

Multi-sector programming at the sub-national level:

A case study of Chipinge and Chiredzi Districts, Zimbabwe



Authors

Report prepared for Emergency Nutrition Network (ENN) by John Borton with input from Natalie Sessions, Carmel Dolan and Jeremy Shoham.

Acknowledgements

In-country

Our thanks go to: Dr George Kembo (SUN Focal Point and Director, Food and Nutrition Council (FNC)); Siboniso Chigova (Nutrition Officer, FNC); Tatenda Mudiwa (Principal Officer, FNC); and Miriam Banda (Multisectoral Co-ordination Manager, FNC), whose support was essential to the success of this work.

Thanks also to Nester Gumbo (Chair, National Food and Nutrition Security Committee (FNCS) and Chief Agricultural Extension Specialist, Ministry of Lands, Agriculture and Rural Resettlement); Yvonne Mavhunga (Deputy Director – Programmes, FNC) and Kudzai Mukudoka (Nutrition Officer – Stunting Reduction, United Nations Children’s Fund) for their helpful insights.



Acronyms

ANC	Antenatal Care
DFNSC	District Food and Nutrition Security Committee
DLLC	District Literacy and Learning Coordinator
ENN	Emergency Nutrition Network
ESAP	Economic Structural Adjustment Programme
ESAR	East and Southern African Region
EU	European Union
FAO	Food and Agriculture Organization
FNC	Food and Nutrition Council
FNCS	Food and Nutrition Security Committee
FNCSs	Food and Nutrition Security Committees
GNI	Gross National Income
IPC	Integrated Food Security Phase Classification
MCSBM	Multi-Sectoral Community Based Model
MoH	Ministry of Health
NGO	Non-governmental Organisation
NRTM	Near-real-time monitoring
ODK	Open Data Kit
OPC	Office of the President and Cabinet
PMR	Programme Monitoring and Response
SUN	Scaling Up Nutrition
SUNRAP	Scaling Up Nutrition Research and Academia Platform
TAN	Technical Assistance for Nutrition
UNICEF	United Nations Children’s Fund
VHWS	Village Health Workers
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
ZCSOSUNA	Zimbabwe Civil Society Organisation for Scaling Up Nutrition Alliance
Zim Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

Contents

Executive Summary	1
Section 1: Setting the scene	3
Introduction	3
The national level	4
Chipinge and Chiredzi Districts	5
Methodology for this study	6
Section 2: The National Food and Nutrition Security Policy	7
Section 3: The Multi-Sectoral Community-Based Model (MCBM) and its operation in Chipinge and Chiredzi Districts	9
Piloting the MCBM in the four pilot districts	10
Inter-district learning	11
Functionality assessment	11
Identification of drivers of stunting	12
Section 4: Analysis and findings on the operation of the MCBM in the two districts	13
Multi-sector working	13
Views of the committees on the achievements and impact of the MCBM	14
The introduction of the mentorship approach in the MCBM	15
The introduction of model wards and model villages in the MCBM	15
The role of the chiefs and traditional leaders	16
The operation of the near-real-time monitoring system (NRTM)	17
Logistical and economic challenges	18
Challenges stemming from cultural and religious beliefs and practices	19
The role of VHWs and volunteer VHWs in the MCBM	19
The impact of Cyclone Idai	20
Section 5: Conclusions	21
Annex 1. List of interviewees and those consulted	23
Annex 2. Questions used in group discussions at field level	25
Annex 3. NRTM data-collection tools for pregnant women and children under two years of age	26



WFP/Talenda Macheka

Executive summary

Children attending school in Zvishavane, Zimbabwe, benefit from the home grown school feeding programme

Zimbabwe is currently ranked 107 of 119 countries on the Global Hunger Index 2018, with 38% of the population defined as chronically food-insecure. However, trends for child malnutrition have seen substantial declines in stunting (from 33.8% in 2010 to 26.2% in 2018¹) and underweight (from 10% in 2010 to 8.8% in 2018), although wasting has risen marginally (from 2.1% in 2010 to 2.5% in 2018). The country has a long history of multi-sector nutrition programming, with the Food and Nutrition Council (FNC) established in 2001 as a multi-stakeholder platform to convene cross-sector actions and provide leadership to stakeholders with academics, donors and non-governmental partners. In 2012, the FNC led the development of the Food and Nutrition Security Policy for Zimbabwe, with an accompanying Implementation Plan/Matrix. As part of this policy, a multi-sector approach to reducing stunting was developed two years later; the ‘Multi-Sectoral Community Based Model for addressing food and nutrition insecurity for Stunting Reduction’ (commonly referred to as ‘MCBM’). Four pilot districts were selected for the programme on the basis of their stunting rates, poverty levels and other indicators.

Key elements in the design of the MCBM pilot include:

- Participatory planning at the community level to identify and address the specific causes of stunting in each community;
- Targeting of nutritionally at-risk households (vulnerable pre-pregnant, pregnant and lactating women, children under two years of age and adolescent girls) with nutrition-specific and nutrition-sensitive programmes to improve maternal and child nutrition and reduce household food insecurity;
- Developing community-based processes aimed at empowering adolescent girls, pre-pregnant and pregnant women and mothers;

- The explicit involvement of local chiefs and headmen, given their significant role in influencing local practices;
- An explicit commitment to building capacities at district, ward and village levels;
- Achieving greater efficiencies in the delivery of government services at district, ward and village levels;
- Leveraging additional resources through the involvement of donor and non-governmental organisation (NGO) partners;
- Strengthening of monitoring and feedback mechanisms at the different levels.

Between April and September 2019, Emergency Nutrition Network (ENN) conducted field visits to understand and document the MCBM approach. Key informant interviews were conducted in Harare as well as Chipinge and Chiredzi, two districts that were part of the pilot districts in the MCBM model. Fifteen national-level interviews were conducted with stakeholders from the FNC, the ministries responsible for agriculture and health, the United Nations Children’s Fund (UNICEF), the Food and Agriculture Organization of the United Nations (FAO), and donor partners. At a sub-national level, interviews were conducted with a chief, and five focus-group discussions were held with members of Food and Nutrition Security Committees (FNCSs) at district, ward and village levels (40 people). Meetings were also held with members of local community gardens and health clubs (approximately 50 people).

The findings noted a number of important successes of the model thus far. First, it has enabled and **enhanced multi-sector ways of working, with joint planning and implementation being seen**. There was broad agreement that the MCBM significantly increased the level of joint planning and practical

¹ 2010 and 2018 National Nutrition Survey.

collaboration between different government ministries. The MCBM's requirement for district, ward and village FNSCs to undertake joint assessments, identify and agree on local needs and priorities, then collaborate on addressing those priorities was seen as central to the increased collaboration. Wards develop their own action plans based on the agreed needs, which can then be used to hold wards and sectors accountable. Critically, a number of behaviour changes have taken place since the programme began, such as dairy farmers retaining some milk for their own consumption rather than selling it all, and the encouragement of community gardens. While some of the changes may well have occurred in the absence of the MCBM, there was a widely shared sense that it had contributed positively to the changes by focusing attention on stunting and the many different factors contributing to it. By bringing the different ministries together at district, ward and village levels to focus on stunting reduction, and by helping to conscientise and mobilise communities to focus on stunting reduction, the MCBM contributed significantly to the positive changes in behaviours. Second, the MCBM enabled the **introduction of the mentorship approach**, which has helped to improve the quality of stunting-reduction efforts. The approach involves members of the District FNSC mentoring one or two wards. The system is generally regarded as a positive innovation and ward members were appreciative of the support provided by their mentor. Opportunities for the mentors to meet their ward FNSC are taken whenever they present themselves. The sort of issues that ward FNSCs asked for support on included: requests for specific documents; advice on data collection, the sending of data, including 'data bundling'; and questions on how to improve the information flow between members so as to fully exploit opportunities presented by a particular ministry visiting the ward.

Similarly, the concept of **model wards and model villages** was developed in the MCBM approach. This involves the initial identification of the 'best' or 'most effective' ward within each district, and subsequently the best or most effective village within that ward, as a means of sharing their experience and good practices with other wards and villages. The criteria used in assessing 'best' and 'most effective' include the level of engagement and motivation of the ward and village with the MCBM in terms of designing and implementing activities aimed at reducing stunting, and the level and quality of reporting.

Furthermore, from the outset of the MCBM, **chiefs and traditional leaders were recognised as having**

an important role to play in changing behaviours and practices. On the basis of the two district visits, it is clear that chiefs and traditional leaders are indeed playing a key role in influencing behaviours and practices that contribute to stunting. After identifying their role at sub-national level, chiefs from the four pilot districts were sensitised during the initial stages of MCBM on stunting and its causes, and briefed on the overall MCBM initiative.

The **operation of a near-real-time monitoring system (NRTM)** proved valuable and was seen as a vital part of the MCBM approach as it provided districts and wards with data to help set priorities and action plans, revise priorities where necessary, and indicate progress. The feedback provided to the communities by the NRTM was seen by many in the two districts as integral to the success of the MCBM.

However, certain challenges remain. For example, since the **external funding for the NRTM ended** around mid-2017, it has encountered a number of challenges and its effectiveness and coverage has declined. Some at the national level regard the NRTM as not having functioned properly for the last two years. In Ward 22 in Chiredzi, for instance, the tablet device was sent to Harare for updating in February 2019, and it had not been returned seven months later (although the ward was informed of the reasons for the delay. There are also **a number of logistical and financial challenges**, such as availability of fuel, which mean that visits to model villages and wards and mentoring visits are limited. Many districts also face prolonged power cuts, which makes work difficult, particularly where tasks require computers. Furthermore, an issue that was raised in almost every discussion in the two districts concerned **the level of work expected of the village health workers (VHWs), given their modest allowances.** (The current VHW allowance is 50 RTGS dollars every two months or 25 RTGS dollars/month; the equivalent of US\$2.10 per month.) Given this, some VHWs lack motivation and the job is subject to high staff turnover.

Critically, there is **a lack of robust recent surveys of stunting levels** in the two districts studied to compare with those undertaken immediately prior to the start of the MCBM. It is therefore not possible to assess whether the increased collaboration and focus on stunting reduction has had a clear positive impact on rates of stunting in the two districts. While **it is clear that the MCBM has had tremendous positive impacts on a multi-sector approach to nutrition improvement**, the lack of data to assess success accurately is disappointing.

1

Setting the scene

Water from the community garden provides drinking water for households, cattle and to grow vegetables in Manjerajera, Zimbabwe

WFP/Matteo Cosulich

Introduction

Emergency Nutrition Network (ENN) has been conducting case studies on multi-sector programming across South Asia, East Africa and West Africa since 2017 as part of its role as knowledge-management provider to the SUN Movement, Department for International Development-funded project Technical Assistance for Nutrition (TAN). ENN has worked closely with the SUN Secretariat to identify potential countries of study. Selection criteria were: countries that had been part of the SUN Movement for a relatively long period of time (i.e., who joined the SUN Movement prior to 2013-2014); were not part of the SUN Movement's own evaluative country case studies; who had available nutrition data; who had sufficient 'decentralisation' of institutions and processes in-country and/or reported presence of multi-sector programmes at sub-national level; who had exhibited national progress in reducing undernutrition; and who had demonstrated interest in undertaking such a case-study documentation process. Zimbabwe was selected as having met all such criteria.

For practitioners and policymakers working in nutrition, limited documentation is available on how nutrition-sensitive and multi-sector programmes are being implemented and supported by the institutional architecture at a national and sub-national level in countries with high levels of malnutrition. To date, this has been particularly limited at the sub-national level. ENN's primary objective for this work was not to analyse drivers of change leading to new approaches to nutrition programming, but rather to construct case studies with detailed descriptions of implementation. The focus is on *how* sectors are working together to roll out programmes and *how* new programme approaches fit within existing institutional architecture.

By documenting the experience of different sector stakeholders involved in multi-sector nutrition programming at sub-national and implementation levels, important lessons can be learned to help shape future approaches and practice.

