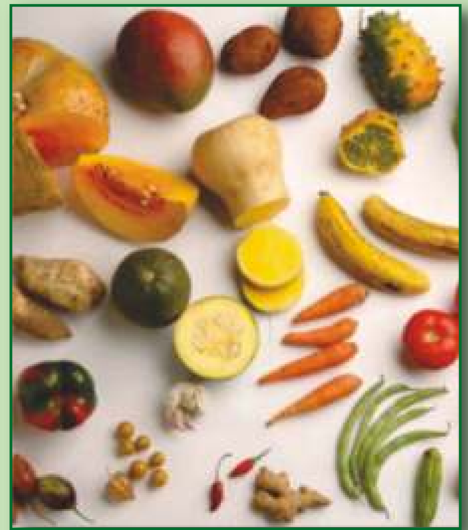

Zimbabwe National Nutrition Strategy

2014-2018

June 2014

Zimbabwe
National Nutrition Strategy
2014-2018

ACRONYMS

ARI	Acute Respiratory Infection
ARNS	African Regional Nutrition Strategy
BF	Behaviour Change Communication
BFHI	Baby Friendly
BMFHI	Baby - Friendly Hospital Initiative
BMI	Baby and Mother Friendly Hospital Initiative
CAADP	Comprehensive African Agriculture Development Program
CHW	Community Health Worker
cIYCF	Community Infant and Young Child Feeding
cMAM	Community - based Management of Acute Malnutrition
Dps	Development Partners
DPT	Vaccine against diphtheria, pertussis (whooping cough), and tetanus
DRM	Disease Related Malnutrition
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
EH	Environmental Health
EHTs	Environmental Health Technician
ENA	Essential Nutrition Actions
EPI	Expanded Programme on Immunization
FNC	Food and Nutrition Council
FNSAG	Food and Nutrition Security Advisory Group
FNSCs	Food and Nutrition Security Committees
FNSP	Food and Nutrition Security Policy
GAIN	Global Alliance for Improved Nutrition
GAM	Global Acute Malnutrition
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
GNP	Gross National Product
GOZ	Government of Zimbabwe
HDDS	Household Dietary Diversity Score
H.E	His Excellency
HFSS	Health Facility Systems Strengthening
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDD	Iodine Deficiency Disorder
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
ITNs	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
KABP	Knowledge, Attitudes, Beliefs, and Practices
KRAs	Key Result Areas

M&E	Monitoring and Evaluation
MoAMID	Ministry of Agriculture, Mechanization and Irrigation Development
MCHIP	Maternal Child Health Integrated Programme
MDG	Millennium Development Goals
MIMS	Multiple Indicator Monitoring Survey
MLGPWNH	Ministry of Local Government, Public Works and National Housing
MoHCC	Ministry of Health and Child Care
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
MoWAGCD	Ministry of Women Affairs Gender and Community Development
N4G	Nutrition for Growth
NCD	Non - Communicable Diseases
NFNSP	National Food and Nutrition Security Policy
NMNS	National Micronutrient Survey
NND	National Nutrition Department
NNPSP	National Nutrition Policy and Strategic Plan
NNS	National Nutrition Strategy
NUA5	NUA5 Bean Variety
OPC	Office of the President and Cabinet
PESTEG	Political, Economic, Social, Technological, Environmental, and Governance
PHHE	Participatory Health and Hygiene Education
PLWHA	People Living With HIV and Aids
PMTCT	Prevention of Mother To Child Transmission
PPP	Public Private Partnership
RBM	Results Based Management
RLA	Rural Livelihood Assessment
SAZ	Standards Association of Zimbabwe
SDC	School Development Committee
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infection
SUN	Scaling - Up Nutrition
TB	Tuberculosis
ToT	Training of Trainers
U5MR	Under - five Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WG	Working Group
WHO	World Health Organisation
WQ	Wealth Quintile
WRA	Women of Reproductive Age
ZDHS	Zimbabwe Demographic and Health Survey
ZimAsset	Zimbabwe Agenda for Sustainable Socio - Economic Transformation
ZIMSTAT	Zimbabwe National Statistics Agency
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZNASP	Zimbabwe National Aids Strategic Plan

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FOREWORD

On 16 May 2013, His Excellency the President Cde. R. G. Mugabe launched the Food and Nutrition Security Policy (FNSP) of Zimbabwe whose goal is to **"promote and ensure adequate food and nutrition security for all people at all times in Zimbabwe, particularly amongst the most vulnerable and in line with our cultural norms and values and the concept of rebuilding and maintaining family dignity".**

Food and nutrition security exists when all people, at all times have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs for a healthy and productive life. On the other hand, food and nutrition insecurity leads to the vicious cycle of malnutrition, increased susceptibility to disease, impaired mental and physical development, reduced productivity and poverty, resulting in compromised respectability an dignity.

Zimbabwe faces a growing level of chronic malnutrition which is exacerbated by food insecurity and deepening poverty. This challenge is certainly beyond the capacity of a single sector or agency to address, hence requires multi-sectoral interventions. To this end, the Government of Zimbabwe (GOZ) has developed a National Nutrition Strategy (NNS) 2014-2018 whose main objective is to implement Commitment V (5) of the Food and Nutrition Security Policy. Commitment V (5) of the FNSP states that the GOZ is committed to ensuring nutrition security for all through the implementation of evidence-based nutrition interventions that are integrated within a broad public health framework including health services, water and sanitation. Indeed, these efforts are in line with the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset) which has identified Food Security and Nutrition as one of the Four Clusters and pillars for implementation in the next five years.

The Food and Nutrition Security Policy and its implementation matrix provide a holistic framework in which the National Nutrition Strategy will address the challenges of malnutrition in a multi- sectoral manner. Further, the reconstitution of the Food and Nutrition Security multi stakeholders Committees at the National Provincial, District and Ward level will buttress the implementation of the National Nutrition Strategy.

FOREWORD

The implementation of the Strategy will require the participation and involvement of stakeholders at all levels from the community to the national level, including the public sector (Line Ministries, Agencies and Local Government Authorities); higher learning and training institutions, professional bodies, private sector, development partners, civil society, the media and the community at large.

Addressing issues of nutrition security remains top on the agenda of Government, and as such the Government of Zimbabwe shall assume primary responsibility for resource mobilisation funding the strategy and delivering targets set while development partners will complement Government efforts. The Ministry of Health and Child Care's National Nutrition Department shall spearhead the implementation of the strategy with the Food and Nutrition Council maintaining its coordination role of multiple stakeholders.

Government sincerely appreciates and acknowledges all the support rendered by various stakeholders.

Hon. E. D. Mnangagwa
Vice President of the Rebuplic of Zimbabwe

PREFACE

Malnutrition is one of the most serious health problems affecting infants, children and women of reproductive age in Zimbabwe. Despite progress to date, millions of children and women in Zimbabwe continue to suffer from one or more forms of under nutrition, including low birth weight, stunting, anaemia, underweight, wasting, Vitamin A deficiency, and Iodine deficiency disorders.

Scientific evidence has shown that chronic under nutrition of a child below the age of 2 years leads to irreversible long term effects. Malnutrition increases the likelihood of Non-Communicable Diseases (NCDs) in latter life, such as, cancer, diabetes and cardiovascular disease. Such non-communicable diseases cause the death of 8 million people in developing countries before they reach 60 years of age.

Poor nutrition affects the performance of children in school; it affects economic productivity in adults, thereby affecting overall productivity of a nation.

It is undebatable that addressing malnutrition brings considerable economic and social benefits as it reduces mobility and mortality; leads to resource savings in health; improves education outcomes; enhances productivity and increases incomes. Improved nutrition will contribute to six of the Millennium Development Goals (MDGs) including goals for the eradication of extreme poverty and hunger, reduction of child mortality and improved maternal health.

It is therefore imperative that efforts to prevent malnutrition are redoubled so that women and children are protected from detrimental effects of being malnourished. To this end, the Government of Zimbabwe, has developed a National Nutrition Strategy (NNS) 2014-2018 whose Vision is "a Zimbabwe free from hunger and malnutrition", and its Mission is to: "implement evidence based nutrition interventions that are integrated within a broad multi-sectoral collaboration framework". The National Nutrition Strategy is in line with and will contribute to the Food and Nutrition Security Policy and its Implementation Matrix.

The NNS identifies that maternal malnutrition from conception, during pregnancy and through lactation and particularly maternal short stature and iron deficiency anaemia are associated with increased risk of stillbirths, miscarriages, low birth weight, maternal and infant mortality. Maternal overweight and obesity are associated with maternal morbidity, pre-term birth and increased risk of infant death. In addition, maternal micronutrient deficiencies are associated with low birth weight in infants and increased risk of maternal morbidity and mortality.

PREFACE

The MOHCC adopts essential nutrition actions for improving maternal, newborn, infant and young child nutrition and health at health facility and community levels. This set of high impact nutrition interventions includes maternal iron, folate, Vitamin A, iodine and calcium supplementation, use of Insecticide Treated Nets (ITNs), family planning and adequate birth spacing, and nutritional care and support for pregnant and lactating women in emergencies. The MOHCC, health facility and community based service delivery platforms adopts this standard maternal nutrition package and implements it at scale, as a proven strategy to decrease under-nutrition during pregnancy and lactation as well as have positive nutrition outcomes for the infant.

The NNS also adopts appropriate infant and young child feeding practices that contribute to improvements in early childhood nutrition, reduces under-nutrition, and also contributes to improved health outcomes in children. Additionally, strengthening clinical nutrition services in prevention and management of non-communicable diseases, HIV/AIDS and related opportunistic infections and promotion of healthy lifestyles as a preventive measure has been incorporated into the NNS. Apart from this, ensuring that nutrition surveillance systems provide timely, complete and accurate information on the nutritional status of all people is a priority for the NND. Research that informs the development of high impact strategies needed for the reduction of prominent nutrition problems in the country is given prominence in the NNS. The NNS also strengthens advocacy to ensure that the evidence obtained from research and evaluation of nutrition programmes is used to sensitize decision makers in government, stakeholders and funders.

The MOHCC shall lead the implementation of strategies in collaboration with other ministries, seizing on the coordination efforts of the Food and Nutrition Council by bringing in other development partners, non-governmental organisations (local and international), the private sector, and UN agencies and communities to comprehensively address malnutrition problems. The private sector's role in food fortification and developing the value chain for nutritious foods is supported, so is capacity building of community level structures and systems for sustaining government and development partner efforts in addressing the aforesaid nutrition challenges. Facilitation of behaviour change to improve nutrition practices of children and the adult population is a key area of investment of the strategy.

The MOHCC shall take advantage of available platforms for collaborative work in reducing all forms of malnutrition, utilising international and national laws, policies and proven- international and local best practices to improve the nutritional status of the citizens of the county. Zimbabwe remains committed to intensifying its efforts at addressing nutrition in the context of the broader regional and global initiatives and commitments under the Scale-Up Nutrition (SUN) Movement.

Dr P. D. Parirenyatwa (Senator)
Minister of Health and Child Care

EXECUTIVE SUMMARY

BACKGROUND

The Zimbabwe National Nutrition Strategy (NNS) for 2014 to 2018 was developed following a wide consultative process of all stakeholders to food and nutrition issues in government, the private sector, non-governmental organisations (NGO), the UN, community-based organisations and the community at large. The first objective of the strategy is to operationalize Commitment V of the Food and Nutrition Security Policy which states that the Government of Zimbabwe (GOZ) is committed to ensuring nutrition security for all through the implementation of evidence-based nutrition interventions that are integrated within a broad public health framework including health services, water and sanitation. The second objective is to contribute towards making further progress against the other Scaling up Nutrition (SUN) targets.

Over the last 30 years, Zimbabwe made remarkable progress in reducing both underweight and wasting in children under the age of five years. Multi-sectoral approaches involving the Ministry of Agriculture, Health and others were important in ensuring the successes. Nevertheless the prevalence of underweight has continued to be 10% or above (10% in 1999, 13% in 2005, 10% in 2010/11,11% in 2012) according to various sources including the ZDHS 2010/11 and the Micronutrient Survey of 2012 and not meeting the MDG 2015 target of reducing it by half.

Moreover, the high prevalence of stunting in children under-five years of age remains Zimbabwe's top nutrition challenge. In 2010, 32% of children below five years were found stunted (ZDHS, 2010/11). In addition, the results of the MNS, 2012 indicate a slight improvement to 30%. However, the prevalence of stunting (of 30% on average, 33% in male children and above 40% in some districts) remains at an unacceptably high level, with significant social and economic consequences on the country.

Currently, an estimated 161,105 children die before their fifth birthday (under-five mortality rate (U5MR) of 84/1000) according to UNICEF Information by country, 2011. Although the causal factors are many, malnutrition is one of the leading underlying causes of under-five deaths. Prevalence of micronutrient deficiencies is high across all age groups of the Zimbabwean population. Vitamin A deficiency affects 19% of under-fives, 25% of children living with HIV, 23% of women (15-49 years of age) and 27% of rural women (MNS, 2012). It also affects 35.8% of pre-school children and 20% of pregnant women according to the WHO 1999. About 58% of pre-school children are also anaemic (**Hb<11 g/dl)**, together with 47% of pregnant women **(ZDHS, 2005-06)**, and iodine deficiency affects all population groups, with recent studies showing that one-out-of every six school children is iodine deficient (15.5%) **(MoHCW and UNICEF, 2009)**.

The main causal factors of the above situation in Zimbabwe are summarized below:

1) Inadequate knowledge and practices regarding appropriate and healthy diets for children and adults, especially among mothers and caregivers of children in the first 1,000 days of their life;

2) Weak value chain for nutrient-dense foods (processed and unprocessed);

3) Weak coordination and inadequate resourcing of nutrition interventions in the country resulting in service coverage that is below scale, comprehensiveness and quality recommended for high impact interventions;

4) Inadequate knowledge and practices in relation to water, sanitation and hygiene (WASH) and other pro-health seeking behaviours (such as immunisation, family planning and malaria control), especially among mothers and caregivers of children under the age of five years;

5) Absence of tailored nutrition services to meet needs of adolescents and adults outside the scope of regular maternal and child nutrition services;

6) Weak capacity of systems for delivery of community-based nutrition services;

7) Nutrition-blind social protection and other sectoral services; and

8) Inadequate information to guide the design of relevant nutrition interventions, and assessment of progress made by on-going nutrition services within the Zimbabwean context.

The consequences of nutritional deficiencies and disorders are significant; so are the benefits of investing in efforts to address them. There is strong international evidence that eliminating under-nutrition saves lives, prevents more than one-third of child deaths per year, and reduces the burden of disability for children under five by more than half according to Black R. E. et al. The evidence from recent World Bank studies also shows that tackling under-nutrition will result in significant economic benefits both now and in the long term.

Productivity in agriculture, industry and other sectors will increase due to better health of the working population and this will contribute to an increase in gross national product (GNP) of between 2% and 8% in Africa (and potentially further up to 11% in high burden countries). These studies also show that reducing stunting will result in school attainment being increased by at least one year. The combination of higher levels of education and improved health of the workforce will result in an increase in lifetime wages of between 5% and 50%, hence a reduction in poverty. Children who are not stunted are 33% more likely to escape poverty as adults. Stunted mothers are three times more likely to have malnourished infants. In addition, women who are well nourished as girls are 10% more likely to own their own business when they become adults.

The negative effects of under-nutrition are compounded by those of overweight and obesity which are rising in Zimbabwe contributing to an increase in incidence of chronic and non-communicable diseases (NCDs). In Zimbabwe, 10.6% of the population is obese and the problem is worse among women in urban areas where 41% are overweight or obese, compared with 26% of rural women (ZDHS 2010/11). In Zimbabwe, obesity worsens with higher income levels. Obesity among people in the highest income quintile is four times that for the lowest quintile.

The human and economic consequences of the current micronutrient deficiencies in the Zimbabwean population are grave. About 7,700 children and mothers are dying every year due to micronutrient deficiency (iron, vitamin A, zinc, and folic acid). Cognitive growth losses in children will debilitate about 900,000 of the current population of under-fives resulting in future productivity deficits equivalent to USD16 million in annual GDP. In adults, productivity performance deficit is estimated to affect more

than 500,000 workers, resulting in an estimated GDP deficit of USD43 million annually. Micronutrient deficiencies are also contributing to higher morbidity that is preventable, for instance about 3.5 million more cases of diarrhoea, acute respiratory infections, low birth weight and birth defects which are estimated to cost the health system and families an additional USD4 million per annum.

PROGRESS TOWARDS MEETING GLOBAL COMMITMENTS

Zimbabwe has already made progress in the first two of three primary areas of performance measurement monitored by the SUN Movement. Firstly, the launch of the FNSP and adoption of the ZimAsset economic blueprint are evidence of progress in meeting some of the SUN commitments.

The FNSP expresses a shared vision and seven commitments for accelerated action by the government namely to improve national and household level food security, improve the quality of diets, ensure food safety, improve nutrition for adolescents, pregnant women and young children and reduce stunting.

Secondly, reconstitution of multi-stakeholder platforms of Cabinet committee on food and nutrition security, national, provincial, district and ward food and nutrition security committees to spearhead the multi-sectoral Implementation Matrix of the FNSP counts as another milestone achieved. However, the third milestone in achieving the SUN movement benchmarks yet to be achieved is the mobilizing and tracking of resources with an impact on nutrition.

NATIONAL NUTRITION STRATEGY DEVELOPMENT PROCESS

The NNS development process was led by the National Nutrition Department (NND) in the Ministry of Health and Child Care (MOHCC) and the Food and Nutrition Council (FNC). The NND carries the mandate to coordinate the implementation of the strategy while the FNC provides the technical guidance and coordination support for the formulation process.

Eleven steps, including community, district, provincial and national consultation workshops were part of the NNS development process. Two district-level workshops and several project site visits to communities were undertaken to ensure that all relevant stakeholders at district and community level contributed. At national level, six thematic workshops, two NNS drafting workshops, one multi-stakeholder validation workshop, one monitoring and evaluation (M&E) workshop and one costing workshop were organised for maximum stakeholder input at all stages of the formulation process. The thematic workshops were Health and Nutrition; Food Fortification; Agriculture and Nutrition; Early Warning Food and Nutrition Security Information Systems; Education and Nutrition; and Social Protection and Nutrition.

STRUCTURE OF THE NATIONAL NUTRITION STRATEGY

The structure and content of the NNS follows the GOZ results-based management (RBM) template for strategic planning released in 2010. The strategy is presented in 16 chapters based on this. The first chapter is the introductory one followed by subsequent NNS chapters with the vision; mission; guiding principles; terms of reference for the NND; functions of the NND; an environmental scan; key result areas (KRAs) together with their impact and weighting; responsible institutions; client needs, problems and causes; stakeholder analysis; policy requirements (internal and external); goals of the NNS; main strategies, assumptions and risks for each KRA of the strategy; the strategic results chain highlighting the description of the result, the indicators to be used for performance measurement and aspects to be measured, annual targets for impact and outcome indicators and allowable deviations from the set milestones; the monitoring and evaluation framework; and lastly the magnitude and type of resources required to successfully implement the strategy.

The NNS will guide individual sectors in mainstreaming nutrition into the sector plans which will be developed and or reviewed in due course. Notably the NNS is not a road map for a single ministry or department since it is multi-sectoral in nature. However, it is a given that the main driver of the strategy will be the MOHCC through the NND. In light of this, the NNS was developed using a highly participatory bottom-up process involving all sectors starting in June 2013 and ending in December 2013.

VISION AND MISSION

A vision of "a Zimbabwe free from hunger and malnutrition" and a mission to "implement evidence-based nutrition interventions that are integrated within a broad multi-sectoral collaboration framework" serve as the NNS' fundamental guides in establishment of the country's strategic objectives.

To this end, the NNS emphasises prevention of malnutrition especially focusing on addressing stunting during the first 1,000 days of life together with a broader mandate to address malnutrition problems affecting the other age-groups of children 2 years and above, adolescents and adults, both females and males, rural and urban, poor and wealthy.

At programme execution level, the NNS is designed to address stunting, infant and young child malnutrition, nutrition-related non-communicable diseases, and micronutrient deficiencies in children and adults by solving eight main causal factors contributing to these problems, using high impact interventions informed by the UNICEF conceptual framework for nutrition.

GUIDING PRINCIPLES OF THE NATIONAL NUTRITION STRATEGY

Ten guiding principles inform the implementation conundrum of the strategy namely:

Guiding Principle 1: Nutrition is a basic human right and will be safeguarded for all age groups and social and economic strata.

Guiding Principle 2: Evidence-based programming: The NNS will prioritise investments in proven and universally accepted high-impact nutrition interventions to maximise results from limited resources. Evidence generation on barriers to the uptake of optimal maternal and child nutrition behaviours will be a top priority.

Guiding Principle 3: Collaborative and coordinated action across multiple sectors: The NNS strengthens collaboration across sectors, minimises duplication, and fosters collective accountability towards a shared goal of nutrition security for all.

Guiding Principle 4: Community empowerment and participation: Communities as rights holders should be empowered to identify, prioritise and respond to their nutrition challenges, barriers and bottlenecks. Support of government and development partners is required to enhance these community led initiatives by addressing barriers at household, community, district and national levels.

Guiding Principle 5: Overcoming barriers to the uptake of optimal maternal and child nutrition behaviours: Addressing knowledge gaps and promoting sustainable nutrition social behaviour change will remain a core cross-cutting strategy for the NNS.

Guiding Principle 6: Life-cycle approach: The NNS recognises that key nutritional impact towards reducing stunting is achieved by interventions reaching children in their first 1,000 days of life. However, broader public health nutrition interventions should be provided throughout the life-cycle, tailored to specific needs at each stage, in order to ensure nutrition security for all.

Guiding Principle 7: Continuum of care: Health facility based services alone are not adequate to address nutrition security. Therefore the NNS recognises the need for nutrition services to be provided in an integrated manner that links health facility care and support with community based nutrition services.

Guiding Principle 8: Ensuring equity and inclusiveness: The NNS ensures that nutrition needs of the whole populace are addressed, and no part of the population is left out as a result of religion, poverty, gender, age, race, geographical location or political orientation.

Guiding Principle 9: Emergency preparedness and risk mitigation are central to nutrition security: The NNS recognises the role and impact of climate change related disasters on nutrition security and incorporates strategies that ensure early warning, emergency preparedness and risk mitigation.

Guiding Principle 10: Good governance for nutrition security: The NNS defines clear roles and responsibilities and fosters accountability of multi-sectoral actors at various levels from national down to community level.

LEGISLATIVE, POLICY AND INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

To complement and deepen commitment to these guiding principles is a comprehensive legislative and policy framework that conforms to international, regional, national and sub-national contexts in food and nutrition security and related matters.

Nationally, the Zimbabwe Agenda for Socio Economic Transformation (ZimAsset) is a government driven economic blue print with a cluster-based thrust in four thematic areas of food and nutrition security; social services and poverty eradication; infrastructure and utilities and value addition and beneficiation. As an all-encompassing policy, ZimAsset has mandates for each cluster to have policies, strategies with a monitoring and evaluation framework complete with outcome and impact indicators that conforms to the GOZ's RBM system.

The Food and Nutrition Security Cluster has among many policies the FNSP, with GOZ backed commitments to Policy Analysis and Advice; Agriculture and Food Security; Social Assistance and Social Protection; Food Safety and Standards; Nutrition Security; Food and Nutrition Security Information; and Enhancing and Strengthening National Capacity for Food and Nutrition Security. The NFNSP fosters a multi-sectoral approach to solving food and nutrition security problems in the country. The coordination mechanism to achieve results, has a national and sub-national structure on food and nutrition that reaches up to the ward level.

At national level, the Office of The President and Cabinet (OPC) is at the helm of the food and nutrition security implementation framework. The Cabinet Committee on Food and Nutrition Security chaired by the Honourable Vice-President reports to the Cabinet and below the Cabinet Committee on Food and Nutrition Security is the Working Party of Permanent Secretaries that is chaired by the Deputy Chief Secretary and involves 17 critical ministries. Below the WPPS is the FNC which coordinates the Zimbabwe Vulnerability Assessment Committee (ZIMVAC) and the Food and Nutrition Security Advisory Group (FNSAG) and these bodies are composed of government, NGOs and the UN partners at different levels of responsibility.

Below this level is the National Food and Nutrition Security Committees (NFNSC/ PFNSC/ DFNSC/ WFNSC) with structures at provincial, district and ward levels. All the sub-national structures interact with development committees at both provincial and district level to discharge the mandate of the food and nutrition security implementation matrix.

Not withstanding the policy and legislative framework as put forth by ZimAsset, FNSP and other relevant legislation and policy pronouncements the NNS is bound by, there are several hurdles to the smooth implementation of the strategy.

The less conducive macroeconomic environment characterised by deflation, low foreign direct investment, high unemployment rate, depressed economic growth figures and changing climatic conditions negatively impacting on food and nutrition security are prominent examples.

KEY RESULT AREAS GOALS AND STRATEGIES

The content of the strategy is 6 KRAs and 19 goals, 66 strategies and several specific activities under each KRA and Strategy. High impact interventions as mentioned in the Lancet 2013 series and Copenhagen Consensus are at the core of the strategy and, along with local evidence on what works, have guided prioritisation of interventions in the NNS (2014-2018).

1) KRA 1 Adolescent and Maternal Nutrition Services

- **a. Goal 1:** Coverage of health and community nutrition services for adolescents increased to 50% by 2018
- **b. Goal 2:** Standard maternal health and nutrition package scaled up to 90% coverage by 2018

c. **Goal 3:** 50% of women of reproductive age have positive support from spouses and communities for decisions on maternal health, nutrition, healthy lifestyles and safe living environment by 2018.

2) KRA2: Infant and Young Child Nutrition

a. **Goal 4**: All health institutions provide the standard IYCF package (BMFHI, BF, CF, multiple micronutrient supplementation and fortification, dietary diversification, disease prevention and management, nutrition interventions in emergencies, feeding behaviours and stimulation, PMTCT, WASH and IMAM) by 2018

b. **Goal 5**: Community IYCF counseling package increased from 44% to 100% of districts and in at least 90% of the wards by 2018

c. **Goal 6:**Coverage of growth monitoring and promotion for under-fives increased from 2 districts to 20 districts by 2016 and to 40 districts by 2018 and covering 5 wards per district by 2018

3) KRA3 Clinical Nutrition Services

a. **Goal 7:** To increase the proportion of the adult population practicing at least one or a combination of the top 5 healthy lifestyles to 40% by 2018

b. **Goal 8:** Proportion of health facilities (central, provincial, mission and district hospitals) providing quality nutrition services for communicable (schistosomiasis, HIV, malaria, soil transmitted helminthes) and non-communicable diseases increased to 75% by 2018.

c. **Goal 9:** 30% of institutions adopt national food service and nutrition guidelines by 2018.

4) KRA4 Enhancing the Quality of Nutrition Information Systems and Effectiveness of Advocacy

a. **Goal 10:** Timely availability of relevant nutrition information that incorporates disaster risk reduction at all levels adequate for disaster preparedness planning and nutrition programming by 2018.

5) KRA 5 Strengthening Multi-sectoral Coordination and Collaboration for Integrated Nutrition Response

a. **Goal 11:**80% of women of reproductive age have the capacity to safely provide for their food, health and nutrition security using appropriate technologies

b. **Goal 12:** Coverage of health and community nutrition services for school children increased to 50% by 2018

c. **Goal 13:** All provinces and districts have Food and Nutrition Security Committees that are fully discharging their terms of reference by 2014, 50% of ward level committees functioning by 2018

d. **Goal 14:** To increase the proportion of households consuming safe and acceptable diets all year round to at least 80% by 2018

e. **Goal 15:** Scale up evidence-based nutrition sensitive interventions in social protection services to 80% coverage by 2018

f. **Goal 16:** At least 50% of community based health workers promote WASH related behaviour change whilst integrating nutrition messaging by 2018
g. **Goal 17:** To ensure that at least 50% of imported and locally produced foods are evaluated for safety by 2018.

6) KRA6 Capacity Development for Nutrition Service Delivery and Resource Mobilization

a. **Goal 18:**To ensure that the National Nutrition Department has a critical mass of staff with the ability, tools, supportive supervision and resources to integrate nutrition into other sectors
b. **Goal 19:** To increase resource allocation to nutrition to 1% of GDP per year by 2018.

Overall, the KRAs, goals, strategies, activities, indicators and performance targets for the NNS reflect the emphasis that has been put in comprehensively addressing the multiple nutrition-related problems according to the key result areas 1-6.

The NNS identifies that maternal malnutrition from conception, during pregnancy and through lactation and particularly maternal short stature and iron deficiency anaemia are associated with increased risk of stillbirths, miscarriages, low birth-weight, maternal and infant mortality. Nutritional status of a mother at conception clearly determines the size of and growth of the foetus (Kramer and Kakuma, 2003).

Maternal overweight and obesity are associated with maternal morbidity, pre-term birth and increased risk of infant death. Also maternal micronutrient deficiencies are associated with low birth weight in infants and increased risk for maternal morbidity and mortality. The Lancet series 2013 clearly identifies the need to address the nutritional needs of a woman from conception through the second birthday of her child in order to promote good nutrition outcomes for both mother and infant. The WHO has identified essential nutrition actions for improving maternal, newborn, infant and young child nutrition and health at health facility and community levels. This set of high impact nutrition interventions includes maternal iron, folate, Vitamin A, iodine and calcium supplementation, use of ITNs, family planning and adequate birth spacing, and nutritional care and support for pregnant and lactating women in emergencies and to be implemented at scale at health facility and community levels for maximum effect.

The NNS, therefore, adopts this standard maternal nutrition package for implementation through health facility and community platforms. Primary focus is on preventive strategies, like capacitating community and health facility workers to deliver the standard adolescent and maternal nutrition package, promoting nutrition education through the school curriculum, using community platforms to promote behaviour change on reproductive and sexual health and nutrition, and strengthening planning and management of adolescent and maternal nutrition programmes.

IMPLEMENTATION PLAN

Short to medium term mobilisation of resources for nutrition, institutional strengthening of the NND and other agencies responsible for implementation of the NNS has been prioritised. Additionally, recruitment of staff, strengthening of nutrition-related training programmes for health professionals and procurement and distribution of complementary job aids and working tools is top on the priority list.

Priority focus in the short term is on children under the age of two years. This will be achieved through strengthening adolescent and maternal nutrition and community IYCF services. Other key areas identified include development and dissemination of information, education and communication materials, effective delivery of IMAM services, micronutrient supplements to adolescent girls, de-worming; micronutrient supplementation to women aged 15 - 49 years, pregnant women and women post-partum and supplementary feeding for pregnant and lactating women with acute malnutrition. Implementation of the national food fortification strategy will be prioritised within the first 2 years as this is also essential for reducing anaemia in children under the age of five. Other short to medium term interventions prioritised include:

- Promotion of BCC on maternal and adolescent health, SRH, hygiene and nutrition targeting adolescents using community platforms and addressing the gap observed in adolescent nutrition services which are either absent or have very limited coverage.
- Generating evidence for strengthening nutrition programming, strengthening coordination of the multi-sectoral collaboration and coordination approach, and development, printing and dissemination of policies, standards and implementation guidelines.
- Development of a BCC strategy on healthy lifestyles, reviewing and updating IEC/BCC materials on healthy life styles, promoting social behavioural change on healthy lifestyles using various types of mass media, carrying out social outreach activities and development of a protocol on prevention and management of NCDs.

In the long term focus is given to:

- Strengthening the multi-sectoral approach including development of nutrition social marketing tools for the school environment,
- Strengthening the integration of nutrition into education, social protection, agriculture and health
- Integration of nutrition into water, sanitation and hygiene promotion activities is considered paramount but not a short term undertaking.
- Strengthening of the national system for promoting food safety, post-harvest handling to increase shelf life and food safety of harvested foods will be on-going.
- Advocacy for increased production of small live-stock, aquaculture and apiculture and consumption of animal source protein foods,
- Research and development of improved varieties of bio-fortified seeds, and awareness promotion and demand creation for nutritious foods, with an emphasis on production, processing, preservation, storage and preparation of a more diverse food basket.

The NNS also promotes the integration of nutrition into social protection from a longer term perspective. Integration of nutrition education and BCC into all social assistance programmes shall be part of the NNS. Other long term strategic interventions include integrating nutrition sensitive DRM into sector programmes and budgets, integrating nutrition indicators into targeting, monitoring and evaluation systems for social protection programmes, and provision of timely social safety nets in emergencies and crisis situations that meet universally accepted minimum standards and national food and nutrition standards

MONITORING AND EVALUATION

Core indicators at impact levels like proportion of under-fives who are stunted by age group (stunting expected to be reduced by 1% annually), proportion of low birth-weight babies, incidence of type II diabetes and hypertension among adults, infant mortality rate (IMR), maternal mortality ratio and child mortality rate will be used to assess the impact of the strategy.

Outcome indicators will be the following: rates of exclusive breastfeeding, dietary diversity rates for different age categories, proportion of under-fives with underweight wasting categorised according to different ages of children and adults, proportion of obese and overweight individuals categorised from children to adults, proportion of under-fives, school going age children and women of child bearing age with anaemia, proportion of women of child bearing age and children below five years with vitamin A deficiency and proportion of relevant groups with urine iodine concentrations below 50µg/L.

Other areas with outcome indicators relate to improvement in information systems, improvement of quality of diets in institutions of special care, improvement in hygiene practices at household levels and the proportion of GDP allocated to nutrition. Additionally, levels of increasing dietary diversity, capacity of Food and Nutrition Security Committees strengthened, proportion of budget allocated to nutrition expected to increase. The NNS M&E plan is linked to the RBM, a GOZ planning, monitoring and evaluation template through which the country's programmes are implemented and monitored. ZimAsset targets and indicators will also be part of the M&E plan.

