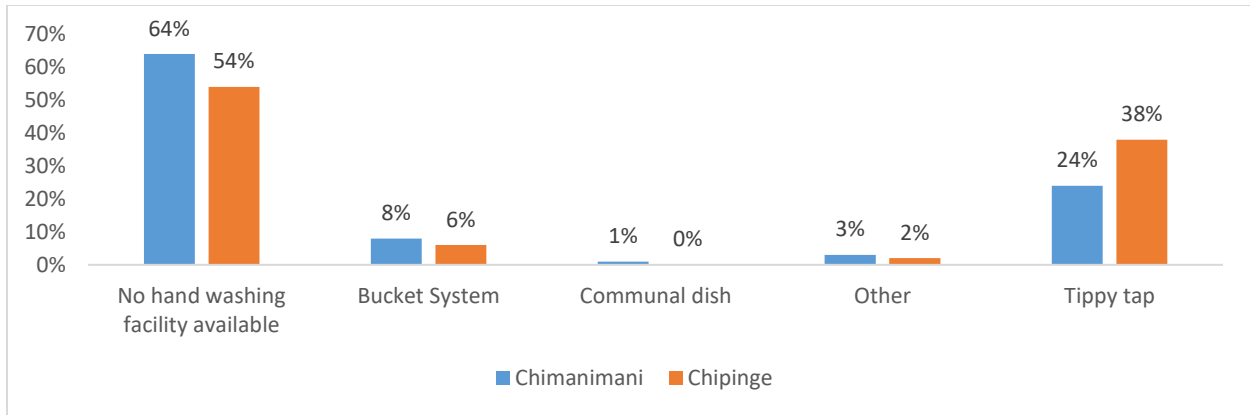


Figure 8: Hand Washing Facility Used

The survey asked the respondents if they had knowledge on prevention of diarrheal diseases. 55% of the respondents mentioned that they can prevent diarrheal diseases through safe disposal of human excreta, whilst 59% mentioned hand washing as another method. Most respondents (81%) mentioned drinking safe and clean water as one of the important measures to prevent diarrhea. In general, it can be deduced that more than 50% of the respondents knew the most basic measures of preventing diarrheal diseases.

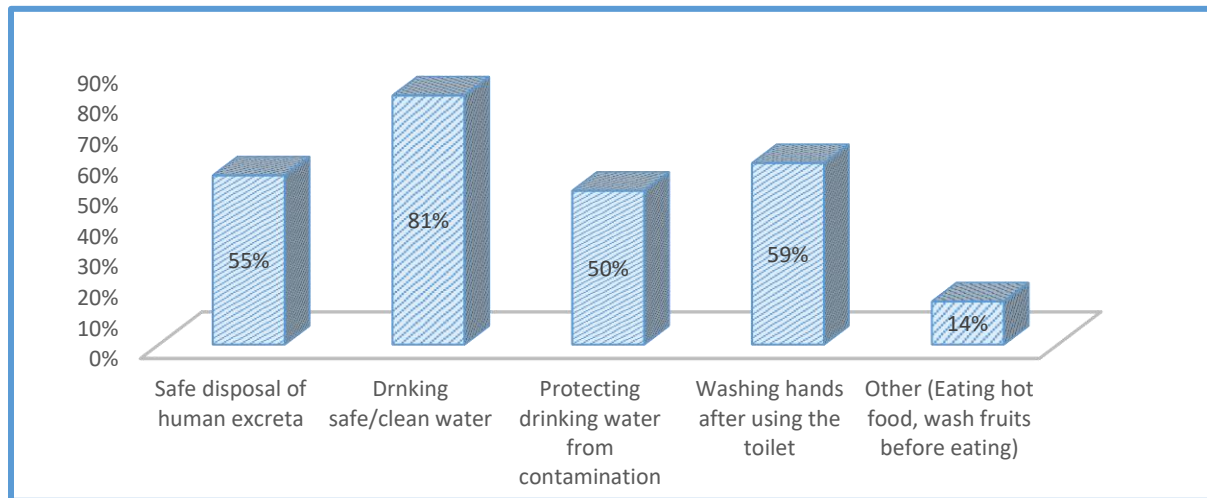


Figure 9: Methods of Preventing Diarrheal Diseases

4.7 Prevalence of Water Related Diseases

One of the proxy indicators of community access to clean and safe water was to also check the prevalence of water related diseases over a recall period of 10 days. Baseline survey data revealed that there were more recorded cases (78%) of diarrheal diseases in Chimanimani on a 10 day recall period. Conversely, Chipinge district had 22% of the sampled population confirmed incidences of diarrheal related diseases.

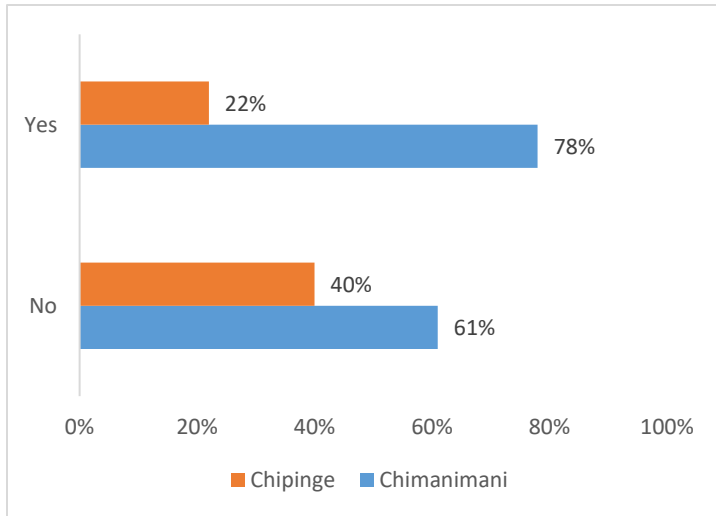


Figure 10: Prevalence of Diarrheal Diseases

Diarrheal diseases are a common phenomenon in the aftermath of cyclone due to excessive contamination of water sources and poor hygiene behavior which would require intensification of health and hygiene education, safe water sources and purification of drinking water. It can be noted that due to higher levels of contamination of many water sources and collapsing of sanitation facilities, chances of more diarrheal cases were recorded in Chimanimani district. Prevalence of diarrhea incidences confirmed by sampled population are

shown on fig 7.