This study was compiled with information collected from a series of semi-structured key informant interviews at the national level and a series of focus-group discussions conducted at the sub-national level in two districts: Chipinge District in the Eastern Highlands area bordering Mozambique, and Chiredzi District in the drier 'Lowveld' area of Masvingo Province in the south-east of the country. Both districts were part of the four pilot districts in Zimbabwe's Multi-Sectoral Community-Based Model (MCBM) programme launched in 2014. In 2017, a rollout process for the MCBM across Zimbabwe was started and, in addition to the four original pilot districts, it is at various stages of development in another 38 of Zimbabwe's 60 rural districts.

Fifteen national-level interviews were conducted with stakeholders from the Food and Nutrition Council (FNC), the ministries responsible for agriculture and health, the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization of the United Nations (FAO), and with donor partners. At a sub-national level, interviews were conducted with a chief, and five focus-group discussions were held with members of Food and Nutrition Security Committees (FNCSs) at district, ward and village levels (40 people). Meetings were also held with members of local community gardens and health clubs (approximately 50 people). An opportunistic meeting was also held with a group of chiefs and their officials in Chiredzi. The sub-national visit was conducted over six days in August/September 2019. A questionnaire with 34 questions had been developed for individual interviews at the field level, but did not prove

viable, given that nearly all the interviews were actually group discussions and the time available for the field visits was limited. A reduced set of key questions was therefore used for the group discussions and expanded where appropriate (see Annex 2).

The study was undertaken at a time when Zimbabwe was experiencing renewed economic hardship after several years of recovery following the collapse of its banking system and currency in the early 2000s; a period which culminated in severe hyperinflation in 2008. An El Niño-related drought event in 2016 and Cyclone Idai in March 2019, which caused severe damage in eastern areas, contributed to increased food insecurity in the country. At the time of the sub-national visit, many areas of the country were experiencing prolonged power outages and fuel shortages.

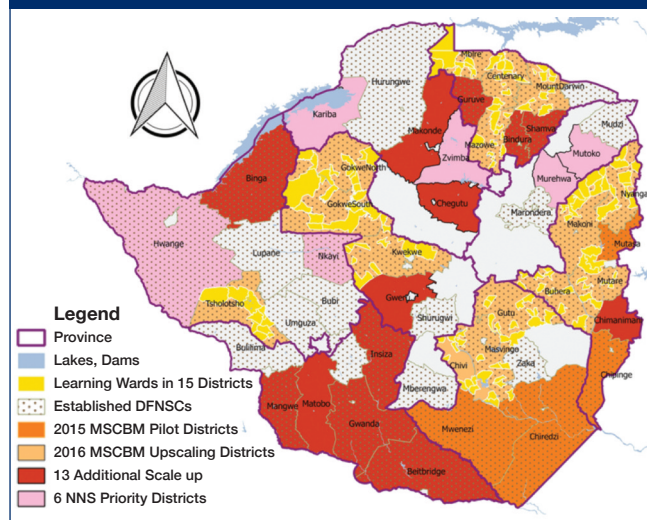
This report is divided into five sections. Section 1 sets the scene by describing the economic and food security and nutrition situation in Zimbabwe, providing an overview of the two districts and outlining the methodology used by the study. Section 2 describes the National Food and Nutrition Security Policy. Section 3 describes the emergence of the MCBM and its piloting in the four districts, as well as the near-real-time monitoring (NRTM) system that ran alongside it. Section 4 assesses the operation of the MCBM in the two districts and the more recent innovations of the mentorship approach, as well as the process of identifying model wards and villages. The achievements of the MCBM as viewed from district, ward and village levels are presented, together with an assessment of the challenges faced by the MCBM. Section 5 draws conclusions on the MCBM and considers the possible evolution of the NRTM.

The national level

Zimbabwe is a landlocked southern African country with a population of 17.3 million,³ of whom 67% are rural and 33% urban. Agriculture is the backbone of the economy, providing employment and income for 60-70% of the population, and making up 40% of total export earnings and 17% of GDP.⁴ Zimbabwe is ranked 156 of 189 countries in the 2018 Human Development Index.⁵ In 2012, 63% of the population lived below the poverty line and 16% lived in extreme poverty.⁶ Thanks to large investments in education since independence, the country has one of the highest adult literacy rates in Africa, with 89% of the adult population literate.⁷

Zimbabwe's economy grew steadily during the first 20 years after independence, but suffered severe contraction between 2002 and 2008, when both the banking system and the national currency collapsed.

The location of the four original pilot districts and the subsequent rollout of the MCBM to other areas of the country



The 'dollarisation' of the economy⁸ in 2009 saw an economic recovery. In 2013, the government introduced the Zimbabwe Agenda for Sustainable Socio-Economic Transformation ('Zim Asset') as an economic blueprint for development.⁹ In 2019, the World Bank changed its classification of Zimbabwe from a 'low-income' economy to a 'lower-middle-income' economy, with a GNI/capita of US\$ 1,790.¹⁰

The country's economy still faces major challenges. Exogenous shocks in the form of El Niño-related droughts significantly reduced harvests in 2016 and 2018. In March 2019, Cyclone Idai caused over 600 deaths, displaced more than 50,000 people and caused widespread damage to infrastructure, community assets, agricultural production and local economic activity in the east of the country. In June 2019, facing a shortage of US dollars and in an effort to tighten its control of the economy, the government ended the dollarisation phase. As of September 2019, much of the country was experiencing prolonged power cuts and fuel shortages.

² Source: Food and Nutrition Council

³ 2019 based on UN estimates.

⁴ FAO 'Zimbabwe at a glance' www.fao.org/zimbabwe/fao-in-zimbabwe/zimbabwe-at-a-glance/en/

⁵ <http://hdr.undp.org/en/composite/HDI>

⁶ Zimbabwe National Statistics Agency. 2013. Poverty, Income, Consumption and Expenditure Survey: 2011/2012 Report. Harare.

⁷ UNESCO Institute for Statistics 2014.

⁸ During the 'dollarisation' period, a number of foreign currencies, including the US dollar, the South African rand, the UK pound and the Botswana pula became acceptable legal tender.

⁹ Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset). www.zw.one.un.org/resources/publication/zimbabwe-agenda-sustainable-socio-economic-transformation-zim-asset

¹⁰ World Bank 2019 <https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2019-2020> The World Bank's lending programme in Zimbabwe is currently inactive due to arrears and the Bank's role is limited to technical assistance and analytical work through trust funds.

As the main source of livelihood for the majority of the population, the performance of the agriculture sector is a key determinant of food security, nutrition and poverty levels. Scoones (2018)¹¹ identifies three broad phases in the evolution of Zimbabwe's food economy. In the immediate post-independence period, there was considerable emphasis on food production (particularly on white maize, which is the main staple crop), with significant government support to communal-area farmers. Towards the end of the 1980s and into the 1990s, government support to communal-area agriculture declined as a result of the economic structural adjustment programme (ESAP) and production levels in these areas declined. At the same time, globally driven market incentives encouraged a shift in the commercial sector away from maize to higher-value crops, such as beef and tobacco, and wildlife and game farming. With the rapid change in land ownership in the commercial sector after 2000, irrigated maize production was dramatically reduced and the years in which maize had to be imported became more frequent.

In the 2018 Global Hunger Index, Zimbabwe ranked 107 of 119.¹² Between 2009 and 2014, an annual average of one million people – 8.3% of the population – were food-insecure; of whom 38% were chronically food-insecure.¹³ General challenges facing smallholder farmers include low and erratic rainfall, low and declining soil fertility, low investment, shortages of farm power (labour and draft animals), poor physical and institutional infrastructure, poverty, and recurring food insecurity. The communal sector, which produces 70% of staple foods (maize, millet and groundnuts), is particularly vulnerable as it has access to less than 5% of national irrigation systems.¹⁴

The 2018 National Nutrition Survey¹⁵ and its predecessors provide a good overview of nutritional status and trends in Zimbabwe. National rates for the under-5 population were: wasting 2.5%; stunting 26.2%; underweight 8.8%; and overweight 2.6%. Stunting is higher in rural areas (26.5%) than in urban areas (22.7%) and is markedly higher among boys (28.5%) than girls (23.9%). Trends for indicators of child malnutrition show a gradual decline from around 2006. Comparisons between the 2010 and 2018 National Nutrition Surveys show a decline in stunting (from 33.8% to 26.2%) and in the proportion underweight (from 10% to 8.8%), but a marginal increase in wasting, from 2.1% in 2010 to 2.5% in 2018.¹⁶

Dietary diversity is a major issue in Zimbabwe as the majority of smallholder farmers have traditionally relied heavily on maize, the main staple crop, which is

calorie-dense but not very nutritious.¹⁷ National assessments have shown that only 54% of the population consume the minimally acceptable diet and there is a lack of protein-rich foods in the diets.¹⁸ The 2018 National Nutrition Survey found that only 16% of children in the 6-23 month age group consumed at least four food groups in the 24 hours preceding the survey.¹⁹

El Niño-related reductions in production had a significant impact on levels of food insecurity in 2016 and again in 2019. In the 2016 event, 2.8 million people were food-insecure.²⁰ In 2019, the combination of El Niño-related crop reductions, the impact of Cyclone Idai and the rising prices of basic goods as a result of the economic challenges led to 2.29 million people (25% of the rural population) facing severe acute food insecurity (IPC Phase 3 classification 'in crisis' and the more severe Phase 4 'in emergency') during the June to September period. These numbers were projected to increase to 3.58 million people (38% of the rural population) for the October to December period. Of this overall figure, 2.47 million are projected to be in Phase 3 'in crisis' and 1.11 million in Phase 4 'in emergency'. The two districts that are the focus of this study, Chipinge and Chiredzi, are currently classified as Phase 3.

Chipinge and Chiredzi Districts

Chipinge and Chiredzi Districts were both part of the original MCBM pilot and both were visited for this study. Chipinge District is part of Manicaland Province and shares a border with Mozambique. It has 30 rural and eight urban wards. Its 2012 population was 299,000. The district covers no less than five agri-

¹¹ Scoones, Ian (2018) 'Land Reform in Zimbabwe: Challenges for Policy'. Brighton: Create Space

¹² www.globalhungerindex.org/zimbabwe.html

¹³ WFP and the National Food and Nutrition Council integrated context analysis, 2015. Cited in WFP Zimbabwe Country Strategic Plan (2017–2021) March 2017, Rome.

¹⁴ Scoones, Ian (2018) *ibid.*

¹⁵ Zimbabwe National Nutrition Survey 2018. Food and Nutrition Council, Harare.

¹⁶ Zimbabwe National Nutrition Survey 2018. Food and Nutrition Council, Harare. Page 106

¹⁷ Murendo, Conrad et al. 'Nutrition education, farm production diversity, and commercialization on household and individual dietary diversity in Zimbabwe.' *Food & nutrition research* vol. 62 10.29219/fnr.v62.1276. 17 May. 2018. doi:10.29219/fnr.v62.1276

¹⁸ Zimbabwe Vulnerability Assessment Committee. Zimbabwe Vulnerability Assessment Committee (ZimVAC) rural livelihoods assessment. Harare, Zimbabwe; 2016. Available from: www.fnc.org.zw/downloads/Bulletins/2016%20Bulletins/ZimVAC%202016%20Rural%20Livelihoods%20Assessment.pdf

¹⁹ Zimbabwe National Nutrition Survey 2018. Food and Nutrition Council, Harare. Page 72.

²⁰ WFP Zimbabwe Country Strategic Plan (2017–2021) March 2017, Rome.

ecological zones and farming practices vary considerably, with maize being a staple in the drier 'Lowveld' areas and potatoes in the higher-rainfall areas. The district is home to commercial farms growing tea, coffee, macadamia nuts and bananas.

Chiredzi District is part of Masvingo Province and shares a border with both Mozambique and South Africa. Covering a larger area than Chipinge and with a 2012 population of 276,000, it is more sparsely populated and a significant area is allocated to the Gonarezhou National Park. It is an arid area, but the red soils are quite rich and, with irrigation, can be productive. Irrigated commercial farms produce cotton and sugar, but maize is the main staple for communal-area farmers. The district has 32 rural and eight urban wards. While some wards are termed 'communal wards', others are 'resettlement wards', where farmers were allocated plots in areas that were previously zoned as either game reserves or commercial farms. Resettlement wards do not have traditional leadership structures.