M&E Systems will be a central part of strategy implementation and tracking of results achieved. Routine administrative data collection systems will collect data on reach and coverage of nutrition services and the outcomes will be assessed through the national food consumption and ZimVAC surveys while impacts on nutrition and health status of the population will be assessed through national surveys such as the ZDHS, National Micronutrient Surveys, and National Nutrition Surveys. Nutrition indicators that have been proposed in this strategy will track results in each target group of the population covered by the strategy and will assess knowledge, behaviour change, nutrition practices, outcomes and impacts. Core indicators with a common definition and method of data collection and analysis (and interpretation) will be used to harmonize tracking of results, they will be used by each and every programme, project or intervention designed to address food and nutrition insecurity in any part of the country, regardless of its size.

Additionally, some research like the cost of hunger will be commissioned and the results will be jointly used to assess the potential economic impact of the strategy and lobbying for resources. Baseline

data will be established for each indicator proposed in the impact and outcome plans of the M&E system for the Strategy. Day by day activities will be monitored for alignment with the strategy, and for comprehensiveness and quality of service delivery by the National Technical Working Group (NTWG) on Nutrition and the Food and Nutrition Security Committees from national right up to community level. Citizen feedback on satisfaction with the food and nutrition services rendered will be commissioned from time to time to check on appropriateness of service coverage, quantity and quality.

COST ESTIMATE

The total budget of the strategy is estimated at USD599.6 million and the resources are allocated to:

1) Direct health and nutrition interventions proven to reduce stunting in under-fives by about one third if implemented at scale;

2) Critical activities such as nutrition information systems, human resources for nutrition service management and coordination, and resource mobilisation; and

3) Strengthening the multi-sectoral interventions that complement direct health and nutrition interventions. More specifically, adolescent and maternal nutrition interventions are allocated10%, IYCF – 16%, promotion of healthy lifestyles – 5%, quality information systems and advocacy - 1%, resource mobilisation - 1%, human resource costs towards filling of (district nutritionists' posts, dieticians posts, on the job training of staff and nutritionists positions across sectors) – 0.2% and anthropometric equipment – 0.2%, health and community nutrition services for school children - 10%, integrating nutrition and scaling up nutrition-sensitive interventions in social protection with a focus on strengthening disaster risk management and resilience capacities of vulnerable populations - 47%, promotion of dietary diversity at the household level - 5.6%, ensuring safety of imported and local produced foods - 3.2%, empowering women of reproductive health age to have the capacity to safely provide for their food, health and nutrition security using appropriate technologies - 0.5%, among others.

FINANCING THE STRATEGY

The GOZ assumes primary responsibility for resource mobilisation, funding the strategy and delivering targets set while development partners will complement government efforts. Budgeting for fiscal resource allocation, planning and implementation of strategies under each goal will be done by line ministries tasks in close collaboration with international cooperating partners, the UN agencies, NGOs, entities and the private sector. Each line ministry will also coordinate implementation and review of the specific strategies foreseen under its mandate and in collaboration and with the active engagement of all relevant stakeholders who will also be invited to support the efforts with resources. Planning and review of progress will be jointly done between ministries and partners. Overall direction and support in resource mobilisation and tracking, and strategy implementation will be provided by the MOHCC, through the NND.

CONCLUSION

The NNS shall be a five year roadmap for resolving mounting nutrition problems in Zimbabwe while taking advantage of programmes and strategies proven to have the highest impact in improving the nutritional status of all of the country's citizens especially the vulnerable ones. The approach shall be multi-sectoral and resources shall primarily be mobilised by the GOZ and development partners coming in to plug funding gaps.

1 INTRODUCTION

1.1 Global nutrition situation

Globally, Scaling-Up Nutrition (SUN) has taken centre-stage in development efforts to promote child survival, human capital development and economic growth. Worldwide, 10.6 million children below 5 years of age die every year[1]. Two-thirds of the childhood deaths occur during infancy, with slightly more than one third taking place during the first month of life and closely associated with the high maternal mortality rate. About 45% of all child deaths beyond infancy are closely associated with nutrition-related causes[2]. Stunting, severe wasting and intra-uterine growth retardation are the major contributors to child mortality, accounting for about 2.3 million deaths of under-fives annually (The Lancet Series, 2013). About 43% of all deaths among under-fives occur in Africa (Black et. al., 2008). Under-nutrition is also the number one cause of morbidity for all age groups, accounting for 11% of the disease burden[3]. With regard to maternal mortality, iron deficiency is the leading cause, contributing 20% of the estimated 536,000 deaths (WHO, 2005 statistics).

1.2 Nutrition progress and challenges in Zimbabwe

Over the last 30 years, Zimbabwe made remarkable progress in reducing both underweight and wasting in children under the age of five years. In the 1980s, concerted efforts were made to identify undernourished children and target them with food assistance. In the 1990s, a transition was made from food aid to community-based nutrition programmes with strong coordination between health and agriculture[4] to promote sustainability of the nutrition impact. Early success was recorded in reducing underweight prevalence in under-fives through the multi-sectoral coordination approach. The close partnership between health and agriculture, which was forged through the mechanism of the District Food and Nutrition Management Teams and a strong involvement of village health workers,was instrumental in significantly reducing the prevalence of underweight and wasting in under-fives.That Zimbabwe accomplished what few other African countries were able to after Independence is evidence that Zimbabwe can tackle its most pressing nutrition problems.

Nevertheless, reducing the prevalence of under-weight in under-fives by half by the year 2015 in line with MDG Target No. 1, has remained elusive, with the rate even temporarily rising from 10% in 1999, to 13% in 2005, declining back to 10% in 2010 (ZDHS, 2010/11), then rising slightly again to 11% (according to the Micronutrient Survey (MNS) carried out in 2012). Moreover, the high prevalence of stunting in children under-five years of age remains Zimbabwe's top nutrition challenge. In 2010, one in every three children (32%) was found to be stunted (ZDHS, 2010/11), and this situation has not improved in the last decade. Results of the MNS, 2012 indicate a slight improvement to 30%. The prevalence of stunting (of 30% on average, 33% in male children and above 40% in some districts) remains at an unacceptably high level, with significant social and economic consequences on the country. Currently, an estimated 161,105 children die before their fifth birthday (under-five mortality rate (U5MR) of 84/1000)[5]. Although the causal factors are many, malnutrition is one of the leading underlying causes of under-five deaths. Prevalence of micronutrient deficiencies is high across all age groups of the Zimbabwean population. Vitamin A deficiency affects 19% of under-fives, 25% of

[1]The Lancet Series on Nutrition, 2008, Executive Summary.
[2]The Lancet Series on Nutrition, 2013 (Executive Summary) indicates that the causes include foetal growth restriction (among children <1 month), stunting (1-59 months), under-weight (1-59 months), wasting (1-59 months), severe wasting (1-59 months), zinc deficiency (12-59 months), Vitamin A deficiency (6-59 months), and sub-optimal breastfeeding (0-23 months).
[3]The Lancet Series on Nutrition, 2008.
[4]Zimbabwe IYCF Programme Review, 2012.
[5]UNICEF, 2011, Information by Country: Zimbabwe Statistics, DHS, 2010/11.

children living with HIV, 23% of women (15-49 years of age) and 27% of rural women (MNS, 2012). It also affects 35.8% of pre-school children and 20% of pregnant women[6.] About 58% of pre-school children are also anaemic **(Hb<11 g/dl)**, together with 47% of pregnant women **(ZDHS (2005-06))**, and iodine deficiency affects all population groups, with recent studies showing that one-out-of every six school children is iodine deficient (15.5%)(**MoHCW and UNICEF (2009)**)[7].

There are eight main causal factors contributing to the above situation and these are:

1. Inadequate knowledge and practices regarding appropriate and healthy diets for children and adults, especially among mothers and caregivers of children in the first 1,000 days of their life;
2. Weak value chain for nutrient-dense foods (processed and unprocessed);
3. Weak coordination and inadequate resourcing of nutrition interventions in the country resulting in service coverage that is below scale, comprehensiveness and quality recommended for high impact interventions;
4. Inadequate knowledge and practices in relation to water, sanitation and hygiene (WASH) and other pro-health seeking behaviours (such as immunisation, family planning and malaria control), especially among mothers and caregivers of children under the age of five years;
5. Absence of tailored nutrition services to meet needs of adolescents, and adults outside the scope of regular maternal and child nutrition services;
6. Weak capacity of systems for delivery of community-based nutrition services;
7. Nutrition-blind social protection and other sectoral services; and
8. Inadequate information to inform design of relevant nutrition interventions, and assessment of progress made by on-going nutrition services within the Zimbabwe context.

1.1 Consequences of under-nutrition and benefits of investing in nutrition

The consequences of nutritional deficiencies and disorders are significant; so are the benefits of investing in efforts to address them. There is strong international evidence that eliminating under-nutrition saves lives, prevents more than one-third of child deaths per year, and reduces the burden of disability for children under five by more than half[8]. The evidence from recent World Bank studies also shows that tackling under-nutrition will result in significant economic benefits both now and in the long term. Productivity in agriculture, industry and other sectors will increase due to better health of the working population (less down time due to illness and higher work efficiency due to stronger and larger bodies) and this will contribute to an increase in gross national product (GNP) of between 2% and 8% in Africa (and potentially further up to 11% in high burden countries)[9]. These studies also show that reducing stunting will result in school attainment being increased by at least one year[10]. The combination of higher levels of education and improved health of the workforce will result in an increase in lifetime wages of between 5% and 50%, hence a reduction in poverty. Children who are not stunted are 33% more likely to escape poverty as adults. Stunted mothers are three times more likely

[6]WHO (1999).
[7]Although iodine deficiency affects the entire population, and one of the most important target groups is pregnant women, school-children are assessed because they are a convenient sample and act as a proxy for other groups.
[8]Black R.E. et. Al, 2008, Maternal and child under-nutrition: global and regional exposures and health consequences, *The Lancet Series on Nutrition* 2008.
[9]The World Bank, 2006, The World Bank: Repositioning nutrition as central to development. A strategy for large-scale action. Washington DC.
[10]Sources: a) DIFD 2013, Business Proposition - Nutrition for Growth, for Discussion, May 2013; b) Alderman H, Hoddinott J, Kinsey B. Long term consequences of early childhood malnutrition. Oxf Econ Pap 2006; 58: 450–74; c) Daniels MC, Adair LS. Growth in young Filipino children predicts schooling trajectories through high school. J Nutr 2004; 134: 1439–46.
(d)Maluccio JA, Hoddinott J, Behrman JR, Martorell R, QuisumbingA.R. The impact of nutrition during early childhood on education among Guatemalan adults. Middlebury College Economics Discussion Paper number 06-14. Middlebury College, VT, 2006.
[11]Leary S, Fall C, Osmond C, et al. Geographical variation in relationships between parental body size and offspring phenotype at birth. ActaObstetGynecolScand 2006; 85: 1066–79.

to have malnourished infants[11]. In addition, women who are well nourished as girls are 10% more likely to own their own business when they become adults[12]. The negative effects of under-nutrition are compounded by those of overweight and obesity which are rising not only in Zimbabwe but globally, contributing to an increase in incidence of chronic and non-communicable diseases (NCDs). In Zimbabwe, 10.6% of the population is obese and the problem is worst among women in urban areas where 41% are overweight or obese, compared with 26 % of rural women (ZDHS 2010/11)[13]. In Zimbabwe, obesity worsens with higher income levels. Obesity among people in the highest income quintile is four times that for the lowest quintile.

The human and economic consequences of the current micronutrient deficiencies in the Zimbabwean population are grave. About 7,700 children and mothers are dying every year due to micronutrient deficiency (iron, vitamin A, zinc, and folic acid)[14.] Cognitive growth losses in children will debilitate about 900,000 of the current population of under-fives resulting in future productivity deficits equivalent to USD16 million in annual GDP. In adults, productivity performance deficit is estimated to affect more than 500,000 workers, resulting in an estimated GDP deficit of USD43 million annually. Micronutrient deficiencies are also contributing to higher morbidity that is preventable, for instance about 3.5 million more cases of diarrhoea, acute respiratory infections, low birth weight and birth defects which are estimated to cost the health system and families an additional USD4 million per annum.

1.1 On-going efforts to address malnutrition in Zimbabwe

In Zimbabwe, attaining the goal of food and nutrition security has been given high priority on the country's development agenda. On May 16, 2013, the Food and Nutrition Security Policy: Promoting Food and Nutrition Security in Zimbabwe in the Context of Economic Growth and Development (FNSP) was officially launched by the His Excellency, President Robert Gabriel Mugabe. The policy expresses a shared vision and seven commitments[15] for accelerated action by the government, to improve national and household level food security, improve the quality of diets, ensure food safety, improve nutrition for adolescents, pregnant women and young children and reduce stunting. A multi-sectoral approach in addressing the goal of reducing under-nutrition is critical and requires multiple actors which include government, civil society, development agencies, as well as public-private partnerships. The special place for business and science in addressing specific nutritional problems and developing and scaling up interventions to strengthen the food system and enable the healthy growth of young children is also fostered by the policy.

1.1 Commitments by the government and global community towards addressing malnutrition

Addressing nutrition has also become a major global development objective. Zimbabwe's progress on policy on food and nutrition security is in pursuit of its commitmentsas an **"early riser"** under the global Scaling-Up Nutrition (SUN) Movement. The SUN Movement has developed a Framework and a road map towards the prioritization of food and nutrition security in national programmes and advocates for national governments to be the main investors. The SUN Movement is based on common principles bringing together the entire spectrum of actors globally whose work affects nutrition. It has a clear focus on improving nutrition during the critical first 1,000 days of life from minus 9 months to 24 months of age and advocates for intensification and scale-up of proven high impact interventions aimed at reducing the prevalence of stunting, anaemia and low-birth

[12]DIFD 2013, Business Proposition - Nutrition for Growth, for Discussion, May 2013.
[13]The MNS 2012 found that for women aged 15-49years: 5.4% were thin; 59.1% had normal weight; 22.2% were overweight; and 13.4% were obese.
[14]The human and economic losses presented here are based on "Initial Findings of Consultant Mission to Support Development of Zimbabwe National Fortification Strategy" commissioned by UNICEF and the National Nutrition Department, Ministry of Health and Child Care in 2013.
[15]The commitments are on: I) Policy Analysis and Advice; II) Agriculture and Food Security; III) Social Assistance and Social Protection; IV) Food Safety and Standards; V) Nutrition Security; VI) Food and Nutrition Security Information; and VII) Enhancing and Strengthening National Capacity for Food and Nutrition Security.

weight. Commitment V of the Food and Nutrition Security Policy puts emphasis on actions that improve nutrition status during this window of opportunity (first 1,000 days) aimed at stunting reduction.

Addressing child and maternal nutrition was also at the top of the agenda for the **2010 MDG Summit.** At the current pace of progress in addressing under-weight, Zimbabwe is highly unlikely to achieve the MDG Target of reducing by half the prevalence of under-weight in under-fives by 2015. Furthermore, in June 2013, a new **Global Nutrition for Growth (N4G) Compact** saw donors pledging £2.7 billion ($4.15 billion) as additional funding to tackle under-nutrition up-to 2020 and governments in developing countries also made commitments[16]. Twenty-two businesses (including those in Southern Africa), also pledged to improve nutrition and, consequently, improve productivity and health of over 927,000 workforce members in more than 80 countries.

Zimbabwe has already made progress in the first two of the following three primary areas of performance measurement monitored by the SUN Movement, namely:

i) Ensuring the existence of a coherent policy and legal framework for nutrition – a national policy on food and nutrition security has been officially launched, and Food Security & Nutrition, is a pillar in the new economic blueprint Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset);

ii) Bringing people in the same space through multi-stakeholder platforms – multi-sectoral food and nutrition security governance structures have been established from the highest level in Cabinet (Cabinet committee on Food & Nutrition Security) to the community level through the establishment of Food & Nutrition Security Committees at National, Provincial, District and Ward levels. Common results framework for national nutrition plan (aligned programming); this is seen in the multi-sectoral Implementation Matrix of the Food & Nutrition Security Policy and

iii) Mobilising and tracking resources with an impact on nutrition. Zimbabwe is yet to cost the national action plan, and begin tracking of investments in food and nutrition security.

Zimbabwe realises that progress in scaling up nutrition would be easier if the country had a national strategy to address nutrition, a strategy that would have clear priorities, strong rationale, produced through an inclusive consultative process and is costed.

1.6 The National Nutrition Strategy

This National Nutrition Strategy (2014 – 2018) has been developed with two objectives in mind: a) to operationalize Commitment V of the NFNSP[17] and b) to contribute towards making further progress against the other SUN targets. The vision of the NNS is "**a Zimbabwe free from hunger and malnutrition**". The mission of the NNS is to "**implement evidence- based nutrition interventions that are integrated within a broad multi-sectoral collaboration framework"** that emphasises investment in prevention of malnutrition. Whilst the NNS assumes a special focus on addressing stunting (the first 1,000 days), it has a broader mandate to address nutrition-related challenges affecting the other age-groups of children (2 years and above), adolescents and adults, both females and males, rural and urban, poor and wealthier[18].

[16] Zimbabwe's commitment under the Nutrition Global Compact was USD3.04 million.

[17] Commitment V states that: The Government of Zimbabwe is committed to ensuring nutrition security for all through the implementation of evidence-based nutrition interventions that are integrated within a broad public health framework including health services, water and sanitation.

[18] Findings of the DHS, 2010/11 indicate that prevalence of obesity among adult women in urban areas increases with increasing per capita income, with the highest income group having four times higher prevalence than the lowest income quintile.

The NNS adopts a life-cycle-based multi-sectoral-integrated programming approach. This shapes the strategies that will be implemented under the six key result areas prioritised for investment. The main interventions prioritised are (i) the strengthening and scaling up of: a) adolescent and maternal nutrition services; b) infant and young child nutrition services; and c) clinical nutrition services; ii) enhancing the quality of nutrition information systems and effectiveness of advocacy; iii) strengthening multi-sectoral coordination and collaboration for integrated nutrition response; and iv) capacity development for nutrition and resource mobilization. The indicators and performance targets for the NNS reflect this orientation as well.

The NNS is designed to address stunting, infant and young child malnutrition, nutrition-related non-communicable diseases, and micronutrient deficiencies in children and adults by solving eight main causal factors contributing to these problems, using high impact interventions informed by the UNICEF conceptual framework for nutrition[19].

The process of developing the NNS was led by the National Nutrition Department in the Ministry of Health and Child Care, the institution which carries the mandate to coordinate its implementation. The Food and Nutrition Council (FNC) provided the NND with technical guidance and coordination support for the formulation process. The NNS is not a road map for a single ministry or department since it is multi-sectoral in nature, but the main driver of the strategy will be Ministry of Health and Child Care through the NND. In light of this, the NNS was developed using a highly participatory bottom-up process involving all sectors starting in June and ending in December 2013. The process had eleven steps, including community, district, provincial and national consultations. All provinces were consulted through provincial workshops attended by members of the provincial development committee and facilitated by the Food and Nutrition Security Committee at provincial level. In addition, in each province, two district-level workshops and several project site visits to communities were undertaken to ensure that all relevant stakeholders at district and community level contributed. At national level, six thematic workshops, two NNS drafting workshops, one multi-stakeholder validation workshop, one M&E workshop and one costing workshop were organised ensuring maximum stakeholder input at each stage of the formulation process. The thematic workshops were: 1) Health and Nutrition; 2) Food Fortification; 3) Agriculture and Nutrition; 4) Early Warning Food and Nutrition Security Information Systems; 5) Education and Nutrition; and 6) Social Protection and Nutrition.

The structural content of the NNS follows the Government of Zimbabwe's results-based management (RBM) template for strategic planning, released in 2010. The Strategy is presented in 16 chapters, including this introductory one. Chapter 2 outlines the vision, Chapter 3 the mission, and Chapter 4 the guiding principles. Chapter 5 presents the Terms of Reference for the National Nutrition Department mandated to coordinate the execution of the NNS while Chapter 6 describes the functions of the NND. An environmental scan is provided in Chapter 7. The Key Result Areas (KRAs) together with their impact weighting and responsible institutions are presented in Chapter 8. Chapter 9 describes the client needs, problems and causes. Chapter 10 presents the stakeholder analysis. Policy requirements (external and internal) for the NNS are listed in Chapter 11. Goals of the NNS are contained in Chapter 12, whilst the main strategies, assumptions and risks for each KRA of the strategy are described in Chapter 13. Chapter 14 presents the strategic results chain, highlighting the

[19] The UNICEF Conceptual Framework of Malnutrition has three types of causes: 1) immediate causes (inadequate dietary intake and disease burden); 2) underlying causes (inadequate access to food, inadequate care for children and women, insufficient health services and unhealthy environment); and 3) basic causes (inadequate resources – human, economic and organisational; political and ideological factors, and economic structures).

description of the results, the indicators to be used for performance measurement and what will be measured. The chapter also sets out the annual targets for impact and outcome indicators, and the allowable deviations in performance from the set milestones. Chapter 15 presents the M&E framework, while the last Chapter (16) describes the type and magnitude of resources required to successfully implement the NNS.

The NNS will guide individual sectors in mainstreaming nutrition into the sector plans which will be developed and or reviewed in due course.

2 VISION

The vision of the National Nutrition Strategy is **“a Zimbabwe free from hunger and malnutrition”.**

3 Mission

The mission for the NNS is to **“implement evidence- based nutrition interventions that are integrated within a broad multi-sectoral collaboration framework”.**

4 Guiding Principles

Guiding Principle 1: Nutrition is a basic human right and will be safeguarded for all age groups and social and economic strata.

Guiding Principle 2: Evidence-based programming: The NNS will prioritise investments in proven and universally accepted high-impact nutrition interventions to maximise results from limited resources. Evidence generation on barriers to the uptake of optimal maternal and child nutrition behaviours will be a top priority.

Guiding Principle 3: Collaborative and coordinated action across multiple sectors: The NNS strengthens collaboration across sectors, minimises duplication, and fosters collective accountability towards a shared goal of nutrition security for all.

Guiding Principle 4: Community empowerment and participation: Communities as rights holders should be empowered to identify, prioritise and respond to their nutrition challenges, barriers and bottlenecks. Support of government and development partners is required to enhance these community-led initiatives by addressing barriers at household, community, district and national levels.

Guiding Principle 5:Overcoming barriers to the uptake of optimal maternal and child nutrition behaviours: Addressing knowledge gaps and promoting sustainable nutrition social behaviour change will remain a core cross-cutting strategy for the NNS.

Guiding Principle 6: Life-cycle approach: The NNS recognises that key nutritional impact towards reducing stunting is achieved by interventions reaching children in their first 1,000 days of life. However, broader public health nutrition interventions should be provided throughout the life-cycle, tailored to specific needs at each stage, in order to ensure nutrition security for all.

Guiding Principle 7: Continuum of care: Health facility based services alone are not adequate to address nutrition security. Therefore the NNS recognises the need for nutrition services to be provided in an integrated manner that links health facility care and support with community based nutrition services.

Guiding Principle 8: Ensuring equity and inclusiveness: The NNS ensures that nutrition needs of the whole populace are addressed, and no part of the population is left out as a result of religion, poverty, gender, age, race, geographical location or political orientation.

Guiding Principle 9: Emergency preparedness and risk mitigation are central to nutrition security: The NNS recognises the role and impact of climate change related disasters on nutrition security and incorporates strategies that ensure early warning, emergency preparedness and risk mitigation.

Guiding Principle 10: Good governance for nutrition security: The NNS defines clear roles and responsibilities and fosters accountability of multi-sectoral actors at various levels from national down to community level.

5 Terms of Reference of the National Nutrition Department

The Ministry of Health and Child Care, through the National Nutrition Department is the institution mandated by the Government of Zimbabwe to execute the National Nutrition Strategy as well as any relevant policies, legal instruments and guidelines that directly advance the nutrition agenda. The NND will do so in collaboration with other line ministries, and government entities. In carrying out its role, the NND is guided by its mission and functions as elaborated in the statute that created this department. The Terms of Reference of the Nutrition Department are not found in a single document but are spelt out in various Acts, policy instruments, strategic plans and guidelines that define and govern nutrition activities in the country. The most relevant policies, legislative instruments, strategies and guidelines that define the scope of work the NND is expected to carry-out include those in Box 1.

Box 1: Relevant Acts, Policies, Strategic Plans and Guidelines for the NND

1. Public Health Act
2. Food and Food Standards Act
3. Health Professions Act
4. Infant and Young Child Feeding Policy
5. Reproductive Health policy
6. Family Planning guidelines
7. PMTCT Guidelines
8. Supplementary feeding guidelines
9. National Child Survival strategy
10. IMCI guidelines
11. Zimbabwe National Aids Strategic Plan (ZNASP) II
12. Maternal and Neonatal Health Road Map
13. National Health Information Strategy
14. Zimbabwe National Health Strategy
15. National Food Fortification Strategy
16. Health Information SOPs
17. Food and Nutrition Security Policy
18. Nutrition and HIV and AIDS Strategy
19. Nutrition Guidelines for People Living with HIV and AIDS
20. cMAM Protocols
21. cIYCFCounselling Package

6 Overall Functions of the National Nutrition Department

From the above policy and legislative instruments, the functions of the Ministry of Health and Child Care through the National Nutrition Department consist of the following:

1. Identify core advocacy concerns for the nutrition sector and develop key messages that influence national and sectoral policies, strategies, plans and activities and ensure that nutrition concerns are kept high on the policy agenda.
2. Develop, update and disseminate national nutrition policies and strategic plans in collaboration with the Food and Nutrition Council.
3. Ensure appropriate coordination, liaising and working with relevant counterparts especially within departments of the Ministry of Health and Child Care and partners to promote integration, convergence and effectiveness of nutrition interventions.
4. Advocate for nutrition sensitive programming within the Ministry of Health and Child Care and across sectors.
5. Ensure prioritization of nutrition issues, to substantiate investment and implementation for high impact nutrition interventions.
6. Develop, update and disseminate standards and guidelines based on emerging global and regional evidence.
7. Facilitate and support resource mobilization for nutrition, for interventions within and across sectors.
8. Support capacity development and knowledge sharing of best practices, lessons learned, and research findings, to keep stakeholders at National, Provincial and District levels abreast of new research findings and their implications for the Zimbabwe context.
9. Ensure to the extent possible that sector partners use common standards and tools for information collection/sharing and data management, including in needs assessments and monitoring.
10. Ensure early warning systems and emergency preparedness for nutrition arein place.
11. Identify evidence gaps and research priorities to inform the design of more effective nutrition interventions in the context of Zimbabwe.

7 ENVIRONMENTAL SCAN

7.1 Situation analysis: An overview of Zimbabwe's nutritional status and trends – the main problems

In Zimbabwe, approximately one out of every three children under the age of five years (32% according to ZDHS 2010/11, and 30% according to MNS 2012) is stunted. Due to the country's scaling up of the management of acute malnutrition and related livelihood and feeding programmes implemented by partners, the prevalence of acute malnutrition has declined significantly by over 50% over the past decade and only 2.4% of children under five have global acute malnutrition[20] (GAM) which is acceptable according to global thresholds[21]. According to the latest ZDHS of 2010/11, 10% of new-borns have a low birth weight (<2500g). Underweight has declined slightly as compared to the early 90s, but not enough to meet the MDG goal of halving the rate by 2015. The situation of stunting remains at best stagnant (Figure 1). There are also geographic, age, gender and socio economic disparities in nutritional status.

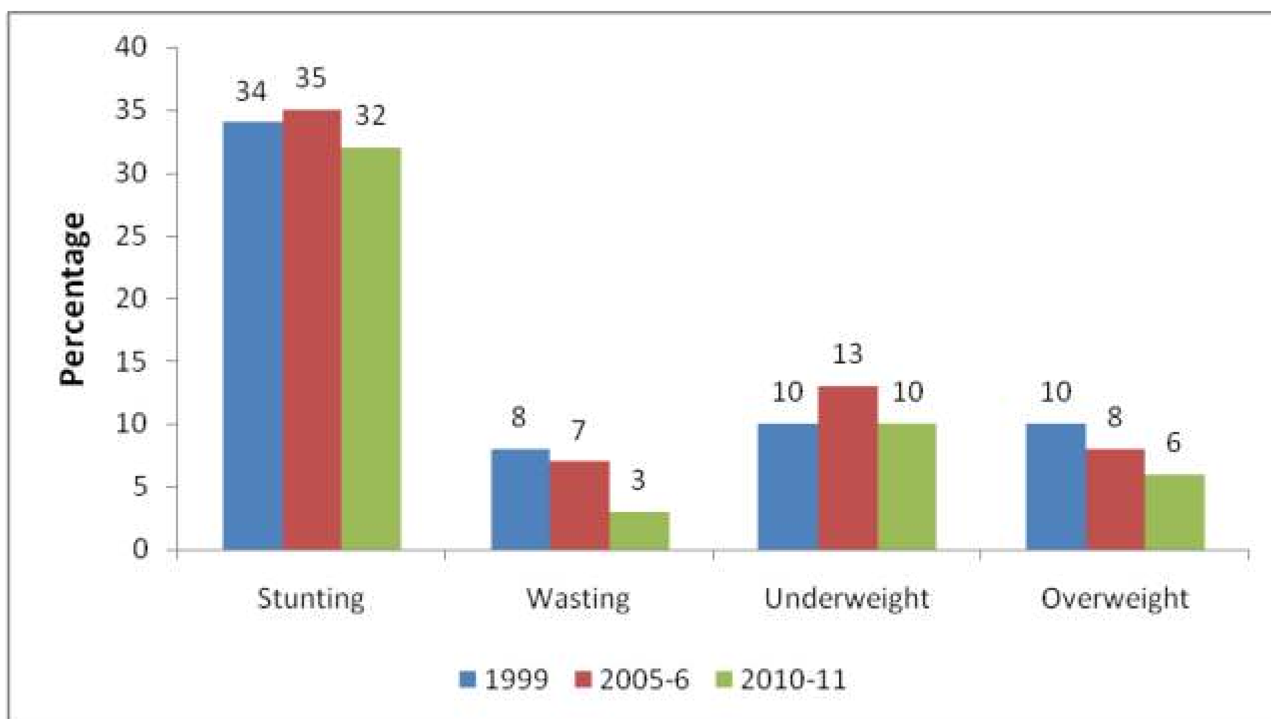


Figure 1: Trends in Nutritional Status of Children in Zimbabwe Under Five Years
Source: ZDHS, 2010/11.

[20]Having a z-score of <-2SD weight for height of with presence of bilateral pitting oedema
[21]Commonly used threshholds for GAM are:<5% = acceptable; 5% to 9.9% = poor; 10% to 14.9% = serious and >15% = critical

Zimbabwe is experiencing a double burden of malnutrition with steadily rising rates of obesity in women which in 2010 stood at 40.5% in urban areas and 25.5% in rural areas (ZDHS, 2010/11) and a high rate of stunting prevalence in under-fives. In 2010, a total of 33% of children living in rural areas were stunted, versus 28% of children in urban areas (ZDHS, 2010/11). Thirty percentage or more of children are stunted in all provinces except Bulawayo (26%) and Harare (29 %). Stunting steadily decreases as the level a of mother's education increases, from a high of 41% among children of mothers with no education to a low of 19% among children of mothers with more than secondary education (NNS 2010). Stunting is also higher in boys (36%) than in girls (28%). While stunting prevalence according to the latest MIMS 2009 is higher among the poor in Zimbabwe at 33%, wealth doesn't necessarily protect children from stunting as almost one in five (19%) of children in the highest wealth quintile is stunted. This suggests that, in the current context in Zimbabwe, adequate income doesn't necessarily guarantee adequate nutrition. Across all wealth quintiles, stunting has generally increased over the past two decades (Figure 2) although there are signs that stunting prevalence in under-fives may have started to decline as the results of the MNS 2012 indicate a modest decline to 30% in 2012.

According to the 2010/11 ZDHS, stunting is lower amongst the 0-6 month's age group and increases sharply from around 8 months to a peak at around 50% in the 24 months age group then gradually decreases and levels off at around 15% by age 59 months. Worth noting is the 10% stunting prevalence at birth which indicates that some children are born already stunted. This reflects a need for maternal, pre-pregnancy and adolescent nutrition interventions. The sharp increase in prevalence in stunting from 6 months is likely due to inappropriate complementary feeding and care practices for this age group. The latest MNS 2012, shows that child care practices especially in relation to breastfeeding are improving compared to findings of the ZDHS and the National Nutrition Survey (NNS) both conducted in 2010. However, more work is still required. At the time of the MNS 2012, 76%of children 0 – 23 months were still breastfeeding, 32%of children below six months of age were reported to be exclusively breastfed and the median duration of any breastfeeding was 9 months.