The baseline survey implored on community knowledge levels regarding prevention of diarrheal diseases. There are many health and hygiene practices which communities can embark on to eliminate prevalence of diarrhea and the list included but not limited to safe disposal of human excreta, drink safe and clean water, protecting drinking water from contamination, washing hands after using toilet and eating hot food. As illustrated on the graph in fig 12 below, 55% of the sampled population indicated that they can prevent diarrheal diseases through safe disposal of human excreta, whilst 59% mentioned hand washing as another method. 81% pointed out that drinking safe and clean water as one of the important measures to prevent diarrhea. About 56% of the sampled population knew at least three (3) ways of preventing diarrheal diseases.

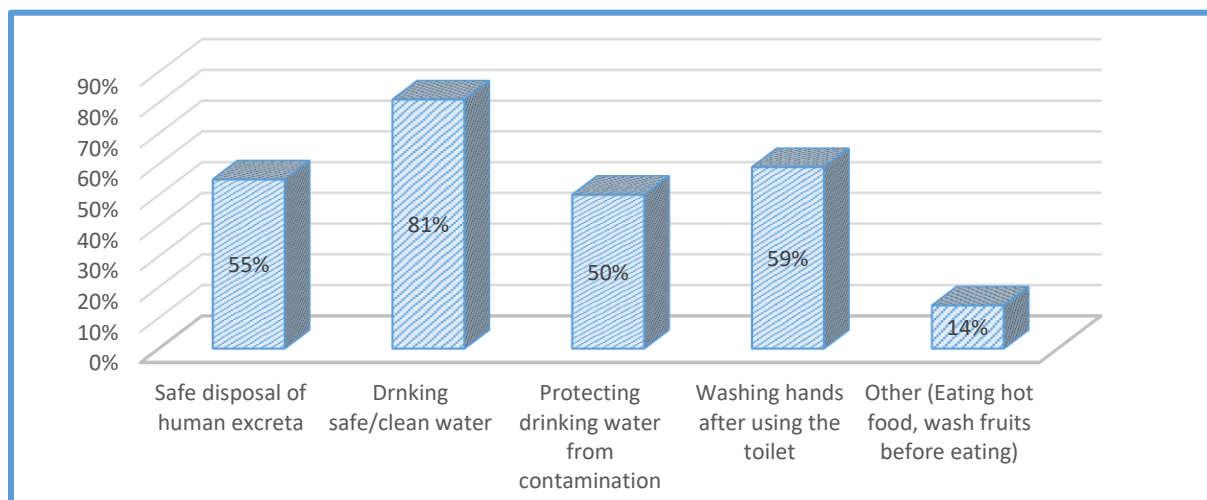


Figure 11: Methods Used to Prevent Diarrheal Diseases

Indicator 3: Average Coping Strategy Index (CSI) score for the target population

4.8 Coping Strategy Index

The Coping Strategy Index (CSI) is used to show how households cope with the difficulties of food insecurity. This is computed based on the options that households employ in bad times in order to cope or to respond to food shortages after Cyclone Idai disaster. Although the index does not have a standard reference threshold, the higher the index reflects the more difficult it is for a household to access food. A household that is not coping at all will have a coping strategy index of zero and therefore any index above zero reflects some level of coping by the household.

The CSI tool relies on counting coping strategies that are not equal in severity. Different strategies are “weighted” differently, depending on how severe they are considered to be by the people who rely on them. The frequency answer is then multiplied by a weight that reflects the severity of individual behaviors. Finally, the totals are added to give the coping strategy score. The evaluation used a full coping strategy index and not the reduced based on the WFP CSI guideline¹. Based on the full strategy index, the average score for the respondents of the baseline was 39.

The baseline survey assessed the beneficiary coping strategies using the recall of how many days in the past 7 days they had used the following coping strategies: relying on less preferred and less expensive food; limiting/reducing portion size at meals; restricting/reducing consumption by adults in order for small children to eat; reducing number of meals eaten in a day; and borrowing food or relying on help from friends and relatives. The frequencies were recorded and multiplied by each strategy’s standard weight to give the total household score. The totals were then broken into three thresholds (no/low coping strategy, medium, and high coping) for interpretation. The figure 13 below illustrates the classification of the respondents’ coping strategies.