For Chipinge, the 2017 Drivers of Stunting Assessment identified the main drivers as: food shortages; low rates of dietary diversity (23%), minimum acceptable diet (9%); and minimum meal frequency (37%). Exclusive breastfeeding rates were low (35%) and only 5% were continuing breastfeeding for up to two years. Vitamin A supplementation was low (28%) and 57% of households were accessing iodised salt, against a national target of 90%. Measles immunisation coverage was 63%. Safe water coverage was low and hygiene and sanitation practices poor, with 91% of households not using soap or ash when washing hands, 31% using pit latrines without a slab and 15% practicing open defecation.²²

For Chiredzi, the 2017 Drivers of Stunting Assessment²³ identified immediate causes as: inadequate dietary intake (12% of children aged 6-23 months receiving a minimum acceptable diet); poor access to fruits and vegetables; and a high disease burden, with frequent illnesses in children (diarrhoea, cough and fever) and malaria. The underlying causes identified were: food insecurity (lack of draught power and poor livestock production dynamics); inadequate care practices (low vitamin A coverage; low rates of children accessing growth monitoring; low exclusive breastfeeding rates among children aged 0-5 months (45%)); high levels of domestic violence against women; and inadequate access to water, sanitation and hygiene, with 40% of households practicing open defecation and 40% not accessing improved water supplies. The basic causes identified were: child/early marriages; caregiver

2014 Baseline profile of key nutrition indicators for the two districts²¹

Indicator	Chipinge	Chiredzi
Proportion of children 6-59 months stunted	43.8%	27.4%
Proportion of children 6-59 months wasted	3.0%	0.9%
Proportion of children 6-59 months severely wasted	3.0%	0.9%
Exclusive breastfeeding in children 0-5 months	43.7%	42.1%
Proportion of children 6-23 months meeting minimum acceptable diet	1%	5.8%

resources and intra-household control/gender issues; climate change; economic shocks and natural hazards/disasters; inadequate education coverage (17% of girls and 14% of boys not attending school due to affordability issues); and poor post-harvest handling practices and poor agricultural extension coverage.

Methodology for this study

A five-day scoping visit was undertaken to Harare in April 2019, during which information was gathered from and discussions held with government and other key actors at the national level to ensure their buy-in, guidance and involvement in the case study. A second visit was undertaken at the beginning of September 2019, during which nine further interviews were conducted in Harare and six days were spent visiting Chipinge and Chiredzi Districts, supported and accompanied by staff of the FNC. In the two districts, discussions were held with members of FNSCs at district, ward and village levels, chiefs and traditional leaders, and members of community gardens and health clubs. As Chipinge and Chiredzi Districts were two of the original four pilot districts, the MCBM project had been operating for nearly four years in both. Of the three wards visited, two were 'model wards' and, of the three villages visited, two were 'model villages'. This report is therefore conscious that it is presenting 'good' and 'best' practice within the MCBM approach, rather than a representative cross-section of the range of experiences across all 38 of the districts (including the four original pilot districts) currently at different stages of the MCBM rollout.

²¹ Source: 2014 SMART Survey and 2014 LQAS Reports. Reproduced from FNC (undated) A Community Based Multi-Sectoral Approach to Address Food and Nutrition Insecurity in Selected Vulnerable Districts of Zimbabwe with a Special Focus on System Strengthening.

²² FNC (2017) Drivers of Stunting Assessment Chipinge District <http://fnc.org.zw/wp-content/uploads/2019/01/drivers-of-stunting-chipinge-district.pdf>

²³ (FNC (2017) Drivers of Stunting Assessment Chiredzi District http://fnc.org.zw/wp-content/uploads/2019/01/drivers-of-stunting_chiredzi-district.pdf



WFP/Islanda Macheke

2

The National Food and Nutrition Security Policy

A small holder farmer from Mudzi Rushinga, Zimbabwe

The need to integrate food, nutrition and agricultural policy in Zimbabwe has long been recognised. A first national consultative workshop on this theme convened by the University of Zimbabwe took place in 1990.²⁴ The conference was presented with evidence of the paradox of substantial maize surpluses being produced by the commercial sector at the same time as mortality resulting from undernutrition, a situation described as “the silos are full but many stomachs are empty”.²⁵ In 1995, the government established a task force to recommend sustainable solutions to the persistent and growing problem of hunger and malnutrition, and this led to the submission of a Food and Nutrition Security Policy framework paper to the cabinet in 1998. In 2001, the FNC was established as a multi-stakeholder platform for the purpose of convening cross-sector actions and providing leadership to stakeholders in government and with academics, donors and non-governmental organisation (NGO) partners. In 2011, Zimbabwe joined the Scaling Up Nutrition (SUN) Movement, with a letter of commitment from the Director of the FNC.

In November 2012, following a major consultation process led by the FNC with different parts of government, academics, UN and donors and NGO partners, a Food and Nutrition Security Policy for Zimbabwe was published, with an accompanying Implementation Plan/Matrix. The policy was officially launched by His Excellency, President Robert Mugabe in May 2013.

The goal of the Food and Nutrition Security Policy 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.”

Policy principles

Principle 1: To be relevant to the social and economic context of Zimbabwe and reaffirm investment in nationally owned policy instruments, commitments, strategies and plans.

Principle 2: To reaffirm the fulfilment of the obligations in the UN Human Rights Charter and the ‘right to adequate food’.

Principle 3: To reaffirm investment in evidence-based best practices based on universally accepted and/or national research and to reinforce results-based strategies.

Principle 4: To strengthen collaboration across sectors, minimise duplication and foster collective accountability towards a shared goal.

Principle 5: To reinforce the central role and responsibility that communities and civil society have in ensuring food and nutrition security.

Principle 6: To reinforce the role of diverse stakeholders and partnerships between government and non-government partners, especially the role of a dynamic private sectors that complies with national standards, as well as an engaged civil society.

Principle 7: To reaffirm that relief, recovery and development are not sequential but can and should occur simultaneously, and place risk reduction and the mitigation of shocks as central, particularly in the context of climate change.

Principle 8: To foster a multi-sector approach in assessment, analysis and action.

²⁴ UZ/MSU Food Security Project 1990. Proceedings of the First National Consultative Workshop on Integrating Food, Nutrition and Agricultural Policy. Montclair Hotel, Juliasdale, July 15-18. The workshop was co-sponsored by the Economics and Markets Branch, Ministry of Lands, Agriculture and Rural Settlement; Nutrition Unit, Ministry of Health; University of Zimbabwe/Michigan State University Food Security Project.

²⁵ Rukuni, M. (1990) ‘Zimbabwe’s Food Insecurity Paradox’, in UZ/MSU Food Security Project 1990 Proceedings of the First National Consultative Workshop on Integrating Food, Nutrition and Agricultural Policy. Montclair Hotel, Juliasdale, July 15-18.

Underpinned by eight policy principles, the Food and Nutrition Security Policy sets out seven commitments.

For each of the seven commitments, the accompanying Implementation Plan/Matrix set out the strategic objectives within each commitment, together with their necessary key actions, outputs, outcomes, anticipated challenges, opportunities and budgets over a three-year Implementation Plan/Matrix.²⁶

To ensure effective implementation of the Food and Nutrition Security Policy, a high-level national ministerial task force was established to provide the necessary political leadership and effective coordination of the various sectors, chaired by the Honourable Vice President and with the Minister of Agriculture, Mechanisation and Irrigation Development as Deputy Chair. Other ministries represented on the national task force included: Health and Child Welfare; Labour and Social Services; Economic Planning and Investment Promotion, Finance; Women Affairs, Gender and Community Development; Local Government, Urban and Rural Development; Science and Technology Development; Lands and Rural Resettlement; Education, Sport, Art and Culture; Higher and Tertiary Education; Small and Medium Scale Enterprises and Cooperative Development; Tourism and Hospitality Industry; Transport, Communications and Infrastructural Development; Industry and Commerce; Environment and Natural Resource Management; and Water Resources Development and Management.

FNSCs were then established at national, provincial, district and sub-district (ward and village) levels. By September 2013, eight of the 10 provinces²⁷ (80%) and 24 of the country's 60 districts (40%) had established FNSCs.²⁸

²⁶ Food and Nutrition Council (2012) Implementation Plan/Matrix for the Food and Nutrition Security Policy for Zimbabwe. FNC: Harare.

²⁷ Of the 10 provinces, two are urban areas with provincial status (Harare and Bulawayo). The other eight provinces are: Manicaland; Mashonaland Central; Mashonaland East; Mashonaland West; Masvingo; Matabeleland North; Matabeleland South; and Midlands.

²⁸ Intersectoral Coordination for Scaling Up Nutrition In Zimbabwe – The Food and Nutrition Security Policy in the context of Economic Growth and Development. PowerPoint presentation by Kudzai Mukudoka, Intersectoral Collaboration Officer, FNC. CAADP Nutrition Capacity Development Workshop for Southern Africa, Gaborone, 9-13 September 2013.

Policy commitments

Commitment 1: Ensuring that policy instruments that protect and enhance food and nutrition security, particularly amongst the most vulnerable, are formulated and inform government and non-government decision-making and action.

Commitment 2: Ensuring food security for all, including access to adequate, diverse and nutritious food by all people at all times.

Commitment 3: Ensuring that where social protection, including social assistance, programmes are implemented, they must contribute to and enhance food and nutrition security of the most vulnerable in the short and medium term.

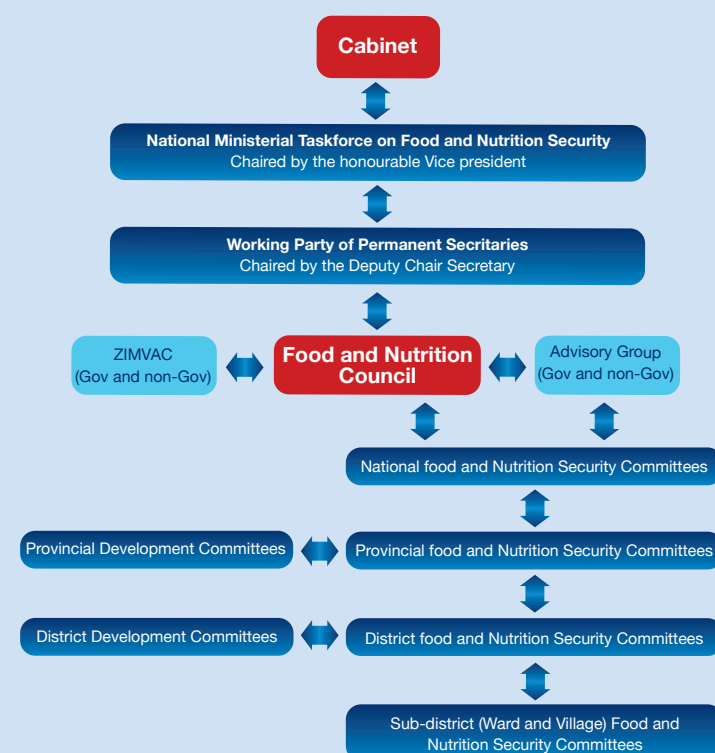
Commitment 4: The provision of safe and wholesome food. Food, whether imported or locally produced, shall meet national public health legislation and international standards for quality and safety.

Commitment 5: 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.

Commitment 6: Ensuring a national integrated food and nutrition security information system that provides timely, reliable information on the food and nutrition security situation, effectiveness of programmes, and decision-making.

Commitment 7: Enhancing and strengthening national capacity in food and nutrition security, primarily through supporting and reinforcing local community capacity and responsibility for food and nutrition security, applied context-specific research, and learning and multi-sector professional training in food and nutrition security.

