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## Zimbabwe: Nutrition Profile

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Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. It also has far-reaching consequences for human capital, economic productivity, and national development overall. These consequences of malnutrition are a concern for policy makers in Zimbabwe, where around 650,000 children under 5 years (27 percent) suffer from chronic malnutrition (stunting or low height-for-age) and 35 percent of women 15–49 years are overweight or obese, according to the most recent Demographic and Health Survey (DHS) (ZIMSTAT and ICF 2016).

### Background

Zimbabwe, a country of about 14.8 million people in southern Africa, has faced political and economic upheaval that disrupted its previous standing as a relatively prosperous and resilient country (World Bank 2017; ZIMSTAT 2015; USAID 2018). GDP growth declined from 11.9 percent in 2011 to 0.6 percent in 2016, but was expected to rise in 2017 and 2018 (ZimVAC 2017).

Ninety-two percent of Zimbabwean rural households practice agriculture as their primary livelihood, and food crop production and casual labor are the most important sources of income (ZimVAC 2017). The most commonly cultivated food crops are maize, small grains, groundnuts, and cowpeas. Almost half of rural households raise cattle (45 percent) and/or goats (46 percent), however livestock mortality is high with 10 percent of cattle and 17 percent of goats succumbing primarily to disease and drought (ZimVAC 2017). Recent agricultural seasons suffered from drought-reduced harvests, but agricultural production increased in 2017 (USAID 2017). Rural households are vulnerable to multiple shocks including cash shortages (faced by 46 percent of households), water-logging (43 percent), drought (32 percent), crop pests (30 percent), as well as price changes, health issues, livestock disease and death, and sometime floods. In 2017, about 40 percent of rural households reported being unable to cope with shocks in the coming year, while 45 percent could cope, but with difficulties (ZimVAC 2017). The peak hunger season is January to March and households are most food secure from April to June. It is estimated that 1.1 million people will be food insecure in the 2018 hunger season (ZimVAC 2017).

Zimbabwe is a young country in which half of the population is younger than 18 years (ZIMSTAT and ICF 2016). Annual population growth was 2.3 percent in 2016 (World Bank n.d.). The total fertility rate of 4.0 children per woman in 2016 has remained almost unchanged since 2010, when it was 4.1 children per woman. According to the most recent DHS (2015), the maternal mortality ratio is very high at 651 deaths per 100,000 live births, and 12 percent of female deaths are related to pregnancy or childbearing. One in 15 children will die before reaching 5 years of age (ZIMSTAT and ICF International 2016). Currently, Zimbabwe ranks 121<sup>st</sup> out of 157 countries in terms of progress toward meeting the Sustainable Development Goals (Sachs et al. 2017) and is 154<sup>th</sup> out of 188 countries on the Human Development Index (UNDP 2016).

### Nutrition and Food Security Situation

With 76 percent of the rural households considered poor and 23 percent extremely poor, on average, households spend over half of their income on food and 33 percent suffer from food deprivation (Sachs et al. 2017; ZimVAC 2017). While households used fewer and less extreme coping strategies in 2017 than in previous years, there was a decrease in households consuming an acceptable diet and an increase in households consuming a poor diet, as defined by the food consumption score. Overall, 10 percent of rural households experienced severe hunger in 2017, based on the household hunger score (ZimVAC 2017).

Stunting levels among children under 5 improved from 32 percent in 2010–2011 to 27 percent in 2015, which is considered high according to WHO/UNICEF (ZIMSTAT and ICF 2016; WHO/UNICEF 2017). Stunting levels vary geographically from 19 percent in Bulawayo province to 31 percent in Matabeleland South, and are higher in rural areas (29 percent) than urban areas (22 percent). Differences in stunting levels can also be seen according to maternal education and wealth levels—25 percent of children whose mothers have secondary education are stunted, while the prevalence rises to 45 percent of children whose mothers had no formal education. Similarly, 17 percent of children in the highest wealth quintile are stunted, while 33 percent of children in the lowest wealth quintile are stunted (ZIMSTAT and ICF 2016). Thirty-seven percent of children 6–59 months are anemic, a substantial improvement from 2010–11 when over half of children suffered from anemia. Anemia prevalence varies regionally, from 29 percent in Masvingo to 40 percent in Manicaland (ZIMSTAT and ICF 2016).

At 6 percent, prevalence of thinness among women 15–49 years has reduced slightly since 2010–2011. However, overweight has increased from 31 percent to 35 percent in that same period, which is a continuation of an ongoing upward trend (ZNSA and ICF 2016). Overweight and obesity are more common among women living in urban areas than rural and higher among wealthier and more educated women (ZIMSTAT and ICF 2016).

Poor infant and young child feeding practices contribute to child malnutrition in Zimbabwe. Although breastfeeding is nearly universal (98 percent), only 58 percent of children in 2015 were breastfed within the first hour of birth, a decline from 2010–2011, and less than half of children 0–6 months are exclusively breastfed. Exclusive breastfeeding prevalence further decreases to only 20 percent among children 4–5 months. Among children 6–23 months, only 10 percent are fed a minimally acceptable diet with appropriate frequency and diversity. The coverage of vitamin A supplementation among children 6–59 months is 67 percent, which is virtually unchanged from 2010–2011 (ZIMSAT and ICF 2016). Several additional factors may also contribute to poor nutrition outcomes. Childbearing begins early in Zimbabwe. By 19 years, almost half (48 percent) of adolescent girls had begun childbearing in 2015, which is unchanged from 2010–2011 (ZIMSTAT and ICF 2016; ZIMSTAT and ICF 2012). This has serious consequences because adolescent girls are more likely than older mothers to be malnourished and have a low birth weight baby who is more likely to become malnourished, and be at increased risk of illness and death, than those born to older mothers (CSA and ICF 2016). The risk of stunting is 33 percent higher among first-born children of mothers under 18 years in sub-Saharan Africa, and as such, early motherhood is a key driver of malnutrition (Fink et al. 2014). Sanitation is also a challenge in Zimbabwe, with only 61 percent of rural households accessing improved sanitation and 30 percent of households practicing open defecation (ZimVAC 2017).

