UNICEF ZIMBABWE

Sectoral Report for Nutrition for the period January to December 2016

Submitted in March 2017

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Cover Photo: *UNICEF Zimbabwe/ 2016*

Caption: *Solven Chipenyu's daughter feeds on plumpy nut while recovering from malnutrition at their family home in Mwenezi District*

Map of Zimbabwe

1.0 Executive Summary

The focus of the UNICEF nutrition programme as guided by the Convention on the Rights of the Child (CRC) is to promote the rights of children to adequate nutrition. The nutrition programme ensures interventions implemented embrace an equity-based approach to address the causes of child malnutrition. The Zimbabwe's Food and Nutrition Security policy of 2013 and the National Nutrition Strategy (2014-2018) provide the overarching framework for the UNICEF response to nutrition challenges in Zimbabwe. UNICEF's nutrition programme is also guided by the 2014 - 2017 UNICEF Strategic Plan. The strategic plan is designed to support global efforts to reduce under nutrition, with a particular focus on stunting, through improved and equitable use of nutritional support, improved nutrition and care practices.

The nutrition programme implemented by UNICEF Zimbabwe was also guided by the Country Programme 2016 – 2020, The Zimbabwe United nations Assistance Framework (ZUNDAF 2016 – 2020) and also the Sustainable Development Goals (SDGs 2016 – 2030). The specific SDGs to the nutrition programme are SDG 2 and 3. Goal 2 focusses on zero hunger to achieve food security and improve nutrition. Goal 3 refers to good health and wellbeing by ensuring healthy life styles. (https://sustainabledevelopment.un.org/post2015/transformingourworld).

The nutrition programme seeks to ensure that infants, young children and mothers have increased and equitable access to nutritional services, have improved nutrition and care practices with a focus on reducing stunting. Working with the Government of Zimbabwe (GoZ), local and International Non-Governmental organizations (NGOs), UN agencies, other sectors within UNICEF (WASH, Education, Health, HIV and Child Protection) and development partners, the main programme focus of UNICEF Nutrition are Maternal, Infant and Young Child Nutrition; Integrated Management of Acute Malnutrition and Control of Micronutrient Deficiencies including Universal Salt Iodisation.

In 2016, UNICEF successfully coordinated the emergency response due to humanitarian crises caused by the El Nino induced drought. The drought resulted in an estimated 4.1 million people in Zimbabwe, including 1.9 million children, needing humanitarian assistance (ZIMVAC, 2016). A vulnerability assessment conducted in June 2016 showed that the levels of acute malnutrition had deteriorated to the highest limit experienced in 15 years, with Global Acute Malnutrition (GAM) rates ranging from 5 % to 17 % in the 20 most affected districts. The Nutrition Sector initially targeted a humanitarian response to 20 districts with GAM levels of 5% and above. However, by the end of 2016 the humanitarian response was covering 27 districts with high GAM rates. A total of 17,769 children under the age of five were admitted into the Integrated Management of Acute Malnutrition programme and treated for severe acute malnutrition (SAM). Active screening and case finding was conducted by Village Health Workers (VHWs) at community level on a monthly basis in the emergency districts to ensure that children with severe and moderate malnutrition are identified, followed up and referred to health facilities for appropriate treatment. Mothers and caregivers of children under the age of five were supported and counselled for appropriate infant feeding practices in emergencies. Children aged 6 to 59 months were supplemented with vitamin A while women were supplemented with Iron and folate supplements in pregnancy.

The multi-sectorial community based model for stunting reduction was successfully implemented in 4 districts. Communities in the four districts were capacitated to develop and implement village level action plans. Lessons learnt from the initial four districts will be used to expand the programme to 15 more districts in 2017. Vitamin A supplementation for children aged 6 to 59 months with two annual doses remained low particularly for children older than two years. Mothers find it difficult to carry children older than two years to health facilities which are sometimes more than 10 km from their homes. As a result, once children have completed the primary course of immunisation they are no longer brought to the health facility for growth monitoring and vitamin A supplementation. The ministry of health and Child Care (MOHCC) has plans to capacitate Village health workers to give the vitamin A supplements in the community which will go a long way in increasing the vitamin A supplementation coverage for children 6 to 59 months.

UNICEF would like to thank all the donors who contributed to the achievements outlined in this report, and to Sweden for the flexible funding which enabled the programme to achieve planned results in 2016. UNICEF looks forward to continued partnerships with all donors in 2017, with the aim to achieve even better results for the women and children of Zimbabwe.

2.0 Strategic Context of 2016

The effects of the El Nino weather conditions experienced during the 2015/2016 agricultural season resulted in the worst drought ever experienced in Zimbabwe in the past 35 years. The June 2016 Zimbabwe Vulnerability Assessment Committee (ZimVAC) report revealed that 20 districts had Global Acute Malnutrition (GAM) of 5% and above. The focus of the nutrition programme in 2016 was on planning and responding to the drought emergency. UNICEF contributed to the development of key emergency documents including emergency guidelines for nutrition response, Humanitarian Action for Children (HAC) 2016, regional nutrition emergency response plan, Humanitarian Needs Overview (HNO) and Humanitarian Response Plans (HRP).

In partnership with Non-governmental Organisation (NGOs) and government, UNICEF implemented nutrition emergency response activities initially in 20 districts and later increasing the number of districts to 27 districts with high GAM rates. The nutrition emergency response provided women and children access to life-saving essential nutrition and health services, strengthening community-based management of acute malnutrition, in priority geographical areas. The intervention prioritised children and pregnant women at highest risk of morbidity and mortality due the drought.

UNICEF supported the Ministry of health and Child Care to build capacity of both community based and health facility based health workers to actively and correctly identify, refer and treat severe acute malnutrition (SAM) as per global protocols. During active screening children with moderate acute malnutrition were also identified and referred for treatment of moderate acute malnutrition in collaboration with the World Food Programme (WFP). UNICEF has also supported the government in procurement of IMAM supplies for the year. A total of 33,279 ready to use therapeutic food (RUTF) cartoons were procured and distributed which covered all the requirements for the year. Vitamin A capsules were procured and distributed to all health facilities in the country to cover children aged 6 to

59 months with two doses throughout the year. Sector coordination for both the humanitarian response through weekly emergency meetings and the regular programming through the monthly Nutrition Technical working group meetings was prioritized throughout the year to ensure that targeted districts were reached with critical lifesaving interventions and women and children in all other districts in the country could still access nutrition services from health facilities nearest to them.