Food and Nutrition Security Implementation Framework





3

The Multi-Sectoral Community-Based Model (MCBM) and its operation in Chipinge and Chiredzi Districts

Home grown school feeding programme in Zvishavane, Zimbabwe

Following the May 2013 launch of the Food and Nutrition Security Policy, The Lancet Maternal and Child Nutrition Series identified the importance of the prevention of stunting, especially during the first 1,000-day period, as a critical national priority.³⁰ With global evidence of the value of multi-sector programming in preventing stunting, the government developed a national economic blueprint, which included stunting reduction as part of its strategy for improving food and nutrition security.³¹ Over the course of 2014 and early 2015, the FNC (with support from UNICEF and other partners, including the World Food Programme (WFP), FAO, and the World Health Organization (WHO), developed a multi-sector approach to programming to reduce stunting that was to be piloted in four districts (Chipinge and Mutasa in Manicaland and Chiredzi and Mwenezi in Masvingo). (Note: The ‘Multi-Sectoral Community-Based Model for addressing food and nutrition insecurity for Stunting Reduction’ is more commonly referred to in Zimbabwe by the acronym ‘MCBM’.)

The MCBM is based in particular on two of the Food and Nutrition Security Policy’s guiding principles; namely principle 4 (strengthening collaboration across sectors, minimising duplication and fostering collective accountability towards a shared goal) and principle 5 (reinforcing the central role and responsibility that communities and civil society have in ensuring food and nutrition security policy). An FNC paper describes the MCBM³² model as:

“... a people-centred approach that places ownership and control of the development process within the community. They cease to be just beneficiaries of projects and programmes but become masters of their own destiny. It enables a greater layering of interventions, fostering complementary measures that build a stronger rationale for synergies across programme areas. This is so because the community based approach establishes a sustainable common planning platform that facilitates local coordination.”

The paper goes on to state:

“Given that stunting is a result of multiple causes, the model will therefore call for efforts of multi-stakeholders including Health, HIV, WASH [Water, Sanitation and Hygiene], Agriculture, Education, Women Affairs and Social Protection. The existing food and nutrition security coordination mechanism at provincial, district, ward and village levels will be utilized to implement this model. It is envisaged that the proposed model will contribute towards building the resilience of communities in the event of some shocks threatening food and nutrition security. It will also promote ownership of the initiatives and empower communities to be able to assist in solving their own problems.”

²⁹ Stunting is low height-for-age, reflecting a past episode or episodes of sustained undernutrition. In children under five years of age, stunting is defined as height-for-age less than - 2 standard deviations below the WHO Child Growth Standards median.
³⁰ www.who.int/nutrition/publications/lancetseries_maternal_and_childundernutrition/en/

³¹ Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) 2013 www.zw.one.un.org/resources/publication/zimbabwe-agenda-sustainable-socio-economic-transformation-zim-asset
³² FNC (no date), *ibid*.

Piloting the MCBM in the four pilot districts

The four pilot districts were selected on the basis of their rates of stunting, poverty and other indicators.³³ The total under-5 population in the four districts was approximately 160,000. Key elements in the design of the MCBM pilot³⁴ include:

- Participatory planning at the community level in order to identify and address the specific causes of stunting in each community;
- Targeting of the nutritionally at-risk households (vulnerable pre-pregnant, pregnant and lactating women, children under two years of age, and adolescent girls) with nutrition-specific and nutrition-sensitive programmes to improve maternal and child nutrition and reduce household food insecurity;
- Achieving an integrated response towards stunting reduction through improved coordination in the planning and delivery of services by different ministries at the district, ward and village levels;
- Developing community-based processes aimed at empowering adolescent girls, pre-pregnant and pregnant women and mothers;
- The deliberate involvement of local chiefs and headmen, given their significant role in influencing local practices;
- An explicit commitment to building capacities at district, ward and village levels;
- Achieving greater efficiencies in the delivery of government services at district, ward and village levels;
- Leveraging additional resources through the involvement of donor and NGO partners;
- Strengthening monitoring and feedback mechanisms at the different levels.

The implementation steps in setting up and operationalising the MCBM in the four pilot districts were:³⁵

Step 1: A national-level Joint Action Plan Committee was established, bringing together ministries of Local Government, Health, Agriculture, Social Services, Education, Women and Gender, Trade and Industry, Finance and Economic Planning.

Step 2: Sensitisation and coordination workshops were held at national, provincial and district levels.

Step 3: Sensitisation training on stunting and the MCBM approach (in Harare) for chiefs in the four pilot districts.

Step 4: Training provided to ward FNSCs in each of the four districts on micro-planning, coordination and analysis of drivers of stunting.

Step 5: Nutritionally vulnerable households identified at ward and village levels by the ward and village-level FNSCs.

Step 6: The drivers of stunting at ward and village level are identified through focus-group discussions, household interviews and secondary data analysis by ward FNSCs and community members.

Step 7: Micro-plans for reducing stunting are formulated at ward and village levels by ward FNSCs and village heads.

Step 8: Implementation of micro-plans and interventions by community and service providers (Health, Agriculture, WASH, Social Protection and Gender).

Shortly after work had begun on developing the MCBM approach, UNICEF, in conjunction with the Gates Foundation, decided to initiate an institutional strengthening support initiative in the East and Southern African Region (ESAR) to improve the programme monitoring and response (PMR) capacity of the government decision-making bodies and communities in relation to the health of women and children. Four countries were selected for the PMR project: Kenya, Swaziland, Uganda and Zimbabwe. In Zimbabwe, it was decided to use the Gates-funded project to pilot and test a community-based system for monitoring and reporting on the MCBM pilot project. Working closely with colleagues in UNICEF, the Analysis, Research, Monitoring and Evaluation Unit in the FNC developed an innovative 'near-real-time monitoring system' (NRTM) in support of the MCBM pilot project.

The principal elements of the NRTM are that village health workers (VHWs) and volunteer VHWs collect data from the pregnant women and from the mothers of children under the age of 24 months in their village once a month using two survey instruments (see Annex 3), and present the data to their village FNSC. Using carbon copies in the survey instruments, the village FNSCs then ensure their delivery to their ward FNSC. Two members of the ward FNSC (the Nurse in Charge at the clinic and the Environmental Health

³³ Stunting rates for children aged between 6-59 months as measured by the 2014 SMART survey and the 2014 LQAS reports were: Chipinge (43.8%); Chiredzi (27.4%); Mwenezi (32.5%); and Mutasa (29.9%). FNC (undated).

³⁴ The list is based on points made in FNC (undated) 'A Community Based Multi-Sectoral Approach to Address Food and Nutrition Insecurity in Selected Vulnerable Districts of Zimbabwe with a Special Focus on System Strengthening'.

³⁵ These steps are a composite of the planned steps outlined in FNC (undated) and information provided by interviewees during the second visit in August-September 2019.

Technician) then collate the data from the villages and enter it into Android tablets pre-programmed with open data kit (ODK) software, which then upload the data directly to the FNC server in Harare. Pre-set thresholds for key indicators are then used to provide feedback to the ward FNCS using Rapid Pro (an SMS messaging system), using traffic-light colour coding (green, amber and red) to indicate to the committee if their data results were 'good', 'satisfactory' or 'concerning'.³⁶ Funding from the Gates Foundation ran from November 2014 to June 2016 and was followed by a cost extension, then a no-cost extension. In practice, this meant that funding for the NRTM began reducing from around mid-2017. Since the ending of the external funding, the FNC has faced challenges in sustaining the full functioning of the NRTM in the four pilot districts, as described in Section 4.

Inter-district learning

In 2017, after more than two years of implementation in the four pilot districts, district 'Lessons Learned' reports were prepared for the four districts and an inter-district learning workshop was held in Mutare, bringing together representatives of FNCSs from district, ward and villages levels to learn from each other through the sharing of experience, knowledge and good practices.³⁷ A review workshop of the NRTM was undertaken at the same event.³⁸

Lessons from the pilot districts were used in preparing for the rollout of the MCBM in 15 more rural districts in

2017 and in 13 more rural districts in 2018. In 2019, six more rural districts were selected for the continuing rollout of the MCBM. Currently, therefore, the MCBM is well-established in 19 rural districts (the four pilot districts and the 15 districts added in 2017) and partially established in the other 19 rural districts added in 2018 and 2019.

In summary, therefore, 38 of Zimbabwe's 60 districts are currently participating (though at different stages of operationalisation) in the MCBM (see Map 1).

A further rollout to the remaining rural districts is intended, but a timetable is not yet finalised. FNC and its partners are currently considering how urban districts might be incorporated into the MCBM.

Functionality assessment

In order to assess how the MCBM was functioning at district, ward and village levels, work began in 2017 on the development of a functionality-assessment tool. A draft version of the tool was reviewed at the 2017 Inter-District Learning Workshop. The tool identified the eight core functions of the FNCSs as:

- Coordination of food and nutrition stakeholders at all levels;
- Liaise with sub-national development committees and national-level structures on food and nutrition security (through the documentation and sharing of decisions and the submission of workplans and progress reports);
- Facilitate prioritisation and planning of programmes (so that clear links to the National Food and Nutrition Security Policy and best practices are demonstrated);
- Advocate and communicate (through lobbying for resources and in the appropriate fora and media and providing evidence of interventions undertaken and gaps remaining);
- Monitor and evaluate effectiveness of programme interventions (through the provision of regular reports and the sharing of all relevant monitoring and evaluation activities);
- Facilitate and participate in food and nutrition security assessments, surveillance and early warning activities (and ensure that information from such assessments is shared with all other actors and that it distinguishes between chronic, transitory and acute vulnerability to food and nutrition insecurity);



WFP/Maitete Cosonoti

Food for Assets (FFA) project
Mbire district, Zimbabwe

³⁶ An excellent short film, 'Near Real Time Monitoring System: A convergent monitoring approach for reduction of stunting' is available on YouTube at www.youtube.com/watch?v=oz8yG2I9TVg

³⁷ Report on the Inter-District Learning Workshop 8 August 2017, Holiday Inn, Mutare. FNC.

³⁸ Multi-Sectoral Community Based Model for Addressing Food and Nutrition Insecurity to Reduce Stunting (MSCBM) Near Real Time Monitoring System (NRTM) National Review Workshop, 8 August 2017, Mutare Holiday Inn. FNC.



Participants in a community garden in Mount Darwin District, Zimbabwe

- Facilitate learning and capacity development (through the identification and sharing of best practices and learning in relation to capacity development);
- Ensure that important cross-cutting issues are monitored and integrated into food and nutrition security analysis and programming (and recognise the important role of traditional leaders and women in addressing food and nutrition insecurity and the importance of HIV and AIDS as a potential driver of food and nutrition insecurity);
- A final category, 'FNSC Innovativeness', allows additional points to be added for innovativeness displayed by the FNSC in executing its core functions.

Identification of drivers of stunting

Another development during 2017 was the initiation of assessments by district FNSC members in each district to better understand the drivers of stunting and to enable comparison with the baseline assessments conducted in the four districts in 2015.³⁹ The assessments used the results of the 2015 MCBM baseline surveys and other assessments to categorise drivers into 'immediate', 'underlying' and 'basic'. It is understood that the drivers of stunting assessments have now been completed in 19 of the 38 districts currently included in the rollout of the MCBM.⁴⁰

Subsequent initiatives taken in relation to the MCBM were the introduction of the model ward and model village concept and the mentorship approach. The model ward and model village concept was developed in 2018. Each district FNSC (DFNSC) is required to select the ward within the district that is performing best in terms of the MCBM, using a guide or checklist of indicators. Indicators include the

frequency of meetings, the timeliness of data submission, the preparation and updating of action plans, follow up of the priority items identified, and the degree of collaboration between members of the ward committees. Having selected the best performing ward, the DFNSC then supports the selected ward FNSC in selecting the best performing village in the ward. In this way, each district has a model ward and a model village that are used as models of good and best practice to share with other wards and villages in the district.