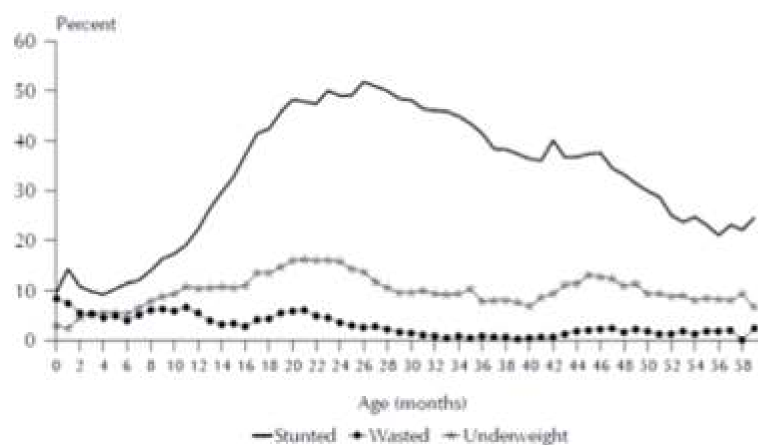


Figure 2: Stunting trends by age group

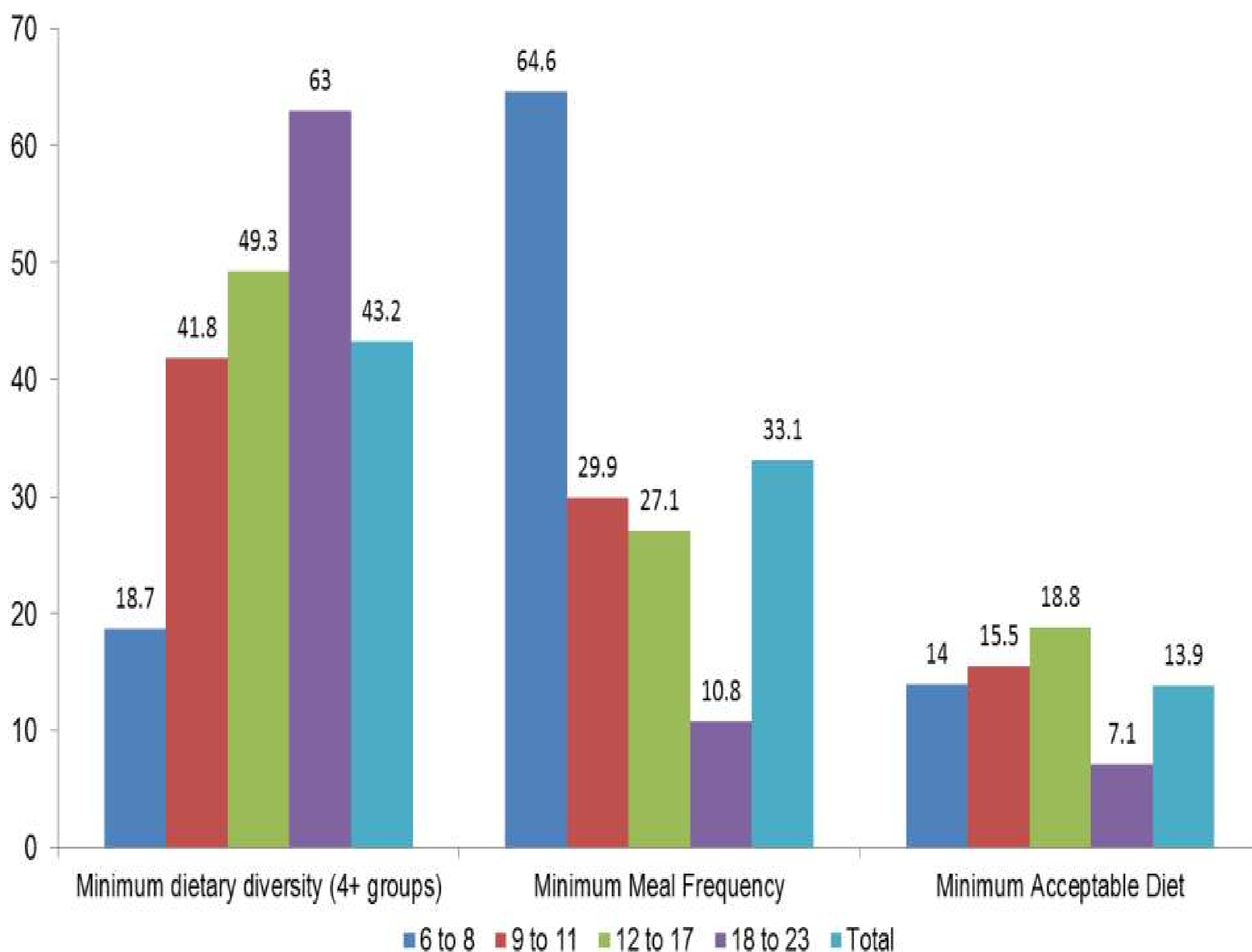


Figure 3: Adequacy of diets for infants
Source:MNS, 2012

The ZDHS 2010/11 observed that based on the mean body mass index (BMI), 7.1% of women in Zimbabwe were underweight whereas 31.3% of women 15-49 years of age were overweight and 10.6% were obese. Obesity is steadily rising in women and rates are currently at 40.5% in urban areas and 25.5% in rural areas (ZDHS, 2010/11). Results of the latest MNS 2012 indicate that prevalence of obesity among women in the age-group 15-49 years stood at 13.4% and it is higher than the average for the entire population. About one in five women aged 15-49 years was overweight (MNS 2012).

Findings of the latest MNS 2012 indicate that 72% of children 6 – 59 months are iron deficient. Thirty-one percent of the children 6 – 24 months have anaemia, 24% have iron deficiency anaemia (IDA), 48% have iron deficiency without anaemia and 8% have anaemia without iron deficiency.Among the children with anaemia, 67% had iron deficiency. Other recent studies have confirmed that more than half (56%) of Zimbabwean children aged 6 – 59 months are anaemic while 28% of women and 14% of men are anaemic (Table 1). Anaemia prevalence is very high among young children affecting (71% for children aged 6-9 months, and 74% for age group 9-18 months), and among pregnant women (32%) according to ZDHS 2010/ 11. In 2012, the national micronutrient survey included biomarkers of iron and vitamin A. The table below indicates the most recent data available on micronutrient status.

Table 1: Prevalence of Micronutrient Deficiencies by Age Group

Indicator	Status	Source
Prevalence of iron deficiency among children 6 – 59 months	72%	MNS 2012
Prevalence of anaemia among children 6 – 59 months	31%	MNS 2012
Prevalence of iron deficiency anaemia (IDA) among children 6-59months	24%	MNS 2012
Prevalence of iron deficiency without anaemia in children 6-59months	48%	MNS 2012
Prevalence of anaemiawithout iron deficiency among children 6-59months	8%	MNS 2012
Proportion of children who had anaemia, who had iron deficiency 6-59months	67%	MNS 2012
Prevalence of vitamin A deficiency (RBP < 0.825 µmol/l) among children 6-59 months	19%	MNS 2012
Prevalence of vitamin A deficiency (RBP < 0.825 µmol/l) among children 6-59 months living with HIV	25%	MNS 2012
Prevalence of vitamin A deficiency (RBP < 0.825 µmol/l) among children 6-59 months living in rural areas	24%	MNS 2012
Prevalence of vitamin A deficiency (RBP < 0.825 µmol/l) among children 6-59 months living in urban areas	9%	MNS 2012
Prevalence of vitamin A deficiency among pre-school children (serum retinol < 0.70 µmol/l)	35.8%	WHO 1999
Prevalence of vitamin A deficiency among women 15-49 years	23%	MNS 2012
Prevalence of vitamin A deficiency among pregnant women (serum retinol < 0.70 µmol/l)	20%	WHO 1999
Prevalence of anaemia among pre-school children (Hb<11 g/dl)	56%	ZDHS(2010/11)
Prevalence of iron deficiency in women 15-49 years	61%	MNS 2012
Prevalence of iron deficiency in non-pregnant women 15-49 years	62%	MNS 2012
Prevalence of iron deficiency in pregnant women 15-49 years	54%	MNS 2012
Prevalence of anaemia in women 15-49 years	26%	MNS 2012
Prevalence of iron deficiency among women with anaemia aged 15-49 years	67%	MNS 2012
Proportion of non-pregnant women with anaemia	26%	MNS 2012
Proportion of pregnant women with anaemia	19%	MNS 2012
Prevalence of anaemia among pregnant women (Hb<12 g/dl)	32%	ZDHS (2010/11)
Prevalence of anaemia among women (Hb<12 g/dl)	28%	ZDHS (2010/11)
Median urinary iodine concentration among children 5-12 years	113 µg/L	MNS 2012
Median urinary iodine concentration among non-pregnant women 15-49 years	116 µg/L	MNS 2012
Prevalence of iodine deficiency among school-aged children (urinary iodine < 100 µg/L)	15.5%	MoHCW& UNICEF (2009)

While the coverage of iodized salt is high, estimated at 88% of households (ZDHS, 2011) there appears to be inconsistency between coverage and use of the iodised salt as 16% of school children are iodine deficient.

Currently, there are no statistics on nutritional status of adolescents and the elderly. Data on men is limited with the 2010/11ZDHS measuring BMI and anaemia.

7.2 SWOT analysis

The strengths, weaknesses, opportunities and threats of past, on-going and future interventions and institutional arrangements for implementation of nutrition programmes in Zimbabwe are summarised in Table 2.

Table 2: SWOT Analysis

Strengths	Weaknesses
1. Existence of a common results framework for addressing food and nutrition insecurity(e.g., the FNSP Implementation matrix) 2. Strong political will and commitment for food and nutrition 3. Availability of nutritionists across the country up to district level 4. Well trained technical levels	1. Inadequate resources 2. Brain drain 3. Ability to attract and retain nutritionists 4. Quality of nutrition information management systems 5. Low number of medical nutrition therapy guidelines and training 6. Lack of dieticians at all levels
Opportunities	*Threats*
1. High level recognition of the role of nutrition in development and a correspondingly supportive high level political establishment 2. Presence of a multi-sectoral collaborative platform for coordination of food and nutrition security issues 3. Repository of evidence and information on best practices in nutrition intervention programmes the worldwide 4. Improved efficiency and room for improvement 5. Sub-national coordination and governance structures in place(Food and Nutrition Security Committees up to ward level)	1. Inadequate long term financing 2. Climate change and food insecurity 3. Competing programmes and resources needed to support food and nutrition security programming 4. Lack of capacity of translating the simple concept of food and nutrition security to the community 5. Strong cultural & religious beliefs hindering adoption of appropriate feeding practices

7.3 Political, economic, social, technological, environmental, and governance (PESTEG) analysis

7.3.1 Political analysis

Currently the political environment is stable following the general harmonised elections of 2013 which were closely followed by the government of Zimbabwe outlining its strategic plans for national development priorities. After inauguration, the GOZ proposed the Zimbabwe Agenda for Sustainable Socio-economic Transformation (ZimAsset) 'in pursuit of accelerated growth and wealth creation[22]" for a five year period running from October 2013 to December 2018. Included in the five clusters to spearhead the objectives of the programme is the Food Security and Nutrition Cluster.

To complement the food and nutrition security cluster, the GOZ has a Food and Nutrition Security Policy meant to promote food and nutrition security in the context of economic growth and development in Zimbabwe. This policy was launched on the 16th of May 2013 by H.E. the President of Zimbabwe and takes cognisance of the inter-sectoral nature of food and nutrition security issues. The main objective of the policy is to "promote and ensure food and nutrition security for all people at all times and particularly among the most vulnerable...[23]"

The policy intends to achieve its other aims and objectives along with other global, regional and local strategies such as the African Regional Nutrition Strategy (ARNS), Comprehensive African Agriculture Development Programme (CAADP), SUN Movement and the MDGs.

Further to the political will shown by the GOZ through the launch of the Food and Nutrition Security Policy, the policy is underpinned by eight principles and the GOZ has made seven Commitments to these. The Commitments ensure the presence of the right socio-economic policy instruments, food security, social assistance, food safety and standards and nutrition security[2] . Additionally the four core Commitments (food security, social assistance, food safety and standards and nutrition security) cover the continuum from availability, to access and utilisation. The rest of the commitments cover capacity development and information systems, including assessment, analysis and early warning and disaster risk reduction.

In order to give full meaning to these Commitments, the GOZ has an implementation and coordination structure for the Food and Nutrition Security Policy that involves all ministries at the ministerial, permanent secretary and director levels. These structures confirm the unequivocal commitment of the government regarding food and nutrition security issues at the highest level.

7.3.2 Economic analysis

Zimbabwe experienced a deterioration of the socio-economic environment which accelerated from the year 2000 onwards and resulted in a decline in industrial capacity utilisation to a level less than 10%. The gross domestic product was reduced by 50% in 2008[1]. The deep social and economic crisis that ensued was also characterised by hyperinflation which depleted stocks in the food chain and household assets, and together severely affected food and nutrition security of the whole country and

[22] ZimAsset Document – October 2013.
[23] Food and Nutrition Security Policy for Zimbabwe - Preface Signed by H.E. the President of Zimbabwe, May 2013.

more so for the vulnerable groups. Following the stabilisation of the economy through the introduction of a multi-currency system, the resulting single digit inflation and GDP growth of between 4% and 10% has been maintained.

The stable macro-economic environment creates conditions conducive to promotion of better health and nutrition. Improved health and nutrition status has been linked with increased productivity and economic growth[24]. Poverty and poor nutrition and health are inextricably linked and the economic performance of any given country or community will be on a development path if good nutrition and health are maintained.

With this background, government has put in place a new economic development blue print, the ZimAsset, complemented by an existing results-based system that seeks to optimise utilisation of allocated resources in the public sector. Ministries and their departments are to be re-oriented to formulate policies and programmes guided by the results based management system which focuses on clear organisational visions, missions, values, key results areas, goals and objectives which are translated into a results framework of outcomes, outputs, strategies and resources. The RBM system has guided the structure and content of this National Nutrition Strategy.

7.3.3 Social analysis

The socio-economic challenges the country experienced since the year 2000 resulted in the deterioration of social services such as quality of health and education service delivery and failure to meet the millennium development goal (MDG) targets. In particular, the third commitment of the national Food and Nutrition Policy states that GOZ is committed to ensuring that where social protection including social assistance programmes are implemented, food and nutrition security needs of the most vulnerable should be met[25].

Further, the policy's implementation matrix's other strategic objectives aim to ensure that social and cultural factors affecting food and nutrition security strategies are systematically recognised and reflected including distinguishing the different roles and responsibilities that men, women, siblings and the elderly have in food and nutrition security[26.]

The Food and Nutrition Security Policy's thrust is in the backdrop of several social and cultural barriers that are unfavourable to the achievement of food and nutrition security objectives. Some practices that are mainly influenced by socio-cultural beliefs include low rates of early initiation of breastfeeding (65%), early introduction of pre-lacteal feeding (13%) and low average duration of breastfeeding (17.8 months). Other IYCF indicators among children 6 months to 23 months are as follows – minimum dietary diversity – 24%, minimum meal frequency – 45% and minimum acceptable diet is 11%. These percentages are unacceptably low and can only be improved through a multi-sectoral intervention including the social protection sector.

[24] H. Alderman et al. Health, Human Capital and economic Growth – PAHO, August 2003.
[25] National Food and Nutrition Security Policy – 2013.
[26] Implementation Plan/ Matrix of the Food and Nutrition Security Policy of Zimbabwe – November 2012.

7.3.4 Technological analysis

Zimbabwe has a food and nutrition security information system which is currently undergoing improvements that will enable data to be collected, analysed, disseminated and utilised at local level, whilst contributing to the national system. Zimbabwe also has a working health management information system. The system is currently undergoing modifications that will enable it to accommodate more nutrition information. The changes have provided an opportune moment for the addition of a standard set of indicators into the routine data collection system with a view to monitor food and nutrition related indicators.

Some of the major nutrition problems can best be solved through comprehensive food and nutrition security interventions adapted to local conditions, with community participation including male and other opinion leaders or significant others' involvement. Interventions such as food fortification will help with the prevention of problems like iron deficiency anaemia, iodine deficiency disorders, vitamin and other micronutrient deficiencies of public health significance.

Other strategies and innovations need to be adopted that address food and nutrition security throughout the spectrum from production, processing and preservation, storage, consumption and utilisation. All this needs to be considered in the context of available technological capacities.

7.3.5 Environmental analysis/ climatic conditions

Zimbabwe experiences moderate to severe drought conditions regularly. These conditions have an impact on food and nutrition insecurity and are made worse by climate change that has become a regular phenomenon in many places of the world. Additionally, natural disasters and man-made disasters have also increased the chances of food and nutrition insecurity.

There are a number of measures to mitigate these problems such as disaster risk reduction, early warning systems, development of drought resistant crops such as small grains. These strategies have been developed to increase community resilience to shocks through supporting agro-based sustainability programmes targeted at ecologically fragile regions of the country.

7.3.6 Governance analysis

The launch of the Food and Nutrition Security Policy in May 2013 was followed by the resuscitation, capacitation and strengthening of food and Nutrition Security Committees (FNSCs) whose structures have representation at national, provincial, district and ward levels. The National Food and Nutrition Security Committee (NFNSC) is the national body responsible for the coordination of all the FNSCs.These FNSCs spearhead the multi sectoral and broad-based coordination of food and nutrition security issues - a cornerstone of the governance structure of food and nutrition in Zimbabwe.

The Food and Nutrition Council is the convenor of platforms for discussion of key issues on food and nutrition security and coordinates stakeholders in this field. At national level, there are supporting coordinating structures such as the Food and Nutrition Security Advisory Group (FNSAG) which is

composed of senior officials of UN agencies and corresponding heads for NGOs and government departments. The FNSAG provides strategic guidance to the FNC and assists with resource mobilisation.

The Zimbabwe Vulnerability Assessment Committee (ZimVAC), as a technical committee coordinated by the FNC, is responsible for collecting, analysing and reporting on inter-sectoral information pertaining to food and nutrition security.

The above is the complete governance structure for food and nutrition security in the country. This governance structure also interacts with other development-related coordination platforms such as the provincial and district development councils. Together they coordinate the various issues related to food and nutrition security in Zimbabwe.

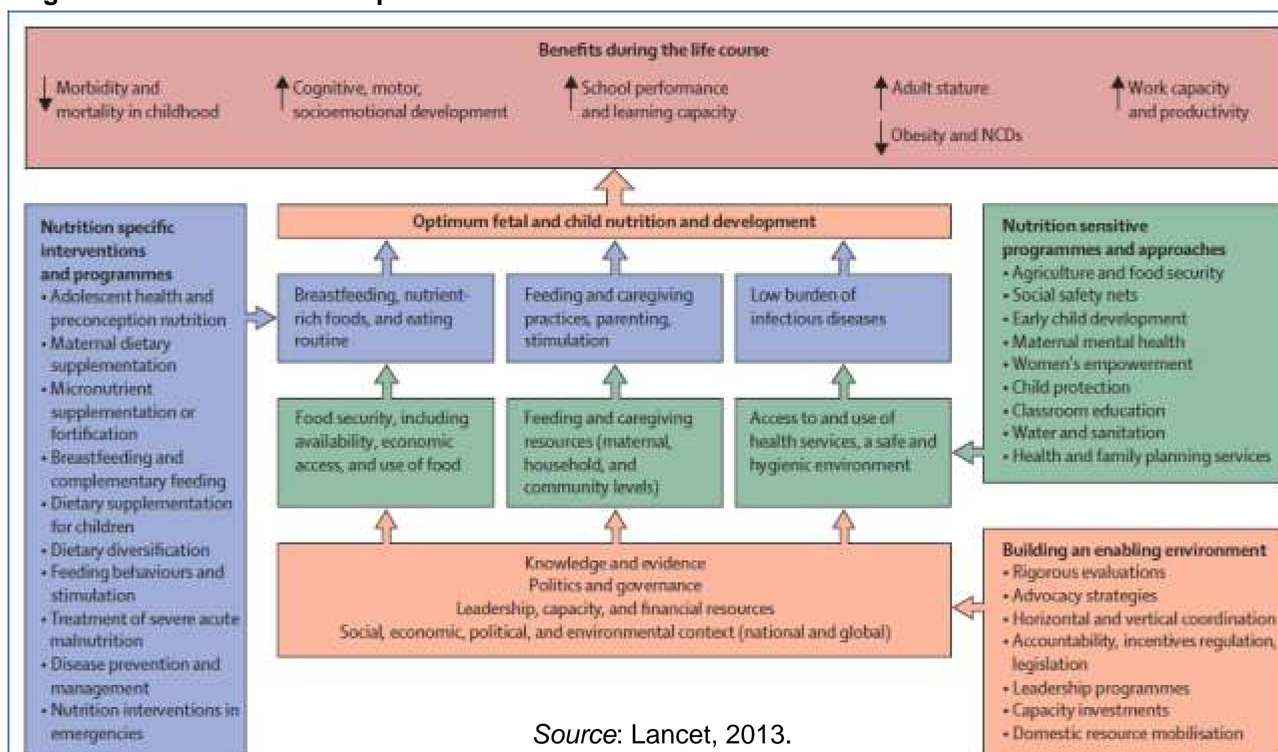
8 KEY RESULT AREAS

8.1 Prioritising the Main Areas of Investment to Achieve Results for Nutrition

The NNS prioritises interventions that are informed by global best practice in terms of “what works for nutrition”. Resources for investing in nutrition are scarce and need to be carefully targeted to areas that will produce the highest positive results during the fairly limited period of implementation of the strategy i.e. 5 years. Specific attention is given to addressing the most pressing needs in three priority areas of investment which are affecting national development, namely: maternal under-nutrition, stunting in children under the age of two years and anaemia in both children and women of child-bearing age. At least 43% of the estimated resource requirements will be spent on strategies to address these challenges[27].

Based on a) the 2013 Lancet Series on Nutrition which provided a wealth of information on global evidence on what works and at what scale, b) the experience of countries in the region with a wide menu of strategies to address nutrition, and most importantly c) local experience in Zimbabwe, the NNS identifies six main areas of investment towards securing nutrition for all in Zimbabwe in the five year period (2014-2018). These are: a) enhancing the quality of nutrition services (to all target groups using the life-cycle approach); b) behavioural change communication/legislations for optimal nutrition; c) coordination and mainstreaming of nutrition into other sectors; d) technical capacity building of health professionals; e) advocacy and resource mobilization; and f) research and M&E.

Figure 3: Malnutrition conceptual framework



Source: Lancet, 2013.

[27] A third of the budget for nutrition-sensitive social protection is estimated to go towards interventions that address challenges in these three areas.

The Key Result Areas are drawn from the menu of high impact interventions highlighted in the Lancet Series (2013) which fall within 3 broad types of investments: a) nutrition-specific programmes and approaches which address the immediate causes of malnutrition; b) nutrition-sensitive interventions and programmes which address the underlying causes, and c) interventions to build an enabling environment for nutrition by addressing the basic causes of malnutrition (Figure 3).

The prioritised areas of investment will achieve results in six key areas, which are:

1. Improved adolescent and maternal nutrition;
2. Infant and young child nutrition;
3. Strengthened clinical nutrition services;
4. Quality nutrition information systems and advocacy;
5. Strengthened multi-sectoral coordination and collaboration for integrated nutrition response; and
6. Capacity development for nutrition service delivery and resource mobilization.

The intervention packages proposed under each of these KRAs are tailored to the specific context of Zimbabwe. Locally, the interventions are consistent with the priorities already identified in the FNSP Implementation Matrix. Globally, they are also consistent with the “Copenhagen Consensus” best buys in development. While there has been good evidence on 'what needs to happen', the main gap has been in the limited evidence on 'how to scale up the proven interventions in a cost effective and sustainable way in a country like Zimbabwe'. To inform the second part, the country's past experience has been a valuable source of guidance. An understanding of the prevailing PESTEG environment within which the NNS will be implemented has also been important.

Furthermore, a strong element of operational research has being included as a critical element of evidence generation on efficacy of specific aspects of the interventions and in tracking overall implementation and performance as part of the broader monitoring and evaluation framework of the strategy and sufficient resources have been earmarked to evidence generation on “best scaling up approaches” to specifically address this observed gap. More details on the key result areas impact weightings, and references to sectoral, national and global strategies is presented below.

8.2 Key Result Areas for the National Nutrition Strategy

The Key Result Areas of the NNS, the weights attached to them in terms of their relative contribution to the planned outcomes and impacts, responsible departments and reference to national plans and global goals are summarized in Table 3.

Table 3: Key Result Areas, Linkages with National and Global Objectives and Responsible Departments

No.	Key Result Area	Weight	Responsible Department/s	Sector KRA Reference	National KRA Reference	MDG Reference
KRA1	Improved adolescent and maternal nutrition	25%	-MOHCC (Reproductive health, EPI, Nutrition, Quality, Health Promotion, AIDS/ TB Epidemiology, & Disease surveillance) -MoWAGCD -Ministries of Primary & Secondary Education --NGOs -Local authorities	National Health Strategic Plan - MOHCC (KRA 1, 2 and 3)[28]	ZimAsset[29] Food and Nutrition Security Policy	1. Poverty 2. Improve Maternal Health 3. Promote gender equality and empower women
KRA2	Infant and Young Child Nutrition	25%	-MOHCC (Reproductive health, EPI, Nutrition, Quality, Health Promotion, AIDS/TB,Epidemiology, NCD, Rehabilitation & Disease surveillance, health promotion) -MoWAGCD -Ministries of Primary & Secondary Education -NGOs -Local authorities -UN partners	National Health Strategic Plan – MOHCC Health Transition Fund	ZimAsset National Food and Nutrition Security	- Eradicate Extreme Poverty - Reduce child mortality
KRA3	Strengthening clinical nutrition services	15%	-MOHCC (Reproductive health, EPI, Nutrition, Quality, Health Promotion, AIDS/TB,Epidemiology & Disease surveillance, health promotion) -MoWAGCD -Ministries of Primary & Secondary Education --NGOs -MAMID -Local authorities -UN partners	National Health Strategic Plan - MOHCC	ZimAsset National Food and Nutrition Security	- Eradicate Extreme Poverty - Improve Maternal Health - Reduce child mortality - Promote gender equality and empower women
KRA4	Quality nutrition information systems and advocacy	10%	-MOHCC (Reproductive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology, NCD, Rehabilitation& Disease surveillance , health promotion) -MoWAGCD -Ministries of Primary & Secondary Education -FNC -NGOs -Local authorities -UN partners	National Health Strategic Plan - MOHCC	ZimAsset National Food and Nutrition Security	Develop a global partnership for development
KRA5	Strengthening multi-sectoral coordination and collaboration for integrated nutrition response	15%	-MOHCC (Reproduct ive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology, NCD, Rehabilitation & Disease surveillance, health promotion) -MoWAGCD -MAMID -FNC -Ministries of Primary & Secondary Education --NGOs -MoLGPWNH -MoPSLSW -Local authorities -UN partners	National Health Strategic Plan - MOHCC	ZimAsset National Food and Nutrition Security	Develop a global partnership for development
KRA6	Capacity development for Nutrition and Resource Mobilization	10%	-MOHCC (Reproductive health, EPI, Nutrition, Quality, AIDS/TB, E pidemiology, NCD, Rehabilitation & Disease surveillance, health promotion) -FNC -NGOs -Local authorities -UN partners	National Health Strategic Plan - MOHCC	ZimAsset National Food and Nutrition Security	Develop a global partnership for development

[28] KRA 1: Improving the health status of the population, KRA 2: Improving the quality of care. KRA 3: Health Systems Strengthening.
[29] ZimAsset – Reference to the Food and Nutrition Security Cluster

9 CLIENT NEEDS AND PROBLEM ANALYSIS

The NNS is informed by a thorough analysis of needs of the clients and an understanding of the characteristics of the problems they are facing. These clients are identified using a life-cycle approach and are listed in Table 4, together with the specific needs/problems and an analysis of the extent of the needs/gaps to be met through the NNS.

Table 4: Characteristics of Client Needs and Problems to be addressed through the NNS

External Clients		Needs/Problems	Characteristics/ Extent
1	Women of Reproductive age (WRA) (15-49 years)	***Needs:*** Education on importance of good nutrition for child birth Access to quality of mother friendly health and nutrition services Community and family support Male involvement in child care Maternity protection through Labour laws Breast feeding supportive work environments (breast feeding corners) Protection from marketing on Breast milk substitutes Micronutrient supplements HIV preventive services Low secondary school completion for girls Labour saving technologies Calcium supplementation	**Extent:** – 7.1% < 18.5 BMI (thin) – 31.3% (40.5% urban, 25.5% rural) >= 25.0 BMI (overweight or obese) – 10.6% (15.6% urban, 7.5% rural) >= 30.0 (Obese) – 28.2% (30.6% urban, 26.9% rural) total anaemia – 32.4% anaemia among pregnant – 26.6% anaemia breastfeeding – 40.2% (43.1% urban, 38.8% rural, 29.3% no education, 43.9% secondary, 33.4% lowest wealth quintile, 48.1% highest wealth quintile) received postpartum vitamin A. – 4.9% (1.5% no education, 5.3% secondary education, 3.8% lowest WQ, 5.3% highest WQ) took iron tablets or syrup for at least 90days during last pregnancy – 57.4% (43.2% no education, 71.1% more than secondary) ever tested for HIV and received results – 17.7% HIV positive – Labour laws – BFHI coverage, less than 1%
		Problems: Vitamin A deficiencies High anaemia prevalence Iron-deficiency anaemia Iodine deficiency NCD prevalence is rising Obesity increasing High prevalence of HIV among WRA High burden of labour in the home and the field Lack of knowledge on importance of good nutrition for child birth Low access of mother friendly health services Lack of community and family support Lack of male involvement in child care High rates of pregnancy -induced hypertensive disorders in pregnancy and pre-eclampsia	**Causes:** – Poor dietary diversity – Poor monitoring of iron and folate adherence by health delivery system – Urbanisation – Nutrition transition from traditional to western diets – No nutrition BCC strategy – Cultural beliefs – Lack of exercise – Lack of decision making power over their own health
2	Children 0 - < 6 months	***Needs:*** Early initiation of breast feeding to reduce infant mortality Immunisation Exclusive breast feeding to improve infant survival Optimum care practices by mothers Growth and development stimulation to realise growth milestones Growth monitoring and screening for early detection and treatment of acute malnutrition Appropriate complementary feeding Hygienic environments	**Extent:** – 3.6% severe stunting – 9.8% moderate stunting – 1.4% severe wasting – 5.3% moderate wasting – 1.4% severe underweight – 5.3% moderate underweight – 65.2% breastfed within one hour of birth – 91.7% breastfed within one day – 31.4% exclusively breastfed – 70.0% are vaccinated with DPT/pentavalent – 9.5% low birth weight – Legislative and by-laws and general work environment not conducive to EBF for 6 months

External Clients		Needs/Problems	Characteristics/ Extent
		Problems: Poor suckling reflex Low birth weight Early Introduction of pre-lacteal feeds Birthing complications Early introduction of solids Congenital deformities Poor hygiene & environments	**Causes:** – Birth asphyxia – Poor adolescent and maternal nutrition – Poor health status – Cultural beliefs – Poor knowledge of recommended IYCF practices – Poor positioning and attachment – Mixed messages for IYCF in the context of HIV – Poor decision making power of women over infant feeding practices
3	Children 6 - < 24 months	***Needs:*** Continued breast feeding Timely introduction of solids Appropriate complementary feeding Active responsive feeding Growth monitoring and screening for early detection and treatment of acute malnutrition Immunisation De-worming Safe water and sanitation facilities Optimal care practices	**Extent:** – 10.6% severe stunting – 27.2% moderate stunting – 1.3% severe wasting – 5.2% moderate wasting – 2.2% severe underweight – 10.4% moderate underweight – 79.2% receiving breast milk, milk or milk products – 23.5% (34.2% urban, 19.2% rural, 15.2% mom primary ed, 26.7% mom secondary ed.) receiving 4+ food groups – 45.2% receiving minimum meal frequency – 87.0% continued breastfeeding at one year – 20% continued breastfeeding at 2 years – 86% received timely introduction of solid, semi-solid or soft foods (6-8months) – 69.3% received measles vaccination – 55.6% received all basic vaccinations – 73.8% received the same amounts of liquids during diarrhoea as usual – 62.7% received the same amount of food during diarrhoea as usual
		Problems: Non-availability of nutritious and diverse diets at household level Short duration of breast feeding/ premature weaning Incorrect and inadequate feeding during and after illness Early introduction of complementary feeds Poor stimulation Inadequate supplies for treatment of acute malnutrition Poor management of childhood illnesses (diarrhoea, malaria and ARI) Barriers to immunisation against childhood illnesses due to religious and cultural beliefs	**Causes:** – Only 11% meet the minimum standards with respect to all 3 of IYCF practices – Poor quality of complementary foods – Poor health seeking behaviours – Poor care practices – Poor household food security – Poor decision making power of women over infant feeding practices – Unsupportive environment
4	24 months – 59 months	***Needs:*** Diversified diet Immunisation Growth monitoring and screening for early detection and treatment of acute malnutrition Safe water and improved hygiene and sanitation ECD facilities De-worming Management of early childhood illnesses	**Extent:** – 11.6% severe stunting – 37.2% moderate stunting – 1.5% severe wasting – 3.8% moderate wasting – 1.7% severe underweight – 9.9% moderate underweight
		Problems: Poor diet quality at household level Childhood illnesses Inadequate access to ECD facilities Inadequate care by mothers and other care givers Non- availability of medical supplies at health facilities to treat common childhood illnesses Poor water and sanitation facilities	**Causes:** – Poor household food security – poor health seeking behaviours – religious and cultural beliefs – Lack of child spacing – Poor decision making power of women over their children's access to health – Unresolved early childhood stunting – Delayed milestones
5	5 years to 14 years	***Needs:*** Diversified diet Food supplements Obesity prevention Safe water and improved hygiene and sanitation Basic education facilities De-worming Management of common illnesses Good agricultural practices	**Extent:** Appropriate indicators will be included in the next rounds of relevant national surveys to establish extent of needs.
		Problems: Poor diet quality at household level Common illnesses Inadequate access to basic education Inadequate care by duty bearers Non- availability of medical supplies at health facilities to treat common illnesses Child abuse Early pregnancies	**Causes:** – No baseline information or programmes targeting adolescent nutrition and health – Unresolved childhood malnutrition – Poor health seeking behaviour – Negative cultural and religious beliefs/perceptions – Lack of family planning services for adolescents
6	15 years to 24 years	***Needs:*** Continued diversified diet Iron supplements for adolescent girls Screening for obesity Safe water and improved hygiene and sanitation Continuing education facilities Management of common illnesses HIV prevention SRH education (HIV/AIDS, STIs, early pregnancies) ***Problems:*** Unavailability of diversified diets at household level Common illnesses Inadequate access to secondary and tertiary education Inadequate care by duty bearers Non- availability of medical supplies at health facilities to treat common illnesses Child abuse Early pregnancies Lack of SRH education	**Causes:** – Poor household food security – Poor health seeking behaviour – Religious and cultural beliefs – Poverty – Schools not accessible either too far or too expensive – Girls sometimes need to seek lodging nearer to schools, live alone or with friends

External Clients		Needs/Problems	Characteristics/ Extent
7	Men 15 – 49 years	***Needs:*** Information on appropriate diets and healthy life styles Continuing SRH Education Sport and recreation facilities Vocational skills for active employment Orientation of male involvement in child care Wellness centres HIV/AIDS prevention services Male involvement in family planning	**Extent:** – 15.3% (13.0% urban, 16.6% rural) thin – 8.9% (14.7% urban, 5.7% rural) overweight or obese – 1.8% (3.3% urban, 0.9% rural) – 35.9% (13.3% no education, 62.4% more than secondary education) ever tested for HIV and received results – 9.1% report having been circumcised – 12.3% HIV positive
		Problems: Alcohol and substance abuse Unemployment HIV/AIDS, STIs Obesity Poor health seeking behaviour	**Causes:** - No direct nutrition interventions targeting men - Poor male involvement in health issues - Cultural environment promoting multiple partners - Poor household resource base
8	Elderly women above 49 years	***Needs:*** Micronutrient supplements Safe water and improved hygiene and sanitation facilities Diversified diet Dental care Wellness awareness, counselling and screening services Mineral supplements (Calcium) Access to health care facilities	**Extent:** Appropriate indicators will be included in the next rounds of relevant national surveys to establish extent of needs.
		Problems Post menopause effects Affordability of supplements NCDs HIV/ AIDS, STIs Dental and optical problems Limited livelihood options	**Causes:** - No direct nutrition interventions targeting elderly women - Unresolved malnutrition during child bearing age - Poor diet diversity - Nutrition transition from traditional to western diets - Lack of empowerment over own reproductive health
9	Elderly (men above 65 and women above 49 years)	***Needs:*** Safe water and improved hygiene and sanitation facilities Diversified diet Dental care Wellness awareness, counselling and screening services	**Extent:** Appropriate indicators will be included in the next rounds of relevant national surveys to establish extent of needs.
		Problems NCDs HIV/ AIDS, STIs Dental and optical problems Limited livelihood options Access to health care facilities Exclusion from mainstream health programmes	**Causes:** - No direct nutrition interventions targeting elderly men - Unresolved malnutrition during child bearing age - Poor diet diversity - Nutrition transition from traditional to western diets
	Household indicators	***Needs:*** Safe water and improved hygiene and sanitation facilities Access to health care facilities Adequate shelter Diversified diet Management of common illnesses Sources of livelihoods ***Problems:*** **Limited livelihoods options** Unavailability of diversified diets at household level Common illnesses Non- availability of medical supplies at health facilities to treat common illnesses Climate change adverse impacts	**Characteristics/Extent and Priorities** – 79% of Zimbabwean households are using an improved source of drinking water – Five in ten children under age five have a birth certificate – Approximately one fifth of children under the age of 18 are orphaned (one or both parents deceased) – 35.5% (44.9% urban, 30.8% rural) of households have access to an improved, not shared toilet facility

10 STAKEHOLDER ANALYSIS

This section provides an overview of the stakeholders that will be involved in the implementation of the NNS as well as their expectations from the implementation of this strategy. They include oversight bodies set up by the Government as part of the Food and Nutrition Security Policy: the Food and Nutrition Council for policy coordination, monitoring, and advisory support, the 17 sector ministries that will implement specific aspects of the NNS through the multi-sectoral collaboration and coordination approach, United Nations agencies, civil society organisations, the private sector and bilateral and multi-lateral funding partners (Table 5). Communities and individuals that will benefit from the NNS are also important stakeholders in the implementation of the strategy.