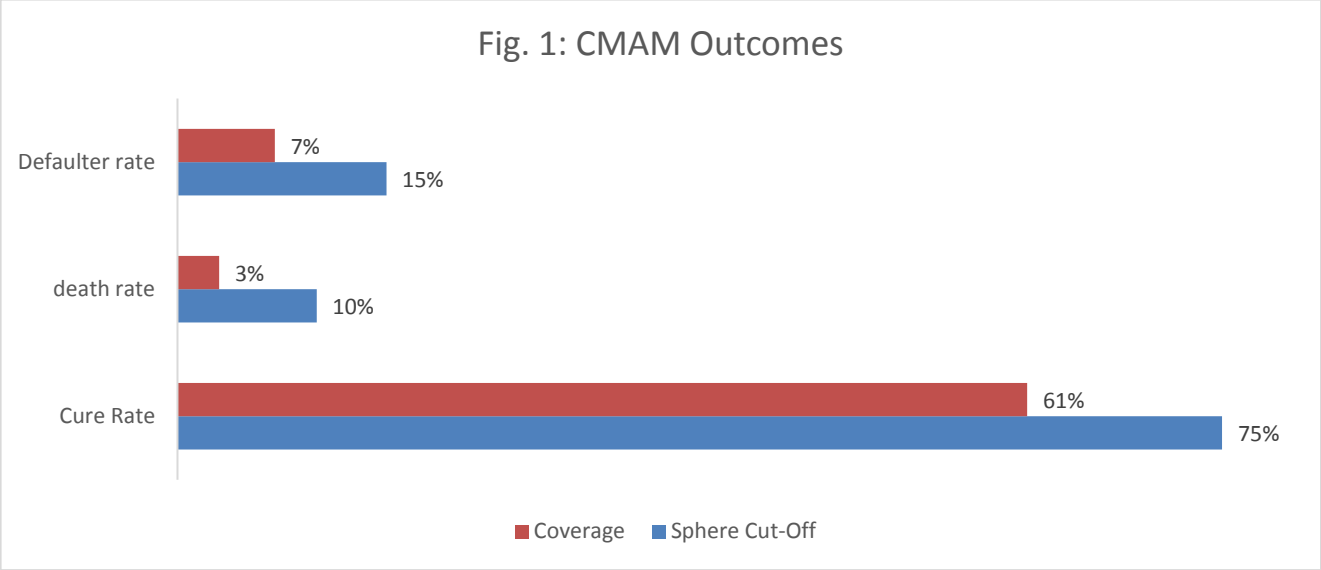
UNICEF Nutrition programme in collaboration with Food and Nutrition Council and Ministry of Health and Child Care are innovating on monitoring implementation of multi-sectoral nutrition interventions for stunting reduction using near real time monitoring system. To date, all the 110 wards from 4 pilot districts are reporting on nutrition sensitive and specific data on a monthly basis. The stunting reduction model is also being scaled up to 15 more districts with support from DFID. The last quarter of 2016 saw the initiation activities to start implementation of the scaling up to 15 districts. A total of 180 Nutrition ward coordinators were recruited and trained to help Ward Food and Nutrition Security Committees (WFNSC) to compile and implement the ward level micro plans. The training capacitated the coordinators to start their function in their catchment areas. They appreciated the need for multi-sectoral coordination for stunting reduction. As a result, formation of Ward Food and Nutrition Security Committees have commenced in the 15 districts and the programme will be rolled out in 15 districts in 2017

3.0 Results in the Outcome Area

The nutrition sector ensured that infants, young children and mothers had increased access and equitable use of nutrition services throughout 2016. This included fostering improved nutrition and care practices with a focus on stunting reduction. UNICEF provided financial and technical support in the implementation of guidelines and training package for active screening for acute malnutrition and the integrated management of acute malnutrition guidelines. The revised guidelines and training package were used for capacity building of 3,522 community workers and 411 health workers from 311 health facilities to manage acute malnutrition.

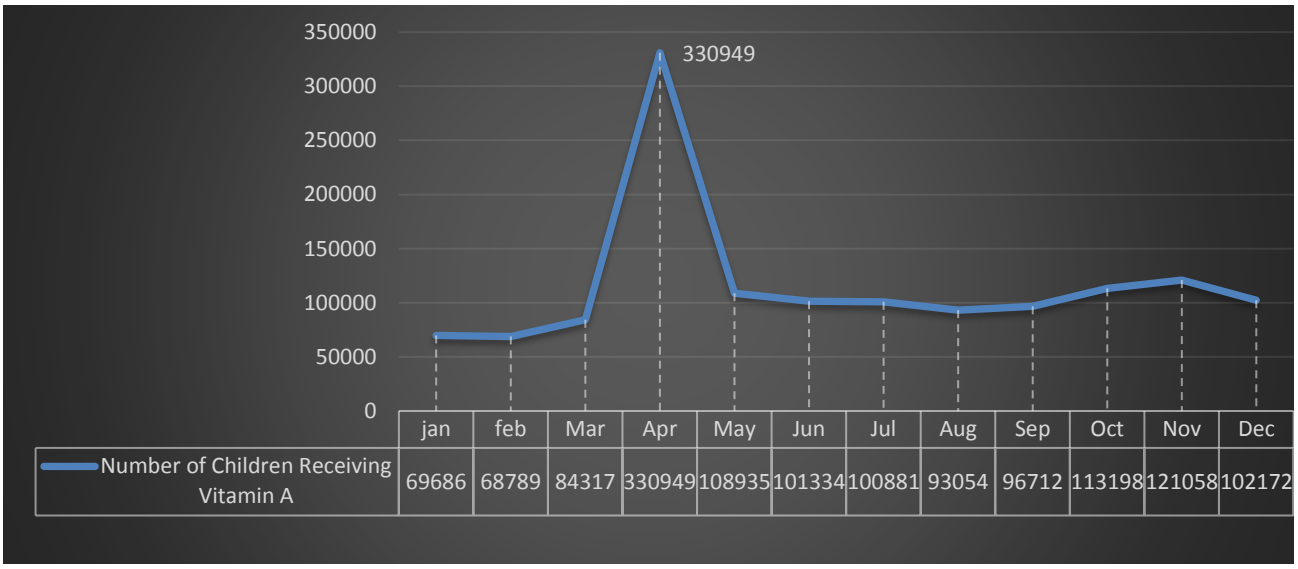
Capacity enhancement of health workers including Village Health Workers (VHW) in active screening resulted in an increased in the number of children that were actively screened and referred for Severe Acute Malnutrition (SAM) treatment from the 20 districts (Kariba, Gweru, Shamva, Binga, Chegutu, Gokwe, Chimanimani, Umguza, Buhera, Mwenezi, Hwange, Matobo, Gwanda, Nyanga, Mt Darwin, Chipinge, Bindura, Makonde, Guruwe, Mangwe) that benefited. A total 538,413 children were screened for acute malnutrition using mid-upper arm circumference (MUAC) by VHWs in the community (active screening) from January to December 2016. 17,769 children aged 6 to 59 months were admitted and treated for Severe Acute Malnutrition (SAM) in 2016. The weekly nutrition emergency meetings showed that several partners stepped up their efforts to capacitate health workers in active screening for SAM as well as treatment of the same. It was evident from the districts that implemented the comprehensive active screening and SAM treatment package that combining both yielded better results.

