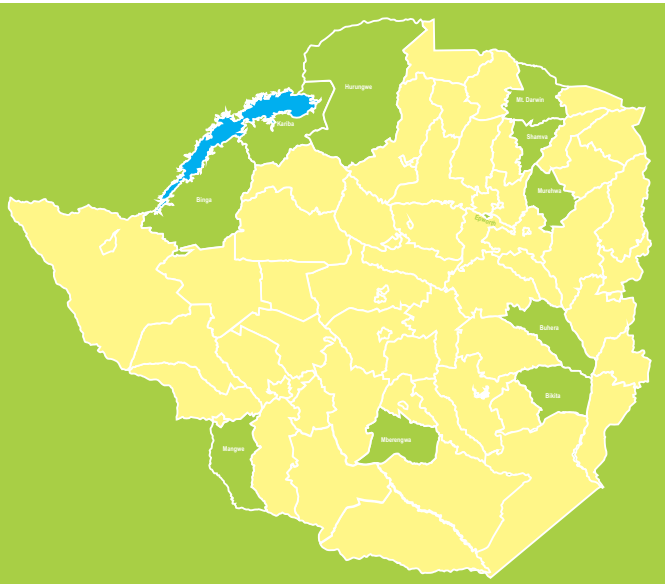
SMART SURVEY 2019



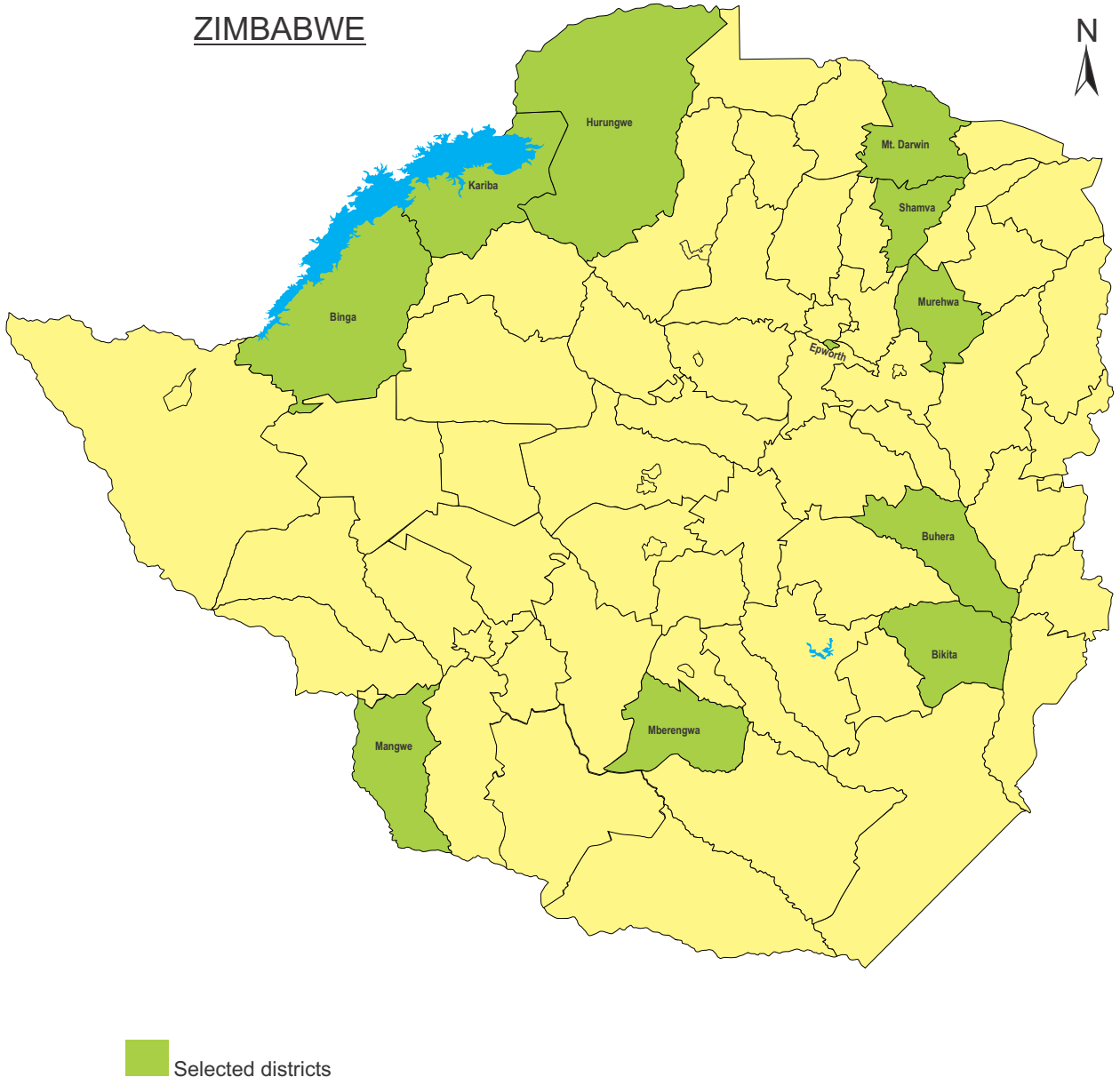
Results of The Emergency Nutrition Assessment in 11 Selected Districts, Zimbabwe