¹ https://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp211058.pdf

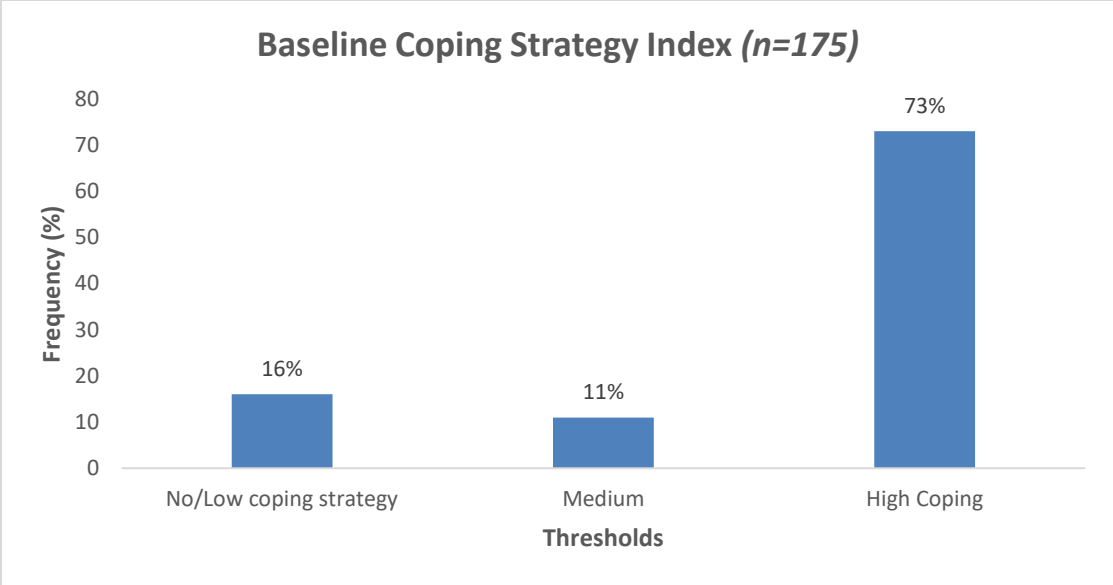


Figure 12: Coping Strategy Index

From the graph 16% of the respondents were in the ‘no or low coping strategy’, 11% in the ‘medium’ and 73% in the ‘high coping strategy’ cohorts respectively. The majority (73%) were in the high coping strategy threshold implying that they were food insecure. The justification for such a proportion of beneficiaries falling into this threshold was that the program had avoided double-dipping and selected vulnerable members of the target population not receiving any forms of assistance from other agencies or organisations. It is recommended that the program monitors the change over time of households especially those in the high coping strategy cohort at baseline so that the impact of the program can be measured effectively over time.

4.9 Additional Context Specific Coping strategies

The baseline survey included context specific coping strategies as a way of determining other beneficiary coping behaviors over and above the standard five discussed above. The basis for this inclusion was the mention of these strategies by key informants during the needs assessments and interactions with the beneficiaries and community leaders during the data collection sessions for ward profiling.

The survey probed the households if they were selling their assets in the past 30 days because there was not enough food or money to buy food. The survey data in figure 14 established that the majority (85%) of the respondents did not sell assets (such as radios, cellphones) in order to buy food in the past 30 days and the minority (15%) did. This loosely translates to 85% being food secure and 15% being food insecure. However, further enquiry indicated that a segment (25%) of those that did not sell their assets had already exhausted that strategy meaning that they were probably adopting other strategies with long term negative impacts on household food security. It is hoped that the program through Multi-purpose Cash Transfer (MPCT) and Cash for Work (CfW) interventions will address food insecurity among the targeted communities and the numbers of those in the ‘high coping’ threshold will reduce.

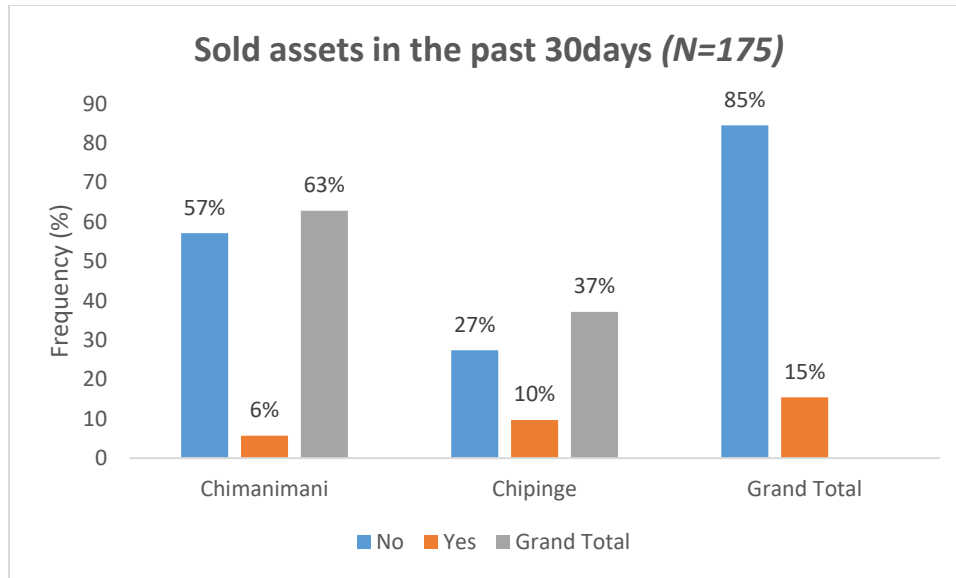


Figure 13: Household selling assets.

Spending savings was one of the proxies the survey used to establish the pre-intervention household food security among the targeted population. From the figure 15 below, cumulatively 23% had spent savings in order to buy food while 77% had not. Using the district ranges (difference between 'Yes' and 'No' responses) there were more beneficiaries using this coping strategy in Chipinge than Chimanimani respectively. A follow up on those that said that they had not used savings indicated that 32% had already exhausted that strategy, therefore on a cumulative basis 47% of the total respondents had adopted this coping strategy. Based on that these were all disaster affected (Cyclone Idai) community members, the other 57% may not have used this coping strategy because they did not have savings at all.

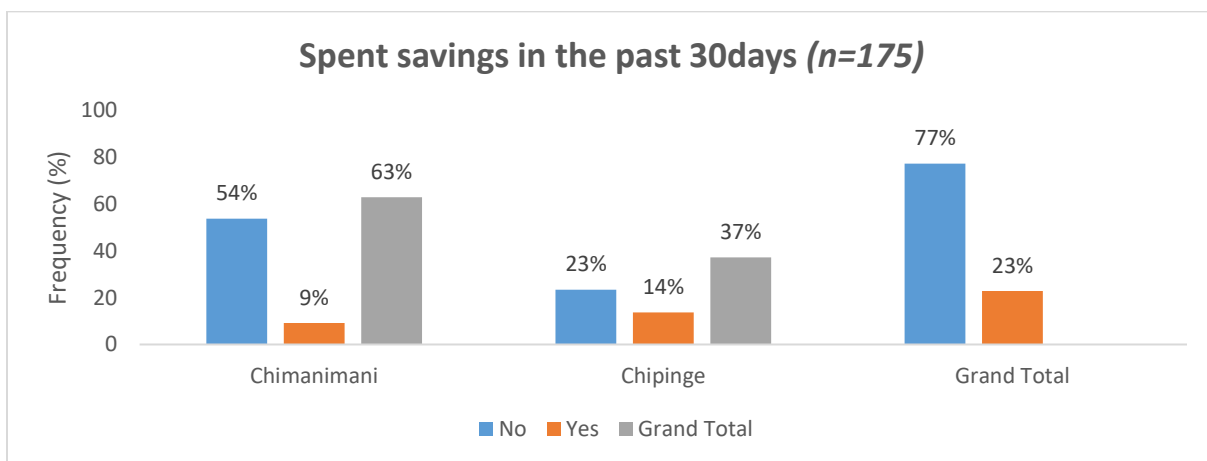


Figure 14: Households spending their savings

The baseline survey established that 61% of the respondents had not purchased food on credit or borrowed food in the past 30 days while 39% had adopted this strategy in the same period as illustrated by figure 16 below.