Due to the enhanced capacity of health workers to effectively manage children with severe acute malnutrition, the programme outcomes have greatly improved as shown in Figure1 below. Both defaulter and death rates are below the targets for SPHERE standards.



All public health facilities (100%) in the country surveyed during (VHMAS, September 2016) had Vitamin A in stock. A total of 764,101 (42%) children received the first dose of vitamin A supplements between January and June 2016. The second dose for July 2016 to December 2016 recorded a lower coverage of 34%. A higher proportion (83%) of the children aged 6 to 11 months old received Vitamin A supplements compared to children aged 12 to 59 months. The 2016 Ministry of Health and Donor Organisations (MODO) meetings recommended the use of village health workers in administering vitamin A to children in the community to improve coverage. UNICEF and other partners such as Clinton Health Access Initiative (CHAI) will assist MoHCC to implement this recommendation from 2017 using lessons learnt from a pilot conducted in Manicaland. It was interesting to see that coverage for the first dose of Vitamin A was high as reflected in Figure 2 below mainly due to the utilisation of outreach services during the Africa Vaccination Week. In 2017 efforts will be made to conduct more social mobilisation for the Africa Vaccination Week and integrate more with the EPI department.

Figure.2: Number of children aged 6 to 59 months receiving Vitamin A supplements by month in 2016



More than 86% of the health facilities had ferrous and folic tablets in stock on the day of the VHMAS, September 2016 survey

With thematic funding, UNICEF supported the Ministry of Health and Child Care (MoHCC) to come up with legislation for mandatory food fortification. UNICEF supported several National Food fortification Task Force meetings and workshops that enabled the taskforce to develop the statutory instrument (SI 120 of 2016) which was legislated and signed by in October 2016. UNICEF supported the Ministry in training health workers in community infant and young child feeding (cIYCF). A total of 674 VHW and 28 HW from Binga, Tsholotsho, Lupane, and Buhera districts were trained in cIYCF in 2016. After the training each VHW served at least 10 mother child baby pairs and thus about 6,740 mother baby pairs were reached with IYCF counselling in 2016. Having mothers counselled on IYCF is key in the promotion of the key IYCF recommended practices. The country has witnessed an improvement in exclusive breastfeeding rates and this can be attributed to the capacity that has been provided to the VHW and health workers. Reports from community IYCF trained village health workers indicate an increase (an average of 10 care givers per VHW) in the number of primary care givers of children under two years and pregnant women accessing community support and counselling on key child caring practices. More capacity building on cIYCF for community health workers to increase access to community level counselling for appropriate age specific infant feeding practices is planned for 2017.

Discussions to roll out the Nutrition Communication Strategy were initiated in 2016. The strategy focuses on creating demand for services among targeted population groups in the community. These services normally target pregnant and lactating mothers, as well as children 0-59 months old. UNICEF supported the Ministry of Health and Child Care to procure, distribute and monitor the iron and folate supplements. The third quarter Vital Medicines Availability and Health Services (VMAHS) survey showed that 86.6% of the facilities were providing iron and folate tablets for pregnant women. Data on the numbers of pregnant women who received iron and folate has now been included in the national health information system (NHIS) which will make future reporting much easier. According to programme data available at health facilities in the ANC registers, over 90% of pregnant women booked are accessing iron and folate supplements. Health facilities were adequately stocked of the iron and folate supplements in 2016.

Flexible thematic funding has been critical for addressing intervention areas of Food Fortification and Universal Salt Iodisation which are not adequately funded and yet critical for stunting reduction. The reduced thematic funding experienced in 2016 resulted in the low outcomes for the Control of Micronutrient Deficiencies programme. Bottlenecks had been identified in salt iodisation monitoring but were not adequately addressed due to limited funding.

Due to the El Nino induced drought, the prevalence of global acute malnutrition increased significantly as seen in the map in figure 3 below, with 20 districts experiencing GAM levels of 5% and above. UNICEF"s quick and timely response to the humanitarian crisis in the 20 districts through active screening of children with acute malnutrition in the community and follow-up and referral to health facilities for treatment quickly reduced the levels of acute malnutrition to less than 5% by January 2017 (ZIMVAC, Jan 2017). Health facilities throughout the country were supplied with lifesaving therapeutic foods to ensure prompt treatment of children with severe acute malnutrition also mothers of children

less than two years were supported and counselled on appropriate infant and young child feeding to prevent further deterioration of the nutrition status of the children.