Table 5: Stakeholder demands, expectations and characteristics

External	Demands/expectations	Characteristics/ Extent
1. Policy oversight OPC Working party of Permanent Secretaries	• Clear information on the situation on the ground • Clear strategies on how best to solve problems • Fulfilment of basic human rights	• 40% • 40% • 20%
2. Food and Nutrition Council	• Strong institutional capacity • Collaboration from implementing partners and relevant sector ministries	• 50% • 50%
3. The 17 sector ministries (Health and Child Care, Agriculture, Social Welfare, Education, e.t.c.)	• Strong institutional capacity • Supporting Policy in relevant sector ministries • Adequate human resources • Clear, up-to-date and widely disseminated National Nutrition Guidelines	• 40% • 20% • 20% • 20%
4. UN, Civil Society	• Supporting policy environment • Motivated and skilled government employees • Less red tape	• 60% • 40% • 20%
5. Donors, Private sector	• Clear accountability mechanisms • Adequate and accurate baseline data • Tangible and sustainable impact/results	• 50% • 20% • 30%
INTERNAL	**Demands/expectations**	**Characteristics/ Extent**
1. Staff from the 17 sector ministries	• Mentoring/supportive supervision • Capacity development • Opportunities for cross fertilisation from other sectors and internationally • Appreciation of importance of role played/recognition	• 25% • 25% • 25% • 25%
2. Communities	• Recognition of their own priorities and needs • Respect for their own background knowledge and experience • Fulfilment of rights (access to health, food, e.t.c.) • Full involvement in own development (planning, implementation, monitoring, evaluation)	• 25% • 25% • 25% • 25%

11 POLICY REQUIREMENTS

Whilst the NNS will serve as the main driver of nutrition interventions, it has not been designed, and will not be implemented, in a vacuum. Zimbabwe's FNSP provides the overarching framework from which the NNS is drawn. The targets set in the NNS are drawn from and harmonized with those already set in national and global policies, strategies and agreements. These targets are consistent with the MDGs, the post-MDG Agenda and the World Health Assembly targets. The NNS recognizes the existence and importance of development partners, Paris Declaration Principles on Aid Effectiveness and the post-Busan Global Partnership as a guiding policy framework for the relationship between Zimbabwe and her DPs, let alone with non-state actors (private sector and civil society).

Recognition is also made of the fact that many other relevant national policies and strategies exist and are being implemented over the same period of the NNPSP, some that operationalize specific aspects of the NNS whilst others complement it by addressing other critical factors that determine the health and nutrition of the population but some of which have not been included in the NNS since they are best addressed by other sectors (see Box 2 for the typology of policies, strategies and other national documents linked to the NNS).

Box 2: National Policies, Strategies and Guiding Documents relevant for the NNS
External
ZimAsset, 2013
Zimbabwe National Strategic Plan (ZNASP) 2006
National Food and Nutrition Security Policy 2012
Mid-Term Plan 2011
Comprehensive African Agriculture Development Programme (CAADP)
Strategic Grain Reserve (AGR) Policy
Comprehensive Agriculture Policy Draft
Comprehensive African Agriculture Development Programme (CAADP)
ZNASP for education of girls, orphans and vulnerable children
Internal
Infant and Young Child Feeding Policy 2013
National Health Strategy for Zimbabwe (2009-2013)
PMTCT & Paediatric HIV Prevention, Treatment & Care National Plan 2011
Reproductive Health Policy and Maternal and Neonatal Health Road Map 2007

12 GOALS

The NNS seeks to achieve 19 goals which have been drawn up using the life-cycle approach (Table 6). At each stage of the life cycle, at least one goal is set corresponding to the needs at that level. Each goal is given a weighting relative to the other goals. The weight is based on the importance of the goal in the achievement of the overall vision of the NNS and to some extent the resource allocation.

Table 6: Goals of the National Nutrition Strategy, relative Weighting and Responsible Departments

No.	Goals	Weight-age[30]	Responsible Department/s	KRA Ref.
G1	Coverage of health and community nutrition services for adolescents increased to 50% by 2018	10%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/T B, Epidemiology & Disease surveillance) MoWAGCD Min Primary & Secondary Education UN Agencies MCHIP USAID NGOs Local authorities	KRA 1
G2	Standard maternal health and nutrition package scaled up to 90% coverage	10%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology & Disease surveillance)	KRA1
G3	50% of women of reproductive age have positive support from spouses and communities for decisions on maternal health, nutrition, healthy lifestyles and safe living environment by 2018	5%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology & Disease surveillance) MAMID Min Women Affairs, Gender & community development	KRA 1
G4	All health institutions provide the standard IYCF package (BMFHI, BF, CF, multiple micronu trient supplementation and fortification, dietary diversification, disease prevention and management, nutrition interventions in emergencies, feeding behaviours and stimulation, PMTCT, WASH, IMAM) by 2018	10%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology & Disease surveillance)	KRA2
G5	Community IYCF counseling package increased from 44% to 100%of districts and in at least 90% of the wards by 2018	10%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB, Epidemiology & Disease surveillance, Environmental Health, Health Promotion)	KRA2
G6	Coverage of growth monitoring and promotion for under-fives increased from 2 districts to 20 districts by 2016 and to 40 districts by 2018 and covering 5 wards per district[31]	5%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environ mental Health, Health Promotion)	KRA2
G7	To increase the proportion of adult population practicing at least one or a combination of the top 5 healthy lifestyles (in relation to consumption of alcohol, fats, and salts; tobacco use, and physical activity) to 40% by 2018	5%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion) Private Sector	KRA3
G8	Proportion of health facilities (central, provincial, mission and district hospitals) providing quality nutrition services for communicable (schistosomiasis, HIV, malaria, soil transmitted helminthes) and non-communicable diseases increased to 75% by 2018	5%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environm ental Health, Health Promotion)	KRA3
G9	30% of institutions adopt national food service and nutrition guidelines by 2018	5%	MOHCC(Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion) Education Social Welfare Prisons	KRA3
G10	Timely availability of relevant nutrition information that incorporates disaster risk reduction at all levels adequate for disaster preparedness planning and nutrition programming	10%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion) FNC Local Government	KRA4
G11	80% of women of reproductive age have the capacity to safely provide for their food, health and nutrition security using appropriate technologies by 2018	2%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/ TB Epidemiology &Disease surveillance)MoAMID MoWAGCD MoPSLSW NGOs	KRA1
G12	Coverage of health and community nutrition services for school children increased to 50% by 2018	3%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion) Ministry of Primary & Secondary Education Ministry of Higher and Tertiary Education	KRA5
G13	All provinces and districts have food and nutrition security committees that are fully discharging their terms of reference by 2014, 50% of ward level committees functioning by 2018	2%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion) FNC	KRA5

[30]Impact weighting refers to the contribution of the Goal to the desired impact of the Strategy. It may guide res ource allocation but does not strictly refer to resource allocation as allocation of resources is dependent upon the nature of actual activities envisaged and their coverage.

[31] Although growth monitoring promotion is not an evidenced intervention of infant and young child nutrition it is considered necessary for informing programming such as nutrition counselling of mothers and caregivers.

No.	Goals	Weight-age	Responsible Department/s	KRA Ref.
G14	To increase the proportion of households consuming safe and acceptable diets all year round to at least 80% by 2018	2%	MoAMID MOHCC (Nutrition, Health Promotion, Environmental Health)	KRA5
G15	Scale up evidence-based nutrition sensitive interventions in social protection services to 80% coverage by 2018	2%	MoPSLSW MOHCC (Nutrition) FNC	KRA5
G16	At least 50% of community based health workers promote WASH related behaviour change whilst integrating nutrition messaging by 2018	2%	MOHCC(Reproductive health, EPI, Nutrition, Quality, AIDS/TB,Epidemiology & Disease surveillance, Environmental Health, Health Promotion)	KRA5
G17	By 2018 ensure that at least 50% of imported and locally produced foods are evaluated for safety	2%	MOHCC(Nutrition, Environmental Health, Health Promotion) MoAMID	KRA5
G18	By 2018 the national nutrition department has a critical mass of staff with the ability, tools, supportive supervision and resources to integrate nutrition into other sectors	5%	MOHCC(Nutrition, Environmental Health, Health Promotion)	KRA6
G19	To increase resource allocation to nutrition to 1% of GDP per year by 2018.	5%	MOHCC(Nutrition, Environmental Health, Health Promotion) FNC Ministry of Finance	KRA6

13 STRATEGIES, ASSUMPTIONS AND RISKS

In this section the NNS describes what needs to be done to achieve the above stated goals, and the justification for such strategies. How it will be done will be elaborated in a separate document on the implementation plan. The implementation plan will articulate concrete activities and outputs to be achieved each year over the 5-year period for the Strategy together with "how much it will cost". Responsibility for implementation is provided in the section on institutional arrangements. Detailed activities, their timing, annual output targets and annual cost estimates are contained in an Excel spreadsheet for ease of tracking the milestones and budget. An extract of the information in presented in Annex 1. A strong emphasis of the NNS strategies is on prevention which is allocated 89% of the resource envelope.

13.1 KRA 1: Improved Quality of Adolescent and Maternal Nutrition Services

Adolescent and Maternal nutrition services Bearing in mind that there are no specific adolescent nutrition programmes in Zimbabwe, the NNS seeks to improve their nutritional status, nutrition and preventive health knowledge and access to education. The growth rate of adolescents is second only to that of the first year of life. Their nutrient requirements are higher than any other time during the lifecycle. Nutrition needs of adolescents tend to double during growth spurts and when reaching puberty. Nutrition is also important during this time to help prevent adult diet-related chronic diseases, such as cardiovascular disease, cancer, and osteoporosis. Adolescents are also sensitive about their body structure at this stage.In addition, adolescents are involved in a lot of physical activity during sports at school, increasing their nutrition requirements.

The NNS identifies the maternal nutrition period as nutrition for a woman, from conception, during pregnancy and through lactation. Maternal malnutrition particularly maternal short stature and iron deficiency anemia are associated with increased risk for stillbirths, miscarriages, low birth weight, maternal and infant mortality. Nutritional status of a mother at conception clearly determines size of and growth of the fetus(Kramer and Kakuma, 2003). Maternal overweight and obesity are associated with maternal morbidity, pre-term birth and increased risk for infant death (Sheiner E, Levy A, Katz M, *et. al.*, 2005). Maternal micronutrient deficiencies are also associated with low birth weight in infants and increased risk for maternal morbidity and mortality. The Lancet series 2013 clearly identifies the need to address nutritional needs of a woman from conception through the second birthday of her child in order to promote good nutrition outcomes for both mother and infant. The World Health Organization has identified essential nutrition actions for improving maternal, newborn, infant and young child nutrition and health at health facility and community levels. This set of high impact nutrition interventions includes maternal iron, folate, Vitamin A, iodine and calcium supplementation, use of ITNs, family planning and adequate birth spacing, and nutritional care and support for pregnant and lactating women in emergencies (ENA2013). When implemented at scale at health facility and community levels, this standard maternal nutrition package has been proven to decrease under-nutrition during pregnancy and lactation as well as have positive nutrition outcomes for the infant. The NNS, therefore, adopts this standard maternal nutrition package for implementation through health

facility and community platforms. Primary focus is on preventive strategies, including among others capacitating community and health facility workers to deliver the standard adolescent and maternal nutrition package, promoting nutrition education through the school curriculum, using community platforms to promote behaviour change on reproductive and sexual health and nutrition, and strengthening planning and management of adolescent and maternal nutrition programmes. The specific strategies under KRA 1 are summarized in Table 7

Table 7: Main Strategies, Assumptions and Risks for Key Result Area 1

No.		Strategy	Assumptions	Risks
Key Result Area 1: Improved quality of adolescent and maternal nutrition services				
G1	Coverage of health and community nutrition services for adolescents increased to 50% by 2018	Equip community health workers with skills and knowledge on maternal and adolescent nutrition service delivery	Ability to integrate nutrition skills building into Reproductive health services, EPI & Antenatal care Adequate staffing at health facilities at all levels Health workers are willing to become role models within their communities	Integration occurs in documents, and guidelines, but is not implemented
		Review and update school curriculum to incorporate adolescent and maternal nutrition	Ministry of Primary and Secondary Education is inclusive of Ministry of Health and Child Care in Curriculum Review process Teachers willing to adapt weekly teaching plans to align with new curriculum Teaching aids are adequate to support teaching of nutrition in the new curriculum New nutrition and health updates are disseminated timely to teachers	Teachers may not have adequate knowledge and skills on nutrition to effectively teach what is in the curriculum
		Promote behaviour change communication on maternal and adolescent health, SRH, hygiene and nutrition targeting adolescents using community platforms (such as the youth friendly corners approach)	Community based platforms exist in every community Adolescent girls are fully participating in available community based platforms (e.g., youth friendly corners)	SRH platform may not be an accepted platform for health and nutrition education
G2	Standard maternal health and nutrition package scaled up to 90% coverage	Equip health facility and community-based health workers with skills and knowledge to deliver the standard package of maternal health and nutrition services (including family planning and adequate birth spacing)	Ability to integrate nutrition skills building into reproductive health services Adequate staffing at health facilities at all levels	Lack of documentation on nutrition services delivered Staff rotation at referral hospitals moves trained personnel to non-nutrition related services
		Promotion of family-focused and evidence-based behaviour change communication on appropriate adolescent, maternal and child care practices	Population targeted with BCC has an environment conducive to changing behaviour and are willing to change	Lack of funding
		Ensure availability of standardised anthropometric equipment and supplies for delivery of adolescent, maternal and child nutrition care services through health facilities	Adequate skilled staffing to take care of other competing tasks and to release time for nutrition services	Non-availability of funds to procure equipment
		Promotion of healthy eating for optimal weight management before and during pregnancy (to prevent obesity and under-weight)	Staff available for counselling at health facility and community levels	Marketing for profit at the expense of the population's health
		Promoting the distribution and consumption of micronutrient supplements and fortified foods through community-based channels (pharmacies, schools and community health workers) targeting women and infants	Mechanisms will be put in place to ensure adequate and appropriate monitoring and documentation of coverage and quality of services	Low community acceptance
		Build capacity of national and district programme managers in effective planning, implementation, monitoring and management focusing on increasing quality and coverage of effective interventions for adolescent and maternal health and nutrition	Information, resources and motivation are adequate for effective interventions	High attrition

G3	50% of pregnant and lactating women receive positive support from spouses and communities for decisions on maternal health, nutrition, healthy lifestyles and safe living environment by 2018	Promote behaviour change communication on decisions on maternal health, nutrition, healthy lifestyles and safe living environment targeting men, community and religious leaders and all other influential structures	Positive behaviour change communication support from the spouses and community for decisions on maternal health, nutrition, health lifestyles and safe living environment	Inadequate resources to support the behaviour change

13.2 Key Result Area 2: Infant and Young Child Nutrition

Inappropriate infant and young child feeding practices contribute to under-nutrition. Improving feeding of children below 2 years of age can lead to significant reductions in malnutrition rates. Improvements in early childhood nutrition also contribute to improved health outcomes in later life (The Lancet Series, 2008).

A review of child survival interventions in 42 countries revealed that promotion, support and protection of exclusive breastfeeding for the first six months of a child's life prevents 19% of all deaths under 5 years in countries with a high child mortality rate (WHO, 2001). The review also showed that continued breastfeeding up to two years with appropriate introduction of solid/semi-solid foods at six months (complementary feeding) contributes to a 6% reduction in child mortality (Jones G et.al. 2004, How many child deaths can we prevent this year? Lancet, 2004, 362:65–71).According to the ZDHS of 2010/11, only 11% of Zimbabwean children in the age group 6-23 months meet the minimum standards with respect to three recommended IYCF feeding practices (that is, children fed with breast milk or milk products; 4+ food groups, and the minimum meal frequency). This evidence supports the strong focus on infant and young child nutrition in the NNS. Table 8 shows the proposed strategies under Key Result Area 2 which covers IYCF which also emphasizes preventive measures.

Table 8: Main Strategies, Assumptions and Risks for Key Result Area 2

No.		Strategy	Assumptions	Risks
Key Result Area 2: Infant and Young Child Nutrition				
G4	All health institutions provide the standard IYCF package (BMFHI, BF, CF, multiple micronutrient supplementation and fortification, dietary diversification, disease prevention and management, nutrition interventions in emergencies, feeding behaviours and stimulation, PMTCT, WASH), IMAM by 2018	Integrate nutrition into pre-service curricula for health professionals	Time, tools and guidelines are available for the trained cadres to discharge their duties related to proven high impact IYCF interventions Presence of community demand for the standard IYCF package	High attrition rate of trained cadres in IYCF standard packages Changes in priority arising from outbreak of diseases/ epidemic situations
		Develop capacity of institutions and communities to provide comprehensive IYCF services	Strategies for demand stimulation are effective in encouraging positive health seeking behaviour and uptake of improved/ recommended IYCF services	Presence of barriers like transport, religious beliefs from accessing the services
		Strengthen the provision of supportive supervision to ensure quality service delivery on IYCF	The existence of a legal framework for enforcement of supervisor observations and recommended follow-up actions	Low staff motivation for quality service delivery
		Promote, protect and support optimal feeding practices at health facility level (including review of labour regulations)	The community see benefits in changing feeding practices and are willing to take-up the services	Cultural and religious barriers Access to the health facility (transport etc)
G5	Community IYCF counselling package increased from 44% to 75% of districts with coverage of at least 90% of the wards by 2018	Empower community development structures to provide quality IYCF services	Communities actively take-up IYCF services and community structures prioritise these as their needs for child survival	Competing needs in the community could 'crowd out' IYCF package delivery
		Enforcement of the Code on marketing of breast-milk substitutes and the statutory instrument to protect and to promote breastfeeding	All retail shops are aware and comply with the Code of Marketing of Breast milk Substitutes Police force is supportive of EH practitioners in enforcement and are capacitated to complement their actions	Profit prioritised ahead of compliance with the code Corruption hinders enforcement
G6	Coverage of growth monitoring and promotion for under-fives increased from 2 districts to 20 districts by 2016 and to 40 districts by 2018 and covering 5 wards per district	Build capacity of community cadres (CHWs, EHTs, extension workers, community development workers) and development structures to improve early detection of malnutrition cases and provide appropriate counselling & referral services (skills and equipment)	Communities are willing and able to bring their children for growth monitoring Availability of treatment after screening	Community volunteer fatigue High attrition rate of community volunteers Breakdown and non-replacement of GMP equipment

13.3 Key Result Area 3: Strengthening Clinical Nutrition Services

Currently, there is no information available regarding nutrition services for hospitals, schools, institutional feeding including prisons, orphanages, military and police camps and other institutions. Improved nutrition in schools and other institutions is expected to contribute to the overall national efforts of promoting optimal nutrition. Clinical nutrition services have a role to play in prevention and management of non-communicable diseases, HIV/AIDS and related opportunistic infections. The NNS incorporates strengthening of clinical nutrition services to address promotion of healthy lifestyles as a preventive measure as well as management of nutrition related diseases and specific strategies are presented in Table 9.

Table 9: Main Strategies, Assumptions and Risks for Key Result Area 3

No.		Strategy	Assumptions	Risks
Key Result Area 3: Strengthening clinical nutrition services				
G7	To increase the proportion of adult population practicing at least one or a combination of the top 5 healthy lifestyles (in relation to consumption of alcohol, fats, and salts; tobacco use, and physical activity) to 40% by 2018	Promote social and behaviour change communication on healthy lifestyles (diversified diets -including consumption of at least 5 servings of fruits and vegetables - decreased consumption of sugary beverages, intake of<400mg of sodium per day,physical exercise of recommended duration) using multi-media channels	Willingness of target audience to adopt healthy lifestyles Proposed alternative foods are available, affordable and accessible	The social and economic costs of adopting a healthy lifestyle may not be affordable
		Promote health screening and wellness days through various community based platforms such as pharmacies, workplaces and faith based organizations	All platforms willing and able to take-up the health screening and wellness days initiative	Prioritisation of curative over preventive services
		Generate information on food consumption patterns, obesity, overweight and key drivers of adult lifestyles (physical activity, alcohol and other substance abuse, diets, eating habits) to inform behaviour change communication strategies	There is demand and appreciation for evidence	The socio-economic cost of behaviour change will be prohibitive
G8	Proportion of health facilities (central, provincial, mission and district hospitals) providing quality nutrition services for communicable (schistosomiasis, HIV, malaria, soil transmitted helminthes) and non-communicable diseases increased to 75% by 2018	Promote the establishment of wellness clinics with adequate equipment for screening and treatment of NCDs	Communities attend well-ness clinics once they are established	Low motivation of the health workers
		Strengthen the knowledge and skills of health workers for the prevention and management of NCDs	Complementary supplies for service delivery are available	High staff attrition rate
		Effective monitoring of prevalence of nutrition related NCD risk factors (overweight, obesity, abnormal lipids, raised blood sugar)and supportive supervision of services delivered by wellness clinics	The existence of a legal framework for enforcement of supervisor observations and recommended follow-up actions	Low staff motivation for quality service delivery
		Management of moderate and severe acute malnutrition in PLWHA	Capacity and commitment for national response exist	Shortage of health workers
		Raise awareness of Under 2 malnutrition as risk factor for NCDs in health facility departments and communities	Health workers are able to prioritise and set aside sufficient time to actively screen and counsel clients and their work in this regard is recognised and appreciated	Low motivation
G9	30% of institutions adopt national food service and nutrition guidelines by 2018	Ensure nutrition services and education are implemented through institutions of special care(such as hospitals, prisons, orphanages) to promote the reinforcement of nutrition practices	Institutions of special care have the requisite capacity to implement the national food services and nutrition guidelines	Lack of resources

13.4 KRA 4: Quality nutrition information systems and advocacy

Ensuring that nutrition surveillance systems provide timely, complete and accurate information on the nutritional status of all people (especially the vulnerable ones) is a priority for the NND. Research (including operational research) on nutrition interventions that informs the high impact strategies needed for the reduction of prominent nutrition problems in the country is much needed, as well as monitoring and evaluation of nutrition programmes. There is also a need to strengthen advocacy to ensure that the evidence obtained from research and evaluation of nutrition programmes is used to sensitize decision makers in government, stakeholders and funders. Specific strategies to strengthen the quality of information systems, key assumptions and the likely risks are presented in Table 10.

Table 10: Main Strategies, Assumptions and Risks for Key Result Area 4

No.		Strategy	Assumptions	Risks
KRA 4: Quality nutrition information systems and advocacy				
G10	Timely availability of relevant nutrition information that incorporates disaster risk reduction at all levels adequate for disaster preparedness planning and nutrition programming	Ensure nutrition indicators are integrated into the national Health Information System	Utilisation of nutrition information generated	Low capacity for response
		Strengthening coordination of nutrition surveillance activities andtimely information sharing (subcommittee, indicators, integrated operational plan, nutrition surveillance guidelines)	Extra resources will be mobilised for an effective response	Competing priorities
		Strengthen monitoring and evaluation of nutrition programmes	The existence of a legal framework for enforcement monitoring and evaluation recommendations	Low staff motivation
		Ensure availability of functional equipment for monitoring nutrition trends in Zimbabwe	Skills and knowledge for use of the equipment is adequate at all levels Equipment is safely stored and maintained	High attrition rate
		Build capacity of FNSCs in early warning and disaster risk management	100% resuscitation of FNSCs	Competing tasks from sector responsibilities
		Operational research to identify context specific drivers of stunting and possible interventions that address the causal factors of malnutrition	Capacity and commitment for national response exist Buy-in from relevant institutions to conduct operational research	Shortage of resources

13.5 Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

The causes of malnutrition in a population are many and often interlinked. The immediate causes are related to nutrient intake and to health. The underlying causes are embedded in the household and community level context in which under-nutrition occurs, including poor access to food at household level, poor care for women and children and poor health environment. The basic causes of malnutrition are rooted in institutional, political and economic issues such as poverty, economic growth, governance and use and control of natural resources and the environment. Addressing nutrition challenges therefore calls for collaboration across sectors. Acceleration of progress in nutrition will require effective, large-scale nutrition-sensitive programmes that address key underlying determinants of nutrition and enhance the coverage and effectiveness of nutrition-specific interventions (Lancet, 2013). According to the World Bank, 2013, multi-sectoral actions can strengthen nutritional outcomes in three main ways; (a) by accelerating action on determinants of under-nutrition, (b) by integrating nutrition considerations into programmes in other sectors which may be substantially larger in scale; and (c) by increasing policy coherence through government-wide attention to policies or strategies and trade-offs, which may have positive or unintended negative consequences on nutrition. The key sectors for maximizing nutrition impacts are health, agriculture and food security, social protection (especially social safety nets), education (especially girl's education), water and sanitation and the private sector(Ruel, 2008). While strong evidence exists for inter-sectoral collaboration across sectors for improved nutrition, little evidence exists demonstrating the success of multi-sectoral projects improving nutrition outcomes. Experience and evidence exists that points to thinking and planning multi-sectorally, with sector specific actions tailored to specific contexts, objectives and sectoral operating environments (World Bank, 2013). In this Key result area the NNS strategy will strengthen the capacity of Food and Nutrition Security Committees to enable them to coordinate and monitor nutrition activities at all levels. Through the agriculture sector, food based approaches to ensuring dietary diversity for good nutrition will be promoted, coupled with post-harvest management for year round availability of safe nutritious food. Through the social assistance programmes, nutrition will be well integrated into the design and implementation of social protection programmes informed by evidence based vulnerability and food and nutrition assessment results. The NNS will also promote continued education of the girl child and women empowerment for improved nutrition outcomes.

Improving Nutrition in Water and Sanitation

Water and sanitation services are an essential part of the National Nutrition Strategy. According to the 2010/11 ZDHS, "Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children. Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta." Clean water is essential to the preparation of food that is safe to eat. Hand washing at critical times, e.g. before eating and after using the toilet is an essential part of decreasing diarrhoea and improving nutritional status. The ZDHS 2010/11 found that diarrhoea is more prevalent among children living in households without improved sources of drinking water. Similarly, the prevalence of diarrhoea is higher in children living in rural areas and also in households with unimproved, shared sanitation facilities. Care needs to be taken during the period of introduction of complementary foods as incidences of diarrhoea among children aged 6 to 11 months increases drastically after the exclusive breastfeeding period. Continued and sustained education on proper hygiene practices has the potential to both prevent and decrease rates of malnutrition in Zimbabwe.

Improving nutrition of school-age children

Nutrition interventions for school-age children have been prioritized for inclusion in the National

- Nutrition Strategy in recognition of the central role the school curriculum plays in promoting nutrition knowledge and behaviour change, on the one hand, and the contribution of the education sector to sustainable, longer-term and equitable reduction in under-nutrition on the other. The package of nutrition interventions that has been prioritized for implementation as part of the NNS encompasses the following:
- Integrating nutrition into the basic education curriculum, covering essential topics such as nutrition and growth, family planning, pregnancy and infant feeding, and hygiene promotion;
- Teacher training on curriculum enhanced by integrating nutrition;
- Promoting enrolment and improving attendance, especially of girls in schools with curriculum strengthened in relation to nutrition, and supporting their joining of school health and nutrition clubs;
- Strengthening school health and nutrition management, which includes incorporation of health and nutrition services into school calendars; these include immunization, de-worming, family planning, school feeding in locations vulnerable to household food insecurity during emergencies, and increasing access to improved sanitation facilities;
- Promoting social behaviour change in nutrition and WASH through establishment and capacitation of school health and agriculture clubs;
- Promoting healthy lifestyles directly (through dietary diversification as part of practical lessons on agriculture and home economics, and physical activity as part of extra-curricular activities); and
- Strengthening community-based health and nutrition clubs led by children that promote appropriate nutrition practices at the household and local levels targeting out-of-school children.

Global evidence confirms that improvements in women's education are linked to better nutritional outcomes for their children. Under-nutrition is significantly less among children born to mothers with secondary education. For example, the risk of stunting has been found to be about 2.5 times lower in Burundi, half in Lagos and more than 4 times lower in Niger when the mother attended secondary school compared with no schooling. This is achieved in three main ways: a) by improving child care practices through improved access to information (better literacy); b) strengthening economic prospects of educated women (employment opportunities); and c) delaying the first pregnancy (schools protect adolescents from early marriages).

Food Safety

Food safety and standards are critical for protection of the food supply in Zimbabwe. The NNS recognizes the role that food safety and standards have for the prevention of malnutrition in Zimbabwe. It is with this understanding that the NNS incorporates priority actions such as updating laws to control the safe production, processing and distribution of safe foods within the country and from outside, investment in food safety testing equipment to be used at main border posts and within the country in order to avoid sub-standard foods from coming into the country as this compromises the safety of foods distributed and consumed, ensuring that all ports of entry are manned by trained personnel to monitor food imports are a priority.

Social Protection

The deliberate integration of food and nutrition security indicators into social protection programmes needs to be an integral part of the Social Protection agenda in the country. Among many social protection programmes like the harmonized social cash transfer system and treasury supported social welfare grants for instance, there is a general lack of integration of nutrition into social protection services to address nutrition needs for infants, young children, adolescents and women of reproductive age in difficult circumstances; lack of nutrition education and behaviour change communication within all social assistance programmes and lack of integration of nutrition into targeting, monitoring and evaluation systems for social protection programmes. With this background there is need for:

1) accommodation of nutrition indicators for instance in targeting of the vulnerable in the communities using nutrition sensitive programming for social protection;
2) provision of timely food assistance in emergency situations (adequate for the nutrition requirements of the different population groups);
3) assisting vulnerable populations prepare for emergency by re-establishing livelihoods after-shocks; and
4) providing a consistent adequate cash transfer to ultra-poor households for them to meet their needs for a healthy productive life.

11: Main Strategies, Assumptions and Risks for Key Result Area 5

The main strategies for KRA 5 as well as the assumptions and risks are summarised in Table 11.