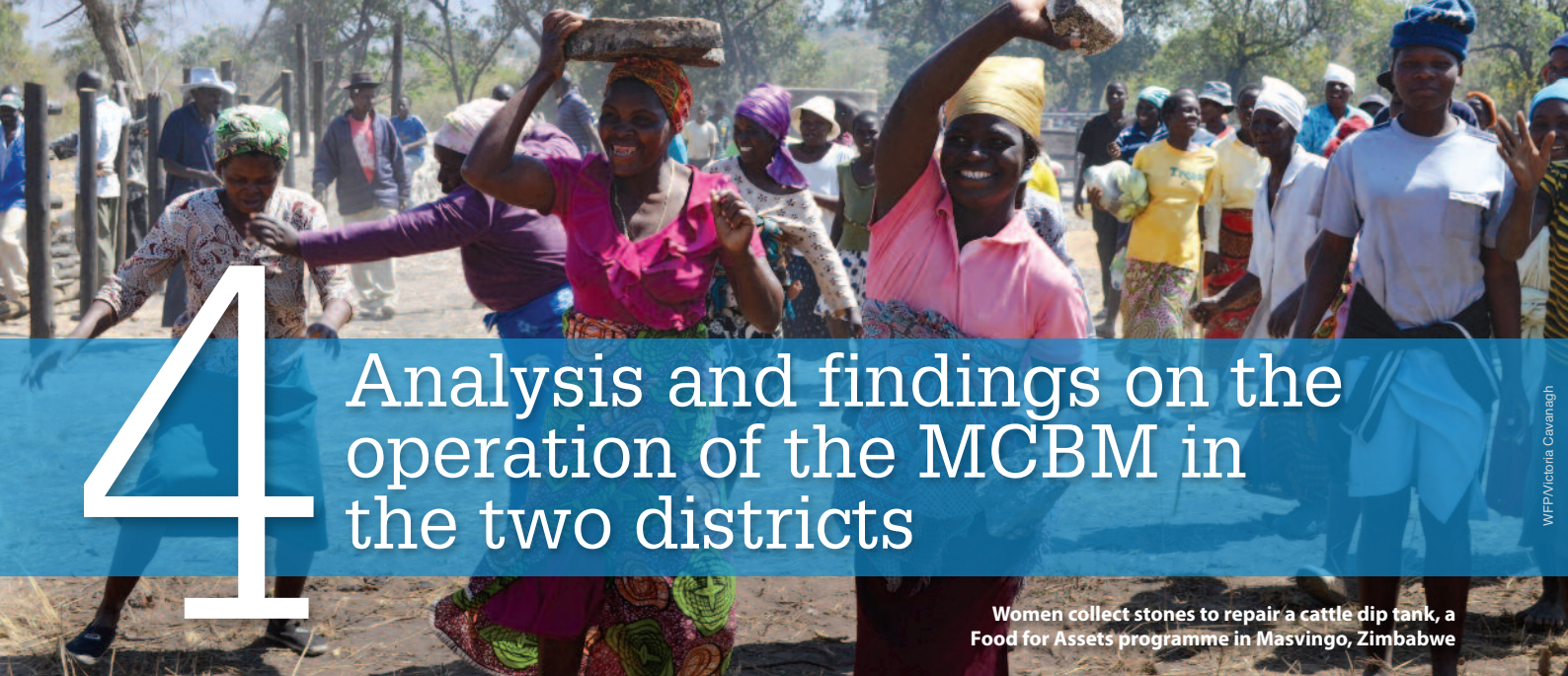
The mentorship approach began implementation in March 2019. At each level of the MCBM (national, district, ward and village), members of the FNSC take responsibility for mentoring and supporting members at the next level down. For instance, the chair of the national FNSC has responsibility for supporting the district FNSCs in Mazowe and Mbire Districts.⁴¹ In Chipinge District, each member of the DFNSC has responsibility for supporting two ward FNSCs, and each member of the ward FNSC has responsibility for supporting one of the two village FNSCs in their ward. Initial results indicate that the mentorship approach is helpful to FNSCs in addressing challenges that they encounter. A draft 'Mentorship Manual' for use at all levels has been prepared by the national FNSC and is in the process of being finalised.

These innovations in the MCBM are discussed in more detail in Section 4.

³⁹ e.g. FNC (2017) Drivers of Stunting Assessment Chipinge District <http://fnc.org.zw/wp-content/uploads/2019/01/drivers-of-stunting-chipinge-district.pdf>; Drivers of Stunting Assessment Chiredzi District http://fnc.org.zw/wp-content/uploads/2019/01/drivers-of-stunting_chiredzi-district.pdf

⁴⁰ Miriam Banda. Interviewed 2 September 2019.

⁴¹ Nester Gumbo. Interviewed 2 September 2019.



WFP/ICBria Gavanach

4

Analysis and findings on the operation of the MCBM in the two districts

Women collect stones to repair a cattle dip tank, a Food for Assets programme in Masvingo, Zimbabwe

Multi-sector working

As attested by the quotes noted in the adjacent column, there was general agreement that the MCBM had significantly increased the level of joint planning and practical collaboration between the different ministries. The MCBM’s requirement for district, ward and village FNSCs to undertake joint assessments, identify and agree on local needs and priorities, then collaborate on addressing those priorities was seen as central to the increased collaboration.

There was general agreement that there is now a much greater awareness of the drivers of stunting among the staff of ministries beyond the Ministry of Health. During the discussions, different ministry staff would speak not only about their own sectors, but also spoke with conviction on nutrition and social issues. For instance, a Ministry of Education staff member in Chipinge spoke with conviction about the importance of the four-star diet,⁴² exclusive breast-feeding for six months, community gardens, and the need for households to support each other in the construction of improved pit latrines. An Agritex employee in Chipinge was as comfortable talking about vitamin A supplementation and the importance of ‘tippy taps’ for handwashing as he was about seed fairs, small livestock and keyhole gardens (small, raised plots in the home compound that can be watered with wastewater from the kitchen to provide vegetables that can be gathered immediately).⁴³

⁴² The four-star diet refers to the four food groups necessary for a good, balanced diet. Animal-source foods (meat, chicken, fish, liver) and eggs, milk and milk products; staples (maize, wheat, rice, millet, sorghum); roots and tubers (cassava, potatoes); legumes (beans, lentils, peas, groundnuts); and seeds (pumpkin, sesame) and vitamin A-rich fruits and vegetables (mango, papaya, dark-green leaves, carrots, orange sweet potato, pumpkin) and other fruits and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant, cabbage).

⁴³ www.bakerinstitute.org/media/files/page/4e4d6b5e/khg_quick_manual_pdf.pdf

“The Ministry of Health cannot tackle everything on its own ... Previously, I didn’t know the Ministry of Agriculture guys and what they were doing. Now I know them and work closely with them.”

Nurse in Charge, Paidamoyo Clinic, Ward 9, Chipinge District

“We have created many structures that for various reasons haven’t worked, but at the ward level and the district level, the FNSC structures are working.”

Acting District Development Co-ordinator, Chiredzi District

“The MCBM brought us together. If the [Ministry of Health] was doing a project on breastfeeding, we would previously not have been involved. Now such a project will see MoH working with WASH, Youth and Agritex.”

Member of Chiredzi District FNSC

“As a nurse, it was none of my business what Agritex was doing. Sometimes we would meet in a village and say, ‘Oh, you are here! So am I!’ Now we work as a team. If I am going to Village 6, I ask the others [on the ward committee] what messages they want me to take. If a child in a village needs follow-up and I hear that Social Welfare are visiting the village, they can undertake the follow-up for me. Now we have a much better use of our resources.”

Nurse in Charge, Chizvirizvi Clinic, Ward 22, Chiredzi District

Nutrition-specific and nutrition-sensitive actions mentioned in the course of interviewees and group discussions in the two districts

Health-related

- Exclusive breastfeeding
- Vitamin A supplementation
- Reduction of home births/encouragement of clinic births
- Encouragement of early registration of pregnancies to facilitate regular monitoring throughout the pregnancy
- Increasing outreach of clinic services
- Encouragement and support to health clubs
- Encouragement of the four-star diet

Gender and Social Protection-related

- Reduction of child marriages/early marriages
- Reduction/elimination of child abuse

WASH-related

- Reduction of open defecation/encouragement of the construction and use of improved pit latrines
- Construction of pot racks (to keep food preparation utensils off the ground and out of reach of goats) and rubbish pits to separate biodegradable/compostable matter, plastics and metals
- Protecting unguarded water points
- Rainwater collection

Agriculture-related

- Dairy farmers retaining some milk for their own consumption rather than selling it all
- Encouragement of community gardens
- Encouragement of keyhole gardens

- Encouragement of the keeping of small livestock (chickens, guinea fowl and rabbits)
- Seed fairs to encourage the sharing of seed varieties and food-preparation recipes
- Encouragement of crop diversification
- Encouragement of solar driers to preserve the nutrient value of dried foods
- Encouragement of the four-star diet
- Encouragement of green vegetable consumption
- Encouragement of the cultivation and consumption of non-traditional vegetables, such as beetroot and spinach
- Encouragement of the cultivation and consumption of small grains (sorghum and millet) (diversification from over-reliance on maize as the sole cereal) for drought-resilience reasons, as well as dietary-diversification reasons
- Encouragement of the gathering and consumption of traditional fruits (e.g. baobab)
- Encouragement of and support for irrigation projects to increase the supply of locally grown vegetables, pulses and fruits
- Improved crop storage

Education-related

- Increasing school attendance/reducing drop-out rates
- School feeding
- School gardens to grow vegetables and beans for relish
- Pit latrines
- Water supply
- Lifestyle messages – ‘no sex’ and ‘no early marriage’

Although ward and village FNCS had prepared their own action plans, there appeared to be significant commonality in the types of activity being undertaken. Some differences in actions between areas was noted; for instance, in some of the upland areas of Chipinge, where potatoes rather than maize was the dominant crop and consequently dietary diversification had a different meaning here. In Chiredzi, many farmers had sold all their dairy production, so here dietary diversification meant encouraging farmers to retain some milk for consumption in their own households. The following is a list of all the activities mentioned during discussions. (They have been organised here into related groups for clarity, not according to responsibility by a particular ministry or department.)

Views of the committees on the achievements and impact of the MCBM

During meetings with FNCS at district, ward and village levels, with traditional leaders and with the community garden and health clubs, participants were asked to identify the achievements and success of the MCBM

and to list the main behaviour changes that they had witnessed since 2014 when the pilot programme began.

The main behaviour changes since 2014 were identified as:

- Increased breastfeeding and extension of the weaning period;
- Increased institutional deliveries and reduction in the use of traditional midwives for home births;
- Increased number of households developing keyhole gardens;
- Increased domestic consumption of milk that had previously been sold;
- Increased numbers engaged in WASH activities;
- Increased green vegetable production and production throughout the year;
- Increased production of small grain crops (sorghum and millet);
- Increased production of non-traditional vegetables, such as carrots, beetroot and spinach.
- Increased school attendance/reduction in the rate of dropouts (one headmaster attributed a dramatic rise in school attendance from 786 in 2014 to 1,268 in 2019 to improved diets and reduction in poverty);

WFP/Matteo Cosorich



A participant in Manjerajera Nutrition Garden, Mount Darwin District, Zimbabwe

- Reduction in the number of home births and a consequent reduction in the number of emergency labour cases involving emergency transfers from the home to the clinic;
- Increased rearing of goats, chicken and guinea fowl;
- Increased use of traditional fruits (such as the baobab fruit now being used in Chiredzi District to produce oil, powder and as a drink);
- Increased collaboration at the community level to assist each other in the construction of pit latrines;
- Increased number of households improving their hygiene through the use of tippy taps, pot racks (for drying plates and utensils), rubbish pits and pit latrines.

“Our children are growing well.”

“We used to buy vegetables, but no longer. The money that we spent on vegetables can now be spent on school fees.”

“We have received information on diets and different crop varieties.”

“We want to thank the NGO that helped us with the solar-powered pump, but we don’t know how to thank them.”

Quotes from women from Ward 22 community garden club

While some of the changes may well have occurred in the absence of the MCBM, there was a widely shared sense that it had contributed positively to the changes by focusing attention on stunting and the many different factors contributing to it. By bringing the different government ministries together at district, ward and village levels to focus on stunting reduction and by helping to conscientise and mobilise communities to focus on stunting reduction, the MCBM contributed significantly to the positive changes in behaviours.

The introduction of the mentorship approach in the MCBM

The mentorship approach introduced in Chipinge earlier in 2019 involves members of the DFNSC each mentoring one or two ward FNSCs. Thus, the chair of the DFNSC is mentor for Wards 5 and 16, and the Ministry of Education member is mentor for Wards 6 and 9.