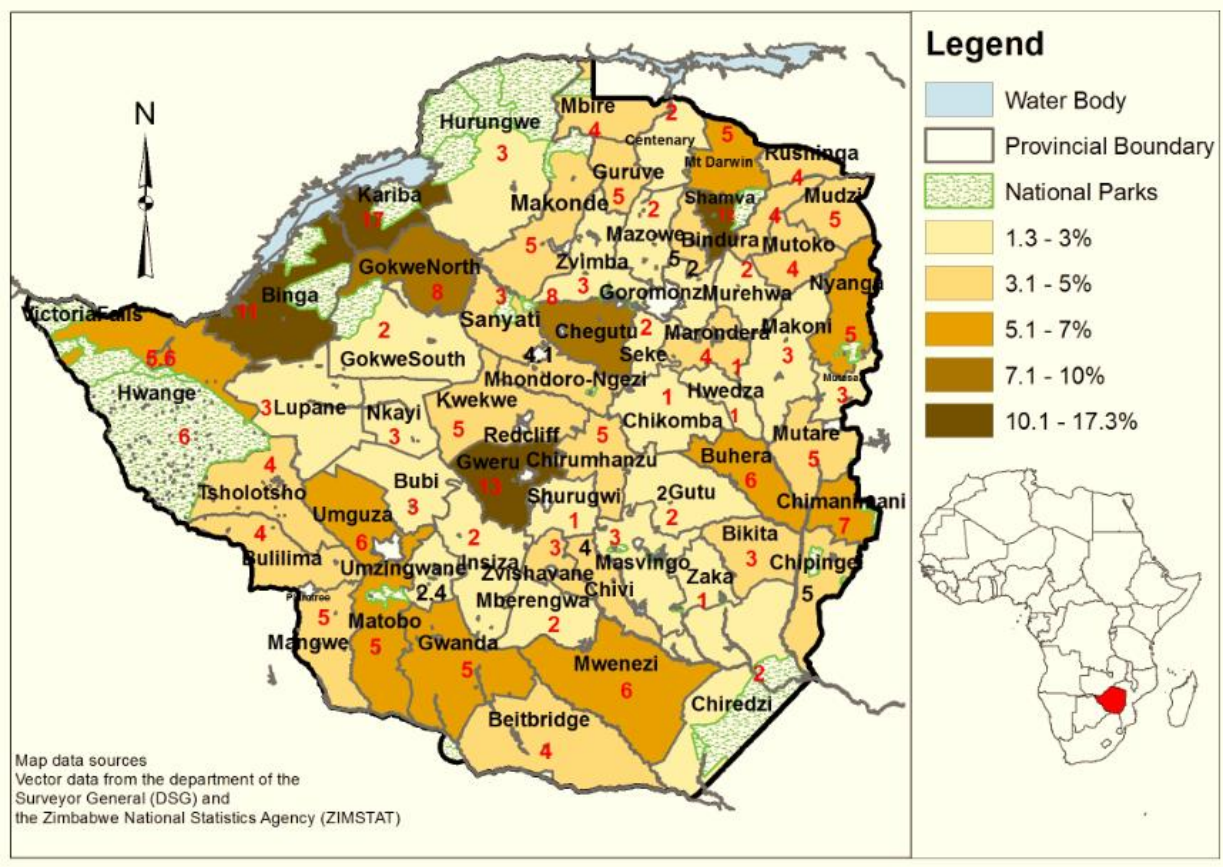


Figure 3: Prevalence of Global Acute Malnutrition (ZimVAC, July 2016)

In response to the El Nino induced humanitarian crises, UNICEF engaged its stakeholders on funding an emergency response. One of the challenges encountered in the emergency response was that of delays in receiving funding for the humanitarian response as well as for scaling up the multi-sectorial model for stunting reduction. Most of the funds were received in the fourth and last quarter of 2016. As a result of the delay, most of the activities that were planned for 2016 will mostly be implemented in 2016. These include training of ward committees, training of health workers on the baby friendly hospital initiative (BFHI) programme, facilitation of complementary feeding demonstrations, as well as the planning and review meetings in the 15 districts. Although rolling out of the nutrition communication strategy process commenced with scheduled capacity building workshops for health workers, the roll out process will be fully implemented in 2017.

Results Assessment Framework

Zimbabwe has witnessed an improvement in exclusive breastfeeding rates from 41% (MICs 2014) to 48% (ZDHS, 2015) and this can be attributed to the capacity building for the VHW and facility based health workers who support and counsel mothers and caregivers of children below two years of age on appropriate infant feeding practices. The 4th quarter VHMAS report showed that about 73% of health

facilities have at least one staff member trained in infant and young child feeding (IYCF). The table below shows the key outcome indicators for stunting reduction.

Key outcome indicators for 2016

Indicator	Baseline *(MICS 2014)*		Target		Achievement[1] *(ZDHS 2015)*	
	Year	Value	Year	Value	Year	Value
Proportion of children breastfed within one hour of birth (timely initiation of breastfeeding).	2014	58.90%	2020	70%	2016	58%
Proportion of children aged 0–5 months exclusively breastfed.	2014	41%	2020	60%	2016	48%
Proportion of children who are fed complementary foods in a timely manner (introduction of solid/semi-solid/soft food).	2014	87.30%	2020	92%	2016	91%
Proportion of children fed minimum acceptable diet.	2014	11%	2020	50%	2016	8%
Proportion of population consuming adequately iodized salt at household level.	2014	57%	2020	90%	2016	95%
Proportion of children who receive vitamin A supplements twice yearly (full vitamin A supplementation coverage). (DHIS*)	2014	43%	2020	80%	2016	34% (DHIS, 2016)
Proportion of provinces with multi-sectoral, costed and sustainable provincial plans (that include clear targets on reducing stunting). (monitoring reports)	2014	0	2020	30%	2016	40%
Proportion of Primary Health Care Centres assessing and managing children with severe acute malnutrition as per the global standard (VHMAS, Q3, 2016)	2014	77%	2020	90%	2016	86%

3.1 Key Strategic Partnerships and Inter-Agency Collaboration

All programmes implemented by UNCEF Nutrition are part of the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) 2016 – 2020. The programmes are discussed and agreed in the UN Nutrition Network. In 2016, UNICEF partnered with the Government of Zimbabwe (GoZ) in the implementation of the regular nutrition programme. In addition, to the humanitarian response, civil society NGOs (Save the Children, World Vision International PLAN, International and IMC) were engaged to work with communities and children in hard to reach areas. Active screening for children with acute malnutrition was conducted at community level and children found to have severe

[1] Since the next round of MICS will be held in 2019, ZDHS 2015 has been used for the purposes of some data

and moderate malnutrition were referred to nearby health facilities for further management. The community level active screening ensured that all children in need accessed nutrition services. Partnerships with NGOs ensured that hard to reach communities had access to life saving nutrition services.

3.2 Value for Money

With the cash shortages in Zimbabwe, UNICEF safe guarded all donor funds by ensuring that supplies are procured off-shore and where possible made direct payments to service providers for training and channelled funding through NGO partners.

Economy: The use of UNICEF procurement procedures with existing partnerships within our supplies and logistics section, ensured nutrition commodities were procured at a lower cost. Procurement through the well-established UNICEF procurement systems and UNICEF's global procurement ensured the best-cost to point of service.