No.		Strategy	Assumptions	Risks
KRA 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response				
G11	80% of women of reproductive age have the capacity to safely provide for their food, health and nutrition security using appropriate technologies by 2018	Target women for livelihood projects that use labour-saving technologies to improve their decision-making power in relation to access to reproductive health services, nutrition,purchasing, occupational health	Proportion of women willing and able to participate in livelihoods projects is adequate Environment is conducive for viability of projects Participation leads to true empowerment and decision making in the home as opposed to gender conflicts and violence	Participation may compromise time for child care and personal health and nutrition
		Nutrition education on safe use of irrigation to prevent malaria, schistosomiasis and any other water-borne diseases	MOHCC and MAMID work together effectively on prevention and treatment of water borne diseases	Community may not accept messages on treatment and prevention of water borne diseases
G12	Coverage of health and community nutrition services for school children increased to 50% by 2018	Knowledge and skills development for education managers, school health coordinators, teachers (pre-service and in-service)and SDC members on health and nutrition	Skills acquired are successfully aligned with already existing teaching plans	High attrition
		Nutrition integrated into the basic education curriculum, covering essential topics such as nutrition and growth, family planning, pregnancy and infant feeding, and hygiene promotion	Availability of teachers, textbooks and teaching aids in schools to give adequate attention to nutrition in the classroom Attendance and appreciation of nutrition among school children is high	Low motivation amongst teachers
		Promotion of continuing girls education focusing on school retention and completion of education by orphans and other vulnerable children in a bid to break cycles of poverty	Willingness and motivation between parents and girls to complete secondary education	Low accessibility to schools by girls Lack of resources for parents to support completion of secondary education
		Promotion of Peer Education on Health and Nutrition in all schools by Q4, 2015	Willingness of pupils to participate in clubs Retention of peer educators	Inadequate parental and school support for activities of Health and Nutrition clubs
G13	All provinces and districts have Food and Nutrition Security Committees that are fully discharging their terms of reference by 2014, 50% of ward level committees functioning by 2018	Capacity development of FNSCs on their core mandates	Line ministries have filled their positions for effective multi-sectoral collaboration in Food and Nutrition Security Committee activities	Competing priorities among Food and Nutrition Security Committee members
G14	To increase the proportion of households consuming safe and acceptable diets all year round to at least 80% by 2018	Promote crop diversification including adoption of bio-fortified crops rich in iron, zinc and vitamin A	Acceptance of bio-fortified seeds among communities	Unfavourable climate and environmental conditions
		Promote improved post-harvest handling, processing, storage and value-addition to increase shelf-life and food safety of harvested foods	Willingness of target groups to shift to improved technologies	High cost of some of the technologies may hinder adoption
		Promote production and availability of small live-stock, aquaculture and apiculture and consumption of animal source protein foods	Availability of technical expertise to promote the enterprises at household level	Unfavourable climate and agro-ecological conditions
		Promote research and development of improved varieties of bio-fortified seeds	Availability of technical expertise to conduct research in bio-fortification	Failure of bio-fortification trials due to unfavourable weather and pests
		Promote awareness of and demand for nutritious food, with an emphasis on production, processing, preservation, storage and preparation of diverse foods	Availability of appropriate technologies for each stage of the food value chain	Food commodity price fluctuations
		Promote consumer awareness, demand for, and market availability of fortified staple foods	Acceptance of fortified foods by households	Households do not appreciate nutritional value of fortified foods

G15	Scale up evidence-based nutrition sensitive interventions in social protection services to 80% coverage	Provision of conditional cash transfers to non-labour constrained vulnerable households under the food poverty line to increase utilisation of health services by pregnant and lactating women and children under-five Providing a consistent adequate nutritionally sensitive unconditional social cash transfer to ultra-poor labour constrained households for them to meet their needs for a healthy, productive life	Health services can cope with increased demand by pregnant and lactating women and children under-five The case load of the target groups below the food poverty line does not exceed the resource base	Religious and cultural norms are a barrier to conditionality Integration of nutrition into social protection is not perceived as expensive and unnecessarily delaying delivery of social assistance to vulnerable groups
		Ensure that nutrition education and behaviour change communication are integral parts of all social assistance programmes	Implementing partners have the capacity to deliver a comprehensive package which includes BCC on nutrition	Socio-cultural and religious practices may hinder behaviour change among target groups
		Empower communities through productive asset creation and information to build a culture of safety and resilience to disasters	Communities are willing to take ownership of their food and nutrition security and are willing to work to create assets that benefit them	Untimely availability of labour and complementary resources for the work
		Integrate DRM into sector programmes and budgets[33](supportive policy, legal and institutional frameworks for DRM; early warning information, social behaviour change towards a culture of safety and resilience; integrating DRM into sector programmes; and DRM capacity building at all levels)	Institutions for DRM exist, Draft DRM policy and strategy are finalised, resource allocation to early warning information system remains a priority	Resistance by sectors to address DRM issues for lack of technical capacity and funds
		Integrate nutrition indicators into targeting, monitoring and evaluation systems for social protection programmes Provision of timely social safety nets in emergencies and crisis situations that meet universally accepted minimum standards and national food and nutrition standards (where applicable	Social services officers can be capacitated to integrate nutrition into their day to day work The social sector has adequate capacity to implement and coordinate emergency response initiatives	The perceived cost of targeting might discourage the use of nutrition indicators as targeting criteria Nutrition indicators may contradict with community targeting and create conflict Climate change-induced shocks may increase the frequency and severity of emergencies
G16	At least 50% of community based health workers promote WASH related behaviour change whilst integrating nutrition messaging by 2018	Integrate nutrition into PHHE delivered through the community health club approach	Community health clubs are revived and functional	Volunteer fatigue
		Capacitate WASH committees at all levels on nutrition and WASH linkages	Functional, revived and pro-active WASH committees	Lack of resources Lack of commitment by WASH committees Competing priorities
		Integrate nutrition into PHHE delivered through the community health club approach	There are programmes that provide complementary resources for community based workers to deliver WASH promotion	Too many competing priorities dependent on the same cadres
G17	By 2018 ensure that at least 50% of imported and locally produced foods are evaluated for safety	All ports of entry capacitated with port health officers	Availability of skilled people who can be recruited and deployed as port health officers Resources available to provide the officers with relevant, state-of-the art equipment	Low motivation of port health officers Corruption
		Harmonisation of regulations related to importation of foods among ZIMRA, MOHCC, MAMID (veterinarians) and SAZ to meet International Standards	Availability of key people and willingness to collaborate between the various government agencies. The reviewed and updated legislation and regulations are effectively used to monitor and ensure food safety	Turnover of key people may derail process in harmonisation. Legislation review processes might take long.
		Provide low cost food safety rapid test kits used at ports of entry and market places	Political will, commitment and resource mobilisation and allocation towards low cost rapid test kits	Sensitivity and specificity of test-kits maybe compromised
		Capacitate (with skills, equipment and supplies) existing Government Analyst laboratory	Availability of utilities (water and electricity) to support efficient functioning of laboratories	Low motivation of laboratory technicians
		Conduct operational research on pesticide residue and aflatoxins and GMOs in household diets	Availability of expertise to conduct research	Lack of resources to support research activities
		Capacitate the National Environmental Health Department to effectively implement and monitor the above mentioned strategies	Capacity created will be effectively utilised and can be retained	Resources to ensure knowledge and skills and equipment provided are not effectively utilised and maintained

[33]This includes disaster risk prevention, preparedness and response.

13.6 KRA 6: Resource mobilisation and capacity development for nutrition

Current resource allocation to the Ministry of Health is between 6-9% of GDP and does not match the 15% Abuja target. Resource allocation to the National Nutrition Department is below 1% of the Ministry of Health and Child Care budget. Yet investment in nutrition is known to hold the potential to increase GDP by 2-8% per annum and lifetime earnings of children prevented from stunting by 45-54%. Most nutrition interventions (both nutrition specific and nutrition sensitive) in Zimbabwe are not being implemented at the scale of coverage ideal to achieve a significant impact on nutritional incomes. This is due to lack of funding. Resource mobilization therefore remains critical to pursue as part of the NNS. This will be pursued through intensification of advocacy for fiscal space for nutrition and the promotion of public-private partnerships for nutrition building upon the momentum gained through the global Nutrition for Growth Initiative. The target should be to allocate sufficient resources to achieve 90% coverage for all nutrition-specific interventions and 80% coverage for nutrition-specific interventions or not less than 1% of GDP (which-ever is less) given that the benefit-to-cost ratio achievable from such investments would be greater than 2.

For the Ministry of Health and Child Care to be able to effectively execute the strategy, it will require adequate human resources. Currently, the National Nutrition Department is headed by one Deputy Director. Current staffing is 3 Nutrition Managers, 58 District Nutritionists, 8 Provincial Nutritionists, 1 logistics officer, 1 principal tutor, 1 HFSS training officer, 2 Dieticians -one for Parirenyatwa and Harare Central hospitals. United Bulawayo Hospital and other hospitals lack dieticians hence reduced quality of nutrition services in these institutions. The NNS seeks to strengthen capacity for nutrition at national and sub-national levels to support effective execution of the functions of the NND (see Table 12 for specific strategies).

Table 12: Main Strategies, Assumptions and Risks for Key Result Area 6

No.		Strategy	Assumptions	Risks
KRA 6: Resource mobilisation and capacity development for Nutrition				
G18	By 2018 the National Nutrition Department has a critical mass of staff with the ability, tools, supportive supervision and resources to integrate nutrition into other sectors	Organisational capacity assessment and establishment of relevant posts	There is no freezing of posts in government	Lack of budget to support salaries
		Recruitment of staff to fill established posts	Availability of skilled Nutritionists from recognised Universities	Lack of conducive working environment to attract qualified Nutritionists
		On the job capacity development	Availability of institutions that offer recognised required professional qualifications	High staff attrition rate
	To increase resource to 4% of GDP by 2018	Strengthen advocacy with Ministry of Finance on the investment case for nutrition (advocacy paper on cost of hunger in relation to economic growth, human capital development)	Stability of the macro-economic environment	External shocks such as international energy price hikes and global recession
		Promote PPP in support of nutrition through strategic partnerships with relevant organisations (such as GAIN)	Private sector is willing to make nutrition for growth commitments and invest in nutrition	Competing priorities

14 IMPLEMENTATION PLAN

The NNS is only effective when implemented. It is a large programme with many strategies under each goal and several sub-activities under each strategy. The financial resources and capacity of institutions responsible of implementing these activities are not adequate to enable simultaneous implementation of all the identified activities. Therefore, the strategy identifies immediate short term actions and those to be implemented in the medium term (see Annex 1).

14.1 Short term strategic activities (Years 1 to 3)

Nutrition is under-funded at the moment, and no meaningful progress can be achieved in the implementation of the strategy without a significant improvement in resources and capacity. The mobilisation of resources for nutrition together with institutional strengthening of the National Nutrition Department and various state and non-state entities, agencies and structures responsible for implementation of the NNS has been given high priority. This includes recruitment of staff, strengthening of nutrition-related training programmes for health professionals (e.g., nutritionists, dieticians, nurses, doctors, and other relevant health professionals), and procurement and distribution of complementary job aids and working tools (e.g., anthropometric equipment, and NCD screening and treatment equipment).

In addition, the number 1 nutrition challenge for Zimbabwe is reducing stunting in under-fives. Addressing this problem is a top priority of the strategy with Year 1 and 2 activities focusing specifically on addressing stunting in children under the age of two years by strengthening adolescent and maternal nutrition, and community IYCF services, especially capacity for face-to-face nutrition counselling of pregnant and lactating mothers and caregivers of children under the age of two years (but also reaching out to children in the age group 24-59 months), development and dissemination of information, education and communication materials and boosting supplies such as therapeutic foods for effective delivery of IMAM services, micronutrient supplements to 400,000 adolescent girls (as future mothers), supplies for deworming (adolescents, mothers, school children), iron and folate supplements to 420,000 women aged 15 - 49 years, calcium supplements to 300,000 pregnant women and vitamin A supplements for 300,000 women post-partum, supplementary feeding for 60,000 pregnant and lactating women with acute malnutrition, and supplements to 500,000 anaemic women of child-bearing age.

Finalisation and implementation of the national Food Fortification Strategy is given high priority and will be done in the first two years of the strategic plan. This will include specific technical support and leveraging of financial support for the private sector companies that deal with fortification 'vehicles' (i.e. processed food commodities like sugar, oil and wheat flour) prioritised by Zimbabwe for industrial fortification to improve the supply of micronutrients through the value chain. Production of fortified processed foods will continue though throughout the five years of the strategy and the volumes of industrially fortified commodities will grow with time as demand for these grows. Support for these activities will be in the form of resources for start-up costs (including equipment and training of staff) for millers, bakers, oil processing firms and sugar companies and recurrent costs in the form of the supply of micronutrients required.

Promotion of behaviour change communication on maternal and adolescent health, SRH, hygiene and nutrition targeting adolescents using community platforms (such as the youth friendly corners approach) is given priority to start in the first year and will continue throughout the tenure of the NNS. The special focus on adolescents is in recognition of the need to catch future mothers young, as this is important for addressing stunting in the first 1,000 days. It also addresses the gap observed in adolescent nutrition services which are either absent or have very limited coverage.

The development of an enabling environment (governance for nutrition) has also been prioritised for strengthening in the first two years of the NNS with high priority being accorded to generating evidence for strengthening nutrition programming, strengthening coordination of the multi-sectoral collaboration and coordination approach, and development, printing and dissemination of policies, standards and implementation guidelines. The component on evidence generation includes: (a) strengthening of the nutrition surveillance system, the food security and disaster preparedness early warning information system; (b) commissioning of two important surveys (food consumption survey and a KABP survey on adolescents and maternal nutrition); and (c) launching of an operational research on exclusive breastfeeding. In relation to standards and guidelines, the NNS prioritises development of maternal and adolescent nutrition guidelines, the review and updating of community IYCF guidelines and manuals based on new evidence from national, regional and global research, updating of the school health manual, and development of national food service and nutrition guidelines, nutrition surveillance guidelines, and guidelines on peer health and nutrition education clubs. Dissemination of these guidelines and provision of support for their use is also given high priority attention.

Identification and training of community cadres (2,180 in total) in early detection of malnutrition cases, provision of appropriate counselling and referral will be an on-going activity until full coverage is reached, but even beyond this point in order to cater for natural attrition of these community volunteers. All trainings therefore are treated as longer term undertakings but starting in the first year of the plan. They will not be phased out, though scale of training may be reduced with time when critical mass is reached.

Strategic activities to address the growing problem of nutrition-related NCDs are important and have been programmed mainly as medium-to-longer term priorities (3-5 years) but there are routine and on-going activities that are urgent and will be continued from Year 1. What will be begin in the short-term (Years 1 and 2) is the development of a behavioural change communication strategy on healthy lifestyles, reviewing and updating IEC/BCC materials on healthy life styles, promoting social behavioural change on healthy lifestyles using various types of mass media, carrying out social outreach activities such as road shows, awareness campaigns, commemorations, agriculture shows, community theatres, radio listening clubs, community films in 30 districts, development of a protocol on prevention and management of NCDs. BCC will remain an important on-going activity till the final year of the NNS.

14.2 Medium-to-long term strategic activities (Years 4 and 5)

Most of the strategic activities that are started in the first two years and continue to be needed will continue throughout the duration of the NNS. In the medium term, the focus will be on strengthening

the multi-sectoral approach including development of nutrition social marketing tools for the school environment, strengthening the integration of nutrition into education, social protection, agriculture and health. These are longer term undertakings as they require, in the case of basic education and agricultural extension training, a review of the curriculum, the formation of school based peer education groups, finalisation of a BCC strategy, preparation of the BCC tools and materials and training of educators. Incorporating nutrition into the basic education curriculum will also require the promotion of school gardening with cooking demonstrations and nutrition education. These will be done mostly in years 3-5.

Trainings that require a ToT approach, such as the BMFHI, and those that are routine and continuous, such as pre-service and in-service training of health professionals, may start in the first two years but will continue and be expanded in the medium to longer term as more resources become available, and the demand for such human resources grows with increased coverage of nutrition services.

Many of the capacity building activities related to infrastructure and introduction of new national events for addressing the issue of nutrition-related NCDs will come mostly in years 3-5. These include equipping and upgrading of 400 pharmacies, workplaces and faith based organisations, conducting quarterly health screening and wellness days in all 89 districts in the country and bi-annual NCD screening (for controlling diabetes, hypertension, overweight and obesity) at 8,112 schools. Other medium-to-longer term activities include identification and equipping of 400 health facilities and 200 wellness clinics, and capacity building of 600 health workers (training on prevention and management of NCDS).

Building the capacity of FNSCs on early warning and disaster risk management, as part of the broader goal of ensuring timely availability of relevant nutrition information that incorporates disaster risk reduction at all levels, is included in the strategy and its implementation will start at the national level and cascade down to provincial, district and ward level. The trainings at ward level will take place at the earliest possible time after completing that at the district and higher levels.

The NNS supports strengthening of health services, agriculture and social protection programming to address nutrition. Integration of nutrition into water, sanitation and hygiene promotion activities is considered paramount but not a short term undertaking. So is the strengthening of the national system for promoting food safety (regulations and mechanisms for enforcement of these laws) will be on-going into years 3, 4, 5 and beyond this strategy. In relation to food safety, the NNS focuses on strengthening staffing in terms of numbers and skills and their capacity in terms of equipment and supplies to test imported and locally traded foods for compliance with minimum food safety standards. Promotion of improved post-harvest handling (processing, storage and value addition) to increase shelf life and food safety of harvested foods will be on-going throughout the five years of the strategy. The NNS also advocates for increased production of small live-stock, aquaculture and apiculture and consumption of animal source protein foods, research and development of improved varieties of bio-fortified seeds, and awareness promotion and demand creation for nutritious foods, with an emphasis on production, processing, preservation, storage and preparation of a more diverse food basket. These activities together with awareness promotion and demand creation for increased consumption of fortified staple foods are long term in nature.

The NNS also promotes the integration of nutrition into social protection from a longer term perspective. Provision of conditional cash transfers to non-labour constrained vulnerable households under the food poverty line is advocated for to increase utilization of health services by pregnant and lactating women and children under-five. In addition, the provision of a consistent adequate nutritionally sensitive unconditional social cash transfer to ultra-poor labour constrained households is supported in order to help them meet their needs for a healthy productive life. Activities to integrate nutrition education and behaviour change communication into all social assistance programmes are promulgated in the NNS. Focus is also put on promoting the empowerment of communities through productive asset creation and information to build a culture of safety and resilience to disasters. Other long term strategic interventions include integrating nutrition sensitive DRM into sector programmes and budgets, integrating nutrition indicators into targeting, monitoring and evaluation systems for social protection programmes, and provision of timely social safety nets in emergencies and crisis situations that meet universally accepted minimum standards and national food and nutrition standards (where applicable).

15 STRATEGIC RESULTS CHAIN AND MONITORING AND EVALUATION FRAMEWORK

15.1 Strategic Results Chain

The impact plan is presented in Table 13 and focuses on higher level results achievable through the implementation not only of the NNS, but other on-going development initiatives that have the potential to make a positive impact on the identified indicators. The indicators focus on maternal, infant and child mortality and higher level nutrition indicators such as stunting and the proportion of new born babies with low birth weights.

In terms of the outcomes plan, these are more directly linked to the implementation of the NNS itself and these focus on behaviour change related outcomes and indicators of transitory under-nutrition (see Table 14). With the successful implementation of the NNS, the coverage and quality of nutrition services are expected to improve resulting in reduction in prevalence of stunting, nutrition-related NCDs, and mortality (maternal, infant and child). The stated outcomes and impacts will be confirmed through periodic impact assessments in the course of the plan most of which will be informed by data collected through national surveys and a few complementary ones that will also capture baseline information for indicators that are outside the existing national surveys.

15.2 Impact Plan

Table 13: Impact Indicators, Baseline Values, Targets and Allowable Variance

Impact Description	Impact Indicator	Measurement Unit (e.g., %, no., etc.)	Baseline			Target [a/]					Allowable Variance	Goal Ref.	KRA Ref.
			Data Source	Baseline	Baseline Period	2014	2015	2016	2017	2018			
Improved maternal outcomes	Maternal mortality ratio	Number of maternal deaths/ 100,000 live births	ZDHS	960	2010/11	900	840	770	690	600	±10%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
Improved infant survival	Infant mortality rate	Number of infant deaths/ 1000 live births	ZDHS	57	2010/11	52	47	42	37	31	±10%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
Improved child survival	Child mortality rate	Number of under-five child deaths/ 1000 live births	ZDHS	84	2010/11	78	70	62	54	46	±10%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
Reduced stunting levels	Proportion of Under 5s who are stunted by age group	% of children 0-5 months <-2 z score	ZDHS	9.8	2010/11	8.8	7.8	6.8	5.8	4.8	±42%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
		% of children 6-23 months <-2 z score	ZDHS	29	2010/11	28	27	26	25	24	±8%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
		% of children 24-59 months <-2 z score	ZDHS	38	2010/11	37	36	35	34	33	±6%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
		% of children 6-59 months <-2 z score	ZDHS	32	2010/11	31	30	29	28	27	±7%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6
Reduction on nutrition related NCDs (cardiovascular diseases, diabetes, hypertension, cancer) in adults	Prevalence of NCDs (cardiovascular diseases, diabetes, hypertension, cancer in adults)	% of adults with Type 2 Diabetes	NCDs risk factor surveillanc e	10%	2005	9.7	9.5	9	8.5	8%	±1%	7,8,9	3
		% of adults with Hypertension	NCDS risk factor surveillanc e	27%	2005	26%	25%	24%	23%	22%	±5%	7,8,9	3
	Incidence of Type 2 Diabetes among adults	Number of new Type 2 Diabetes among adults	NHMIS	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	7,8,9	3,6
	Incidence of Hypertension among adults	Number of new Hypertension cases among adults per year	NHMIS	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	7,8,9	3,6
Improve maternal nutrition	Proportion of low birth weight babies	Percentage of babies born with weight less than 2.5kg	ZDHS	9.5%	2010/11	9.25%	9.00%	8.75%	8.50%	8.30%	±1%	1,2,3,4,5,6,7,9,11, 12,13,14,15,16,17, 18,19	1,2,3,4, 5,6

15.3 Outcome Plan

Table 14: Outcome Indicators, Baseline Values, Targets and Allowable Variance

Impact Ref.	Outcome Indicator	Measurement Unit (e.g., %, no., etc	Baseline			Target					Allowable Variance	Goal Ref.	KRA Ref.
			Data Source	Baseline	Baseline Period	**2014**	2015	2016	2017	2018			
Outcome Description 1: Improved nutritional status													
	Proportion of Under 5s with underweight	% of Under 5s weight for age <-2 z score	ZDHS	9.70%	2010/11	9.00%	8.00%	7.00%	6.00%	5%	±30%	2,3,4,5,6,13, 14,15, 16,18,19	1,2,5,6
	Proportion of Under 5s with wasting	% of Under 5s weight for height < -2 z score	ZDHS	3%	2010/11	3%	2.70%	2.50%	2.20%	2%	±25%	2,3,4,5,6,13, 14,15, 16,18,19	1,2,5,6
	Proportion of Under 5s with obesity	% of Under 5s > weight for length +2 z-scores	ZDHS	5.50%	2010/11	5%	4.50%	4%	3.50%	3%	±33%	2,3,4,5,6,13, 14,15, 16,18,19	1,2,5,6
	Proportion of school age children (5-12yrs) with obesity	% of children weight for length (5-12yrs) >2 z score	TBC	No data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	1,12,13, 14,15, 16,18,19	1,5,6
	Proportion of adolescents with obesity (female 15-19 years)	% of adolescents BMI >29.9	ZDHS	1.70%	2010/11	1.60%	1.40%	1.20%	1%	0.80%	±25%	1,12,13, 14,15, 16,18,19	1,5,6
	Proportion of adolescents with obesity (male 15-19 years)	% of adolescents BMI >29.9	ZDHS	0.20%	2010/11	0.20%	0.15%	0.10%	0.07%	0.05%	±30%	1,12,13, 14,15, 16,18,19	1,5,6
	Proportion of female adolescents underweight (15-19 years)	% of adolescents BMI < 18.5	ZDHS	13.50%	2010/11	13%	12%	11%	10%	9%	±11%	1,12,13, 14,15, 16,18,19	1,5,6
	Proportion of male adolescents underweight (15-19 years)	% of adolescents BMI < 18.5	ZDHS	34.70%	2010/11	34%	32%	30%	28%	25%	±12%	1,12,13, 14,15, 16,17,18,19	1,5,6
	Proportion of women of child bearing age (15-49 years) underweight	% of women of child bearing age BMI < 18.5	ZDHS	7.1	2010/11	7%	6.80%	6.50%	6%	5%	±30%	1,12,13,14, 15, 16, 17 18,19	1,5,6
	Proportion of women of child bearing age (15-49 years) with obesity	% of women of child bearing age BMI >29.9	ZDHS	10.60%	2010/11	10%	9%	8%	7%	5%	±20%	1,12,13,14, 15, 16, 17 18,19	1,5,6
	Proportion of adult men (15-49) with obesity	% of men with BMI >29.9	ZDHS	1.80%	2010/11	1.80%	1.70%	1.70%	1.60%	1.50%	±7%	1,12,13,14, 15, 16, 17 18,19	1,5,6
	Proportion of males 6-14 years of age that are overweight and obese	% of women with BMI >=25.0	ZDHS	No data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	1,12	1,5
	Proportion of females 6-14 years of age that are overweight and obese	% of women with BMI >=25.0	ZDHS	12.60%	2010/11	12%	11%	10%	9%	7%	±29%	1,12	1,5
	Proportion of females 20-29 years of age that are overweight and obese	% of women with BMI >=25.0	ZDHS	26.80%	2010/11	26%	25%	23%	22%	20%	±10%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of females 30-39 years of age that are overweight and obese	% of women with BMI >=25.0	ZDHS	41.50%	2010/11	40%	38%	35%	32%	30%	±13%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of females 40-49 years of age that are overweight and obese	% of women with BMI >=25.0	ZDHS	50.50%	2010/11	49%	47%	45%	43%	40%	±7.5%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of females 50-54 years of age that are overweight and obese	% of women with BMI >=25.5	TBC	no data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of males 6-14 years of age that are overweight and obese	% of men with BMI >=25.5	TBC	no data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	1,12	1,5
	Proportion of males 15-19 years of age that are overweight	% of men with BMI >=25.5	ZDHS	1%	2010/11	1%	1%	1%	1%	1%	±0%	1,12	1,5
	Proportion of males 20-29 years of age that are overweight and obese	% of men with BMI >=25.5	ZDHS	6%	2010/11	6%	5.50%	5.00%	4.00%	3.00%	±33%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of males 30-39 years of age that are overweight and obese	% of men with BMI >=25.5	ZDHS	15.10%	2010/11	15%	14%	13%	12%	10%	±20%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Proportion of males 40-49 years of age that are overweight and obese	% of men with BMI >=25.5	ZDHS	19%	2010/11	19%	18%	17%	16%	15%	±6%	2,7,8,11,14 ,15,18,19	1,3,5,6
	Males 50-54 years overweight and obese	% of men with BMI >=25.5	ZDHS	19.70%	2010/11	19%	18%	17%	16%	15%	±6%	2,7,8,11,14 ,15,18,19	1,3,5,6
Outcome Description 2: Improved micronutrient status in adolescents and women of child bearing age													
	Proportion of Under 5s with Vitamin A deficiency	% of Under 5s with Vitamin A deficiency (retinol binding protein)	NMNS	19%	2012	19%	18%	17%	15%	13%	±11%	2,3,4,5,6,13, 14,15, 16,18,19	1,2,5,6
	Proportion of Under 5s with Anemia	% of Under 5s with Hgb< 110g/L	ZDHS, 2010/11	56.00%	ZDHS, 2010/11	50%	48%	45%	40%	30%	±33%	2,3,4,5,6,13, 14,15, 16,18,19	1,2,5,6
	Proportion of school going age children (6-14 years) with iodine deficiency	% of school going age children (6-14 years) with Iodine deficiency (<100µg/l)	IDD Sentinel Surveillance	15.5% (6-14years, <100µg/L)	2009	10%	8%	7%	6%	5%	±60%	1,12	1,5

Table 14: Outcome Indicators, Baseline Values, Targets and Allowable Variance

Impact Ref.	Outcome Indicator	Measurement Unit (e.g., %, no., etc	Baseline			Target					Allowable Variance	Goal Ref.	KRA Ref.
			Data Source	Baseline	Baseline Period	**2014**	2015	2016	2017	2018			
Outcome Description 1: Improved nutritional status													
	Proportion of school going age children (6-14 years) with anemia	% of school going age (6-14 years) with Hgb< 115g/L	NMS, 1999	18.1% (6-11years) and 27.4% (12 -14 years)	NMS 1999	18%	17%	17%	16%	15%	±11%	1,12	1,5
	Proportion of women of children bearing age with vitamin A deficiency	% of women of children bearing with vitamin A deficiency	NMNS	23%	2012	23%	22%	20%	17%	14%	±13%	1,2,3,9,11, 13,14,15,1 8,19	1,2,3,5 ,6
	Proportion of women of child bearing with anemia	% of women of child bearing with Hgb<120g/L (non-pregnant) and <110g/L (pregnant)	ZDHS, 2010/11	28.00%	ZDHS 2010/11	27%	25%	23%	21%	20%	±10%	1,2,3,9,11, 13,14,15,1 8,19	1,2,3,5 ,6
	Proportion of men 15-54 years with anemia	% of adult men with Hgb<130g/L	ZDHS, 2010/11	14.00%	ZDHS 2010/11	12%	11%	10%	9%	8%	±25%	1,2,3,9,11, 12,13,14,1 5,18,19	1,2,3,5 ,6
	Proportion of pregnant and non-pregnant women of age 15-49 years with urinary iodine <50µg/l	% of women of child bearing with urinary iodine <50µg/l	NMNS	To be confirmed (results available Q1, 2014)	2012	TBC	TBC	TBC	TBC	TBC	TBC	1,2,3,9,11, 12,13,14,1 5,18,19	1,2,3,5 ,6
	Proportion of pregnant and non-pregnant women of age 15-49 years with urinary iodine <100µg/l	% of women of child bearing with urinary iodine <100µg/l	NMNS	To be confirmed (results available Q1, 2014)	2012	NMS, 2012	NMS, 2012	NMS, 2012	NMS, 2012	NMS, 2012	TBC	1,2,3,9,11, 12,13,14,1 5,18,19	1,2,3,5 ,6
	Proportion of school going age children (6-14 years) with urinary iodine <50µg/l	% of school going age children with urinary iodine <50µg/l	IDD Sentinel Surveillance	3.00%	2009	3%	3%	3%	3%	3%	±0%	1,12	1,5
	Median urinary iodine levels in school going age children (6-14 years)	urinary iodine level measured in µg/l	IDD Sentinel Surveillance	185µg/L	2009	185	185	185	185	185	+7.5% or -46%	1,12	1,5
	Median urinary iodine levels in non-pregnant women 15-49 years	urinary iodine level measured in µg/l	NMNS	116 µg/L	2012	mainta in	mainta in	mainta in	mainta in	mainta in	maintain	1,2,3,9,11, 12,13,14,1 5,18,19	1,2,3,5 ,6
	Proportion of households consuming salt with iodine above 15 ppm	% of households consuming salt with iodine content above 15 ppm	ZDHS	94.00%	2010/11	75%	80%	85%	88%	90%	±10%	1,2,3,7,11, 15	1,3,5
	Proportion of households consuming adequately iodized salt	% of households consuming salt with iodine content (between 15 ppm and 55 ppm)	IDD Sentinel Surveillance	61.70%	2009	71%	77%	83%	89%	95%	±5%	1,2,3,7,11, 15	1,3,5
Outcome Description 3: Improved infant & young child feeding practices													
	Proportion of infants 0-5 months exclusively breastfed	% of infants 0-5 months exclusively breastfed	ZDHS	31%	10/11	33%	35%	39%	44%	50%	±10%	2,3,4,5,6	1,2
	Proportion of children born in the past 24 hours who were put to the breast within 1 hour of birth	%of children born in the past 24 months who were put to the breast within 1 hour of birth	ZDHS	65%	182 8/11	66	70	75	81	90	±11%	2,3,4,5,6	1,2
	Proportion of infants & children 6-23 months meeting minimum acceptable diet	% of infants & children 6-23 months meeting minimum acceptable diet	ZDHS	11%	2010/11	11	12	13	14	15	±3.33%	2,3,4,5,6,1 4,15,18,19	1,2,5,6
	Proportion of children 6-23 months who received at least 4 food groups in the last 24 months	%of children 6-23 months who received >/=4 food groups in the last 24 months	ZDHS	24%	11-Oct	26	29	32	35	40	±12.5%	2,3,4,5,6,1 4,15,18,19	1,2,5,6
	Proportion of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid or soft foods	%of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid or soft foods	ZDHS	45%	2010/11	47	50	53	55	60	±8.3%	2,3,4,5,6,1 4,15,18,19	1,2,5,6
	Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk)	%of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk)	ZDHS	11%	2010/11	15	19	23	27	30	±3.33%	2,3,4,5,6,1 4,15,18,19	1,2,5,6
	Proportion of children who consume iron rich or iron fortified foods	%of children who consume iron rich or iron fortified foods	ZDHS	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	2,3,4,5,6,1 4,15,18,19	1,2,5,6
	Proportion of children 12-15 months who were fed breast milk in the past 24 hours	%of children 12-15 months who were fed breast milk in the past 24 hours	ZDHS	87%	2010/11	88	89	90	92	95%	±3%	2,3,4,5,6,1 4,15,18,19	1,2,5,6

Table 14: Outcome Indicators, Baseline Values, Targets and Allowable Variance

Impact Ref.	Outcome Indicator	Measurement Unit (e.g., %, no., etc	Baseline			Target					Allowable Variance	Goal Ref.	KRA Ref.
			Data Source	Baseline	Baseline Period	2014	2015	2016	2017	2018			
Outcome Description 1: Improved nutritional status													
	Duration of breastfeeding	Median duration of months breastfed	ZDHS	17.8 months	2010/11	18	19	20	22	24	±8%	2,3,4,5,6,14,15,18,19	1,2,5,6
	Proportion of children 24 months of age who are fed breast milk	% of children breastfed for 24 months	ZDHS	20%	2010/11	21	22	23	24	25	±4%	2,3,4,5,6,14,15,18,19	1,2,5,6
	Proportion of infants 6-8 months of age who received solids/ semi-solids or soft foods in the past 24 hours	%of infants 6-8 months of age who received solids/ semi-solids or soft foods in the past 24 hours	ZDHS	86%	2010/11	87	89	91	93	95	±5.5%	2,3,4,5,6,14,15,18,19	1,2,5,6
Outcome Description 4: Improved Quality of Diets & lifestyles													
	Proportion of children & adults consuming at least 5 servings of fruits & vegetables per day	% of population consuming at least 5 servings of fruits & vegetables	survey (food consumption survey)	No data	TBC	0	5%	20%	30%	60%	±8%	2,3,4,5,6,14,15,18,19	1,2,5,6
	Proportion of adults consuming < 2400mg of Sodium per day	% of adults consuming < 2400mg of Sodium per day	survey (food consumption survey)	No data	TBC	0	5	15	30	50	±20%	2,7,11,13,15,18,19	1,3,5,6
	Proportion of children & adults consuming < 30% of total calories from fat	% of children & adults consuming < 30% of total calories from fat	survey (food consumption survey)	No data	TBC	0	5	15	30	50	±10%	2,3,4,5,6,14,15,18,19	1,2,5,6
	Proportion of households with acceptable HDDS	% of households with acceptable HDDS	RLA 2013	57%	Apr 2013	65	78	85	92	95	±5%	3,8,9,12,13,14,15,16,17,18	1,3,5
	Proportion of households with acceptable food consumption score	% of households with acceptable Food Consumption score	RLA 2012	60.3	May 2012	70	75	85	90	97	±2%	3,8,9,16,17,18,19	1,3,5
	Proportion of adults 18 years or older achieving 150 minutes of moderate to vigorous intensity physical activity weekly	% of adults 18 years or older achieving 150 minutes of moderate to vigorous intensity physical activity weekly	survey (food consumption survey)	No data	TBC	10	30	45	55	65	±23%	1,2,3,7,8	1,3
	Proportion of 5-17 years achieving 7 hours of moderate to vigorous intensity physical activity weekly	% of 5-17 years achieving 7 hours of moderate to vigorous intensity physical activity weekly	survey (food consumption survey)	No data	TBC	20	40	60	80	100	±10%	1,2,3,7,8,12	1,3,5
	Proportion of women beneficiaries targeted for nutrition sensitive agriculture programmes	% of women beneficiaries targeted for nutrition sensitive agriculture programmes	TBC	No data	TBC	10	15	20	27	33	±21%	2,11,14	1,5
	Proportion of health facilities screening for NCDs	% of health facilities screening for NCDs	TBC	No data	TBC	15	30	45	60	75	±7%	7,8,9	3
Outcome Description 5: Improvement of the quality of diets in institutions of special care													
	Proportion of institutions that are implementing national dietary guidelines (schools, orphanages and rehabilitation centers, prisons and hospitals)	%of institutions by category (schools, orphanages, rehabilitation centers, prisons and hospitals) complying with national dietary guidelines	Institutional Survey	No data	TBC	10%	30%	60%	80%	100%	±10%	9	3
Outcome Description 6: Improvement of hygiene practices at household level													
	Prevalence of diarrhoea among children 0-59 months	%of children who experienced diarrhea in the 2 week period preceding the survey	ZDHS	No data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	1,2,3,4,5, 11, 16, 17	1, 2, 5
	Proportion of households with hand-washing places where water and soap or other washing agents are present	% of households with hand-washing places where water and soap or other washing agents are present	MICS	No data	TBC	TBC	TBC	TBC	TBC	TBC	TBC	1,2,3,4,5, 11, 16, 17	1, 2, 5
Outcome Description 7: Improved nutrition information systems													
	Proportion of health facilities submitting the core nutrition indicators	% of routine data reports submitted on time	HMIS	TBC	Oct 2013	70	80	90	95	100	±10%	7,11	1,2,4
	Proportion of routine data submitted with completeness	% of routine data submitted with completeness	HMIS	93	Dec 2013	100	100	100	100	100	±10%	7,11,	1,2,4
	Proportion of districts with growth monitoring	% of under-fives attending growth monitoring	HMIS	50	Dec 2013	60	70	80	80	80	±10%	6	2
Outcome Description 8: Adequate resource allocation for nutrition services													
	Proportion of national budget allocated for nutrition	% of health budget allocated for nutrition	National Budget Statement	<0.02	Dec 2013	0.1%	0.5%	1%	1.50%	2%	±20%	19	6
	Budget allocation for nutrition expressed as share of GDP	Nutrition budget expressed as percentage of GDP	National Budget Statement	<0.1	2013	0.1%	0.20%	0.40%	0.60%	0.80%	±20%	19	6

15.4 Output Plan

The output plan is compiled in a separate Ms Excel document on the costing of the strategy.