The system is generally regarded as a positive innovation and ward members were appreciative of the support provided by their mentor. Opportunities for the mentors to meet their ward FNSC are taken whenever they present themselves. For instance, one of the Chipinge DFNSC members took the opportunity at the Chipinge Agricultural Show to meet with ward FNSC members who were at the show. The mentor is able to support the ward FNSC by virtue of their knowledge and experience, and their position and authority, which allows them to encourage (and, where necessary, admonish) ward FNSCs to improve their collegiate behaviours to make the MCBM approach work as well as possible.

The issues that ward FNSCs asked for support on included: requests for specific documents; advice on data collection, the sending of data, including ‘data bundling’; and questions about how to improve the information flow between members so as to fully exploit opportunities presented by a particular ministry visiting the ward.

The introduction of model wards and model villages in the MCBM

The concept of identifying model wards and model villages in the MCBM was borrowed from a successful Ministry of Health project. It involves the initial identification of the ‘best’ or ‘most effective’ ward in

each district, and subsequent identification of the ‘best’ or ‘most effective’ village in that ward as a means of sharing experience and good practices with other wards and villages. The criteria used in assessing ‘best’ and ‘most effective’ include the level of engagement and motivation of the ward and village with the MCBM in terms of designing and implementing activities aimed at reducing stunting, and the level and quality of reporting through the NRTM.

In Chipinge, the model ward was selected during a two-day process of reviewing all the available information on the 30 wards in 2018. Ward 1 emerged as the model ward, then the team worked to identify the model village in that Ward. The DFNSC was keen to point out that the grounds for selecting the model village were primarily engagement and motivation, and that there is no guarantee that stunting rates will fall faster in that village than in other villages (even if it were possible to analyse stunting rates at the level of individual villages). The key point was that the village was fully engaged in the effort to reduce stunting and was undertaking a wide range of nutrition-specific and nutrition-sensitive activities. In Chiredzi District, Ward 22 was selected as the model ward and Village 6 as the model village.

“The model village concept is good, because people can see with their own eyes rather than just having to imagine.”

Ward 22 FNS committee member, Chiredzi District

The issue of how knowledge from the model wards and model villages gets shared with other wards and villages in the same district is a challenge that was well recognised in the discussions. The costs of travel and the distances involved make physical visits difficult. In Chipinge District, the model ward (Ward 1) had been visited by two other ward FNSCs, but the cost of transport had limited the number of those visiting to just the Chair and Deputy Chair from the other ward FNSCs. In Chiredzi, it appeared that other ward FNSCs had yet to visit the model ward (Ward 22), but we were informed that members of the Ward 18 FNSC had visited Ward 26, which was over 190 kilometres away. In this case, VHWS and VHW volunteers had taken part in the visit, together with Agritex and Women’s Affairs representatives, and all had found the exchange of information extremely helpful to their work, even though Ward 26 was not considered a model ward. A suggestion made by a chief was that every ward in the district should select its own model village; this reduce the distances involved for village committees in other villages to visit the model village to exchange their

experiences and learnings. Given the economic challenges currently facing the country and the lack of resources available to the district and ward FNSCs, this lower-cost approach appears attractive.

The role of the chiefs and traditional leaders

From the outset of the MCBM, chiefs and traditional leaders were recognised as having an important role to play in changing behaviours and practices. On the basis of the two district visits, it is clear that chiefs and traditional leaders are indeed playing a key role in influencing behaviours and practices that contribute to stunting.

After identifying their role at sub-national level, chiefs from the four pilot districts were sensitised during the initial stages of MCBM on stunting and its causes and briefed on the overall MCBM initiative.

“We used to think that stunting was genetic, but once I learned that it was to do with food and nutrition, I became happy to advocate for stunting reduction and for MCBM.”

Chief Mapungwana, Mt Selinda, Chipinge District

The importance of involving local chiefs and village heads was also recognised at ward level. Chiefs and village heads were invited to join the ward and village FNSCs as they were formed. In this way, the chiefs and village heads are involved in the interpretation of the assessment and can add their support to what the community wants to do and prioritise.

“The first thing we did after our MCBM training was to brief the chief and ask him for his support. The chief then called all the local leaders together and explained the new programme and asked them to help us on the ward committee”.

Nurse in Charge, Chizvirizvi Clinic, Ward 22, Chiredzi District

The support of the chiefs has certainly helped ward and village FNSCs in their efforts to reduce stunting. In Ward 22 in Chiredzi, for instance, the chief lobbies for the MCBM, helps raise resources for the local committees to do their work, and demands feedback from the ward and village committees in his area so that he can monitor progress.



A child helps his parents in the Manjerajera Nutrition Garden, Mount Darwin District, Zimbabwe

The challenge posed by the beliefs of religious objectors is also being tackled by chiefs and traditional leaders. Alongside efforts by the Ministry of Health and other ministries, it appears that encouragement by chiefs has led to behaviour changes in some religious objectors, with some sect leaders now actually promoting conventional health treatments, such as childhood immunisation, and considering letting women give birth in medical facilities.⁴⁴

In Chipinge, a local chief had introduced a bylaw for newly allocated residential plots requiring that a standard pit latrine be constructed before any construction work began on the house. Under another bylaw he had introduced to encourage institutional deliveries rather than home births, parents are fined one goat if they have a home delivery, with a one-goat fine also imposed on the person (perhaps a traditional birth attendant) who assisted them in the home birth. Such measures appear to have achieved positive results, as the local chief reported that, as one of the few owners of a car in the village, he used to be called upon in the middle of the night to transport women to the clinic if they were having complications during labour, but now this rarely happened as most women now give birth in the clinic.

To help raise awareness of the role of chiefs in influencing local behaviours and practices in relation to food and nutrition security, the FNC recently prepared and published a report focusing on four chiefs.⁴⁵ The following emerged as the main roles played by chiefs in championing food and nutrition issues:

- Educating communities;
- Addressing myths and misconceptions;⁴⁶

- Enhancing community participation in food and nutrition initiatives;
- Revival of *Zunde raMambo*⁴⁷ as a strategy for reducing food insecurity;
- Encouraging the cultivation and consumption of small grains (cereals other than maize);
- Administering punitive measures to offenders;
- Acting as community role models;
- Supporting home-grown school-feeding programmes.

The operation of the near-real-time monitoring system (NRTM)

From discussions with FNSCs at district, ward and village levels, there was widespread agreement that the NRTM had been a vital part of the MCBM. It had provided them with data that helped them set their priorities and action plans, revise their priorities where necessary, and provide them with a sense of the progress they were making (in, for instance, improving mothers registering their pregnancies early, how many pit latrines had been constructed, how many families had installed tippy taps, and how many families were now eating a more diversified diet). The feedback provided to the communities by the NRTM was seen by many in the two districts as integral to the success of the MCBM.

“Feedback is very important. The NRTM dashboard is very helpful in highlighting if there is a problem. The data that goes into the dashboard is generated ‘by the foot soldiers on the ground’, so they feel it is their data and so they have some ownership of it.”

Chiredzi FNSC member

“There is now a degree of competition [about their NRTM results] between communities.”

Matimbira Isheunesu, Nutritionist, Ministry of Health and Child Care, Chiredzi FNSC

⁴⁴ Tatenda Kanengoni (2017) ‘Apostolic Churches That Refuse Medicine In Zimbabwe Slowly Reconsider Beliefs’ *Global Press Journal*, 17 January 2017 <https://globalpressjournal.com/africa/zimbabwe/apostolic-churches-refuse-medicine-zimbabwe-slowly-reconsider-beliefs/>

⁴⁵ ‘Documentation of the Role of Traditional Leadership in Addressing Food and Nutrition Insecurity in Zimbabwe’. FNC, December 2018.

⁴⁶ In parts of Chiredzi District, for instance, unmarried women, pregnant women and uncircumcised men were not allowed to eat eggs and chicken. As affordable sources of animal protein, the exclusion of eggs and chicken from their diets could risk their own nutritional wellbeing and that of their unborn children.

⁴⁷ *Zunde raMambo* is a traditional method of building up a community food reserve for allocation by the chief in times of need. It may either take the form of giving labour to a specific plot of land, or contributing part of one’s own crop to the community reserve.

The observation in Chiredzi that the results of the ward-level data generated by the NRTM have introduced a sense of competition between wards is of particular interest, as it suggests that, for some wards at least, their motivation for improving their key indicators draws in part from a desire to do better than other wards in their district and points to another benefit of the NRTM in providing feedback to villages and wards.

The positive perception of the value of the NRTM at district and ward levels is not necessarily shared at national level, where it appears to be regarded as ‘too data-heavy’ and only sustainable for the period in which it received external funding.

“NRTM was innovative but it was data-heavy, technically demanding and was quite dependent on UNICEF support. As such, it was not sustainable and the ending of the Gates funding has seen the NRTM running into problems.”

Yvonne Mavhunga, Deputy Director – Programmes, FNC

Given the different views about NRTM, this section seeks to explain how it was used and continues to be used in the two districts.

The NRTM faced many challenges. The data-collection system was dependent on VHWs and volunteer VHWs visiting all the pregnant women and children aged 0-2 years in their area of responsibility each month. An issue that was raised in almost every discussion in the two districts concerned the level of work expected of the VHWs, the modest level of their allowances, and how they could be provided with a better level of remuneration. The allowance currently received by VHWs is 50 RTGS every two months or 25 RTGS/month; the equivalent of US\$2.10 per month.⁴⁸

Since the external funding for the NRTM finished around mid-2017, it has encountered a number of challenges and its effectiveness and coverage has declined. Some at the national level regard the NRTM as not having functioned properly for the last two years. In Ward 22 in Chiredzi, for instance, the tablet had been sent to Harare for updating in February 2019 and, although the ward had been informed of the reasons for the delay, the tablet had not been returned seven months later. In Ward 1 in Chipinge, the ward FNSC claimed not to have received any feedback from the FNC in Harare from March 2019 to date of study. In Ward 9 in Chipinge, there had been problems with the

tablet’s SIM card in late 2018 and the ward had been unable to upload information to the FNC server.

In both districts, FNSC members felt that the NRTM had been valuable and should be brought back to its previous level of functionality.

“NRTM needs to be made functioning again.”

Chipinge FNSC member

“NRTM does need to be revised as it is not currently working as it should.”

Chiredzi FNSC member

It is significant that even when ward FNSCs do not have a tablet to upload the data onto the FNC server in Harare, the VHWs are still collecting the data and sending it to the ward level for the results to be collated by the Clinic Nurse and Environmental Health Technician and reviewed, together with the other members of the ward FNSC. In some cases, it seems that VHWs are sending key data to Harare via the Social Accountability and Citizen Engagement SMS-based system used by other ministries. So, some data continues to be submitted to the FNC in Harare, despite many of the tablets currently being held in Harare. In effect, therefore, this SMS-based system is operating in place of the Android ODK system.

Since the ending of the external funding of the NRTM, the FNC has faced challenges in sustaining the full functioning of the NRTM in the four pilot districts and it is understood that the rollout of the MCBM in the more recent districts does not include the provision of tablets to the wards and district FNSCs.

Logistical and economic challenges

The size of the districts means that there can be significant distances between the district centre and certain wards. For instance, Chipinge Ward 30 is located 250 kilometres from Chipinge Town. Such distances make it hard for district FNSC members to regularly visit the wards for which they are the assigned mentor. In Chiredzi, with its total of 30 wards, the DFNSC had chosen to cluster the wards into groups of four that are adjacent to each other, so that each mentor on the district committee is supporting four wards. This was felt to be better than having their wards spread around different parts of the district.

⁴⁸ Kudzai Mukudoka, UNICEF Nutrition Officer (Stunting Reduction). Interviewed 10 September 2019.



A participant in Manjerajera Nutrition Garden, Mount Darwin District, Zimbabwe

WFP/Matteo Cosulich

Fuel was in very short supply at the time of our visit to Chipinge and long queues for petrol and diesel had formed at the one garage in the town that had fuel to sell. Not only did this tie up drivers' time, it also introduced an element of uncertainty as to whether a planned long-distance journey could be completed as planned.