Efficiency: The systems strengthening approach for existing multi-sectoral food and nutrition security committees which are government representatives from agriculture, health, WASH, social services and nutrition enhanced efficiency of nutrition service delivery. The multi-sectoral approach and use of existing government of Zimbabwe and UNICEF structures for project delivery ensured leveraging of existing resources. Vehicles, office space, communication systems were available through UNICEF at reduced costs to the programme. Programming efficiency was improved through cascading training of lower level cadres through the existing District food and nutrition structures, enabling lower cost training at the local level to work through existing structures.

Effectiveness: Nutrition specific interventions have been proven effective in delivering the intended nutritional outcomes. Lessons learned from the implementation of nutrition programme in Zimbabwe by UNICEF and from sharing country experiences in multi-country initiatives helped in efficiently delivering nutrition services for greater programme effectiveness.

Equity: The targeted approach under the multi-sectoral community based approach for addressing stunting, has ensured that hard to reach households with adolescents, pregnant and lactation women and children under two years of age are reached with preventive nutrition services at community level. The targeting strategy has also ensured that families with poor health seeking behaviours who would not normally present at health facilities are reached.

3.3 Constraints, Challenges and Lessons Learned

The drought due to the El Nino negatively impacted on the nutritional status for children in Zimbabwe. For two consecutive years, 2015 and 2016, most communities in the country were not able to harvest any crops due to the drought This impacted negatively on food security as most Zimbabweans are dependent on own food production to meet their food security needs.

In addition, the liquidity and cash crisis facing the country has led to delays in nutrition programme implementation as it has become increasingly difficult for implementing partners (IPs) to access cash to pay for services particularly when they are training community level cadres. Some banks are only allowing up to US$100 withdrawals per day. UNICEF through the operations section has engaged RBZ and various banks where the IP accounts are housed, to facilitate access to cash to the IPs for programme implementation so as not to prejudice the children and women benefiting from the nutrition programme.

Vitamin A supplementation coverage for children aged 6 to 59 months has remained low, but a lesson learnt from 2016 is that reaching out to mothers and their children in the community as was done during the Africa Vaccination week increases the number of children served. Further, a pilot for allowing village health workers to administer vitamin A in the community proved efficient and effective in increasing coverage. In 2017, the MOHCC working on modalities of building capacity and authorising village health workers to administer vitamin A in the community.

3.4 Risk Assessment and Risk management

At a programmatic level, the major risk during the implementation of the Nutrition programme in 2016 was that of increased vulnerability due to the El Nino induced drought which would result in an increased number of children with severe acute malnutrition and the risk of increased mortality. UNICEF managed the risk by monitoring the number of children with SAM admitted to health facilities through the weekly SMS based reporting from health facilities throughout the country. Districts showing an increase in the number of children admitted were closely monitored by NGO partners working in those districts and data reported at weekly emergency coordination meetings. Active screening by village health workers in the community ensured that children with acute malnutrition were identified early and referred for treatment. UNICEF ensured a constant supply of RUTF in all health facilities and contingency stocks to cover sudden increases in SAM cases were placed at all provincial stores and partners were on the alert to move those stocks when needed.

On financial risk, UNICEF continued to apply the UN standard Framework, the "Harmonized Approach of Cash Transfers" to Implementing Partners. The harmonized approach calls for a closer alignment of development aid with national priorities and needs. The approach allows efforts to focus more on strengthening national capacities for management and accountability, with a view to gradually shift to utilizing national systems. The first stage of the HACT financial management approach is to conduct a Micro-Assessment of the IP’s financial management systems. The findings of the Micro-Assessment primarily guide the frequency and coverage of assurance activities (spot checks) and capacity building for enhancing financial systems of the IPs. The results of the micro-assessments will inform UNICEF’s ‘risk mitigation measures’ which will determine the level of cash disbursement and the frequency of financial verification – spot checks that can be disbursed to Implementing Partners.

4.0 Financial Analysis

This section provides information on the financial resources that were available to support Nutrition results in 2016. The planned budget for Outcome Area 4 from UNICEF's Regular Resources, and Other Resources (Regular and Emergency) amounted to **US$6,721,699** as illustrated in Table 1 below.

Table 1: Planned Budget for Outcome Area 4: Nutrition Zimbabwe

Output Area	Funding Type[2]	Planned Budget[3] (US$)
04-06 Nutrition # General	RR	500,000
	ORR	6,221,699
Total Budget		**6,721,699**

Under the funding type Other Resources Regular (ORR), donors provide flexible funding as thematic pooled funds to support a specific outcome area. The Government of Sweden continued to demonstrate its commitment to the programme in Zimbabwe by providing country specific thematic funding. This arrangement has been in place since 2011. The flexible nature of thematic funding makes it possible to support under-funded and un-funded components of the country programme crucial to achieving results.

Table 2 below illustrates that there were no country specific thematic funds received in 2016 for outcome area 4. This is because the funds used for achieving the 2016 results had been received in the last quarter of 2015 as illustrated in table 4. The total expenditure on outcome area 4 using thematic funds amounted to **US$579,138.00.**

Table 2: Country-level thematic contributions to Outcome Area 4: Nutrition Zimbabwe

Donors	Contribution Amount[4] (US$)	Programmable Amount[5] (US$)
Government of Sweden	0.00	0.00
Total	**0.00**	**0.00**

The greatest expenditure for the Nutrition Outcome area incurred in 2016 was on community based management of acute malnutrition. Expenditure under this organizational target accounted for 55% of the total expenditure for the outcome area as shown in table 3 below.

[2] RR: Regular Resources, ORR: Other Resources – Regular, ORE: Other Resources – Emergency.
[3] Planned budget for ORR and ORE does not include estimated recovery cost.
[4] Contribution amount: This is the total amount received from SIDA - Sweden
[5] Programmable amount: This is the amount available for programming which is derived from contribution amount less cost recovery

Table 3: Expenditures by Programme Area for Outcome Area 4: Nutrition Zimbabwe

Organizational Targets	Expenditure Amount[6] (US$)			
	Other Resources – Emergencies	Other Resources – Regular	Regular Resources	All Programme Accounts
04-01 Infant and Young child feeding	1,688	607,638	654,611	1,263,936
04-02 Micronutrients	16,796	105,596	12,847	135,239
04-04 Community-based management of acute malnutrition	540,986	1,796,149	35,975	2,373,110
04-06 Nutrition # General	53,990	342,396	132,431	528,817
Total	**613,459**	**2,851,778**	**835,864**	**4,301,102**

The total expenditure for the outcome area was **US$4,301,102** (as shown in Table 3 above). Table 4 below shows the components of this expenditure that were directly supported by thematic funding. From the analysis below, thematic funds were very key in supporting all organizational targets for nutrition.