15.5 Monitoring and Evaluation

As part of a Government-wide initiative, the Ministry of Health and Child Care has introduced the Results Based Management System, which has guided the development of this Strategic Plan. The RBM system requires that key result areas, goals, strategies, and strategic activities be formulated being linked to the vision and mission of the Strategic Plan, which in turn should be linked to the overall national policy or strategy driving development for the five year period. In addition, the results framework of the Strategic Plan should be specified including specific indicators for tracking progress at impact, outcome and output level, and the annual milestones for each of the above results. These are presented in this Chapter as impact plan, outcome plan and output plan. The output plan is linked to the strategic activities for each strategy and they are detailed in a costing template used for costing the strategy (Annex 1).

From the several indicators stated in the impact and outcome plans, a smaller set of **core indicators** for the monitoring of the Strategy will be identified and will be included in the staff performance management system and corporate governance structures of the Ministry of Health and Child Care to support the implementation process. Some of the indicators will be included in the performance contract for the Permanent Secretary and cascaded to the responsible senior staff (relevant directors and deputy directors) in the various directorates in the Ministry. Senior staff in the NND will also have relevant core indicators included in their performance contracts.

The Ministry of Health and Child Care has a planning and M&E department responsible for monitoring the ministry's operations. The NND M&E system which will specifically track the NNS will be harmonised with, and form a sub-set of the ministry-wide M&E system.

Tracking of specific results (based on the specific impact and outcome indicators presented above) will be through specific focal points assigned to report on the indicators. Each indicator will have a focal point for data collection, analysis and reporting. The expanded **M&E matrix** is provided in a separate Ms Excel spreadsheet, and it shows for each indicator, the frequency of reporting on the indicator, the unit of analysis (either national, provincial, district) and other forms of disaggregation (sex, age, etc) necessary when reporting on the indicator.

Many of the impact and outcome indicators are tracked as part of monitoring the overall 5 year national development blueprint, the ZimAsset, and the health strategic plan. They are included in national surveys conducted by ZIMSTAT, the National Statistical Agency, or are reported through the Health Management Information System (HMIS), or the nutrition surveillance system, or the ZimVAC process. They are therefore reported quarterly (if part of HMIS), biannually and annually (e.g., if part of nutrition surveillance or ZimVAC process), biennially (e.g., if part of other special annual surveys like the NMNS, and the IDD Sentinel Surveillance), five-yearly (e.g., if reported through the ZDHS), or once every ten years in the event of them being only tracked through the more expensive national nutrition surveys or micronutrient surveys. Indicators that are new and have not been part of any

existing M&E system will be tracked through new surveys as outlined in section 14.1 on issues relating to strengthening nutrition governance. The new surveys include the food consumption survey, the operational research on exclusive breastfeeding, the KABP on maternal and adolescent nutrition, among others.

The National Working Group on Nutrition will play a critical role in objective assessment of progress achieved in the implementation of the NNS and its results. Joint annual reviews of the strategy will be conducted involving the Ministry of Health and Child Care, FNC, the Ministry of Finance, other key sector ministries, development partners, NGOs, the academia and the private sector. Periodically, the National Nutrition Working Group will meet to discuss lessons learned and emerging best practices being informed by results of nutrition surveillance, routine collection of administrative data via the HMIS, national surveys, location specific research conducted by members of the Working Group, Evaluations of Nutrition Programmes, and the operational research which will be commissioned as an integral part of the NNS M&E framework.

The Ministry of Health will appoint a specific interdepartmental committee to spearhead its efforts to monitor the National Nutrition Strategy. It will draw from the departments within the Ministry and from the other six key sector ministries (these are agriculture, social protection, water, basic education, higher education, and women and gender).

Furthermore, the implementation of the National Nutrition Strategy will be done through the institutional structures created for monitoring the National Food and Nutrition Security Policy. In this regard, the Food and Nutrition Security Committees, the parliamentary bodies, the inter-ministerial working party of officials and Cabinet will periodically review the progress of implementation of the NNS. They will monitor results achieved and identify solutions for challenges that may require attention.

16 RESOURCE REQUIREMENTS

16.1 Plan Cost

The estimated total cost of the strategic plan is US$599.6 million spread over a five year period (see budget breakdown by goal in Table 15). The cost is based on marginal costing which means the amount is over and above the current allocations for salaries and other programme management costs provided to the sectors involved in the implementation of the nutrition interventions. Adolescent and maternal nutrition key result area will absorb 10% of the budget. Infant and young child nutrition interventions will cost 16% of the budget. Promotion of healthy lifestyle will require 5% of the resources. A further 1% will go to quality information systems and advocacy. Sixty-seven percent of the budget is required for strengthening multi-sectoral nutrition interventions, including strengthening the coordination of the multi-sector approach. Out of this, US$30.7 million (5% of total NNS budget) will be required to support implementation of the industrial food fortification strategies. Resource mobilization and institutional strengthening, especially of the National Nutrition Department, will require the balance of 1%.

Of the total NNS resource requirements, the first and second year will each absorb US$96 million (i.e., 16% of total budget per year). Twenty-two percent of the resources are required in the 3rd year, 24% in the 4th year and 23% in the final year.

16.2 Operational Cost

All the resources except the 1% required for resource mobilization and institutional strengthening will be for operational costs.

16.3 Human Resources

The additional human resources costs are estimated at US$1,072,000 (0.2%) and this amount will be spent on:

- Recruitment of 1 national nutrition manager per year starting in 2015;
- Recruitment of 4 focal nutritionists, one each for Agriculture, Social Protection, Education and Women and Gender in 2016;
- Mobilisation of 1 community based nutrition volunteer per village for 70% of wards by 2015;
- Recruitment of 10 district nutritionists to fill vacant posts by 2015;
- Recruitment of 10 provincial hospital dieticians by 2017; and
- On the job training of staff on RBM, nutrition financial tracking tool, and research and data management.

16.4 Materials and equipment

The procurement of anthropometric equipment, and food safety testing equipment will require a budget of US$1.067 million (0.2% of total budget), and US$14 million (2.3%), respectively. Start-up

equipment for the industrial fortification of staple food commodities is estimated to cost US$1.838 million (0.3% of total budget).

Nutrition supplies will cost a total of US$81 million (14% of the budget).

Social protection assistance is estimated to cost a total of US$280 million (47% of the budget). This is consistent with the special attention that the Food and Nutrition Security Policy gives assisting vulnerable groups as part of measures to prevent hunger and malnutrition.

16.5 Space Requirements

The budget does not include any construction of offices or new buildings but establishment of demonstration sites for bio-fortification.

16.6 Financing Strategy

The Government of Zimbabwe shall assume primary responsibility for resource mobilisation, funding the strategy and delivering the targets set and development partners will complement government efforts. The responsibility for budgeting for fiscal resource allocation will lie with the respective line ministries tasked with the mandate to lead planning and implementation of strategies under each goal. The resource planning, mobilisation and allocation will be done in close collaboration with international cooperating partners, the UN agencies, NGOs, other non-government entities and the private sector. Each goal has a sector ministry that will lead on resource mobilisation and tracking. Each line ministry will also coordinate implementation and review of the specific strategies foreseen under its mandate. Implementation of the strategy will be done collaboratively and with the active engagement of all relevant stakeholders who will also be invited to support the efforts with resources and will participate in joint planning and review of progress. Overall direction and support in resource mobilisation and tracking, and strategy implementation will be provided by the Ministry of Health and Child Care, through the National Nutrition Department.

Table 15: Estimated Plan Cost and Breakdown by Cost, Component and Year

Key Result Areas and Goals	Estimated Cost per Year, USD					Total Cost, USD	Percent	
	2014	2015	2016	2017	2018		Goal	KRA
Key Result Area 1: Improved quality of adolescent and maternal nutrition services	13,456,815	12,287,263	11,931,979	12,155,979	12,349,979	62,182,015		10%
Goal 1: Coverage of health and community nutrition services for adolescents increased from X% to 50% by 2018	2,567,443	1,887,600	1,708,000	1,932,000	2,156,000	10,251,043	1.7%	
Goal 2: Standard maternal health and nutrition package scaled up from X% to 90% coverage	10,268,986	9,310,477	9,263,979	9,263,979	9,233,979	47,341,400	7.9%	
Goal 3: 50% of pregnant and lactating women receive positive support from spouses and communities for decisions on maternal health, nutrition, healthy lifestyles and safe living environment by 2018	620,386	1,089,186	960,000	960,000	960,000	4,589,572	0.8%	
Key Result Area 2: Infant and Young Child Nutrition	22,958,748	14,500,093	21,026,939	18,224,239	18,274,747	94,984,765		16%
Goal 4: All health institutions provide the standard IYCF package (BMFHI, BF, CF, multiple micronutrient supplementation and fortification, dietary diversification, disease prevention and management, nutrition interventions in emergencies, feeding behaviours and stimulation, PMTCT, WASH) and IMAM by 2018	16,893,193	7,875,588	7,771,828	7,771,728	7,771,728	48,084,066	8.0%	
Goal 5: Community IYCF counselling package increased from 44% to 100% of districts with coverage of at least 90% of the wards by 2018	5,588,480	6,609,280	13,239,886	10,437,286	10,487,794	46,362,724	7.7%	
Goal 6: Coverage of growth monitoring and promotion for under-fives increased from 2 districts to 20 districts by 2016 and to 40 districts by 2018 and covering 5 wards per district	477,075	15,225	15,225	15,225	15,225	537,975	0.1%	
Key Result Area 3: Promoting Healthy Lifestyles	826,086	2,387,827	7,760,552	9,077,548	9,058,309	29,110,323		5%
Goal 7: To increase the proportion of adult population practicing at least one or a combination of the top 5 healthy lifestyles to 40% by 2018	105,200	280,041	4,938,579	5,593,316	5,565,946	16,483,082	2.7%	
Goal 8: Proportion of health facilities (central, provincial, mission and district hospitals) providing quality nutrition services for communicable (schistosomiasis, HIV, malaria, soil transmitted helminthes) and non-communicable diseases increased to 75% by 2018	7,254	81,654	909,441	1,383,759	1,391,772	3,773,881	0.6%	
Goal 9: 30% of institutions adopt national food service and nutrition guidelines by 2018	713,632	2,026,132	1,912,532	2,100,473	2,100,591	8,853,360	1.5%	
Key Result Area 4: Quality nutrition information systems and advocacy	4,240,630	2,311,935	998,783	998,783	998,783	6,868,815		1%
G10: Timely availability of relevant nutrition information that incorporates disaster risk reduction at all levels adequate for disaster preparedness planning and nutrition programming	4,240,630	2,311,935	998,783	998,783	998,783	6,868,815	1.1%	
Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response	53,373,117	62,545,271	88,442,241	103,995,271	94,314,991	402,722,829		67%
Goal 11: 80% of women of reproductive age have the capacity to safely provide for their food, health and nutrition security using appropriate technologies by 2018	579,400	542,800	542,800	542,800	542,800	2,750,600	0.5%	
Goal 12: Coverage of health and community nutrition services for school children increased to 50% by 2018	9,156,640	9,626,640	15,633,270	17,581,880	7,881,600	59,751,930	10.0%	
Goal 13: All provinces and districts have Food and Nutrition Security Committees that are fully discharging their terms of reference by 2014, 50% of ward level committees functioning by 2018	333,375	479,030	358,840	358,840	358,840	1,888,925	0.3%	
Goal 14: To increase the proportion of households consuming safe and acceptable diets all year round to at least 80% by 2018	8,871,227	6,294,937	6,210,487	6,181,787	6,181,787	33,691,024	5.6%	
Goal 15: Scale up evidence-based nutrition sensitive interventions in social protection services to 80% coverage by 2018	23,413,350	43,352,464	63,396,864	77,346,864	77,366,864	285,105,645	47.6%	
Goal 16: At least 50% of community based health workers promote WASH related behaviour change whilst integrating nutrition messaging by 2018	59,875	163,450	-	-	-	223,325	0.0%	
Goal 17: By 2018 ensure that at least 50% of imported and locally produced foods are evaluated for safety	10,959,250	2,085,950	2,299,980	1,983,100	1,983,100	19,311,380	3.2%	
Key Result Area 6: Resource Mobilisation and capacity development for Nutrition	763,730	1,577,071	907,940	215,020	226,940	3,690,701		1%
Goal 18: By 2018 the National Nutrition Department has a critical mass of staff with the ability, tools, supportive supervision and resources to integrate nutrition into other sectors	130,080	322,817	158,760	132,120	144,040	887,817	0.1%	
Goal 19: To increase resource allocation to nutrition to 1% of GDP by 2018. (To be discussed further after costing)	633,650	1,254,254	749,180	82,900	82,900	2,802,884	0.5%	
Grand Total by Year	95,619,127	95,609,459	131,068,433	144,666,840	135,223,749	599,559,449	100%	

ANNEX 1: GLOSSARY OF TERMS

Acute malnutrition (wasting): Low weight-for-height defined as more than 2 standard deviations(SD) below the mean of the sex-specific reference data. Wasting is usually the result of a recent shock such as lack of calories and nutrients and/or illness, and is strongly linked to mortality.

Adequate Intake (AI): Recommendations for nutrient intake when insufficient information is available to establish a recommended dietary allowance (RDA). Also are based on observed or experimentally determined estimates of the average nutrient intake that appears to maintain a defined nutritional state in a specific population.

Adequately iodized salt: Salt containing l5-40 parts per million of iodine. At the population level, household access to iodized salt should be greater than 90 percent, constituting universal salt iodization

Anaemia: The condition of having a haemoglobin concentration below a specified cut-off point, which can change according to age, gender, physiological status, smoking habits, and altitude at which the population being assessed lives. The World Health Organization (WHO) defines anaemia in children under five years of age and pregnant women as a haemoglobin concentration <110g/1 at sea level. Although the primary cause of anaemia worldwide is iron deficiency, it often coexists with a number of other anaemia causes, including malaria and other parasitic infections; acute and chronic infections that result in inflammation and haemorrhages; deficiencies in other vitamins and minerals, especially folate, vitamin B and vitamin A; and genetically inherited traits, such as thalassemia

Bio-fortification: The development of micronutrient-dense staple crop varieties using traditional breeding practices or biotechnology.

Body Mass Index (BMI): A measure of body fatness, calculated as weight (kg) divided by the square of height (m2). A BMI of <18.5 is considered underweight, >25 signifies overweight, and >30 signifies obesity. Although BMI is a good measure for determining a range of acceptable weights, it does not take into consideration some important factors, such as body build, i.e., relative contributions of fat, muscle, and bone to weight.

Breast-milk substitute: Any food marketed or otherwise represented as a partial or total replacement for breast-milk, whether or not suitable for that purpose.

Childhood obesity: Weight-for-height that is >2 SD (see Over-nutrition). Childhood obesity is associated with a higher probability of obesity in adulthood, which can lead to a variety of disabilities and diseases, such as diabetes and cardiovascular diseases.

Chronic malnutrition (stunting): Low height-for-age, defined as more than 2 SD below the mean of the sex-specific reference data. Stunting is the cumulative effect of long-term deficits in food intake, poor caring practices, and illness.

Colostrum: The first fluid secreted by the breast during late pregnancy and the first few days after birth. This thick fluid is rich in immune factors and protein.

Community-Based Management of Acute Malnutrition (CMAM): The management of acute malnutrition through (a) in-patient care for children with severe acute malnutrition with medical complications and infants under six-months of age with visible signs of severe acute malnutrition; (b) outpatient care for children with severe acute malnutrition; and (c) community outreach.

Community nutrition programme: A community-based programme intended to prevent growth faltering, control morbidity, and improve survival of children by promoting breastfeeding, providing education and counselling on optimal feeding practices, preventing diarrheal disease, and monitoring and promoting growth.

Complementary feeding practices: A set of 10 practices recommended for caregivers to implement from 6 to 24 months, at which point breast milk and/or breast milk substitutes alone are no longer sufficient to meet the nutritional needs of growing infants. Poor breastfeeding and complementary feeding practices, coupled with high rates of infectious disease, are the principal proximate causes of malnutrition during the first two years of life.

Complementary food: Any food, whether manufactured or locally prepared, suitable as a complement to breast-milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant (at about 6 months of age).

Conditional Cash Transfer (CCT): A social safety net programme aimed at reducing both present and future poverty by linking a targeted transfer of cash to compliance with a pre-specified investment, usually in child education or health.

Cretinism: The stunting of body growth and poor mental development in the offspring that result from inadequate maternal intake of iodine during pregnancy.

Demographic targeting: A targeting method in which eligibility is based on age.

Diarrhoea: The passage of three or more loose or liquid stools per day or more frequently than is normal for the individual. Diarrhoea is usually a symptom of gastrointestinal infection, which can be caused by a variety of viral and parasitic organisms. Severe diarrhoea leads to fluid loss and plays a particularly important role in nutrition and growth faltering, perhaps because of its association with mal-absorption of nutrients and appetite suppression. The adjusted odds of stunting at 24 months of age increase by 5 percent with each episode of diarrhoea in the first 24 months of life.

Dietary Diversity: The number of food groups consumed over a given period of time. Household-level dietary diversity can be used as an indicator of household food security, and individual-level dietary diversity is an indicator of diet quality for an individual (typically measured for women or young children)

Early initiation of breastfeeding: Initiation of breastfeeding within one hour of birth. As a public health statistic, it is measured as the proportion of children born in the past 24 months who were put to the breast within one hour of birth.

Exclusive Breastfeeding (EBF): The feeding of an infant only with breastmilk from his/her mother or a wet nurse, or expressed breastmilk, and no other liquids or solids except vitamins, mineral supplements, or medicines in drop or syrup form.

Food-based transfer/food-based safety net programme: A food-based safety net programme intended to support food consumption. It differs from other safety net programmes in that it is tied to food either directly or through cash-like instruments (food stamps, coupons) that may be used to purchase food.

Food fortification: The addition of one or more micronutrients (vitamins and minerals) to a food during processing. Ideally, food fortification provides a public health benefit with minimal risks to health in the population.

Food-For-Work Programmes (FFW): This type of programme provides food rations in exchange for a given amount of work done or a stipulated wage rate. FFW programmes have long been used to protect households against the decline in purchasing power that often accompanies seasonal unemployment, climate-induced famine, or other periodic disruptions by providing them with employment.

Food security: According to the UN, food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritional food to meet their dietary needs and food preferences for an active and healthy life. The concept of food security includes the pillars of food availability, access, utilization, and stability/vulnerability

Fortified Blended Foods (FBF): Blends of partially precooked and milled cereals, soya, beans, or pulses, fortified with micronutrients. Special formulations may contain vegetable oil or milk powder. Corn Soya Blend (CSB) and Wheat Soya Blend (WSB) are often used in emergency food distributions.

Global acute malnutrition is weight-for-height of -2 z-scores or more below the median, according to the WHO's child growth standards (moderate and severe wasting)

Hidden hunger: Micronutrient malnutrition or vitamin and mineral deficiencies, which can compromise growth, immune function, cognitive development, and reproductive and work capacity.

HIV/AIDS: Human immunodeficiency virus (HIV) is a retrovirus that affects cells of the immune system, destroying or impairing their function. As the disease progresses, the immune system becomes weaker, and the person becomes more susceptible to infection. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS)

Home garden / homestead food production: A small plot or plots around the home, managed by household members, where a variety of crops including vegetables, fruits, legumes, tubers, non-food plants, e.g., medicinal herbs, spices, fuel material are grown throughout the year and often livestock and fish are raised, primarily for household consumption. They typically use low-cost inputs and indigenous varieties, as well as local knowledge and practices and community participation. Home gardens have multiple uses, including improving diets within the household, provide inputs for other farm activities, e.g., fodder for animals, provide shade or natural fencing, raise income from the sale of garden produce, and empower women, who most typically manage home gardens. Nutritional impact of home gardening "is increased when combined with nutrition education and linked with other health and development activities in the community

Hunger: A feeling of discomfort, illness, weakness, or pain due to prolonged involuntary lack of food that goes beyond the usual uneasy sensation of temporary absence of food in the stomach (Panel to Review the USDA's Measurement of Food Insecurity and Hunger, 2006). The sensation of hunger that results from a lack of food in the stomach is universal, but there are different manifestations and consequences of hunger, including undernourishment, malnutrition, and wasting.

Infant and Young Child Feeding (IYCF): Refers to specific recommendations and guiding principles for optimal nutrition, health, and development of children. A set of eight population-level IYCF indicators have been developed to: (i) assess IYCF trends over time; (ii) improve targeting of interventions; and (iii) monitor progress in achieving goals and evaluate the impact of interventions (WHO, 2008).

Infant and Young Child Nutrition (IYCN): A term that encompasses all aspects that relate to the nutrition of infants and young children (0 to 24 months).

In-kind transfers: The transfer of ownership of a good or asset other than cash, or the provision of a service without any counterpart.

International Code on Marketing of Breastmilk Substitutes: A set of recommendations to regulate the marketing of breastmilk substitutes, feeding bottles, and teats. This code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (Article 1).

Intrauterine Growth Retardation (IUGR): The poor growth of a baby while in the womb, which results in birth weight below a given percentile cut-off (typically the 10th percentile) for gestational age.

Iodine: An essential component of at least two thyroid hormones that are necessary for skeletal growth and neurological development.

Iodine deficiency: The condition resulting when iodine intake falls below recommended levels, tested through median urinary iodine concentration (normal range 100-199 µ?/l).

Iodine Deficiency Disorders (IDD): All of the consequences of iodine deficiency in a population that can be prevented by ensuring that the population has an adequate intake of iodine. IDD can affect children at any stage of rapid growth, with the greatest negative impacts on cognitive development occurring during pregnancy. Symptoms range from mild impairment of brain development and subtle degrees of brain damage, goitre, hypothyroidism, reproductive disorders (spontaneous abortion, stillbirth, congenital abnormalities, perinatal mortality) to its most severe form, cretinism. Iodine deficiency is the primary cause of preventable mental retardation and brain damage in the world

Iron: A key building block of haemoglobin, which plays a central role in oxygen transport throughout the body.

Iron deficiency: The most common nutritional deficiency in the world, resulting from insufficient iron in the body due to inadequate consumption of bioavailable iron, blood loss, or unmet increased iron requirements due to infection, pregnancy, rapid growth, dietary habits, or any combination of these.

Iron Deficiency Anemia (IDA): The condition in which the body does not have enough healthy red blood cells due to a deficiency in iron. Iron deficiency (above) and iron deficiency anaemia are associated with foetal and child growth failure, compromised cognitive development in young children, lowered physical activity and labour productivity in adults, and increased maternal morbidity and mortality. Women and young children are the most vulnerable to IDA, which increases the risk of haemorrhage and sepsis during childbirth, and is implicated in 20 percent of maternal deaths. Furthermore, children with IDA suffer from infections, weakened immunity, learning disabilities, impaired physical development, and in severe cases, death

Lipid-Based Nutrient Supplements (LNS): Refers generically to a range of fortified, lipid-based products (including RUTF, and other highly concentrated supplements used for "point-of-use" fortification) used for the prevention and treatment of acute malnutrition. LNS typically contain milk powder, high-quality vegetable oil, peanut paste, sugar, and micronutrients, and provide 120 to 250 kcal/day.

Low Birth Weight (LBW): A birth weight of less than 2,500g. At the population level, the proportion of infants with a low birth weight often serves as an indicator of a multifaceted public health problem that includes long-term maternal malnutrition, ill health, hard work, and poor health care in pregnancy

Malnutrition: an abnormal physiological condition caused by deficiencies, excesses or imbalances in energy, protein and/or other nutrients.

Mid-Upper Arm Circumference (MUAC): The circumference of the upper arm measured at the mid-point between the tip of the acromial process (shoulder) and the tip of the olecranon process (elbow).

Micronutrient(s): Vitamins and minerals that are needed in small amounts by the body to produce enzymes, hormones, and other substances essential for proper growth and development. Iodine, vitamin A, iron, and zinc are the most important in terms of prevalence and severity; deficiencies are a major threat to the health and development of populations worldwide, particularly children and pregnant women in low-income countries.

Micronutrient deficiency(ies): Deficiencies in one or more essential vitamin or mineral, often caused by disease and/or lack of access and/or consumption of micronutrient-rich foods such as fruit, vegetables, animal products, and fortified foods. Micronutrient deficiencies increase the severity and risk of dying from infectious disease such as diarrhoea, measles, malaria, and pneumonia. More than two billion people in the world are estimated to be deficient in iodine, vitamin A, iron, or zinc.

Multiple micronutrient powder: A tasteless powder that comes in the form of individual sachets, containing the recommended daily intake of 16 vitamins and minerals for one person. They can be sprinkled into home-prepared food after cooking or just before eating.

Moderate malnutrition: Weight-for-age between -2 and -3 z-scores below the mean of sex-specific reference data (moderate underweight).

Moderate Acute Malnutrition (MAM): Weight-for-height between -2 and -3 standard deviations below the mean of sex-specific reference data (moderate wasting).

Non-Agricultural GDP/worker: The difference between the total national and agricultural GDP divided by the difference between total national and agricultural employment.

Nutrition security: The ongoing access to the basic elements of good nutrition, i.e., a balanced diet, safe environment, clean water, and adequate health care (preventive and curative) for all people, and the knowledge needed to care for and ensure a healthy and active life for all household members.

Obesity: A condition characterized by excess body fat, defined as a BMI of 30 or more.

Oral Rehydration Solution/Salts (ORS): A liquid electrolyte solution that is used for the management of diarrhoea among children. ORS is typically distributed in ready-to-use sachets that are added to one litre of clean water.

Over-nutrition: A state in which nutritional intake greatly exceeds nutritional need. Over-nutrition manifests itself as overweight (BMI~25) and obesity (BMI~30). In children, over nutrition is defined as weight-for-height >2 SD (>2 SD is overweight and >3 SD is obese).

Overweight: A condition characterized by excess body fat, defined as a BMI between 25 and 30kg/m2.

Protein-Energy Malnutrition (PEM): A condition resulting from insufficient consumption of energy and protein, resulting in wasting.

Public works: Social protection programmes where income support for the poor is given in the form of wages (in either cash or food) in exchange for work effort. These programmes typically provide short-term employment at low wages for unskilled and semiskilled workers on labour-intensive projects such as road construction and maintenance, irrigation infrastructure, reforestation, and soil conservation. They are generally seen as a means of providing income support to the poor in critical times rather than as a way of getting the unemployed back into the labour market.

Ready-to-use Supplementary Food (RUSF): A high-energy nutrition supplement that is particularly suited as a nutritional support in emergency situations or in the context of nutritional programmes for the prevention or treatment of moderate malnutrition and deficiency-related illnesses.

Ready-to-use Therapeutic Food (RUTF): A high energy and protein ready-to-eat food with added electrolytes, vitamins and minerals, specifically designed to treat SAM in the rehabilitation phase. RUTF is typically oil- and/or peanut-based; it does not have to be mixed with water so is microbiologically safe and enables outpatient treatment.

Severe Acute Malnutrition (SAM): Weight-for-height more than 3 standard deviations below the mean of sex-specific reference data (severe wasting).

Social protection: The set of public interventions aimed at supporting the poorer and more vulnerable members of society, as well as helping individuals, families, and communities manage risk. Social protection includes safety nets (social assistance), social insurance, labour market policies, social funds, and social services.

Social Safety Net (SSN): Non-contributory transfer programmes targeted in some manner to the poor and those vulnerable to poverty and shocks-analogous to the U.S. term "welfare" and the European term "social assistance."

Stunting (chronic malnutrition): Low height-for-age, defined as more than 2 SD below the mean of the sex-specific reference data. Stunting is the cumulative effect of long-term deficits in food intake, poor caring practices, and/or illness.

Supplementary feeding programmes: A direct transfer of food to target households or individuals, most commonly maternal and child feeding and school feeding. The food may be prepared and eaten on- site or given as a dry ration to take home. Supplementary feeding is often provided as an incentive for participation in public services such as primary health care and education.

Unconditional Cash Transfer (UCT): A social safety net programme aimed at reducing both present and future poverty through a transfer of cash to vulnerable and specifically targeted populations

Undernourished: A person whose usual food consumption, expressed in terms of dietary energy (kcal), is below the energy requirement norm. The prevalence of undernourishment in a specified population is sometimes used as a measure of food deprivation. This term is not to be confused with under-nutrition.

Under-nutrition: when the body contains lower than normal amounts of one or more nutrients, i.e. deficiencies in macro-nutrients (food) and/or micronutrients. Under-nutrition encompasses stunting, wasting and deficiencies of essential vitamins and minerals (collectively referred to as micronutrients).

Underweight: Low weight-for-age defined as more than 2 SD below the mean of the sex-specific reference data.

Vitamin A: An essential micronutrient that plays an essential role in vision and immune response.

Vitamin A Deficiency (VAD): The condition resulting when vitamin A intake falls below recommended levels. Vitamin A deficiency may be exacerbated by high rates of infection, and greatly increases the risk that a child may die from diseases such as measles, diarrhoea, and acute respiratory infections, and is the leading cause of childhood blindness. Vitamin A deficiency compromises the immune systems of approximately 40 percent of the developing world's children under five and leads to the deaths of as many as one million young children each year.

Wasting (acute malnutrition): Low weight-for-height defined as more than 2 SD below the mean of the sex-specific reference data. Wasting is the result of a recent shock such as lack of calories and nutrients and/or illness, and is linked strongly to mortality.

Weather-index insurance: A product designed to provide compensation to farmers when specific weather events are insufficient (rainfall) or destructive (cyclones, floods) for farmers to grow and optimize their yields. Weather index insurance does not measure changes in yields; rather it measures changes in weather, assuming that if the weather is poor, the farmers' yields will be too.

Window of opportunity: The period between conception and age two when irreversible damage caused by malnutrition can and should be prevented.

Zinc: An essential micronutrient that plays a critical role in the structure of cell membranes and in the function of immune cells.