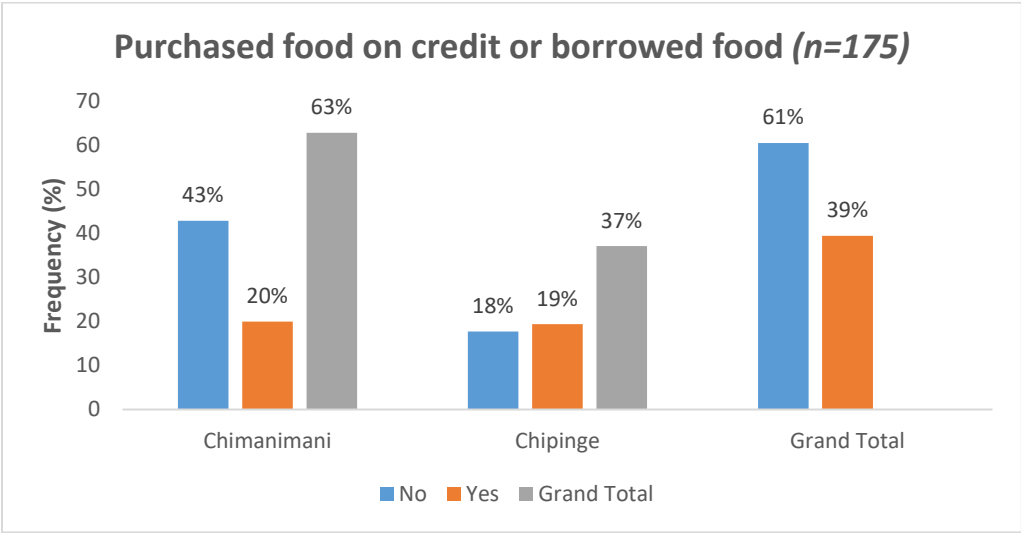


Figure 15: Households who borrowed or purchased food on credit

In Chimanimani district less than a third of the target population had adopted this strategy and this implies that the district was relatively food secure. By contrast Chipinge district had more than half of the targeted population adopting this coping strategy in the same review period. This could be attributable to different climatic conditions and food production possibilities. Purchasing food on credit or borrowing food is a common short-term or immediate coping strategy adopted mostly by the rural folk during times of distress and this explains why about a third of the population in this survey fell in that cohort. In terms of the program, it is envisaged that the beneficiaries will be able upon receiving their cash to offset outstanding debts and be able to meet their basic food needs without accumulating debt.

In the figure 17 below, 33% of the respondents had borrowed money from friends or relatives because there was no enough food in the household in the past 30 days while 67% did not use this coping strategy. For communities in the post disaster recovery phase, this indicates a steady improvement in the household economic activities as most people borrow in anticipation of a near future cash in-flow. Chipinge district however, has a small range (5%) implying that while the majority did not adopt this coping strategy it still remained preferred among a significant segment of the population. It is anticipated that with cash injection from the project interventions the beneficiaries will strengthen their livelihood means and avoid negative coping strategies.

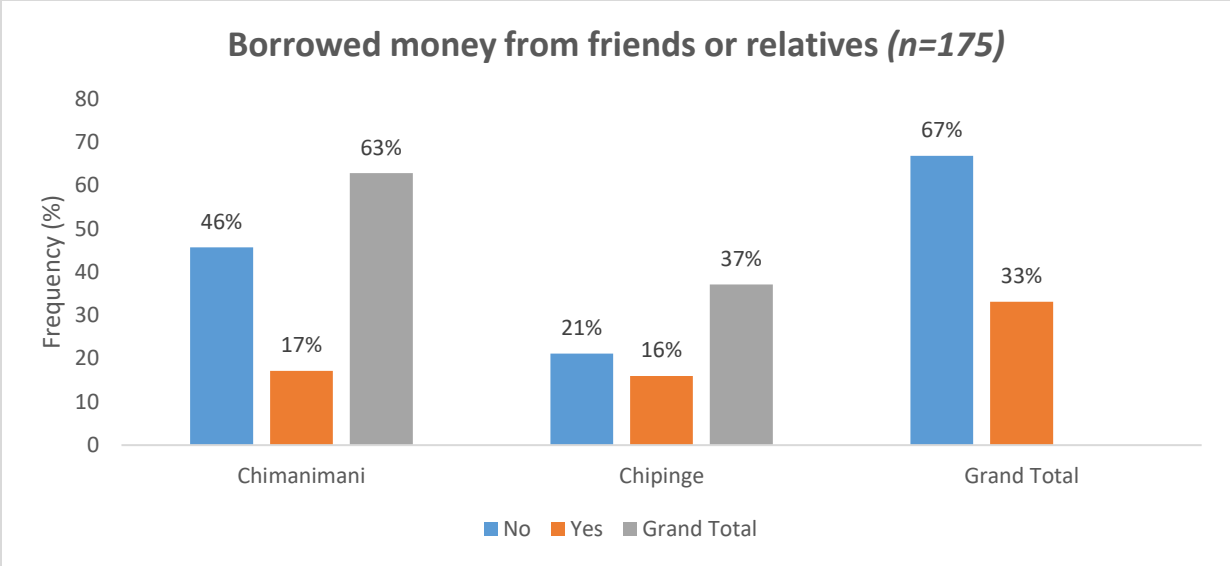


Figure 16: Households who borrowed money from friends or relatives

The research investigated if households were selling productive assets. Selling of productive assets is one of the coping strategies the survey used to assess household food security among the selected beneficiaries. From the figure 18 below, a cumulatively 91% had not sold their productive assets while 9% did. This means that at baseline level the majority of beneficiaries still have their productive assets which forms the basis of their livelihoods and resilience. Against this background the program’s objective of improving food security through the cash interventions will be achievable.