March 2019

unicef

11 Selected Districts

- Bikita
- Binga
- Buhera
- Epworth
- Hurungwe
- Kariba
- Mangwe
- Mberengwa
- Mt Darwin
- Shamva



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Foreword

Food and Nutrition Security (FNS) remain a major priority for national development in Zimbabwe. The multi-causal nature of FNS requires constant monitoring and evaluation according to season and place. Zimbabwe is experiencing a devastating El Nino since the 2015/16 agricultural season and the situation is expected to worsen in 2019. Different districts will be affected differently by the same hazard, shock or crisis. Nutrition crisis may have a rapid or slow onset and as such need to be monitored regularly, particularly following any significant changes in the primary determinants of under nutrition, dietary intake and diseases occurrence. The priority objective of the rapid nutrition assessment was to update the nutrition situation data in 11 problematic districts and domains in the country.

In fulfilment of the Food and Nutrition Security Policy Commitment Six, which calls for the provision of timely food and nutrition security information; the Ministry of Health and Child Care in collaboration with its Partners embarked on Emergency Nutrition Assessment using the SMART methodology. This was following the poor food security projections by the January 2019 Lean Season Assessment , the cholera outbreaks reported in the country and the general price increases for basic foods and commodities.

The results for the survey indicate that the rates of acute malnutrition have not changed significantly from the levels reported in the 2018 National Nutrition Survey. However the contributing factors to acute malnutrition especially feeding and caring and practices, water sanitation and hygiene show a declining trend and need continuous monitoring and strengthening for the country to maintain the prevalence of acute malnutrition within acceptable levels.

Major General (Dr) G. Gwinji (Rtd)
Secretary for Health and Child Care

Acronyms and Abbreviations

EA	Enumeration Area
EBF	Exclusive Breast Feeding
ENA	Emergency Nutrition Assessment
GAM	Global Acute Malnutrition
IYCF	Infant and Young Child Feeding
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversity
MMF	Minimum Meal Frequency
MNP	Micronutrient Powders
MUAC	Mid Upper Arm Circumference
NNS	National Nutrition Survey
RDC	Rural District Council
SAM	Severe Acute Malnutrition
SFP	Supplementary Feeding Program

Acronyms and Abbreviations

• **SMART**	Standardised Monitoring and Assessment of Relief and Transition
• **UNICEF**	United Nation Children's Fund
• **VAS**	Vitamin A Supplementation
• **WASH**	Water, Sanitation and Hygiene
• **WHO**	World Health Organisation
• **ZIMVAC**	Zimbabwe Vulnerability Assessment Committee
• **ZIMSTAT**	Zimbabwe National Statistics Agency

Acknowledgements

The technical and financial support received from the following is greatly appreciated:

- Adventist Development and Relief Agency (ADRA)
- Bikita Rural District Council
- City of Harare
- Ministry of Labour and Social Welfare
- Ministry of Local Government, Public Works and National Housing
- Save the Children
- United Nations Children's Fund (UNICEF)