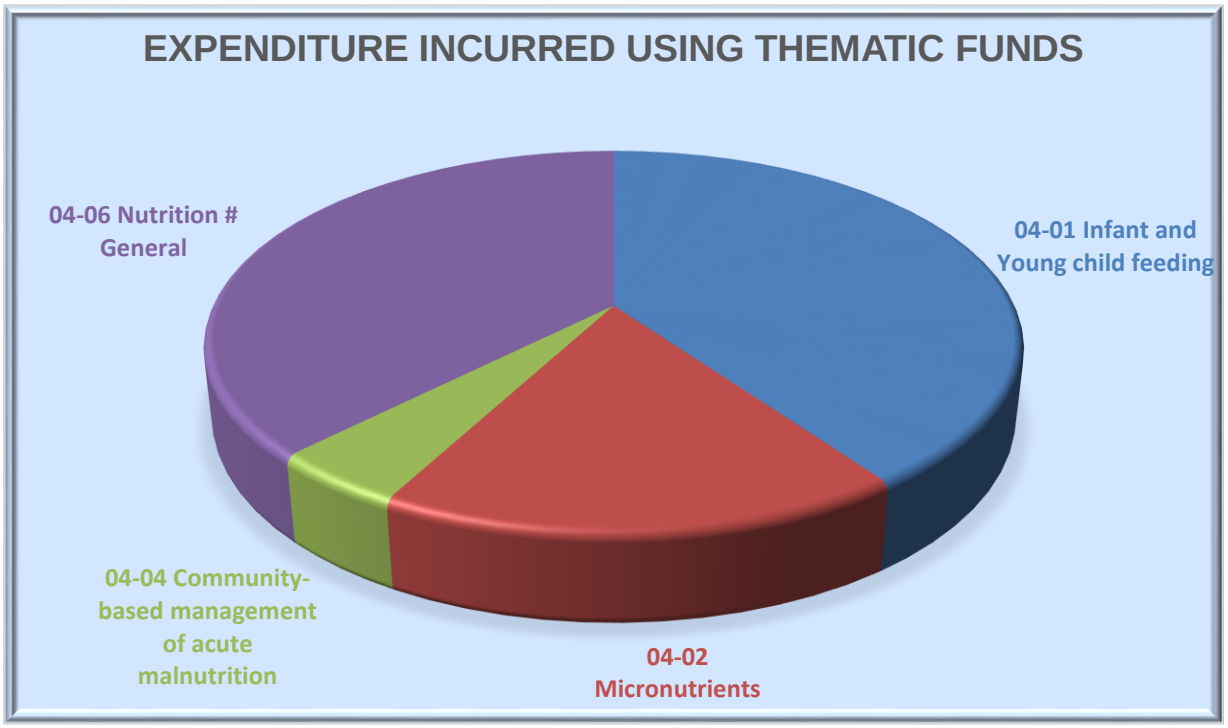
Table 4: Thematic expenses by Programme Area for Outcome Area 4: Nutrition Zimbabwe

Organizational Targets	Total Utilised[7] (US$)
04-01 Infant and Young child feeding	232,642
04-02 Micronutrients	102,272
04-04 Community-based management of acute malnutrition	26,862
04-06 Nutrition # General	217,363
Grand Total	**579,138**

The pie chart below illustrates the key expenditures incurred using thematic funds in 2016

[6] Expenditure figures provided do not include recovery cost, and are indicative figures obtained from UNICEF Performance Management System

[7] Total Utilized figures excludes recovery cost and are indicative figures obtained from UNICEF Performance Management System