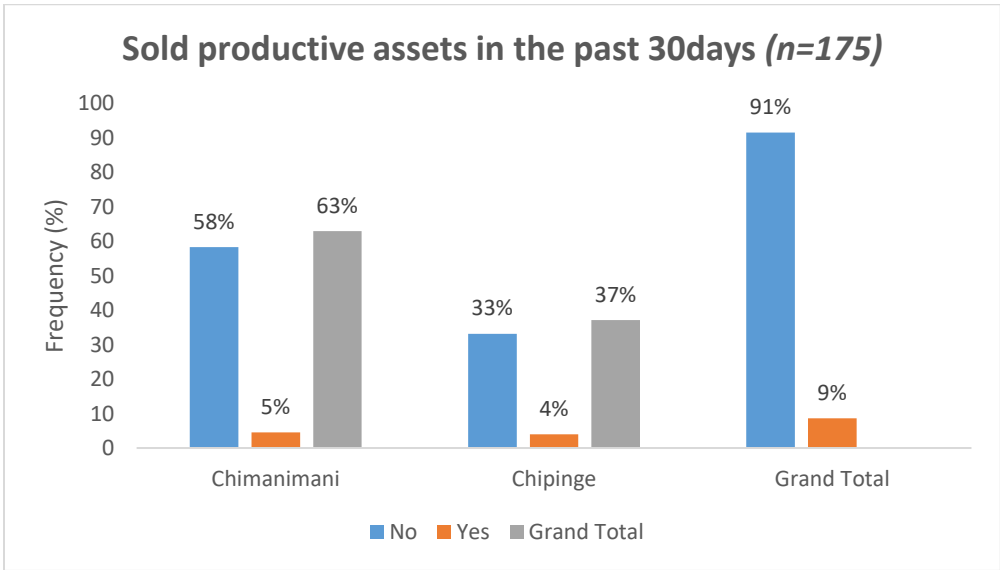


Figure 17: Household who sold productive assets

The survey established that cumulatively 78% of the respondents had not used the coping strategy of withdrawing children from school in order to reduce expenditures because there was not enough food or money to buy food while 22% had adopted this strategy in the past 30 days. In both districts there were less beneficiaries that had used this coping strategy compared to those that did not. Figure 19 below illustrates the responses on withdrawing children from school as a coping strategy disaggregated by district. Both districts are covered by the MPCT and CfW intervention with beneficiaries focusing on addressing their food needs whilst balancing with sending their children to school.

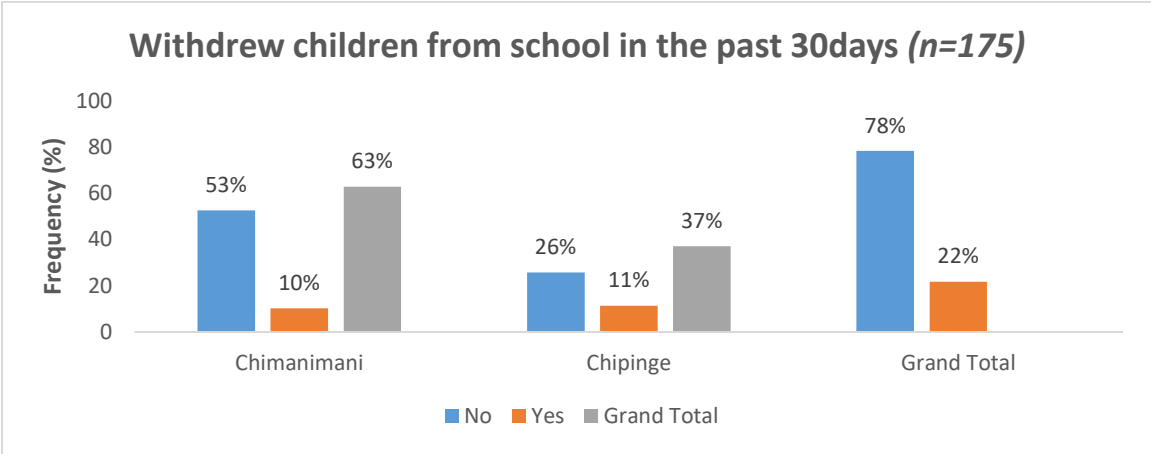


Figure 18: Households withdrawing children from school

The survey established that the majority (77%) of the respondents did not have household members (or themselves) begging in the past 30 days while 23% begged as shown in Figure 20 below. Though begging is a context-specific coping strategy and comparatively few beneficiaries had adopted it, where it was practiced especially by all or most members of the households it suggests severe food insecurity. It is therefore, recommended that the program monitors this strategy. It is also imperative for the program through its gender component to establish gender implications of this strategy - if it was one sex or both that begs and the reasoning behind that.