Zinc deficiency: The condition resulting when zinc intake falls below recommended levels. Zinc deficiency is associated with growth retardation, mal-absorption syndromes, foetal loss, neonatal death, and congenital abnormalities. Zinc supplementation reduces the duration and intensity of diarrheal illness and reduces clinical disease caused by acute respiratory infections and malaria

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ANNEX 3: DETAILED ACTIVITIES, ANNUAL OUTPUT TARGETS AND COSTS

Key Result Area 1: Improved quality of adolescent and maternal nutrition services

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Goal 1: Coverage of health and community nutrition services for adolescents increased from X% to 50% by 2018										2,567,443	1,887,600	1,708,000	1,932,000	2,156,000	10,251,043
Strategy 1: Equip health workers with skills and knowledge on adolescent nutrition service delivery															
Strategic Activity 1	Develop & disseminate adolescent nutrition guidelines to all provinces and districts	1					1	Adolescent nutrition guidelines developed and disseminated to all districts	100,000	100,000	-	-	-	-	100,000
Strategic Activity 2	Train at least one health worker per primary health care, 5 per district and provincial hospital and 10 per central hospital on adolescent nutrition	390	390	390	390	390	1,950			-	-	-	-	-	-
Strategic Activity 3	Conduct quarterly mentoring & supervision of all health facilities	6,000	6,000	6,000	6,000	6,000	30,000	Mentoring and supportive supervision conducted	180	1,080,000	1,080,000	1,080,000	1,080,000	1,080,000	5,400,000
Strategic Activity 4	Provision of micronutrient supplements to 400,000 adolescent girls	400,000	400,000	400,000	400,000	400,000	2,000,000	Adolescent girls provided with iron and folate supplements	0	20,000	20,000	20,000	20,000	20,000	100,000
Strategy 2: Review and update school curriculum to incorporate adolescent and maternal nutrition															
Strategic Activity 1	3 officers participate in working sessions for curriculum review & advocate for incorporation of Nutrition into the Primary &Secondary Education curriculum	1					1	Curriculum updated	19,980	19,980	-	-	-	-	19,980
Strategic Activity 2	Develop nutrition social marketing tools for the school environment	1					1	Social marketing tools developed and disseminated	40,400	40,400	-	-	-	-	40,400
Strategic Activity 3	Participate in updating the school health manual	1					1	School health manual updated	21,190	21,190	-	-	-	-	21,190
Strategic Activity 4	Implement school gardening with cooking demonstrations and nutrition education in 150 schools			50	100	150	300	School gardening project implemented	4,480	-	-	224,000	448,000	672,000	1,344,000

Key Result Area 1: Improved quality of adolescent and maternal nutrition services

Goals and Strategies	Strategic Activities	Annual Output Targets 2014	2015	2016	2017	2018	Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD 2,014	2,015	2,016	2,017	2,018	Total Cost, USD
Strategy 3: Promote behaviour change communication on maternal and adolescent health, SRH, hygiene and nutrition targeting adolescents using community platforms (such as the youth friendly corners approach)															
Conduct KABP survey on adolescents and maternal nutrition	1					1	KABP survey report	406,573	406,573	-	-	-	-	406,573	
Develop & disseminate BCC strategy to communicate nutrition messages to adolescents and women of child bearing age	1					1	BCC strategy in place	91,700	91,700	-	-	-	-	91,700	
Identify & capacitate at least 2 community based youth champions per ward in 30 districts to communicate nutrition messages as per BCC strategy	800	800				1,600	Youth champions trained	252	201,800	201,800	-	-	-	403,600	
Youth champions conduct peer support groups in at least 90% of wards in 30districts	800	800	800	800	800	4,000	Peer support groups established	240	192,000	192,000	192,000	192,000	192,000	960,000	
Equip at least 2 lead mother per ward to provide family focused nutrition counseling and implement BCC strategy	800	800					Lead mothers trained	252	201,800	201,800	-	-	-	403,600	
Lead mothers provide nutrition counselling and implement BCC strategy in at least 90% of wards in 30 districts	800	800	800	800	800	4,000		240	192,000	192,000	192,000	192,000	192,000	960,000	
Goal 2: Standard maternal health and nutrition package scaled up from X% to 90% coverage										10,268,986	9,310,477	9,263,979	9,263,979	9,233,979	47,341,400
Strategy 1: Equip health facility and community -based health workers with skills and knowledge to deliver the standard package of maternal health and nutrition services (inc luding family planning and adequate birth spacing)															
Update nutrition component for pre-service training of nurses and doctors	1					1	Curriculum updated		-	-	-	-	-	-	
Develop & disseminate maternal and adolescent nutrition guidelines & job aides to all health facilities	1					1	Guidelines developed and disseminated	100,000	100,000	-	-	-	-	100,000	

Key Result Area 1: Improved quality of adolescent and maternal nutrition services

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Strategic Activity 3	On the job training on maternal and adolescent nutrition guidelines for at least one health worker per primary health care, 5 per district and provincial hospital and 10 per central hospital	390	390	390	390	390	1,950	Health workers trained	48	18,599	18,599	18,599	18,599	18,599	92,996
Strategic Activity 4	Implement maternal deworming in 8 high prevalence districts	40,000	40,000	40,000	40,000	40,000	200,000	Pregnant women dewormed	0	8,000	8,000	8,000	8,000	8,000	40,000
Strategic Activity 5	Conduct quarterly mentoring & supervision of all health facilities	1,500	1,500	1,500	1,500	1,500	7,500	Mentoring and supportive supervision report	720	1,080,000	1,080,000	1,080,000	1,080,000	1,080,000	5,400,000
Strategy 2: Promote familyfocused and evidencebased behaviour change communication on appropriate adolescent, maternal and child care practices															
Strategic Activity 1	Conduct KABP survey on maternal nutrition	1					1	KABP survey report		-	-	-	-	-	-
Strategic Activity 2	Develop & implement BCC strategy in 30 districts						-	BCC strategy in place		-	-	-	-	-	-
Strategic Activity 3	Equip at least one lead mother per ward to provide family focused nutrition counseling and implement BCC strategy						-	Lead mothers trained in maternal nutrition		-	-	-	-	-	-
Strategic Activity 4	Lead mothers provide nutrition counselling and implement BCC strategy in at least 90% of wards in 30 districts						-	Families counselled on nutrition		-	-	-	-	-	-
Strategy 3: Ensure availability of standardised anthropometric equipment and supplies for delivery of adolescent, maternal and child nutrition care services through health facilities															
Strategic Activity 1	Procure and distribute standardized anthropometric equipment (scales, height boards and MUAC tapes, calibration weights, 1 per primary health centre, 5 per district, 10 per provincial and central hospitals)	1					1	Equipment procured	476,357	476,357	-	-	-	-	476,357
Strategic Activity 2	Train at least one health worker per primary health care, 5 per district and provincial hospital and 10 per central hospital on equipment calibration & maintenance	975	975				1,950	Health workers trained	48	46,498	46,498	-	-	-	92,996
Strategic Activity 3	Procurement & Provision of iron and folate, supplements to 420000 women aged 15 - 49 years	420,000	420,000	420,000	420,000	420,000	2,100,000	Iron and folate provided to anaemic women of child bearing age	0	21,000	21,000	21,000	21,000	21,000	105,000

Key Result Area 1: Improved quality of adolescent and maternal nutrition services

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Strategy 4: Promote healthy eating for optimal weight management before and during pregnancy (to prevent obesity and under- weight)															
Strategic Activity 1	Provide at least four nutrition counseling sessions at health facility and community levels to 1,400,000.00 women of child bearing age before and during pregnancy	150,000	150,000	150,000	150,000	150,000	750,000	Women of child bearing age counselled	12	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	9,000,000
Strategic Activity 2	Develop and disseminate standardized IEC materials to 1600 health facilities	3,000	3,000	3,000	3,000	3,000	15,000	IEC material developed and disseminated	13	39,000	39,000	39,000	39,000	39,000	195,000
Strategic Activity 3	Supplementary feeding for 60,000 pregnant and lactating women with acute malnutrition	60,000	60,000	60,000	60,000	60,000	300,000	Supplementary feeding provided	61	3,672,000	3,672,000	3,672,000	3,672,000	3,672,000	18,360,000
Strategic Activity 4	Develop and implement advocacy calendar for monthly mass media campaigns on nutrition for the family	9	9	9	9	9	45	Media campaigns conducted	4,000	36,000	36,000	36,000	36,000	36,000	180,000
Strategy 5: Promote the distribution and consumption of micronutrient supplements and consumption of fortified foods through community-based channels (pharmacies, schools andcommunity health workers) targeting women and infants															
Strategic Activity 1	Development and dissemination of micronutrient fortification and supplementation IEC materials	5,000	5,000	5,000	5,000	5,000	25,000	Fortification and supplementation IEC materials developed and disseminated	12	58,900	58,900	58,900	58,900	58,900	294,500
Strategic Activity 2	Distribute point of use supplements to 500,000 anaemic women of child bearing age	420,000	420,000	420,000	420,000	420,000	2,100,000	Supplements distributed	5	2,268,000	2,268,000	2,268,000	2,268,000	2,268,000	11,340,000
Strategic Activity 3	Implement Food Fortification Strategy	-	-	-	-	-	-	Awareness campaigns conducted	-	-	-	-	-	-	-
Strategy 6: Build capacity of national and district programme managers in effective planning, implementation, monitoring and management focusing on increasing quality and coverage of effective interventions for adolescent and maternal health and nutrition															
Strategic Activity 1	Train 240 district level staff (DMOs, DNOs, DN) on maternal & adolescent nutrition programme planning & management	240					240	District managers trained	583	139,800	-	-	-	-	139,800
Strategic Activity 2	Routinely collect and report data on adolescent and maternal anemia, underweight and obesity	1,600					1,600	Data collected and reports submitted	151	242,353	-	-	-	-	242,353
Strategic Activity 3	Conduct monthly coordination meetings for 11 district officers in 60 districts and quarterly provincial meetings for 8 provincial officers in 10 provinces	4,800	4,800	4,800	4,800	4,800	24,000	Monthly coordination meetings conducted	37	178,000	178,000	178,000	178,000	178,000	890,000
Strategic Activity 4	Present adolescent and maternal nutrition data and progress at quarterly and annual review meetings	5	5	5	5	5	25	Reports submitted and presented at quarterly and biannual review meetings		-	-	-	-	-	-

Key Result Area 1: Improved quality of adolescent and maternal nutrition services

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Goal 3: 50% of pregnant and lactating women receive positive support from spouses and communities for decisions on maternal health, nutrition, healthy lifestyles and safe living environment by 2018										620,386	1,089,186	960,000	960,000	960,000	4,589,572
Strategy 1: Promote behaviour change communication on decisions on maternal health, nutrition, healthy lifestyles and safe li ving environment targeting men, community and religious leaders and all other influential structures															
Strategic Activity 1	Develop male friendly communication package	1					1	Communication package developed	11,200	11,200	-	-	-	-	11,200
Strategic Activity 2	Identify at least one male champion for nutrition & implement male support groups in 70% of the wards in 30 districts	301	301				602	Male champions identified and trained	429	129,186	129,186	-	-	-	258,372
Strategic Activity 3	Conduct bi-annual road shows on nutrition in 30 districts	30	60	60	60	60	270	Road shows conducted	16,000	480,000	960,000	960,000	960,000	960,000	4,320,000
Sub-Total KRA 1 Improved quality of adolescent and maternal nutrition services										13,456,815	12,287,263	11,931,979	12,155,979	12,349,979	62,182,015

Key Result Area 2: Infant and Young Child Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Goal 4: All health institutions provide the standard IYCF package (BMFHI, BF, CF, multiple micronutrient suppl ementation and fortification, dietary diversification, disease prevention and management, nutrition interventions in emergencies, feeding behaviours and stimulatio n, PMTCT, WASH) and IMAM by 2018										16,893,193	7,875,588	7,771,828	7,771,728	7,771,728	48,084,066
Strategy 1: Integrate nutrition into pre-service curricula for health professionals															
Strategic Activity 1	Stakeholder sensitization on integration of nutrition into pre-service of health professional (Nurses, doctors, EHT, HPO, PCC, VHWs)curricula by Q2 2014	1					1	Sensitisation meetings held	850	850	-	-	-	-	850
Strategic Activity 2	Review curriculum for different health professionals to identify gaps and opportunities to integrate nutrition by 2014 Q2	1					1	Curricula review report and course outlines	17225	17,225	-	-	-	-	17,225
Strategic Activity 3	Support the role out of the new curricula (equipment by Q4 2014) and printing annually	1	1	1	1	1	5	Training kits in all training schools		31,225	5,000	5,000	5,000	5,000	51,225

Key Result Area 2: Infant and Young Child Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Strategy 2: Develop capacity of institutions and communities to provide comprehensive IYCF services															
Strategic Activity 1	Review and update guidelines and manuals based on new evidence from national, regional and global research by Q3 2015 and distribute by Q2 2016, CHC printed annually for 150 000 new born children		1				1	Guidelines updated and CHC printed	103860	27,000	130,860	27,000	27,000	27,000	238,860
Strategic Activity 2	Develop a checklist on requirements to provide comprehensive IYCF services by 2014 and review in Q2 2016	1		1			2	Comprehensive checklist	100	100	-	100	-	-	200
Strategic Activity 3	Procure and distribute micronutrient supplements (vitamin A and zinc for diarrhoeal diseases) annually	1	1	1	1	1	5	All health facilities with micronutrients	515174.8	515,175	515,175	515,175	515,175	515,175	2,575,874
Strategic Activity 4	Procure and distribute anthropometric equipment to assess all under 5s by 2014	1					1	All health activities with anthropometric equipment	11162985	11,162,985	-	-	-	-	11,162,985
Strategic Activity 5	Procure and distribute IMAM commodities (SAM) biannually	1	1	1	1	1	5	All health facilities with IMAM commodities	1776554.67	1,776,555	1,776,555	1,776,555	1,776,555	1,776,555	8,882,773
Strategic Activity 6	Procure and distribute IMAM commodities (MAM) from 2016 to 2018		2	2	2	2	8	CSB in IMAM facilities	1270501.85	-	2,541,004	2,541,004	2,541,004	2,541,004	10,164,015
Strategic Activity 7	Train 240 health professionals (doctors, nurses, EHT, HPO,PCC) training Growth monitoring, IMAM an IYCF on skills to deliver the IYCF package in three quarters by 2018 and train 60 TOT on all three packages by Q4 2018	2	3	3	3	3	14	No of Health professionals trainees	378000	592,025	1,134,000	1,134,000	1,134,000	1,134,000	5,128,025
Strategy 3: Strengthen the provision of supportive supervision to ensure quality service delivery on IYCF															
Strategic Activity 1	Develop mentoring and support checklist which is comprehensive and includes an audit checklist by Q2 2014	1					1	Mentoring checklist available	560	560	-	-	-	-	560
Strategic Activity 2	Train 245 mentors by Q3 2014	1					1	245 mentors trained	87075	87,075	-	-	-	-	87,075
Strategic	Conduct at least 1 mentoring visit each quarter at each health facility	1	4	4	4	4	17	Quarterly visits to each health facility	125150	125,150	500,600	500,600	500,600	500,600	2,127,550

Key Result Area 2: Infant and Young Child Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Strategy 4: Promote, protect and support optimal feeding practices at health facility level (including review of labour regulations)															
Strategic Activity 1	Conduct a Trainer of Trainers of BMFHI for 60 TOTs by Q3 2014	1					1	60 TOT trained	49300	49,300	-	-	-	-	49,300
Strategic Activity 2	Cascade training to all health facilities (public, private and mission hospitals) in BMFHI and all to be compliant by 2016	1	1	1	1	1	5	30 health facilities, 30 private health facilities and 8 Provincial Hospital trained		1,140,250	709,500	709,500	709,500	709,500	3,978,250
Strategic Activity 3	Develop IEC material promoting EBF, appropriate complementary feeding options, dietary diversification to support counselling of mothers at health facilities annually	1	1	1	1	1	5	Communication Strategy for EBF, Dietary diversification, appropriate complementary feeding practices	422895	422,895	422,895	422,895	422,895	422,895	2,114,475
Strategic Activity 4	Establish an ad hoc group of eminent women parliamentarians/professionals and supportive male partners/ parliamentarians to advocate for a review of labour regulations to include 6 month maternity leave for breastfeeding mothers by 2015	4	4	4	4	4	20	Advocacy meetings held	35000	140,000	140,000	140,000	140,000	140,000	700,000
Strategic Activity 5	Operational research in EBF to inform guidelines (RAF project by 2014	1					1		804824	804,824	-	-	-	-	804,824
Goal 5: Community IYCF counselling package increased from 44% to 100% of districts with coverage of at least 90% of the wards by 2										5,588,480	6,609,280	13,239,886	10,437,286	10,487,794	46,362,724
Strategy 1: Empower community development structures to provide quality IYCF services															
Strategic Activity 1	Train 522 community based workers in 40 urban and ruraldistricts on cIYCFcounselling by 2018	2	4	4	4	4	18	CBW trained in cIYCFcounselling	127,600	1,020,800	2,041,600	2,041,600	2,041,600	2,041,600	9,187,198
Strategic Activity 2	Support 16,200 community based workers with resources to carry out their mandate by 2016, stationary and bags @ 12 per set provided annually			1			1	Resources for CBW		194,400	194,400	2,997,000	194,400	194,400	3,774,600
Strategic Activity 3	Establish at least 30 community peer support groups per ward in 2,647 wards by Q4 2018	2	4	4	4	4	18	5,292 peer support groups	1914003	3,828,006	3,828,006	7,656,012	7,656,012	7,656,012	30,624,048

Key Result Area 2: Infant and Young Child Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2,014	2,015	2,016	2,017	2,018	
Strategy 1: Build capacity of community cadres (CHWs, EHTs, extension workers, community development workers) and development structures to improve early detection of malnutrition cases and provide appropriate counseling& referral services (skills and equipment)															
Strategic Activity 1	Conduct 4 awareness campaigns on the code for retailers including pharmacies, manufacturers and the public by Q4 2016	1	1	1	1	1	5	4 awareness campaigns	527400	527,400	527,400	527,400	527,400	527,400	2,637,000
Strategic Activity 2	Develop a robust implement ation and monitoring system of the code by 2018					1	1	Code implementation and monitoring system	50508	-	-	-	-	50,508	50,508
Strategic Activity 3	Conduct a refresher training by carrying out Code monitoring exercises for 10 Provincial nutritionists, 62 District nutritionists and 1,674 EHTs	2	2	2	2	2	10	62 districts trained in code monitoring		17,874	17,874	17,874	17,874	17,874	89,370
Goal 6: Coverage of growth monitoring and promotion for under -fives increased from2 districts to 20 districts by 2016 and to 40 districts by 2018 and covering 5 wards per district										477,075	15,225	15,225	15,225	15,225	537,975
Strategy 1: Build capacity of community cadres (CHWs, EHTs, extension workers, community development workers) and development structures to improve ear ly detection of malnutrition cases and provide appropriate counsel ing& referral services (skills and equipment)															
Strategic Activity 1	Recruit a consultant to prepare training manuals for a Trainer of Trainer's (TOT) course on growth monitoring, detection of malnutrition cases, provide appropriate counselling and referral by 2015	1					1	Training manual on growth monitoring, training manuals and detection of malnutrition and referral	70000	70,000	-	-	-	-	70,000
Strategic Activity 2	Identify and train 2180 community cadres in early detection of malnutrition cases, provision of appropriate counselling and referral	1896	71	71	71	71	2180	Trained Community Cadres	215	407,075	15,225	15,225	15,225	15,225	467,975
Sub-Total KRA 2 Infant and Young Child Nutrition										22,958,748	14,500,093	21,026,939	18,224,239	18,274,747	94,984,765

Key Result Area 3: Promoting Healthy Lifestyles

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Goal 7: To increase the proportion of the adult population practicing at least one or a combination of the top 5 healthy to 40% by 2018										105,200	280,041	4,938,579	5,593,316	5,565,946	16,483,082
Strategy 1: Promote social and behaviour change communication on healthy lif estyles (diversified diets -including consumption of at least 5 servings of fruits and vegetables - decreased consumption of sugary beverages, intake of <400mg of sodium per day, physical exercise of recommended duration) using multi -media channels															
Strategic Activity 1	Develop behavioral change communication strategy on healthy lifestyles by Q1, 2015	75%	25%				1	healthy lifestyles BCC strategy developed	131,500	105,200	26,300	-	-	-	131,500
Strategic Activity 2	Review and update IEC/BCC materials on healthy life styles by Q3, 2015		1.00				1	IEC/BCC materials developed	57,000	-	57,000	-	-	-	57,000
Strategic Activity 3	Promote social behavioral change on healthy lifestyles using various types of mass media starting Q1, 2015 to		0.20	30%	30%	20%	1	Adults adopting healthy lifestyles reached by mass media campaigns	2,706	-	541	812	812	541	2,706
Strategic Activity 4	Carry out social outreach activities such as road shows, awareness campaigns, commemorations,agriculture shows, community theatres, radio listening clubs, community films in 30 districts by Q4, 2018		20%	30%	30%	20%	1	Districts with social outreach activities done	413,000	-	82,600	123,900	123,900	82,600	413,000
Strategy 2: Promote health screening and wellness days through various community based platforms such as pharmacies, workplaces and faith based organizations															
Strategic Activity 1	Development of protocol on prevention and management of NCDs by Q4 2015		1				1	protocol on prevention and management of NCDs developed	113,600	-	113,600	-	-	-	113,600
Strategic Activity 2	Capacity building of 60 health workers by end of 2018			20	20	20	60	60 health workers trained on NCDs	14,170	-	-	283,400	283,400	283,400	850,200
Strategic Activity 3	Equipment upgrade for 400 pharmacies, workplaces and faith based organizations by Q4 2018			80	160	160	400	400 pharmacies workplaces ,faith based organisations and schools equipped	374	-	-	29,938	59,875	59,875	149,688
Strategic Activity 4	Conduct quarterly health screening and wellness days in all 89 districts from Q1 2017 to Q4 2018				44	45	89	quarterly wellness days and health screening done in 89 districts	14,200	-	-	-	624,800	639,000	1,263,800
strategic activity 5	Biannual NCDs screening (Diabetes, Hypertension and Overweight / obesity) for all 8,112 schools in Zimbabwe from Q1, 2016			2,704	2,704	2,704	8112	schools with biannual screening done	1,664	-	-	4,500,529	4,500,529	4,500,529	13,501,588

Key Result Area 3: Promoting Healthy Lifestyles

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 3: Generate information on food consumption patterns, obesity, overweight and key drivers of adult lifestyle s (physical activity, alcohol and other substance abuse, diets, eating habits) to inform behaviour change communication strat egies															
Strategic Activity 1	conduct a food consumption survey	100%					1	food consumption survey conducted		-	-	-	-	-	-
Goal 8: Proportion of health facilities (central, provincial, mission and district ho spitals) providing quality nutrition services for communicable (schistosomiasis, HIV, malaria, soil transmitted helminthes) and non -communicable diseases increased to 75% by 2018										7,254	81,654	909,441	1,383,759	1,391,772	3,773,881
Strategy 1: Promote the establishment of wellness clinics with adequate equipment for screening and treatment of NCDs															
Strategic Activity 1	Identify space for wellness clinics for 75 % of districts and also provide support and supervision starting 2016 ending 2018			22	22	23	67	wellness clinics established	7,934	-	-	174,555	174,555	182,490	531,600
Strategic Activity 2	To equip 400 health facilities that is 200 district, mission, provincial, central institutions and 200 wellness clinics by Q1 2017 to Q4 2018				200	200	400	400 health facilities equipped	1,935	-	-	-	386,966	386,966	773,931
Strategic Activity 3	Capacity building of 600 health workers (training on prevention and management of NCDS) by end of 2018			200	200	200	600	600 health workers trained in NCD management and prevention	690	-	-	138,000	138,000	138,000	414,000
Strategy 2: Strengthen the knowledge and skills of health workers for the prevention and management of NCDs															
Strategic Activity 1	Develop training programme and curriculum and train 89 districts on prevention and management of NCDs			27	31	31	89	districts trained on prevention and management of NCDs	21,838	-	-	589,631	676,984	676,984	1,943,600
Strategy 3: Effective monitoring of prevalence of nutrition related NCD risk factors (overweight, obesity, abnormal lipids, raised blood sugar) and supportive supervision of services delivered by wellness clinics															
Strategic Activity 1	Design a M and E frame work and system						0			-	-	-	-	-	-
Strategic Activity 2	Design quality control and assurance						0			-	-	-	-	-	-
Strategic Activity 3	Design/review data management systems						0			-	-	-	-	-	-
Strategic Activity 4	Conduct support and supervision						0			-	-	-	-	-	-
Strategy 4: Management of moderate and severe acute malnutrition in PLWHA															
Strategic Activity 1	Integration of CMAM into PLWHA training		1				1	PLWHA training package incorporating CMAM	17,400	-	17,400	-	-	-	17,400
Strategic Activity 2	Conduct one day In-service trainings for 3 people at 30% of the CMAM centers reaching a total of 922 trainees by end of 2018.	184	184	184	184	186	922	3 people at 30% of CMAM centres trained	39	7,254	7,254	7,254	7,254	7,333	36,350

Key Result Area 3: Promoting Healthy Lifestyles

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 5: Raise awareness of Under 2 malnutrition as risk factor for NCDs in health facility departments and communities															
Strategic Activity 1	Integrate NCDS into infant and young child training package and design and develop IEC/BCC materials		100%				100%	NCDs integrated into IYCF training package	57,000	-	57,000	-	-	-	57,000
Strategic Activity 2	Carry out social outreach activities such as road shows, awareness campaigns, commemorations,agriculture shows, community theatres, radio listening clubs, community films in 30 districts by Q4, 2018		16%	28%	28%	28%	100%	social outreach activities achieved		-	-	-	-	-	-
Goal 9: 30% of institutions adopt national food service and nutrition guidelines by 2018										713,632	2,026,132	1,912,532	2,100,473	2,100,591	8,853,360
Strategy 1: Ensure nutrition services and education are implemented through institutions of special care (such as hospitals, prisons, orphanages) to promote the reinforcement of nutrition practices															
Strategic Activity 1	Develop national dietary guidelines by Q4 2014	1					1	National Dietary Guidelines Document	113,600	113,600	-	-	-	-	113,600
Strategic Activity 2	Train 10 000 carders from institutions of special care from Q1 2015 to Q4 2018		2500	2500	2500	2500	10000	10 000 carders from institutions trained	525	-	1,312,500	1,312,500	1,312,500	1,312,500	5,250,000
Strategic Activity 3	Review and incorporate into pre service training curriculum for cadres involved in institutions of special care (HFSS, nutritionists, dieticians, doctors)		1				1	Pre-service curriculum reviewed	113,600	-	113,600	-	-	-	113,600
Strategic Activity 4	Recruit 20 dieticians for national, provincial and central levels by Q4, 2018	4	4	4	4	4	20	20 dieticians recruited	8	32	32	32	32	32	160
Strategic Activity 5	By 2018, equip all central and provincial hospital kitchens with adequate equipment = 9 provincial and 5 central = 15 institutions	3	3	3	3	3	15	15 central and provincial hospitals equipped	200,000	600,000	600,000	600,000	600,000	600,000	3,000,000
Strategic Activity 6	Conduct support and supervision visits in 30 % all institutions of special care i.e hospitals , prisons, orphanages, old people homes that have adopted the national nutrition guidelines from Q1 2017 to Q4 2018 = 3 169 institutions				1584	1585	3169	support and supervision visits conducted at 3 169 institutions	119	-	-	-	187,941	188,059	376,000
Sub-Total KRA 3 Promoting Healthy Lifestyles										826,086	2,387,827	7,760,552	9,077,548	9,058,309	29,110,323

Key Result Area 4: Quality nutrition information systems and advocacy

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
G10: Timely availability of relevant nu trition information that incorporates disaster risk reduction at all levels adequate for disaster preparedness planning and nutrition programming										4,240,630	2,311,935	998,783	998,783	998,783	6,868,815
Strategy 1: Ensure nutrition indicators are integrated into the national Health Information System															
Strategic Activity 1	Review existing HIS for Indicators	1					1	Indicators integrated into the HIS	500	500	-	-	-	-	500
Strategic Activity 2	Stakeholder consultation	1					1	Stakeholders Consulted	1,000	1,000	-	-	-	-	1,000
Strategic Activity 3	Presentation and Approval of Indicators to the HMIS technical group	1					1	Presentation done to Technical Group	1,000	1,000	-	-	-	-	1,000
Strategic Activity 4	Integration of Nutrition Indictors into the National Statistical System by Q1 2015	1					5000	National Statistical System integrating nutrition indicators	25,000	25,000	-	-	-	-	25,000
Strategy 2: Strengthening coordination of nutrition surveillance activities & timely information sharing (subcommittee, indicators, integrated operational plan, nutrition surveillance guidelines)															
Strategic Activity 1	Developing and printing of Nutrition surveillance guidelines by 2014	4500					4500	Nutrition Surveillance Guidelines produced	10	45,000	-	-	-	-	45,000
Strategic Activity 2	conduct training on Nutrition surveillance	3	3	2	2	2	12	5080 People trained	294,992	884,975	884,975	589,983	589,983	589,983	3,539,900
Strategic Activity 3	Hold quarterly Nutrition surveillance meetings	8	8	8	8	8	40	Review meetings conducted	51,100	408,800	408,800	408,800	408,800	408,800	2,044,000
Strategy 3: Strengthen monitoring and evaluation of nutrition programmes															
Strategic Activity 1	Design of M and E Frameworks and Systems by 2014	1					1	Mand E Framework Designed	500	500	-	-	-	-	280
Strategic Activity 2	Design of Quality Control and Assurance	1					1	Quality Control and Assurance designed	2,500	2,500	-	-	-	-	280
Strategic Activity 3	Design/Review of Data Management Systems	1					1	Data Management System reviewed	500	500	-	-	-	-	280
Strategic Activity 4	Stakeholder Consultation	1					1	Consultations Done	5,000	5,000	-	-	-	-	560
Strategic Activity 5	Data collection and analysis	4	4	4	4	4	20	M and E Reports	668,250	2,673,000					
Strategy 4: Ensure availability of functional equipment for monitoring nutrition trends in Zimbabwe															
Strategic Activity 1	Situational Assessment									-	-	-	-	-	-
Strategic Activity 2	Equipment upgrade for health centres									-	-	-	-	-	-

Key Result Area 4: Quality nutrition information systems and advocacy

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 3	Equipment upgrade for hospitals									-	-	-	-	-	-
Strategy 5: Build capacity of FNSCs on early warning and disaster risk management															
Strategic Activity 1	Training of Trainers	1					1	TOT done	98,080	98,080	-	-	-	-	98,080
Strategic Activity 2	Training of FNSCs (District Level)		1				1	Trainings Done	1,018,160	-	1,018,160	-	-	-	1,018,160
Strategic Activity 3	Training of FNSCs (Ward Level)	0	0	0	0	0	0	Trainings Done		-	-	-	-	-	-
Strategy 6: Operational research to identify context specific drivers of stunting and possible interventions that address the causal factors of malnutrition (involving university students)															
Strategic Activity 1	Carry out a study to identify casual factors of stunting by 2014	1					1	Study report on causal factors of stunting	40,300	40,300	-	-	-	-	40,300
Strategic Activity 2	Conduct a Food Consumption Survey	1					1	Food Consumption Survey Report	54,476	54,476	-	-	-	-	54,476
Sub-Total KRA 4 Quality nutrition information systems and advocacy										4,240,630	2,311,935	998,783	998,783	998,783	6,868,815

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Goal 11: 80% of women of reproductive age have the capacity to safely provide for their food, health and nutrition security using appropriate technologies by 2018										579,400	542,800	542,800	542,800	542,800	2,750,600
Strategy 1: Target women for livelihood projects that use labor-saving technologies															
Strategic Activity 1	Assess available labour saving technologies, their suitability and acceptability to the various natural farming regions.	1					1	Assessment report	17,100	17,100	-	-	-	-	17,100
Strategic Activity 2	Disseminate report of the Labour Saving Technologies Assessment to key stakeholders	1					1	Dissemination action plan	7,575	7,575	-	-	-	-	7,575
Strategic Activity 3	Train 720 AGRITEX Officers per year on labour saving technologies	720	720	720	720	720	3,600	Trained AGRITEX Officer	258	185,400	185,400	185,400	185,400	185,400	927,000
Strategic Activity 4	Establish 24 demonstration plots per year on labour saving technologies	24	24	24	24	24	120	Demonstration plot	5,000	120,000	120,000	120,000	120,000	120,000	600,000
Strategic Activity 5	Establish 320 ISAL Groups for women per year	320	320	320	320	320	1,600	Functional ISAL Group	50	16,000	16,000	16,000	16,000	16,000	80,000
Strategy 2: Nutrition education on safe use of irrigation water to prevent malaria, schistosomiasis and any other water-borne diseases															
Strategic Activity 1	Develop a nutrition pre-service training module for agriculture colleges	1					1	Pre-service Nutrition Training Module	11,925	11,925	-	-	-	-	11,925
Strategic Activity 2	Train 720 in-service extension officers every year on nutrition education and safe use of irrigation water	720	720	720	720	720	3,600	Trained AGRITEX Officer	258	185,400	185,400	185,400	185,400	185,400	927,000
Strategic Activity 3	Training 72,000 (100 farmers / extension officer) farmers per year on nutrition education and safe use of irrigation water	72,000	72,000	72,000	72,000	72,000	360,000	Trained Farmer	1	36,000	36,000	36,000	36,000	36,000	180,000
Goal 12: Coverage of health and community nutrition services for school children increased to 50% by 2018										9,156,640	9,626,640	15,633,270	17,581,880	7,881,600	59,751,930
Strategy 1: Knowledge and skills development for Education managers, school health Coordinators, teachers (pre-service and in-service)and SDC members on health and nutrition															
Strategic Activity 1	Develop a Training Manual on Health and Nutrition by Q3, 2014	1	-	-	-	-	1	Health and Nutrition Training Manual	128,100	128,100	-	-	-	-	-
Strategic Activity 2	Print 100 000 Training Manuals on Health and Nutrition by Q4, 2015	100,000	-	-	-	-	100,000	100000 training manuals printed	10	1,000,000	-	-	-	-	1,000,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 3	Conduct Training of Trainers at national level on health and nutrition in schools targeting 1 Permanent Secretary, 5 Principal Directors, 11 Head office Directors, 10 PEDs, 14 Head office D/Directors, 20 D/PEDs, 6 Officers (ECD, Learner Welfare, Junior, Secondary, Special needs Education and Curriculum Devpt.), 5 MOHCC + 1 Consultant. Total = 73participants. By Q4 2014	1	-	-	-	-	1	Education Managers trained	81,840	81,840	-	-	-	-	81,840
Strategic Activity 4	Conduct training of trainers at Provincial level on health and nutrition in schools targeting 1x ECD, 2xInspector and 1xDEO per each of the 10 Provinces by Q2 2015.	-	10	-	-	-	10	10 Provincial training of trainers conducted	19,950	-	199,500	-	-	-	199,500
Strategic Activity 5	Cascade training at District level to schools in 82 Clusters (1 cluster = 10 schools, 1 school has 1 Head, 1D/Head, 1SDC, 1 School Health Coordinator and 1 TIC) by Q2 2016	-	41	41	-	-	82	82 cluster trainings conducted	24,620	-	1,009,420	1,009,420	-	-	2,018,840
Strategic Activity 6	Review Supervision Tools to incorporate Health and Nutrition aspects by Q3, 2016	-	-	1	-	-	1	Reviewed Supervision Tool	850	-	-	850	-	-	850
Strategic Activity 7	Review of teacher training curriculum by MoHTET to rope in health and nutrition by Q4, 2014	1	-	-	-	-	1	Teacher training curriculum reviewed	18,600	18,600	-	-	-	-	18,600
Strategy 2: Nutrition integrated into the basic education curriculum, covering essential topics such as nutrition and growth, family planning, pregnancy and infant feeding, and hygiene promotion															
Strategic Activity 1	Curriculum review for all levels from ECD to update and integrate Health and Nutrition - Ongoing	-	1	-	-	1	2	Home Economics , Social Studies Syllabi for (ECD, Gr 1/2, Junior Classes) reviewed and Food Junior and "O" level reviewed	-	-	-	-	-	-	-
Strategic Activity 2	Developing syllabi by Q4 2015	1	6	-	-	-	7	Syllabi developed	46,500	46,500	279,000	-	-	-	325,500
Strategic Activity 3	Syllabus interpretation by Q2,2016	-	5	2	-	-	7	7 Interpreted Syllabi	46,500	-	232,500	93,000	-	-	325,500