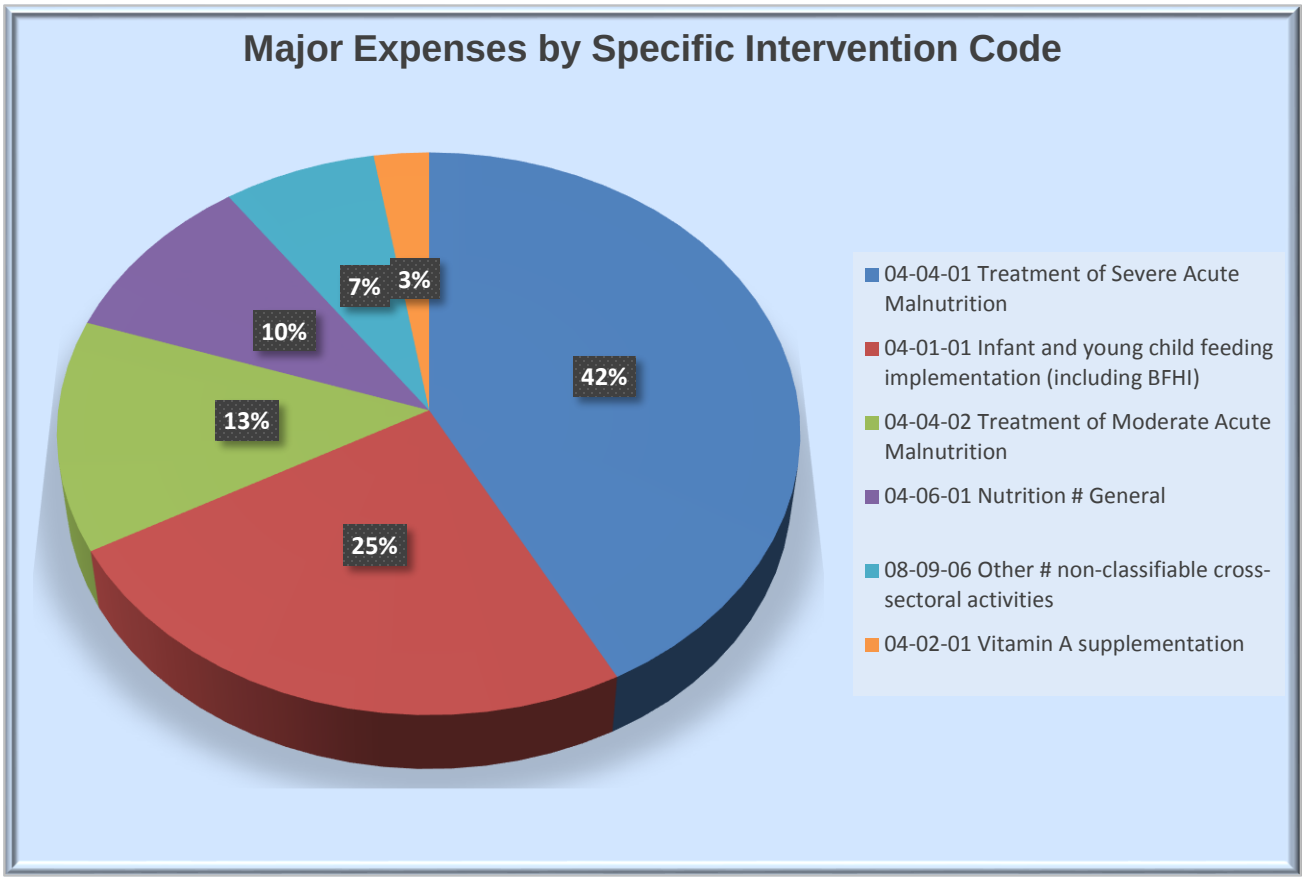


UNICEF also analyses expenditures using Specific Intervention codes. Specific Intervention Codes refer to one of four codes that are used to identify an activity in UNICEF's Performance Management System. They enable compilation of data on expenditure by organizational target and key result area. In 2016, the following were the major expenses incurred in the Nutrition outcome area, analysed using Specific Intervention Codes.

Table 5: Expenses by Specific Intervention Codes for Outcome Area 4: Nutrition Zimbabwe

Specific Intervention Code	Total Utilised (US$)
04-04-01 Treatment of Severe Acute Malnutrition	1,690,720
04-01-01 Infant and young child feeding implementation (including BFHI)	990,236
04-04-02 Treatment of Moderate Acute Malnutrition	530,454
04-06-01 Nutrition # General	400,066
08-09-06 Other # non-classifiable cross-sectoral activities	288,330
04-02-01 Vitamin A supplementation	103,967
Total	**4,003,772**

The pie chart below illustrates the major expenses incurred by Specific Intervention Codes in 2016.



5.0 Future Work plan

Lessons learnt from the previous years are that vitamin A coverage can be improved by task shifting administration of vitamin A capsules from health facilities to the communities through capacity building of village health workers. MOHCC has agreed to pilot the community administration of Vitamin A supplement (VAS) in one province and then scale up to all districts in the country by 2018. The mandatory staple food fortification programme and the Baby Friendly community initiative are also being rolled out throughout the country. UNICEF will continue to coordinate and lead the humanitarian response with partners in the Nutrition Sector. In 2017, UNICEF will:

- Provide technical support towards improving micronutrient interventions for children and pregnant women in 20 districts (vitamin A, deworming, IFA, Zinc with ORS, Iodized salt)
- Promote improved IYCF practices at facility level through capacity building on growth monitoring, integrated IYCF package and Baby Friendly Hospital Initiative in 20 districts
- Provide technical support towards updating and reviewing national policy documents and finalizing implementation plans (IMAM, Micronutrient , HIV and breast feeding , emergency guidelines)
- Organize advocacy and coordination meetings to support implementation of national Nutrition strategy and roll out communication strategy
- Conduct consultative meetings for Nutrition indicators to be integrated into the National Health Information Systems and improve the quality of nutrition information from 20 districts

- Facilitate complementary feeding demonstrations in 450 rural wards for community groups including men and women, boys and girls (including apostolic sect members) in 20 districts through ward coordinators focusing on minimum acceptable diet for children from 6-24 months
- Facilitate social mobilization activities at outreach sessions in hard to reach area to improve community awareness on maternal nutrition and regular intake of ANC services
- Organize village level child health days in hard to reach area for improved growth monitoring of boys and girls under five years and uptake of nutrition services in 15 districts

Table 6: Planned Budget for 2017 for Outcome Area 4: Nutrition Zimbabwe

Output	Funding Type	Planned Budget	Funded Budget	Shortfall
OUTP 4.1: Nutrition Policy, Coord & Mgt.	RR	63,300	58,000	5,300
	ORR	889,157	865,150	24,007
OUTP 4.2: Subnational Implementation	RR	50,000	42,000	8,000
	ORR	7,496,537	7,486,331	10,206
OUTP 4.3: Nutrition Services Utilized	RR	34,455		34,455
	ORR	4,250,000	3,664,165	585,835
OUTP 4.10: Programme Support Costs	RR	556,757	437,600	119,157
	ORR	336,888	245,898	90,990
Sub-total Regular Resources	**RR**	**704,512**	**537,600**	**166,912**
Sub-total Other Resources - Regular	**ORR**	**12,972,582**	**12,261,544**	**711,038**
Total		**13,677,094**	**12,799,144**	**877,950**

6.0 Expression of Gratitude

UNICEF Zimbabwe would like to extend its gratitude to GAVI, the European Union, the Governments of Ireland, Sweden and the United Kingdom as they generously supported the nutrition interventions through the Health Development Fund (HDF 2016 - 2020).

UNICEF is grateful and appreciates the contribution and flexibility of the thematic funding which has made it possible for UNICEF to support less funded programme areas like Food Fortification and de-worming which usually do not receive specific funding. Thematic funding made it possible for UNICEF to support the development and promulgation of the Food Fortification Statutory instrument 120 of 2016 which regulates the mandatory staple food fortification for Zimbabwe