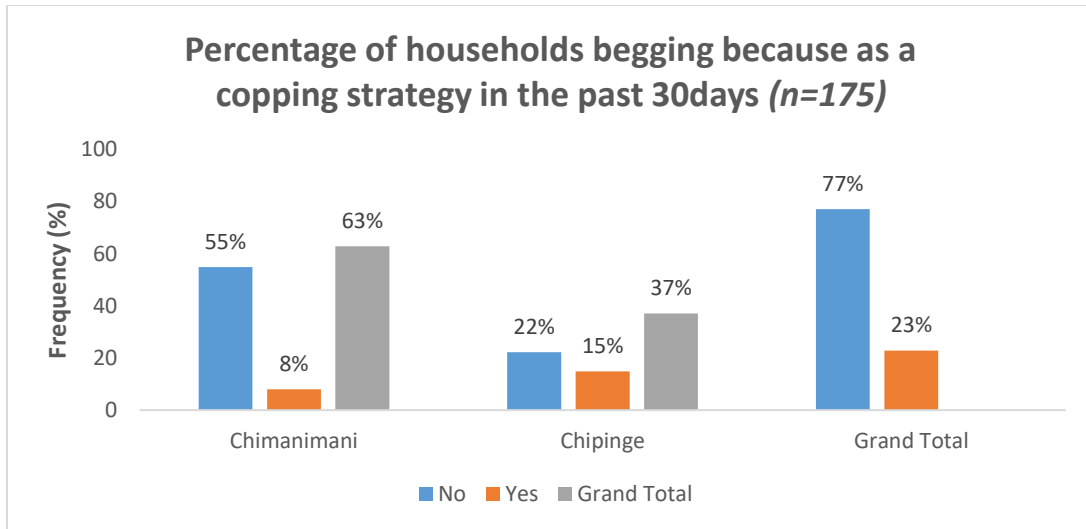


Figure 19: Household who begging for food

The survey also solicited the extreme situation of household hunger as shown in figure 21 below. The figure shows that across all districts there were 86% respondents that had not sold their last breeding female animals as a coping strategy while 14% had adopted this strategy. Chimanimani district has fewer cases of selling female animals mostly because animal production is not a preferred livelihood in the district as compared to Chipinge district. Female animals are usually sold as a last resort and mostly as a long term coping strategy. This coping strategy needs to be monitored on a longitudinal basis together with the standard coping strategies as animal production is one of the sources of livelihood for the target population especially in Chipinge district. This is important because community resilience hinges on the sources of livelihood.

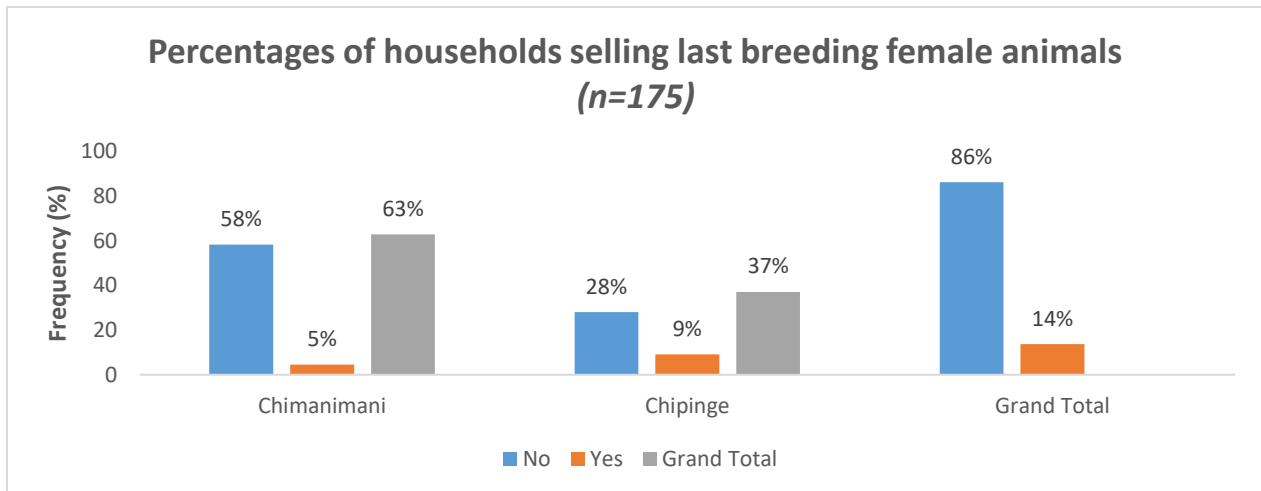


Figure 20 : Households selling female livestock

Indicator 2: Percentage of beneficiaries (disaggregated by sex, age and diversity) reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner

4.10 Information Access about the Project

The baseline survey showed that bulk of the respondents (76%) reported that, they received information about the programme with 24% of the respondents reporting that they did not receive any information. More males (85%) stated to have received more information on the programme as compared to females (79%) as shown in the table below. This is attributed to the high attendance of community gatherings by men as compared to women. Generally, 76% of the participants stated that they know how people were chosen to participate in the project and receive assistance with the remaining 24% reporting that they did not know. Most of the respondents (75%) reported they were told what they would receive while 25% stated that they were not told. The following table 3 shows the sex disaggregation by percentage response.

Table 2: Access to Information about the Project

Question	Sex	No	Yes	Total
Have you ever received information about the programme, including who is included, what will beneficiaries receive and where people can complain?	Female	21%	79%	100%
	Male	15%	85%	100%
Do you know how people were chosen to participate in the project and receive assistance?	Female	2%	98%	100%
	Male	30%	70%	100%
Have you been told exactly what you are entitled to receive?	Female	23%	77%	100%
	Male	28%	72%	100%

Figure 10: Programme Knowledge table

The majority of the interviewed respondents (62%) highlighted that they would go to community leaders if they had a question or need assistance when faced with a problem, whilst 37% would go to Care and the remaining 1% would go to the government. The following table shows the sex disaggregation by percentage response.

Table 3: Beneficiary Preference on Where to Report

Sex	Response			Total
	Care/IRC	Community leader	Government	
Female	37%	62%	1%	100%
Male	38%	60%	2%	100%

4.11 Preferred Feedback Mechanism

The survey asked questions on preferred feedback mechanism amongst beneficiaries and it revealed that 37% preferred help desk followed by the suggestion box (35%). The least preferred mechanism is the Deloitte toll free number (7%) as illustrated by the graph on Figure 12 below.

This can be attributed to the limited knowledge on how the deloitte toll free works. From the key informant interviews it was indicated that there is limited network access in some areas and only sensitive complaints can be channeled through the toll free.