The prolonged power cuts experienced in some of the district centres inevitably impacted on the ability of the DFNSC to function effectively. In Chipinge Town, over the period between July and September 2019, daily power cuts were experienced, typically lasting from 5am to 11pm, severely limiting the use of desktop computers used by government staff in the district centre. Few staff at district level have laptop computers, so are unable to charge their laptops when the power comes on during the night.

The problem of staff turnover and delays in replacing staff was also highlighted as a challenge facing the FNCSs at district, ward and village levels.

Despite such day-to-day challenges, staff involved at all levels of the MCBM continue to work and carry out their roles as best they can.

Challenges stemming from cultural and religious beliefs and practices

During the course of the discussions in the two districts, certain issues kept being mentioned that pose challenges to the efforts to reduce stunting.

In almost every meeting, the issue of Apostolic sects requiring members to seek healing via prayer and reject conventional medicine was raised. Such beliefs have

been found to have a significant impact on the work of clinics and FNCSs to encourage the early registration of pregnancies and reduce the proportion of home births.⁴⁹ Clinic nurses reported how some women and mothers in some Apostolic sects do try to access clinic services by presenting to the clinics at night in order to avoid being seen by other church members.

In some areas, messages about the benefits of the four-star diet are hampered by traditional beliefs about certain food. For instance, in parts of Chiredzi District, unmarried women, pregnant women and uncircumcised men were previously not allowed to eat eggs and chicken. Messages about the risk the exclusion of these important protein sources could pose for the nutritional wellbeing of mothers and their unborn children forms part of the messaging and advocacy of all members of the FNCSs at district, ward and village levels. From the outset of the MCBM, chiefs have been identified as having an important role to play in changing such traditional beliefs.

The practice of early marriage was also mentioned as a negative factor in discussions about stunting, due to the increased likelihood of birth complications and inadequate caring practices among adolescent mothers. In 2016, Zimbabwe's Constitutional Court raised the minimum age of marriage from 16 to 18; together with the messaging by different ministries and traditional authorities, this appears to have contributed to a significant reduction in the proportion of marriages involving adolescent girls under the age of 18.⁵⁰

The role of VHWs and volunteer VHWs in the MCBM

The VWH programme began in the 1980s as part of Zimbabwe's transition to primary healthcare. VHWs are volunteers selected by their communities to serve as a key link between the community and the formal health system, with its network of clinics and hospitals. After an initial eight-week training, VHWs are provided with a modest allowance, paid every two months.

⁴⁹ Maguranyanga, Brian. (2011) 'Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe'. Collaborating Centre for Operational Research and Evaluation. UNICEF Harare. The Apostolic movement comprises hundreds of different sects, and consequently estimates of the proportion of the population following the Apostolic faith vary widely; from 6% to 27% of the total population. Membership appears to be significantly higher in women in the marrying and childbearing age group. There is considerable heterogeneity within the movement and it appears to be only the most ultra-conservative that reject all conventional medicine and, even within the ultra-conservative sects, it is recognised that some members secretly access health services.

⁵⁰ 'Zimbabwe records significant reduction in child marriages. 13 July 2019, YouTube www.youtube.com/watch?v=v-BeFUy1cJQ

When the MCBM was introduced in the two districts, VHWs were utilised as the Ministry of Health's 'foot soldiers'. The data-collection tools for pregnant women and children under two years of age required by the NRTM system significantly increased the time demands on the VHWs; so, to assist the existing VHW, some wards appealed for volunteer VHWs, although they have not been provided with the modest allowance provided to VHWs. As might be expected, motivation levels vary across the VHWs and volunteer VHWs. While many are motivated to serve their community and work hard to complete their data gathering and other tasks, others are less motivated. How to provide additional incentives for the VHWs has been discussed for some time and has included suggestions of the provision of bicycles and soap, plus T shirts and caps to provide them with a clearer identity and recognition within the community. In some districts, the post of ward nutrition coordinator has been introduced to strengthen capacity at ward level. In Ward 9 in Chipinge, the ward nutrition coordinator position was funded by Save the Children.

As an example of how motivation might be affecting the coverage of the NRTM data-collection tasks, the issue was explored in Ward 22 in Chiredzi District. The ward has 13 trained VHWs and seven volunteers covering the 20 villages in the ward that, between them, have a population of 9,600. Interviewees noted that it takes each VHW/volunteer about three weeks to visit each of the target households in their village (those with pregnant women and children aged 0-2 years). The ward FNSCs were asked to estimate the proportion of households that should be covered by the monthly NRTM data collection and the proportion that are actually being covered, and the reply was 70%.

The impact of Cyclone Idai

Cyclone Idai, which hit Mozambique, Zimbabwe and Malawi in March 2019, had a significant impact in Zimbabwe, causing over 600 deaths, displacing more than 50,000 people and causing widespread damage to infrastructure, community assets, agricultural production and local economic activity in the districts in the east of the country.⁵¹ The two worst affected districts were Chimanimani and Chipinge Districts. Visiting Chipinge six months after the cyclone, its impacts were still visible in sections of tarred road that had been washed away and diversions put in place. All meetings in the district included a focus on the impact of the cyclone. The impacts that had a direct bearing on the MCBM and efforts to reduce stunting that were highlighted included: damage to crops and

community gardens; loss of small livestock, particularly chickens; destruction of pit latrines; silting-up of dams; damage to wells; and damage to water supply and irrigation schemes.

The presence of the ward and village-level FNSCs was reported to have significantly helped the effectiveness of the response at the local level by coordinating local responses. The social media groups used by FNSC members in one ward in Chipinge had proved invaluable to their coordination efforts, as some of the members had been away from the ward when the cyclone struck and had not been able to return because of the roads being washed away.

“During the cyclone response, we [the ward FNSC] worked as a team.”

Ward 9 councillor, Chipinge District

The national and international response to the cyclone brought new UN agencies, international NGOs and national NGOs to the area. In most cases, they worked with and through the local community-coordination structures, of which the FNSCs were a central part. Post-cyclone projects highlighted during the meetings included: food and seed distributions; support for the rehabilitation of wells; the rehabilitation of community gardens; a project to replace indigenous free-range chickens killed during the cyclone; support for the formation of health clubs; and the provision of infant and young child feeding training. As part of their cyclone-response programmes, some partners seconded staff to support Ministry of Health and Child Care staff at local clinics, and these staff have been used to support multi-sector efforts at local level.

There were also stories of how communities had mobilised themselves to repair damage caused by the cyclone. Actions taken in Ward 1 (the model ward in Chipinge District) were particularly impressive. Here, the cyclone had silted up the dam that was the source of irrigation water for a large community garden where 115 families had plots located two kilometres away from the dam. To reinstate the irrigation system, the community worked together to desilt part of the dam, replaced damaged pipework, and built night-storage tanks at the community garden. Here again, the ward FNSC and the good working relationship between its members had significantly helped in coordinating this effort.

⁵¹ Centre for Research on the Epidemiology of Disasters. 'EM-DAT: The Emergency Events Database'. Université Catholique de Louvain.



WFP/Victoria Cavanagh

5 Conclusions

Rebuilding the community's infrastructure to stabilize food security and improve sustainability for the future

On the basis of this short assessment, the MCBM in the two districts appears to have been very successful in its objective of encouraging collaboration at district, ward and village levels to focus on the reduction of stunting.

Several key factors appear to have been critical in contributing to this positive outcome. The creation of the FNSCs as part of the MCBM, particularly at district, ward and village levels, played an important role in bringing different actors and departments together to plan and implement collaboratively. The level of collaboration at the planning and implementation stages between different ministries, and between the ministries, chiefs and village leaders, was impressive. At all levels, those interviewed were clear about the positive impact of the MCBM and provided numerous examples of how joint planning and implementation had improved as a result of its introduction.

As well as bringing different actors and departments together, the MCBM does seem to have helped conscientise and mobilise communities to address an issue that they had not previously identified as a priority. The reduction of stunting is now seen as an important objective at ward and village level, but, more importantly, it is identified as an objective in which the communities themselves have a central role to play. The way in which community groups at ward and village levels were focusing on nutrition-sensitive as well as nutrition-specific interventions was impressive. The involvement of VHWs and clinic staff (members of the ward and village FNSCs) in the collection of household data and the participation of the households themselves in the provision of that information appears to be part of the conscientisation and mobilisation process, in that the data is used to

inform the action plans developed by the committees with the participation and collaboration of the different ministries and partners. It is this involvement of, and contribution by, the communities and the ministries and partners that seems to be at the heart of the conscientisation and mobilisation process.

Another factor that appears to have made a significant contribution to the success of the MCBM was the explicit commitment to involve chiefs and traditional leaders. Chiefs and traditional leaders continue to play an important role in rural Zimbabwe and their support for, and encouragement of, particular policies and practices and the work of the ward and village FNSCs can be very influential in their local communities.

Despite all the positive aspects of the MCBM, it is unfortunate that robust recent surveys of stunting levels in the two districts to compare with those undertaken immediately prior to the start of the MCBM are not available; consequently it is not possible to assess whether the increased collaboration and focus on stunting reduction has had a clear positive impact on rates of stunting in the two districts.

The role of the NRTM and what happens to it going forward (given the ending of its external funding around mid-2017) emerged as an important issue for policy consideration. The collection of household data by VHWs and volunteers at village level and its collation and analysis at ward level clearly play an important role in providing FNSCs with information to develop action plans and as a means of monitoring the success of their efforts. One of the members of the Chiredzi FNSC observed that the NRTM data was helping to motivate wards in wanting to do better than their neighbouring wards, thus introducing a

competitive spirit into efforts to reduce stunting. It would seem that the data collected through the two NRTM survey tools forms an integral part of the conscientisation and mobilisation objectives of the MCBM, so there would appear to be a strong case for retaining the NRTM, or a modified version of it, within the MCBM model. Careful consideration needs to be given to the question: How effective can the MCBM model be in the absence of the NRTM, or an NRTM-like system?

It is understood that the FNC and UNICEF are considering how the NRTM should evolve and what an 'NRTM Mark 2' might look like. Clearly, a revised version of the NRTM would need to take on board lessons about the first version being overly data-heavy and dependent on technologies that require a level of funding and support that the FNC is currently not in a position to provide. The long-term sustainability of a future version of the NRTM will need to be a key consideration.

Perhaps the answer lies in a multi-sector approach to information systems, so that the NRTM becomes part of the existing information systems operated by the Ministries of Health (including growth-chart monitoring carried out by clinics) and the Ministries of Agriculture and Education, so that they feed into an integrated food and nutrition security information system. Within the Ministry of Health, it is understood that clinics are being encouraged to increase their outreach into villages through village health days, where VHWs bring families to be measured by the clinic nurses. A combination of greater encouragement to pregnant women and mothers of young children to visit the clinics and more frequent village health days might enable key indicators in the NRTM to be brought within the information collected and analysed by the clinics. Underlying any initiatives in relation to 'NRTM Mark 2' is the issue of the varying levels of motivation among VHWs and VHW volunteers, and how to improve their remuneration or provide them with greater incentives.