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 4	Syllabus Interpretation cascaded by Q4 2017	-	-	180	394	-	574	82 Cluster trainings for 7 syllabi conducted	24,620	-	-	4,431,600	9,700,280	-	14,131,880
Strategic Activity 5	Establishing nutrition gardens at each of the 8112 schools by Q4, 2018	1,622	1,622	1,622	1,622	1,622	8,110	Nutrition gardens established	2,100	3,406,200	3,406,200	3,406,200	3,406,200	3,406,200	17,031,000
Strategy 3: Promotion of continuing girls education focusing on school retention and completion of education by orphans and other vulnerable children in a bid to break cycles of poverty															
Strategic Activity 1	Providing sustainable School-based Feeding Programme for disadvantaged learners - Ongoing	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	School Feeding Programme	4	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	20,000,000
Strategic Activity 2	Provision of Life Skills, Sexuality, HIV and AIDS Education Programmes to eliminate drop outs and break cyles of poverty through 2 x 10 provincial Holiday Camps per year - Ongoing	20	20	20	20	20	100	20 Provincial Holiday camps conducted per year	23,770	475,400	475,400	475,400	475,400	475,400	2,377,000
Strategic Activity 3	Establishing PPP in each of the 73 Districts by by engaging with local businesses in the community willing to support OVC - Ongoing	14	14	15	15	15	73	PPP in 73 Districts	-	-	-	-	-	-	-
Strategy 4: Promotion of Peer Education on Health and Nutrition in all schools by Q4, 2015															
Strategic Activity 1	Develop guidelines on Peer Health and Nutrition Education Clubs for 8112 schools by Q4, 2015	-	1	-	-	-	1	Peer Health and Nutrition Guidelines developed	24,620	-	24,620	-	-	-	24,620
Strategic Activity 2	Print and distribute 100 000 Guidelines on peer health and nutrition education by Q2, 2016	-	-	100,000	-	-	100,000	100000 guidelines printed and distributed	10	-	-	1,000,000	-	-	1,000,000
Strategic Activity 3	Training Peer Health and Nutrition Educators targeting 10 learners at each of the 8112 schools by Q3, 2014	-	-	8,112	-	-	8,112	Trained Peer Health and Nutrition Educators	150	-	-	1,216,800	-	-	1,216,800
Strategic Activity 4	Establishing Peer Health and Nutrition Education Clubs in all schools - Ongoing	-	-	8,112	-	-	8,112	Peer Health and Nutrition School Clubs established	-	-	-	-	-	-	-

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Goal 13: All provinces and districts have food and nutrition security committees that are fully discharging their terms of reference by 2014, 50% of ward level committees functioning by 2018										333,375	479,030	358,840	358,840	358,840	1,888,925
Strategy 1: Capacity development of FNSC on their core mandates															
Strategic Activity 1	Train the NFSC in 2014.	9					1	Functional NFNSC	1,350	12,150	-	-	-	-	12,150
Strategic Activity 2	Train and resuscitate 36 remaining DFNSCs and 8 PFNSCs in 2014	36					44	Functional P&DFNSC	2,295	82,620	-	-	-	-	82,620
Strategic Activity 3	Finalize the M&E training package for FNSCs including DRR	1					1	M&E Training package for FNSCs	1,600	1,600	-	-	-	-	1,600
Strategic Activity 4	Roll out M&E Training to all PFNSC & DFNSC in 2014 and 2015.	35	34				69	National, Provincial & District FNSCs trained in M&E.	3,535	123,725	120,190	-	-	-	243,915
Strategic Activity 5	Provide an annual constraint removal budget for day to day running of FNSCs at all levels.	192	276	276	276	276	1,296	FNSC Coordination Meeting minutes and Field visit report	590	113,280	162,840	162,840	162,840	162,840	764,640
Strategic Activity 6	Train 50% of WFNSCs by 2018.	-	200	200	200	200	800	Functional WFNSC	980	-	196,000	196,000	196,000	196,000	784,000
Goal 14: To increase the proportion of households consuming safe and acceptable diets all year round to at least 80% by 2018										8,871,227	6,294,937	6,210,487	6,181,787	6,181,787	33,691,024
Strategy 1: Promote crop diversification including adoption of bio-fortified crops rich in iron, zinc and vitamin A															
Strategic Activity 1	Establish 60 demonstration plots per year on crop diversification	60	60	60	60	60	300	Functional Demonstration plot.	350	21,000	21,000	21,000	21,000	21,000	105,000
Strategic Activity 2	Train 300 farmers per ward per year on crop diversifications	300	300	300	300	300	1,500	Trained farmer	1	150	150	150	150	150	750
Strategic Activity 3	Stage one seed fair per district annually.	60	60	60	60	60	300	Successful seed fair	100	6,000	6,000	6,000	6,000	6,000	30,000
Strategy 2: Promote improved post-harvest handling, processing, storage and value-addition to increase shelf-life and food safety of harvested foods															
Strategic Activity 1	Train 300 farmers per ward per year on post harvesting handling	300	300	300	300	300	1,500	Trained farmer	1	150	150	150	150	150	750
Strategic Activity 2	Stage one post-harvest technology fair per district per year.	60	60	60	60	60	300	Successful post-harvest technology fair	100	6,000	6,000	6,000	6,000	6,000	30,000
Strategic Activity 3	Establish 60 post-harvest technology demonstrations per year		30	30	30	30	120	Post-harvest technology demonstration centre	1,650	-	49,500	49,500	49,500	49,500	198,000
Strategy 3: Promote production and availability of small live-stock, aquaculture and apiculture and consumption of animal source protein foods															
Strategic Activity 1	Train 300 farmers per ward per year on production of small stock, aquaculture and apiculture	300	300	300	300	300	1,500	Trained farmer	1	150	150	150	150	150	750

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 2	Establish 60 demonstrations on aquaculture annually	60	60	60	60	60	300	Aquaculture demonstration	1,836	110,160	110,160	110,160	110,160	110,160	550,800
Strategic Activity 3	Establish 60 demonstrations on apiculture annually	60	60	60	60	60	300	Apiculture demonstration.	112	6,720	6,720	6,720	6,720	6,720	33,600
Strategic Activity 4	Establish 60 demonstrations on small livestock annually	60	60	60	60	60	300	Small stock demonstration (any of indigenous chickens, shoats, rabbits, guinea fowl etc)	250	15,000	15,000	15,000	15,000	15,000	75,000
Strategy 4: Promote research and development of improved varieties of bio-fortified seeds															
Strategic Activity 1	Set up 13 on-station Multi-location testing sites of already developed bio- fortified varieties	13	13	13	13	13	65	Testing site	925	12,025	12,025	12,025	12,025	12,025	60,125
Strategic Activity 2	Set up 60 on-farm Multi-location testing sites of already developed bio- fortified varieties	60	60	60	60	60		Testing site	820	49,200					
Strategic Activity 3	Establish 60 demonstrations on bio-fortified varieties annually.	60	60	60	60	60	300	Demonstration site	350	21,000	21,000	21,000	21,000	21,000	105,000
Strategic Activity 4	Constitute 50 new bio fortified varieties/ germplasm annually	50	50	50	50	50	250	Rows of new cross combinations	5	50	50	50	50	50	250
Strategic Activity 5	Release 4 bio-fortified varieties by 2018		1	1	1	1	4	Bio fortified varieties	310	-	310	310	310	310	1,240
Strategy 5: Promote awareness of and demand for nutritious food, with an emphasis on production, processing, preservation, storage and preparation of diverse foods															
Strategic Activity 1	Develop a nutrition and agriculture behaviour change and communication strategy in 2014.	1					1	behaviour change communication strategy	13,100	13,100	-	-	-	-	13,100
Strategic Activity 2	Train 720 AGRITEX offices on the behaviour change and communication strategy annually	720	720	720	720	720	3,600	Trained AGRITEX officers	258	185,400	185,400	185,400	185,400	185,400	927,000
Strategic Activity 3	Develop 6 food baskets for specific agro ecological regions	1	3	2			6	Food baskets	4,850	4,850	14,550	9,700	-	-	29,100
Strategic Activity 4	Develop Zimbabwean food composition tables	1					1	Food composition table	650,000	650,000	-	-	-	-	650,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 6: Promote awareness and demand for fortified staple foods															
Strategic Activity 1	Implement the national staple food fortification strategy						1	National Staple Food Fortification Strategy Implemented	30,721,359	7,728,172	5,804,672	5,742,172	5,723,172	5,723,172	30,721,359
Strategic Activity 2	Conduct 2 bio-fortification efficacy studies.	1	1				2	Efficacy study report	17,100	17,100	17,100	-	-	-	34,200
Strategic Activity 3	Market and promote bio-fortified seed and crops through implementing a multi-media marketing strategy every year.	1	1	1	1	1	5	Media Package	25,000	25,000	25,000	25,000	25,000	25,000	125,000
Goal 15: Scale up evidence-based nutrition sensitive interventions in social protection services to 80% coverage by 2018										23,413,350	43,352,464	63,396,864	77,346,864	77,366,864	285,105,645
Strategy 1: Provision of conditional cash transfers to non-labour constrained vulnerable households under the food poverty line to increase utilization of health services by pregnant and lactating women and children under-five															
Strategic Activity 1	Sensitise stakeholders on nutrition sensitive conditional cash transfers in 2014	1					1	Stakeholder meeting	4,050	4,050	-	-	-	-	4,050
Strategic Activity 2	Review the existing unconditional cash transfer programme through integrating a nutrition sensitive conditional cash transfer for vulnerable households by 2014 targeting 50,000 of the 250,000 households by 2018	1					1	Updated cash transfer framework and operational manual and 210 000 households with Pregnant, lactating and with under 5 Children targeted	22,000	22,000	-	-	-	-	22,000
Strategic Activity 3	Vulnerable people beneficiary list continuously updated and reviewed through identifying households on the list with pregnant and lactating women and households with children under-five	16	25	25	25	25	116	Up to date vulnerable beneficiary list	4,400	70,400	110,000	110,000	110,000	110,000	510,400
Strategic Activity 4	Regular training of trainers and Sensitization of district health workers in cash transfer target area	16	25	25	25	25	116	Sensitized health workers and communities	2,250	36,000	56,250	56,250	56,250	56,250	261,000
Strategy 2: Providing a consistent adequate nutritionally sensitive unconditional social cash transfer to ultra-poor labour constrained households for them to meet their needs for a healthy productive life															
Strategic Activity 1	Stakeholder sensitization meeting						-			-	-	-	-	-	-

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 2	Review the unconditional cash transfer framework and operating system to integrate nutrition	16	25	25	25	25	116	Reviewed cash transfer framework		-	-	-	-	-	-
Strategic Activity 3	Develop IEC material on nutrition education by 2014	50,000		50,000		20,000	120,000	Printed pamphlets and posters	1	50,000	-	50,000	-	20,000	120,000
Strategic Activity 4	Educate beneficiaries on nutrition purchasing and referrals to nutrition support programme through family clubs	16	25	25	25	25	116	Nutrition purchasing Educated beneficiaries	540	8,640	13,500	13,500	13,500	13,500	62,640
Strategy 3: Ensure that nutrition education and behaviour change communication are integral part of all social assistance programmes															
Strategic Activity 1	Develop a in service training curriculum for Nutrition education behaviour change communication		1				1	Training Curriculum developed	5,600	-	5,600	-	-	-	5,600
Strategic Activity 2	Train SSOs on Nutrition Education and Counselling	1					1		51,680	51,680	-	-	-	-	51,680
Strategic Activity 3	Support and supervision Activities		1	1	1	1	4	Support visits	31,330	-	31,330	31,330	31,330	31,330	125,320
Strategy 4: Empower communities through productive asset creation and information to build a culture of safety and resilience to disasters															
Strategic Activity 1	Sensitise 30 key stakeholders including funding partners on integration of nutrition in PCW programmes by 2014	1					1	Sensitised key stakeholders	900	900	-	-	-	-	900
Strategic Activity 2	Finalise and print the Productive Community works framework and operational manual integrating nutrition for implementation in 2014	1,000					1,000	Printed Productive community works framework and operational manual	10	10,000	-	-	-	-	10,000
Strategic Activity 3	Launch the policy at national level and invite all stakeholders	1					1	Policy launched	3,000	3,000	-	-	-	-	3,000
Strategic Activity 4	Scale up implementation of PCW programme	100,000	200,000	300,000	370,000	370,000	1,340,000	Households benefit from Public Works programme	200	20,000,000	40,000,000	60,000,000	74,000,000	74,000,000	268,000,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 5: Integrate nutrition sensitive DRM into sector programmes and budgets (supportive policy, legal and institutional frameworks for DRM; early warning informat ion, social behaviour change towards a culture of safety and resilience; integrating DRM into sector programmes; and DRM capacity building at all levels)															
Strategic Activity 1	Set up and capacitate coordination mechanisms for nutrition sensitive DRM at all levels by Q3,2014	1					1	Coordination mechanism for nutrition sensitive DRM established and capacitated	24,075	24,075	-	-	-	-	24,075
Strategic Activity 2	Develop risk profile including an assessment of the nutrition impacts of disasters, underlying causes and programming options by Q3, 2014	1					1	Risk profile on nutrition sensitive DRM developed	13,080	13,080	-	-	-	-	13,080
Strategic Activity 3	Conduct a yearly regular risk and vulnerability assessments, collating and disseminating climate-related information and coordinating mitigation actions across a range of sectors from 2015 to 2018		1	1	1	1	4	Annual risk and vulnerabilityass essment report	1,200	1,200	-	-	-		1,200
Strategic Activity 4	Support top 5 sector ministries to intergrate DRM into their policies, strategies and programmes by 2018		2	3		-	5	sectors that have successfully integrated nutrition sensitive DRM,		-	-	-	-	-	229,240
Strategic Activity 5	Monitor and evaluate the DRM nutrition sensitive mainstreaming process and outcomes		4	4	4	4	16	Quarterly monitoring reports	13,886	-	55,544	55,544	55,544	55,544	222,175
Strategy 6: Integrate nutrition indicators into targeting, monitoring and evaluation systems for social protection programmes															
Strategic Activity 1	Develop, an M and E framework for all social cash transfer programmes which integrates nutrition indicators from Q2 to Q3	1					1	Developed M& E Framework	11,260	11,260	-	-	-	-	11,260
Strategic Activity 2	Train 10 SSOs annually on use of and interpretation of M and E during Q3	10	10	10	10	10	50	M & E Trained SSOs	51,680	516,800	516,800	516,800	516,800	516,800	2,584,000
Strategic Activity 3	Implement the M and E framework quarterly, every 4th Quarter	1	1	1	1	1	5	M & E Report	10,800	10,800	10,800	10,800	10,800	10,800	54,000
Strategic Activity 4	Review beneficiary register for social protection through including nutritional indicators in targeting	1	1	1	1	1	5	Reviewed beneficiary Register with Nutrition Indicators included.	2,640	2,640	2,640	2,640	2,640	2,640	13,200

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 7: Provision of timely social safety nets in emergencies and crisis situations that meet universally accepted minimum standards and national food and nutrition standards (where applicable)															
Strategic Activity 1	Develop a nutritional sensitive emergency preparedness plan and guidelines for social safety nets programmes	1					1	Emergency Preparedness plan Produced	10,100	10,100	-	-	-	-	10,100
Strategic Activity 2	Provide emergency relief that meets the sphere standards	10,000	10,000	10,000	10,000	10,000	50,000	Number of assisted Households per year	255	2,550,000	2,550,000	2,550,000	2,550,000	2,550,000	12,750,000
Strategic Activity 3	Train district food and nutrition security committees in disaster response	15					15		1,115	16,725	-	-	-	-	16,725
Goal 16: At least 50% of community based health workers promote WASH related behaviour change whilst integrating nutrition messaging by 2018										59,875	163,450	-	-	-	223,325
Strategy 1: Capacitate WASH committees at all levels on nutrition and WASH linkages															
Strategic Activity 1	Develop a standard WASH and Nutrition SensitisationGuideline for advocacy by Q2 2014	1	-	-	-	-	1	Standard Wash and Nutrition Sensitisation Guideline produced	22,000	22,000	-	-	-	-	22,000
Strategic Activity 2	Print and distribute 1000 copies of the standard WASH and Nutrition Sensitisation Guideline by Q3 2015	1,000	-	-	-	-	1,000	1000 copies of guideline printed and distributed	15	15,000	-	-	-	-	15,000
Strategic Activity 3	Conduct Nutrition Sensitisation Meetings for the National WASH Committee on the new Guideline and reviewed PHHE tool by Q4 2014	1	-	-	-	-	1	1 National WASH Sensitisation Meeting conducted	8,500	8,500	-	-	-	-	8,500
Strategic Activity 4	Conduct Nutrition Sensitisation Meeting for 10 Provincial WASH Committees on the new Guideline and reviewed PHHE tool by Q1 2015	5	5	-	-	-	10	10 Provincial WASH Committee meetings conducted	2,875	14,375	14,375	-	-	-	28,750
Strategic Activity 5	Conduct Nutrition Sensitisation Meeting for 60 District WASH Committees (Rural) and 29 Urban WASH Committees on the new Guideline and reviewed PHHE tool by Q4 2015	-	89	-	-	-	89	89 District WASH Sensitisation Meetings conducted	1,675	-	149,075	-	-	-	149,075
Strategy 2: Integrate nutrition into PHHE delivered through the community health club approach															
Strategic Activity 1	Review existing PHHE tool kit to include nutrition by Q3 2014	1	-	-	-	-	1	1 Revised PHHE Tool Kit	22,000	22,000	-	-	-	-	22,000
Strategic Activity 2	Printing and distribution of 2000 copies of the reviewed PHHE tool kit by Q4 2014	2,000	-	-	-	-	2,000	2000 printed and distributed revised PHHE tool kits	30	60,000	-	-	-	-	60,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 3	Revive at least 1 Community Health Club per Health Centre catchment area in at least 960 Health Facilities by 2018	-	200	200	300	300	1,000	1000 Community Health Clubs revived	150	-	30,000	30,000	45,000	45,000	150,000
Strategic Activity 4	Train 1600 Community Health Clubs using the revised PHHE Tool Kit by 2018	-	400	400	400	400	1,600	1600 Community Health Clubs trained on the revised PHHE Tool kit	375	-	150,000	150,000	150,000	150,000	600,000
Goal 17: By 2018 ensure that at least 50% of imported and locally produced foods are evaluated for safety										10,959,250	2,085,950	2,299,980	1,983,100	1,983,100	19,311,380
Strategy 1: All ports of entry capacitated with port health officers															
Strategic Activity 1	Advocate for 120 substantive posts for Port Health Officers and Technicians at the 30 Designated Ports of Entry by Q1 2015	1	-	-	-	-	1	120 Port Health and Technicians posts created	300	300	-	-	-	-	300
Strategic Activity 2	Appointment and recruitment of 120 Port Health Officers and Technicians at Designated Ports of Entry by Dec 2016	-	100	20	-	-	120	120 Port Health and Technicians posts filled	100	-	10,000	2,000	-	-	12,000
Strategic Activity 3	Monthly payment of salaries for the Port Health Officers	-	100	120	120	120	120	Port Health Officers paid on a monthly basis	400	-	40,000	48,000	48,000	48,000	184,000
Strategic Activity 4	In- service/ Refresher training of 120 Port Health Practitioners on food safety - Ongoing	-	100	20	30	30	180	180 Port Health Practitioners trained on Food Safety	680	-	68,000	13,600	20,400	20,400	122,400
Strategic Activity 5	Monitoring and enforcement of Port Health Laws and Regulations - Ongoing	-	30	30	30	30	120	Port Health Laws and Regulations enforced and monitored	1,200	-	36,000	36,000	36,000	36,000	144,000
Strategy 2: Harmonisation of regulations related to importation of foods among ZIMRA, MOHCC, MAMID (veterinarians) and SAZ to meet International Standards															
Strategic Activity 1	Identify relevant regulations related to imported food commodities to be harmonized with other relevant sector ministries by Q4 2014	1	-	-	-	-	1	Relevant regulations identified and harmonised	48,000	48,000	-	-	-	-	48,000
Strategic Activity 2	Updating of relevant regulations related to imported food commodities to be harmonized with other relevant sector ministries by Q3 2015	1	3	-	-	-	4	Relevant regulations updated and harmonised	17,250	17,250	51,750	-	-	-	69,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 3	Enforcement of relevant regulations related to imported food commodities to be harmonized with other relevant sector ministries - Ongoing	-	89	89	89	89	356	Relevant regulations enforced	10,800	-	961,200	961,200	961,200	961,200	3,844,800
Strategy 3: Provide low cost food safety rapid test kits used at ports of entry and market places															
Strategic Activity 1	Conduct Situational Assessment of relevant useful rapid food safety testing kits to be used at ports of entry and inland by Q3 2014	1	-	-	-	-	1	1 Situational Assessment conducted	200	200	-	-	-	-	200
Strategic Activity 2	Procurement of relevant food testing kits - Ongoing	40,000	40,000	40,000	40,000	40,000	200,000	Food testing kits procured	20	800,000	800,000	800,000	800,000	800,000	4,000,000
Strategic Activity 3	In- service/ Refresher training of 1,600 Environmental Health Practitioners on the use of food safety rapid test kits - Ongoing	-	400	400	400	400	1,600	Training of Environmental Health practitioners on the use of food safety rapid test kits conducted.	290	-	116,000	116,000	116,000	116,000	464,000
Strategic Activity 4	Monitoring of food at designated ports of entry and inland using low cost food safety rapid test kits - Ongoing						-	Food at designated ports of entry and inland monitored using low cost food safety rapid test kits	-	-	-	-	-	-	-
Strategy 4: Capacitate (with skills, equipment and supplies) existing Government Analyst Laboratory															
Strategic Activity 1	Conduct a situational assessment of skills, equipment and supplies at Government Analyst Laboratory by Q2 2014	1	-	-	-	-	1	Situational assessment of skills, equipment and supplies conducted	500	500	-	-	-	-	500
Strategic Activity 2	Purchase modern equipment and supplies for analysis of food for safety based on the situational assessment by Q4 2014	1	-	-	-	-	1	Modern equipment and supplies for analysis of food for safety purchased	10,000,000	10,000,000	-	-	-	-	10,000,000

Key Result Area 5: Strengthening multi-sectoral coordination and collaboration for integrated nutrition response

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 3	In-service/ Refresher training of 50 health workers at Government Analyst Laboratory on used of modern equipment in testing food for safety by Q2 2015	-	50	-	-	-	50	50 health workers and Government Analyst Laboratory trained on use of modern equipment in testing for safety	30	-	1,500	-	-	-	1,500
Strategy 5: Conduct operational research on pesticide residue and aflatoxins and GMOs in household diets															
Strategic Activity 1	Proposal development for research on pesticide residues and aflatoxin in household diets by Q4 2015	-	1	-	-	-	1	1 Proposal developed		-	-	-	-	-	-
Strategic Activity 2	Submission of proposal for funding by Q1 2016	-	-	1	-	-	1	Research funded by Q1 2016	100	-	-	100	-	-	100
Strategic Activity 3	Conduct Research by Q4 2016	-	-	1	-	-	1	Research conducted by Dec 2016	321,580	-	-	321,580	-	-	321,580
Strategy 6: Capacitate the National Environmental Health Department to effectively implement and monitor above mentioned strategies															
Strategic Activity 1	Purchase of 3 programme vehicles to monitor Food Safety, Port Health and WASH activities by Q4 2014	3	-	-	-	-	3	3 programme vehicles purchased for Food Safety, Port Health and WASH	30,000	90,000	-	-	-	-	90,000
Strategic Activity 2	Purchase and maintenance of equipment and stationery for implementation of strategies - Ongoing	2	1	1	1	1	6	Standard package of stationery and equipment purchased and maintained	1,500	3,000	1,500	1,500	1,500	1,500	9,000
Sub-Total KRA 5 Strengthening multi-sectoral coordination and collaboration for integrated nutrition response										53,373,117	62,545,271	88,442,241	103,995,271	94,314,991	402,722,829

Key Result Area 6: Resource mobilization and capacity development for Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Goal 18: By 2018 the national nutrition department has a critical mass of staff with the ability, tools, supportive supervisi on and resources to integrate nutrition into other sectors										130,080	322,817	158,760	132,120	144,040	887,817
Strategy 1: Organisational capacity assessment and establishment of relevant posts															
Strategic Activity 1	Conduct an organisational capacity assessment in Q4, 2014	1					1	Organisational Capacity Assessment report	130,000	130,000	-	-	-	-	130,000
Strategic Activity 2	Advocate for establishment of national nutrition department manager posts and provincial hospital dietician posts by Q4 2015		14				14	Posts established	8	-	112	-	-	-	112
Strategic Activity 3	Advocate for establishment of 4 focal nutritionists posts in key line Ministries by Q2 2015		4				4	Focal Nutritionists posts established	8	-	32	-	-	-	32
Strategic Activity 4	Advocate for unfreezing of district nutritionist posts by Q2 2015		10				10	Districts Nutritionist posts unfrozen	8	-	80	-	-	-	80
Strategy 2: Recruitment of staff to fill in established posts															
Strategic Activity 1	Recruit 1 national nutrition manager per year starting in 2015		1	1	1	1	4	National Nutrition Managers Recruited	12,000	-	12,040	24,040	36,040	48,040	120,160
Strategic Activity 2	Recruit 4 focal nutritionists, one each for Agriculture, Social Protection, Education and Women and Gender in 2016			4			4	Focal Nutritionists recruited	9600	-	-	38,440	-	-	38,440
Strategic Activity 3	Mobilize 1 community based nutrition volunteer per village for 70% of wards by 2015		8190				8190	Community Based Nutrition Volunteers recruited	29	-	234,048	-	-	-	234,048
Strategic Activity 4	Recruit 10 district nutritionists to fill vacant posts by 2015			10			10	District Nutritionists recruited	9600	-	-	96,160	96,000	96,000	288,160
Strategic Activity 5	Recruit 10 provincial hospital dieticians by 2017	2	3	3	2		10	Provincial Hospital Dieticians recruited	40	80	120	120	80	-	400

Key Result Area 6: Resource mobilization and capacity development for Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategy 3: On the job capacity development															
Strategic Activity 1	Provide on the job training on the government results based management and reporting system targeting 70 nutritionists and 10 HQ staff from the National Nutrition Department in Q1 2015		80				80	Nutritionists and National Nutrition Department Staff trained on RBM	112	-	8,925	-	-	-	8,925
Strategic Activity 2	Provide on the job training on standard reporting format for the nutrition department, targeting 70 nutritionists in Q1, 2015		70				70	Nutritionists trained on the standard report format	307	-	21,510	-	-	-	21,510
Strategic Activity 3	Provide on the job training to 70 nutritionists and 10 HQ staff on the Financial Tracking Tool for Nutrition, in Q2 2015		80				80	Nutritionists and National Nutrition Department Staff trained on the financial Tracking tool for Nutrition	344	-	27,513	-	-	-	27,513
Strategic Activity 4	Provide on the job research and data management training for 70 nutritionists during Q3, 2015		60				70	Nutritionist trained on research and data management	307	-	18,437	-	-	-	18,437
Goal 19: To increase resource allocation to nutrition to 1% of GDP by 2018. (To be discussed further after costing)										633,650	1,254,254	749,180	82,900	82,900	2,802,884
Strategy 1: Strengthen advocacy with Ministry of Finance on the investment case for nutrition (advocacy paper on cost of hunger in relation to economic growth, human capital development)															
Strategic Activity 1	Carry out an assessment on the cost of hunger in Zimbabwe in 2014	1					1	Cost of hunger report	120,000	120,000	-	-	-	-	120,000
Strategic Activity 2	National stakeholder conference on the benefits of investing in nutrition and launch of SUN Movement in Zimbabwe	1					1	SUN Movement launched	53900	53,900	-	-	-	-	53,900
Strategic Activity 3	Develop a Tracking Tool for Monitoring Resources Allocated to Nutrition	1						Nutrition Resource Tracking Tool	10100	10,100	-	-	-	-	10,100
Strategic Activity 4	Orientation of permanent secretaries for the 17 key ministries covered by the NNS through the Working Party of Permanent Secretaries on budgeting for nutrition	17					17	Permanent Secretaries oriented on budgeting for nutrition	1085	18,450	-	-	-	-	18,450

Key Result Area 6: Resource mobilization and capacity development for Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 5	Orientation of budget officers for the key ministries covered by the NNS on budgeting for nutrition	34					34	Budget Officers oriented on budgeting for nutrition	468	15,900	-	-	-	-	15,900
Strategic Activity 6	Sensitize Food and Nutrition Security Committees on the NNS and how to budget for nutrition and keep track of resources allocated to nutrition		576				576	FNSC members oriented on budgeting for nutrition	202	-	116,414	-	-	-	116,414
Strategic Activity 7	Establish Food and Nutrition Security Committees in 70% of rural and urban wards in each district and provide orientation on advocacy for resource allocation through elected political representatives at constituency level	455	455	455			1365	Food and Nutrition Security Committees Established and Orientated on Advocacy	363	165,300	165,300	165,300	-	-	495,900
Strategy 2: Promote PPP in support of nutrition through a strategic partnership with relevant organizations (such as GAIN)															
Strategic Activity 1	Carryout a landscape analysis of the marketplace for nutrition in 2014 to: a) analyze the nutrition burden; b) define target groups in urban and rural areas; c) identify trends, gaps and opportunities in local food production, food processing and consumption; and d) identify investment opportunities and 1 business partner per province with potential for PPP by Q4, 2014	1					1	Landscape analysis of marketplace for nutrition report	250000	250,000	-	-	-	-	250,000
Strategic Activity 2	Support formation and functioning of 1 Marketplace for Nutrition platform at national level and one each at provincial level for knowledge, networking and financing of nutrition related investment in Q1, 2015		44	44	22	22	132	Marketplace for nutrition platform information sharing and networking meetings held	1950	-	85,800	85,800	42,900	42,900	257,400
Strategic Activity 3	Develop a strategy for business -led action to strengthen food value chain to increase marketplace availability of nutrient dense foods and dietary diversity in target populations by Q3, 2015		1				1	A strategy for business -led action developed	17890	-	17,890	-	-	-	17,890

Key Result Area 6: Resource mobilization and capacity development for Nutrition

Goals and Strategies	Strategic Activities	Annual Output Targets					Total outputs	Description of Output	Cost per unit of output, USD	Cost per year, USD					Total Cost, USD
		2014	2015	2016	2017	2018				2014	2015	2016	2017	2018	
Strategic Activity 4	Provide technical support to 12 business partners to develop sellable business plans to produce and supply the market with the prioritized nutritious foods by Q4 2015		12				12	12 business partners have sellable business plans	4300	-	51,600	-	-	-	51,600
Strategic Activity 5	Link 12 business partners to potential providers of finance to finance marketplace nutrition business plans in partnership with GAIN by Q1 2016		8	4			12	12 business partners with financed marketplace nutrition business plans	100,000	-	800,000	400,000	-	-	1,200,000
Strategic Activity 6	Capacitate 3 business partners to locally produce ready-to-use therapeutic foods for IMAM programme using locally available food products by Q3 2016			3			3	3 business partners capacitated to produce RUTF	19360	-	-	58,080	-	-	58,080
Strategic Activity 7	Develop by Q4 2015 a Marketplace Nutrition mutual business accountability framework(MBAF)		1				1	Marketplace Nutrition mutual business accountability framework(MBAF) developed	17250	-	17,250	-	-	-	17,250
Strategic Activity 8	Implement a Marketplace Nutrition Mutual Business Accountability Framework (quarterly review of progress)			4	4	4	12	Joint quarterly review reports with agreed action points for partners	10000	-	-	40,000	40,000	40,000	120,000
Sub-Total KRA 6 Resource Mobilisation and capacity development for Nutrition										763,730	1,577,071	907,940	215,020	226,940	3,690,701