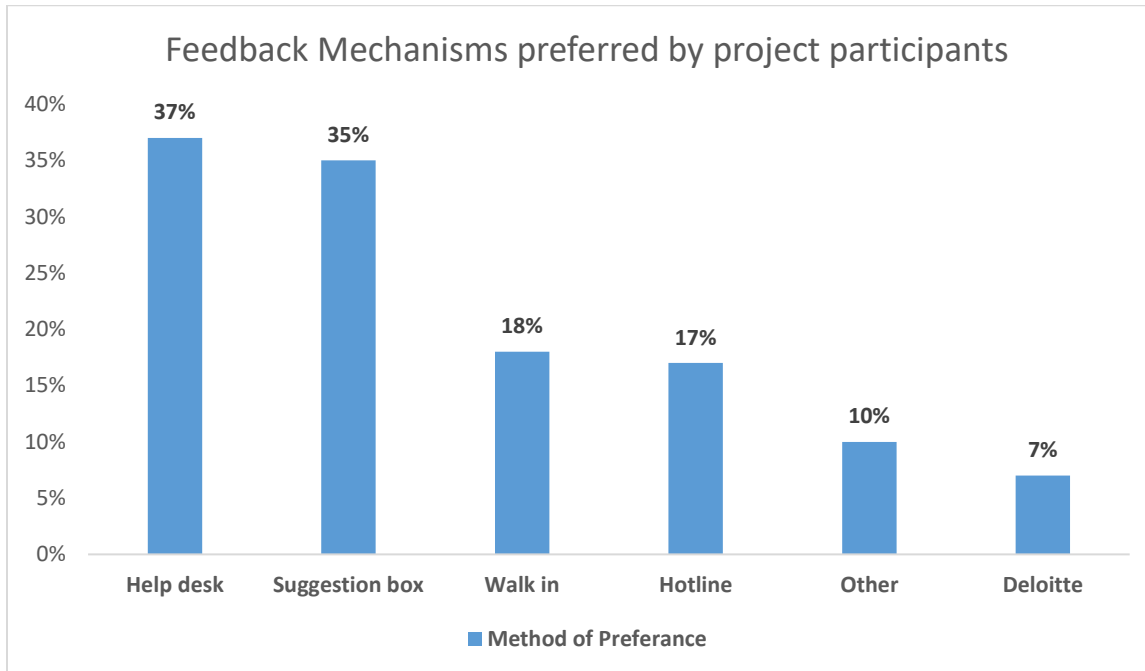


Figure 21: Feedback Mechanisms Preferred by Beneficiaries

4.12 Gender Mainstreaming

CARE and IRC humanitarian obligation is to meet immediate needs of women, men, girls and boys affected by natural disasters and humanitarian conflicts in a way that also addresses the underlying causes of people’s vulnerability, especially as a result and cause of gender inequality. When an emergency hits, women and girls are the worst and most affected. After the destruction of the cyclone a rapid gender assessment was conducted in the affected parts of Manicaland and Masvingo. On an effort to address and in cooperate one of the key recommendation made of ensuring access to equal opportunities by both sexes, the project aims to mainstream gender into project activities. The following baseline findings provided an overview of decision making practices made in relation to gender.

Responses from the survey on figure 22 showed that 49% reported that female HH members go for shopping; that is, buy food and non-food items, whilst 19% reported that male HH members go for shopping and 32% indicate that both females and males participate in HH shopping

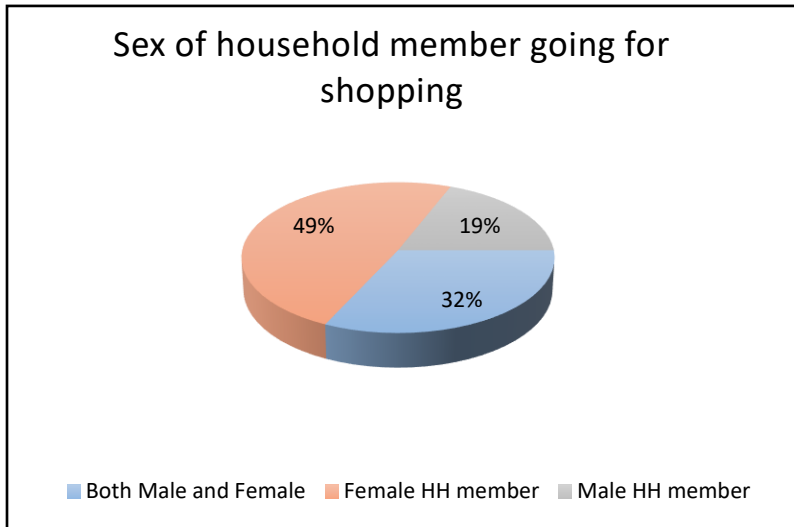


Figure 22: Sex of Who Does Shopping at Household Level

A Chi-square test for association (p-value=0.000) revealed that there is an association between sex and who goes for shopping for food and non-food items. This may be owed to the perception that shopping is a female activity.

The availed data from the survey reflected that 51% of the households make joint decisions on how assistance is utilized, with 39% and 10% of the HHs having female and male sole decision makers respectively as shown in figure 23 above.

The 39% sole female decision statistic is likely due to the fact that 42% of the HH population are female headed, hence male HHs greatly include their spouses in decision making as alluded by the 51% joint decision percentage.