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List of Acronyms

CBM	Community Based Model for addressing stunting
CMAM	Community Management of Acute Malnutrition
CMV	Combined Micronutrient and Vitamin mix
DHS	Demographic Health Survey
ECHO	European Commission Humanitarian Organisation
ENA	Essential Nutrition Actions
EPI	Expanded Programme of Immunization
FAO	Food and Agriculture Organisation
FNC	Food and Nutrition Council
FNSCs	Food and Nutrition Security Committees
GoZ	Government of Zimbabwe
H4+	UN Partnership for women and child health (UNAID, UNFPA UNICEF, WHO and WB)
MR	Measles Rubella
HIV	Human Immunodeficiency Virus
HTF	Health Transition Fund
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
IFA	Iron Folate
JICA	Japanese International Cooperation Agency
MDA	Mass Drug Administration
MICs	Multi Indicator Cluster Survey
MIMS	Multiple Indicator Monitoring Survey
MNS	Micronutrient Survey
MoHCC	Ministry of Health and Child Care
MUAC	Mid Upper Arm Circumference
NHIS	National Health Information System
NNU	National Nutrition Unit
DFNSCs	District Food and Nutrition Security Committee
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SIDA	Swedish International Development Agency
SUN	Scaling up nutrition
CERF	Central Emergency Relief Funds
VHW	Village Health Worker
VMAHS	Vital Medicines Availability and Health Service Survey
WFNSCs	Ward Food and Nutrition Security Committees
WFP	World Food Programme
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Household Survey
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-economic Transformation
ZIMVAC	Zimbabwe Vulnerability Assessment Committee

Annex 1: Case Studies and photos

The Sibanda Family

The Sibanda family leaves in Mberengwa district of Zimbabwe and like many families in the district struggle to meet their food security, water and sanitation needs. Mr Vengai Sibanda is 44years old, married with 4 children. The youngest is only a few months old. Martin Sibanda is a 14 year old boy and the eldest child. He is currently doing his grade 7 at a local school. Martin is the oldest in his class. A few years back he had to pull out of school when he was in grade 5 because his parents could not afford to send him to school. School fees for primary stage range from $10- $15 a term, money which is not easy to come across. After school every day, he changes out of his school uniform and eats what is available. Normally he has a meal of Sadza and vegetables, sometimes with peanut butter or just steamed vegetables. He then helps his father with cattle from another family as they themselves do not have. Martin's father does a lot of casual labour to help look after his family. Looking after the cattle will ensure that they will be able to cultivate their own lands when it comes to the rainy season.

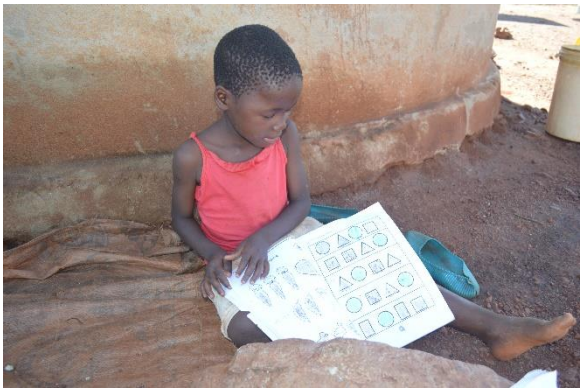
Martin gets his lunch ready after school. He is having a simple meal of Sadza and vegetables with peanut butter.

After eating, Martin helps with either cattle herding, or he goes into the fields. Sometimes he is so tired from school but he still has to help around at home, duties expected from the eldest child.

The meal that the family has is considered to be a healthy meal, however they do not get to eat this every day. The people in Mberengwa survive mostly on Sadza with green leafy vegetables, meat is scarce and only those with cattle have the luxury of milk. On average there is at least one cow every five households. The Sibanda family once had a cow which unfortunately died. The family thus relies on cattle from other families for draught power.

The plants in the family field look healthy enough at this stage, but due to the excess rains (2016/2017 rainy season) there is bound to be a lot of nutrient leaching. Fertilisers are expensive and this results in reduced yields.

Over the past 2 years, the Sibanda family have not had a plant that looks as good as the current crop (photo above), and they are quite hopeful for a better yield. If they have a good harvest, they will be able to buy food and pay school fees.



All the three eldest children go to school. Pictured here is Mayibongwe as she reads from her book. She is in grade 0 and promises to be a bright student. In most cases, it is children like her who are most affected, she might have to drop out from school so her older brother can get to at least Form 4.

The whole family depends on Mr Vengai to provide for them. Mrs Vengai is currently not able to assist with household chores. She is still lactating and complains of a persistent pain in her legs after being attacked by a crocodile. As such, Martin helps in collecting water to be used at home, which is about 2km away. They also collect water at a local well which they use for cooking and drinking.

It is hard for Martin to juggle all these responsibilities, but he has to because the family is dependent on each other. Martin hopes to be a Doctor one day. The ZimVAC research will perhaps pave way for Martin's family to ensure at least a balanced diet, and probably be able to continue with school.

The assessment was also targeting children under the age of 5 years, as they are currently in drought prone areas.

Both Martin and Mayibongwe are eager students and they always get whatever help they can from their mother who also likes to help when she can.

Significant nutrition improvement in a drought prone district

The prevailing drought brought on by the El-Niño phenomenon of 2015-2016, has negatively impacted the agricultural season resulting in food and nutrition insecurity that has left 4.1 million in the rural areas facing starvation. The government of the United Kingdom through the Department for International Development (DFID) has provided grant to tackle the effects of El Niño and La Nina in Zimbabwe and

several countries in Africa. Through this grant UNICEF in collaboration with the MOHCC have designed a social mobilization plan for emergency nutrition response and health care support for 10 most affected districts in four provinces.

The community of Chibikira village (in Mashonaland West) believes in using traditional herbs to treat infant disease over health facilities. According to 23 year old Tinotenda Sibango, *"ever-since I was born, and now I have my own child, we have been using herbs to treat children from childhood disease and elderly women advise us to give our babies porridge to avoid hunger that makes them cry."* Tinotenda said that her child used to be sick and had a weak body but her condition changed after she was advised by the health care workers who paid her community a visit, teaching on the importance of visiting the clinic, immunizing children and getting Vitamin A.

"I now have knowledge on Health care facilities, I visit the clinic to get my child immunized and attend classes with other women on Health care and hygiene" says Tinotenda. Tinotenda mentioned that she used to get the elderly women to help her with child-rearing but not anymore*, "even if my child gets a fever I quickly rush to the clinic because I know I will never go wrong with health care facilities from the clinic."*

The young mother is now proud of herself and her baby's health, Tinotenda says *"I now brew beer to sell, with the little money I get, I buy good food for my child and keep some for transport in case something happens I will be ready to go the clinic.*

Tinotenda's baby is one of the thousand babies in the Mashonaland west province whose nutritional status is improving. Recent results from the ZIMVAC (2014 report) indicate that Mashonaland west has a high percentage of stunted/ malnourished babies with a prevalence of 31 percent. There is now an improvement as communities are being flexible, allowing themselves to access health care facilities to serve every child and the community at large.