<b>Zimbabwe Nutrition Data (DHS 2010–2011 and 2015)</b>		
Population 2016 [ZIMSTAT 2015]	14.8 million	
Population under 5 years of age (0–59 months) 2016 [UNICEF 2017]	2.5 million	
	<b>DHS 2010-11</b>	<b>DHS 2015</b>
Prevalence of stunting among children under 5 years (0–59 months)	32%	27%
Prevalence of underweight among children under 5 years (0–59 months)	10%	8%
Prevalence of wasting among children under 5 years (0–59 months)	3%	3%
Prevalence of low birth weight (less than 2.5 kg) (of children whose birth weights are known)	10%	10%
Prevalence of anemia among children 6–59 months	56%	37%
Prevalence of anemia among women of reproductive age (15–49 years)	28%	27%
Prevalence of thinness among women of reproductive age (15–49 years)	7%	6%
Prevalence of thinness among adolescent girls (15–19 years)	14%	13%
Prevalence of children 0–5 months exclusively breastfed	31%	48%
Prevalence of children 4–5 months exclusively breastfed	15%	20%
Prevalence of early initiation of breastfeeding (i.e., put to the breast within one hour of birth)	65%	58%

Prevalence of children who receive a pre-lacteal feed	13%	13%
Prevalence of breastfed children 6–23 months receiving minimum acceptable diet	13%	10%
Prevalence of overweight/obesity among children under 5 years (0–59 months)	6%	6%
Prevalence of overweight/obesity among women of reproductive age (15–49 years)	31%	35%
Coverage of iron for pregnant women (for at least 90 days)	5%	40%
Coverage of vitamin A supplements for children (6–59 months in the last 6 months)	66%	67%
Percentage of children 6–59 months living in households with iodized salt	94%	95%

## **Global and Regional Commitment to Nutrition and Agriculture**

Zimbabwe has made the following global and regional commitments to nutrition and agriculture:

<b>Year of Commitment</b>	<b>Name</b>	<b>Description</b>
2011	Scaling Up Nutrition (SUN)	SUN is a global movement that unites national leaders, civil society, bilateral and multilateral organizations, donors, businesses, and researchers in a collective effort to improve nutrition. In Zimbabwe, SUN is coordinated through national and sub-national multisectoral food and nutrition security committees.
2012	Committing to Child Survival: A Promise Renewed	Zimbabwe is a signatory to A Promise Renewed, which seeks to end preventable maternal, newborn, and children deaths.
2013	Comprehensive Africa Agriculture Development Program (CAADP)	CAADP is an Africa-led program bringing together governments and diverse stakeholders to reduce hunger and poverty and promote economic growth in African countries through agricultural development. The government has demonstrated commitment to agricultural development, signing a CAADP Compact in 2013.

## **National Nutrition Policies/Legislation, Strategies, and Initiatives**

Zimbabwe’s commitment to improving nutrition is outlined in the following documents, which are aligned with the Zimbabwe Agenda for Sustainable Socio-Economic Transformation 2013–2018:

- Food and Nutrition Security Policy (2013)
- National Nutrition Strategy 2014–2018
- Nutrition Communication Strategy (2016)
- Interim Poverty Reduction Strategy Paper 2016–2018
- National Food Fortification Strategy 2014–2018
- National Social Protection Policy Framework (2016)

- Zimbabwe United National Development Assistance Framework (2016–2020)

## USAID Programs: Accelerating Progress in Nutrition

As of January 2018, the following USAID programs with a focus on nutrition were active in Zimbabwe.

<b>Selected Projects and Programs Incorporating Nutrition in Zimbabwe</b>		
<b>Name</b>	<b>Dates</b>	<b>Description</b>
Enhancing Nutrition, Stepping Up Resilience and Enterprise (ENSURE)	2013–2018	ENSURE is a Food for Peace-funded development food assistance program. It works to build resilience and promote improved nutrition behaviors among vulnerable households in arid and semi-arid areas of Manicaland and Masvingo provinces. It complements the Amalima project (USAID n.d.; The Mitchell Group).
Amalima	2013–2018	Amalima is a Food for Peace-funded development food assistance program. It works to improve food security and nutrition among vulnerable households and strengthen community resilience in Matabeleland North and South. It complements the ENSURE project (USAID n.d.; Mitchell Group).
Feed the Future Zimbabwe Crop Development Program	2015–2020	The Feed the Future Zimbabwe Crop Development Program aims to reduce rural poverty and increase incomes and food security through increased agricultural production, productivity, and market linkages for small-scale crop farmers. The program operates in 15 districts in Matabeleland North, Mashonaland West, Manicaland, Masvingo, and Midlands (USAID n.d).
Feed the Future Zimbabwe Livestock Development Program	2015–2020	The Feed the Future Zimbabwe Livestock Development Program aims to reduce rural poverty and improve household food security among smallholder producers through increased agricultural production, productivity, and market linkages in the beef and dairy cattle sectors. The program operates in 12 districts in Matabeleland North and South, Mashonaland East, Manicaland, Masvingo, and Midlands (Feed the Future Livestock Development Program 2015).

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