makers respectively as shown in figure 23 above. The 39% sole female decision

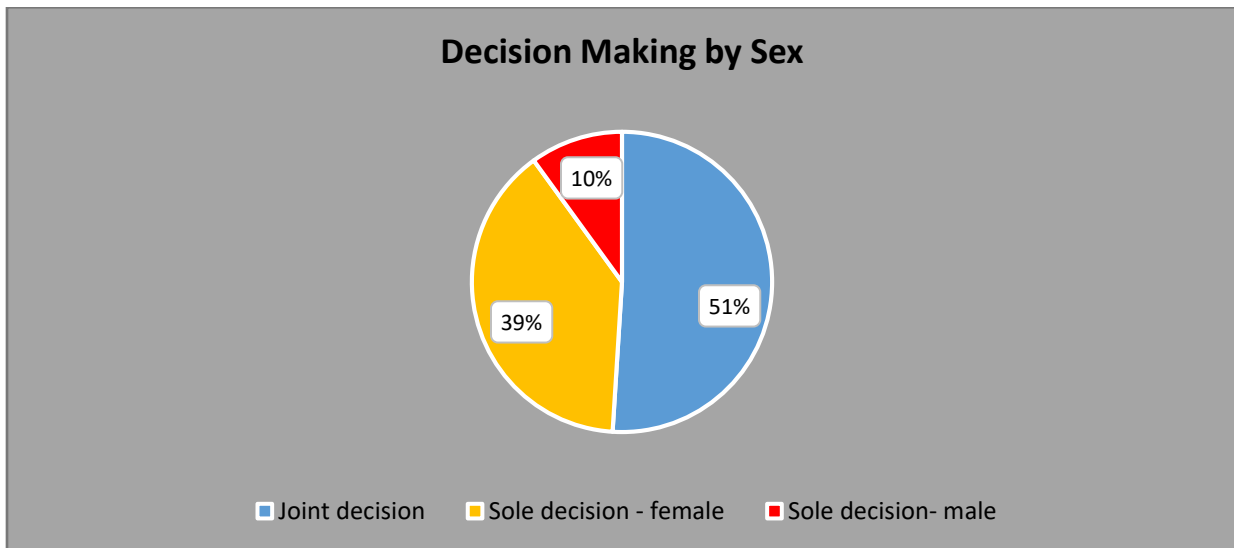


Figure 23: Decision Making on Cash Utilisation

The following figure 24 summarises decision making on household finances. The survey identified that 52% of households make joint decisions on income disposal and 43% of households make joint productive assets decisions. Sole female decision making on income disposal and productive assets averages 34%.

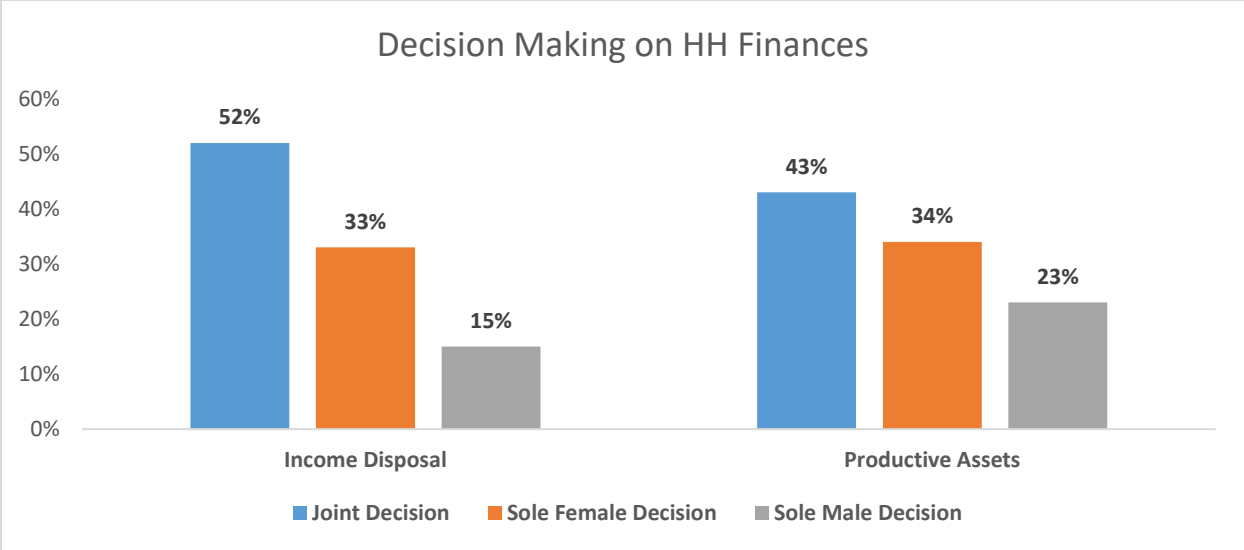


Figure 24: Income and Asset Decision Making by Sex

5.0 Conclusions

The survey showed that beneficiaries largely have knowledge on the programme, selection criteria and entitlement as seen by the 76% that stated that they received program information. The baseline survey data revealed that there is a gap in health and hygiene practices in the communities of Chipinge and Chimanimani. It can be gathered that the greater population does not have adequate access to proper sanitation facilities. Additionally, the wider population has no access to hand washing facilities. Limited access to proper sanitation and hygiene facilities exposes the greater population of the cyclone affected populations for Chipinge and Chimanimani district to the risk of diarrheal diseases. Joint decision making averaged at 49%, there is need to increase the participation of women in decision making processes.

5.1 Recommendations

1. Program to monitor the coping strategies on a longitudinal basis in order to establish if the interventions are effecting a change from high to no or low coping strategies;
2. Program to select such context-specific coping strategies as begging, sale of productive assets and track them alongside the standard coping strategies that make the universal CSI. This will give a better view of the adopted coping strategies in the program area;
3. Inadequate access to standard WASH enabling facilities and services is a great cause of concern in Cyclone affected communities in Chipinge and Chimanimani districts. There is need for an Integrated Participatory Health and Hygiene Education to communities for behavior change communication. This may significantly contribute to changes in attitudes, perceptions and norms which might be hindering the communities to practice recommended WASH behaviors such as hand washing, proper disposal of human excreta, drinking clean and safe water.
4. Encourage registration of female household members, especially for MPCT and Cash for Work interventions to promote adequate needs of family members are meet;
5. Gender dialogues that; establish barriers to women and girls participation and involvement in project activities and how to address challenges raised, allow communities to nominate sign off meeting points that are accessible to them and minimise walking distances;
6. Encourage women to participate in project activities, particularly latrine builder training and construction and project leadership roles; that is; committee leaders , in order to impact skills and for capacity building;
7. Give beneficiaries a brief project summary and description during project meetings and trainings;
8. Ensure all complains response mechanisms are readily available to beneficiaries.