Annex 1 List of interviewees and those consulted

First visit (conducted by Natalie Sessions 8-12 April 2019)

Interviewee	Job title
George Kembo	SUN Focal Point and Director, Food and Nutrition Council (FNC)
The broader FNC team:	
Handrea Njovo	Nutrition Directorate, Ministry of Health and Child Care
Michele Schivo	EU
Julia Tagwireyi	UN Network
Kudakwashe Zombe	Zimbabwe Civil Society Organisation for Scaling Up Nutrition Alliance (ZCSOSUNA)
Kudzai Mukudoka	UNICEF
Dr Matsunga	SUN Research and Academia Platform (SUNRAP)
Deliah Takawira	Nutrition Officer, FAO

Second visit (conducted by John Borton 30 August to 11 September 2019)

Interviewee	Job title
George Kembo	SUN Focal Point and Director, FNC)
Siboniso Chigova	Nutrition Officer, FNC
Tatenda Mudiwa	Principal Officer, FNC
Miriam Banda	Multisectoral Co-ordination Manager, FNC
Herbert Zvirere	Manager, Analysis, Research, Monitoring and Evaluation Unit, FNC
Honest Mahlatini	Data Analyst, Analysis, Research, Monitoring and Evaluation Unit, FNC
Nester Gumbo	Chair, National Food and Nutrition Security Committee and Chief Agricultural Extension Specialist, Ministry of Lands, Agriculture and Rural Resettlement
Yvonne Mavhunga	Deputy Director (Programmes), FNC
Kudzai Mukudoka	Nutrition Officer (Stunting Reduction), UNICEF
Chief Mapungwana	interviewed at his home at Mt Selinda

Members of the Chipinge District FNCS

Interviewee	Job title
Charles Mhandu	Chairperson, Agriculture Extension Supervisor, Ministry of Agriculture
Allington Nhamo	DLLC, Ministry of Primary and Secondary Education
Adele Maposa	Arts Officer, Ministry of Youth, Sports, Art and Culture
Xhedisani Gwenzi	Women Affairs, Community and Small and Medium Enterprise Development
Immaculate Dhliwayo	Ward Officer, Nutrition Action Zimbabwe
Mutsa	Goal Zimbabwe
Chakona Phinias	Social Welfare Officer, Ministry of Public Service, Labour and Social Welfare

Members of the Ward 9 FNCS, Chipinge District

Interviewee	Job title
Hamilton Chimiso	Agritex/Ward Chairperson, Ministry of Agriculture
Karen Mudehwe	Ward Nutrition Coordinator, Save the Children
Tryphine Nyebera	Agritex/Area Chairperson, Ministry of Agriculture
Herbet Magama	Local Government Councillor
Rangairai Tapudzai	Ward Youth Community Coordinator, Ministry of Youth, Sports, Art and Culture
Tafirenyika Garikai	Village Health Worker, Ministry of Health and Child Care
Grace Dhliwayo	Community Care Worker, Ministry of Public Service, Labour and Social Welfare
Dennis Njopera	Environmental Health Technician, Ministry of Health and Child Care
Lynah Matika	Nurse in Charge/Secretariat, Ministry of Health and Child Care

Members of the Ward 9 FNSC, Chipinge District

Interviewee	Job title
Charles Maunganidze	Village Headman, Ministry of Local Government
Chipo Machingura	Village Health Worker, Ministry of Health and Child Care
Nyasha Sithole	Village Health Worker, Ministry of Health and Child Care
Wilson Dhlwayo	Headteacher, Ministry of Education
Phanuel Makuku	Local Government Councillor
Confidence Siziba	Agritex, Ministry of Agriculture

Members of the Chiredzi District FNSC

Interviewee	Job title
Tafadzwa Mufudza	Environmental Health Officer, Ministry of Health and Child Care
Mbinda Jesca	District Health Information Officer, Ministry of Health and Child Care
Albert Jimu	Animal Health Inspector, Ministry of Agriculture
Matimbira Isheunesu	Nutritionist/Secretariat, Ministry of Health and Child Care
Mukaro Phillina	Environmental Health Officer, Rural District Council
S. Shava	OPC, President's Department
Ignatious Chorira	District Development Officer, Ministry of Women Affairs, Community and Small and Medium Enterprise Development
Takaniza S	District Coordinator, District Development Fund
Gift Machukele	Acting District Development Coordinator, Ministry of Local Government
Hlasi Mundau	Chief, Ministry of Local Government
Tomu Obert Morrison	Driver, Ministry of Health and Child Care
Felix H Mundau	Chief, Ministry of Local Government
Chirhilele Hatlani	Chief's Advisor, Ministry of Local Government
Itai Dhlwayo	District Information Officer, Ministry of Information and Publicity
Edson Mundau	Chief's Secretary, Ministry of Local Government

Members of the Ward 22 FNSC, Chiredzi District

Interviewee	Job title
Esnath Sidhuna	Nurse in Charge, Ministry of Health and Child Care
Leonard Kungani	Lead Child Care Worker, Ministry of Public Service, Labour and Social Welfare
Emilda Deka	Deputy Head Teacher, Ministry of Primary and Secondary Education
Tariro Mativenga	Agritex Extension Supervisor, Ministry of Agriculture
Moline Mabihani	Ward FNSC Chairperson, Ministry of Agriculture
Tongai Dhobha	Crop and Livestock Extension Worker, Ministry of Agriculture
Kunwana Chiedza	Ward Coordinator, Ministry of Youth, Sports, Art and Culture

Annex 2

Questions used in group discussions at field level

1. How is the MCBM working here?
2. What do you see as your main achievements and successes?
3. What have been/are your main challenges?
4. How do you determine food and nutrition security priorities when finances are constrained?
5. How have different sectors and partners made their programmes more nutrition-sensitive?
6. How is the near-real-time monitoring (NRTM) system working?
 - Are you getting information and feedback in good time?
 - Do you have examples of changes that were made as a result of NRTM information?
7. How has the response to Cyclone Idai affected the MCBM?
8. What behaviour changes have you observed since the start of the MCBM?

Annex 3

NRTM data-collection tools for pregnant women and children under two years of age

Pregnant women

Front cover

Province:

District:

Ward:

Village:

Name of VHW/Volunteer:

Contact details (phone no.):

Pregnant women constant data

(inside front cover with lines of entry for 30 women)

Household Name:

Mobile Number:

Household Number:

Child ID:

Name of Child:

Sex:

Date of birth:

Was woman tested for HIV? (Y/N)

Antenatal care (ANC)

Is woman still a resident of the village?

Is woman still pregnant?

If no longer pregnant:

- Did woman deliver at health facility?
- Did woman have a live birth?

Did you register this pregnancy at the health facility?

How many months pregnant were you when you first registered this pregnancy?

Before this current ANC visit, how many other visits have you done?

Did you attend ANC in the last 30 days?

Did you receive iron folate tabs in the last 30 days?

Did you take the iron folate tabs in the last 30 days?

How often do you take your iron folate tablet?

- Daily
- Weekly
- Monthly

In the last 30 days:

- Were you counselled on maternal malnutrition?
- Were you counselled on breastfeeding?

Household consumption

In the last seven days (i.e. from this day last week until today), for how many days did household consume the following?

In the last seven days (i.e. from this day last week until

today), for how many days did household consume the following (please list number of days, not the number of times)

- Grains, roots and tubers
- Legumes
- Vegetables
- Fruits
- Meat fish and eggs (record only the days for the item consumed for the most number of days)
- Milk and milk products
- Sugar
- Oil
- Condiments (including spices, little amount of milk in tea)

Household Water and Sanitation

What is the source of household drinking water?

- Piped into dwelling
- Piped into yard or plot
- Piped into public tap
- Borehole
- Protected well
- Protected spring
- Unprotected spring
- Surface water (river/dam/stream)
- Rainwater harvesting
- Water trucking

Does your household boil or treat drinking water (using e.g. tablets, water guard, etc.)?

What kind of toilet facility do members of your household usually use?

- Flush/pour flush
- Flush to piped sewer system
- Flush to septic tank
- Flush to pit (latrine)
- Flush to somewhere else
- Ventilated improved latrine
- Pit latrine with slab
- Pit latrine without slab
- Pit latrine (UNVIP)
- Composting toilet
- Bucket
- No facility (bush, field)

Observe if there is a specific place for handwashing

Observe if specific place for handwashing has water

Observe if specific place for handwashing has soap or ash

Agriculture

Does your household own or is it a member of the following types of garden?

- Community garden
- Household garden
- Irrigation scheme

If household has access to a garden, ask the following question: In your garden right now, do you have:

- Legume crops?
- Root/bulb vegetable?
- Leafy vegetable?
- Fruits/fruit veg?
- Cereal crops?

Did your household access crop extension services in the last 30 days?

Do you have livestock?

In the past 30 days, did your household access livestock extension services?

Did your household access external support (food or cash) from govt/NGOs in the past 30 days?

Social protection

What livelihood activities did your household participate in during the past 30 days?

- Remittance
- Food-crop production/sales
- Cash-crop production
- Casual labour
- Begging
- Livestock production/sales
- Skilled trade/artisan
- Own business
- Petty trade
- Pension
- Normal salary/wages
- Fishing
- Gifts
- Vegetable production/sales
- Small-scale mining/mineral sales
- Beer brewing
- Food assistance
- Cross-border trade
- Currency trade
- Gathering natural products for sale; e.g. firewood
- Collecting scrap/waste material for sale
- Rentals
- Other

Children under two years of age

Front cover

Province:

District:

Ward:

Village:

Name of VHW/Volunteer:

Contact details (phone no.):

Child constant data

(inside front cover with lines of entry for 30 children)

Household Name:

Mobile Number:

Household Number:

Child ID:

Name of Child:

Sex:

Date of birth:

Child birth weight (in grams):

Was child tested for HIV? (Y/N)

Check Questions: Child postnatal care and age-appropriate feeding

Has child attained two years of age? (If yes, stop here and move on to next child)

Has child transferred to another area? (If yes, stop here and move on to next child)

Has child died? (If yes, stop here and move on to next child)

Was child's weight measured in the past 30 days?

Was child's height measured in the past 30 days?

Did child suffer from diarrhoea in the past two weeks?

Did the child receive age-appropriate immunisation in the past 30 days?

Did child take vitamin A supplement in the past 30 days?

Was mother counselled on breastfeeding in past 30 days?

Was mother counselled on complementary feeding in the past 30 days?

Has (name) ever been breastfed?

Child postnatal care and breastfeeding

Is (name) still being breastfed?

Yesterday, during the day or night, did (name) drink anything from a bottle with a nipple?

(Ask for children aged 0-5 months only) In the past 24 hours, did (name) drink any of the liquids listed below during the day or night?

- Plain water
- Juice of juice drinks
- Broth/clear soup
- Milk, such as tinned powdered or fresh animal milk (excluding sour milk taken as solids)

- Infant formula
- If YES to milk: How many times did child drink the milk?
- Solid and/or semi-solid food
- If YES to infant formula: How many times did the child drink infant formula?
- Any other liquids.
- For child aged 6-24 months: Did the child consume a four-star diet in the past 24 hours?

Household consumption

In the last seven days (i.e. from this day last week until today), for how many days did household consume the following (please list number of days, not the number of times)

- Grains, roots and tubers
- Legumes
- Vegetables
- Fruits
- Meat fish and eggs (record only the days for the item consumed for the most number of days)
- Milk and milk products
- Sugar
- Oil
- Condiments (including spices, little amount of milk in tea)

Household water and sanitation

What is the source of household drinking water?

- Piped into dwelling
- Piped into yard or plot
- Piped into public tap or standpipe
- Borehole
- Protected well
- Protected spring
- Unprotected spring
- Surface water (river/dam/stream)
- Rainwater harvesting
- Water trucking

Does your household boil or treat drinking water (using e.g. tablets, water guard, etc.)?

What kind of toilet facility do members of your household usually use?

- Flush/pour flush
- Flush to piped sewer system
- Flush to septic tank
- Flush to pit (latrine)
- Flush to somewhere else
- Ventilated improved latrine
- Pit latrine with slab
- Pit latrine without slab
- Pit latrine (UNVIP)
- Composting toilet
- Bucket

- No facility (bush, field)

Observe if there is a specific place for handwashing

Observe if specific place for handwashing has water

Observe if specific place for handwashing has soap or ash

Agriculture

Does your household own or is it a member of the following types of gardens?

- Community garden
- Household garden
- Irrigation scheme

If household has access to a garden, ask the following question: In your garden right now, do you have:

- Legume crop
- Root/bulb vegetable
- Leafy vegetable
- Fruits/fruit veg
- Cereal crops

Did household access crop extension services in the last 30 days?

Do you have livestock?

In the past 30 days, did your household access livestock extension services?

Did your household access external support (food or cash) from Govt/NGOs in the past 30 days?

Social protection

What livelihood activities did your household participate in during the past 30 days?

- Remittance
- Food-crop production/sales
- Cash-crop production
- Casual labour
- Begging
- Livestock production/sales
- Skilled trade/artisan
- Own business
- Petty trade
- Pension
- Normal salary/wages
- Fishing
- Gifts
- Vegetable production/sales
- Small-scale mining/mineral sales
- Beer brewing
- Food assistance
- Cross-border trade
- Currency trade
- Gathering natural products for sale; e.g. firewood
- Collecting scrap/waste material for sale
- Rentals
- Other



WFP/Tatenda Macheka