Food and Nutrition Security Context

- The 2019 ZIMVAC Lean Season Assessment estimated that 51% of the rural population (4.5 million people) and 40.6% of the urbanites (3 million people) would be food insecure and in need of assistance during the peak hunger period (January to March 2019)

- The proportion of households with poor food consumption scores increased from 20% in 2018 to 31.9% in 2019

- The agricultural season was characterised by late rains; which were poorly distributed as well as high prices of key agricultural inputs such as seed, fertilisers and herbicides **(ZIMVAC Lean Season Assessments 2019).**

- The total area under maize decreased by 7% during the 2018/19 season compared to the 2017/18 agricultural season and the crop condition was generally fair to poor **(Crop and livestock assessment Round 1 2018/19).**

- As of February 2019, the year on year food and non- alcoholic beverages inflation prone to transitory shocks stood at 69.8% whilst the non-food inflation rate was 54.3% **(ZimStat Consumer Price Index 2019)**

Food and Nutrition Security Context

- Food insecurity is one of the three main underlying causes of malnutrition
- Nutrition security requires consumption of healthy foods, good health and care especially for women and children under five.
- National Nutrition Survey of 2018 reported poor Infant and Young Child Feeding practices and only 4% of children 6-23 months received a minimum acceptable diet
- National Global Acute Malnutrition (GAM) was at 2.5%; within acceptable range and stunting stood at 26.2% with inter-district variances for both indicators
- Declining food security and health indicators typically is a good indication that rates of acute malnutrition will also rise over time
- Zimbabwe has experienced a concerning degradation in both determinants
- As food insecurity and rates of diarrheal disease increase progressively, rates of malnutrition are likely to follow a similar trajectory

Rationale

- An Emergency nutrition assessment was conducted in 10 rural districts of Zimbabwe and Epworth identified using the following criteria:
- Relatively higher GAM compared to the national average as described by the National Survey of 2018; the highest GAM of 4.8% was reported in Kariba against a National average of 2.5%
- Higher administrative data on Severe Acute Malnutrition (SAM) admissions (DHIS 2) for the 10 districts compared to other districts in the same Province
- Cholera outbreaks in Shamva, Mt Darwin, Buhera and Epworth districts between September and December 2018 which resulted in **55** deaths and **10,202** suspected and confirmed cases nationally
- General price increases of basic food commodities likely to affect access to food by women and children
- A devastating El Nino since the 2015/16 agricultural season; six of the selected districts are currently in IPC phase 3 and two are in IPC phase 4 (Buhera and Binga)
- The assessment was also meant to provide a data source for secondary IPC Acute Malnutrition Analysis

Objectives

Overall Objective

- To determine the current nutrition status of children 0 to 59 months in 11 hotspot areas (10 rural districts and Epworth) across 8 provinces

Specific Objectives

- To update the prevalence of global, moderate and severe acute malnutrition in 11 problematic areas which was last reported in February 2018
- To estimate prevalence of chronic malnutrition among children aged 6 to 59 months
- To assess vitamin A supplementation coverage among children aged 6 to 59 months
- To determine core IYCF and WASH practices for children 0-23 months
- To determine coverage of the National Food Fortification program in the 11 assessed districts

Methodology

Study design

- This was a cross sectional study conducted across 10 districts and Epworth from 8 rural Provinces

Study population

- All households that resided in the10 rural districts and Epworth. All the households in the districts had an equal chance of selection

Sample Size

- A sample size of 240 households expected to give an estimate of 119 children per districts was calculated using ENA for SMART software based on the parameters shown in the table below:

Table 1: Parameters used in sample size calculation

Estimated Prevalence of GAM	**5%**
± Desired precision	**5%**
Design Effect	**1.5**
Children to be included	**11.9**
Average HH size	**4.2**
Percentage of children under -5	**15%**
Percentage of non-response Households	**3%**
Households to be included	**217**

Selection of Enumeration Areas and Households

- A total of 30 Enumeration Areas were randomly selected in each district using the ZIMSTAT master sample
- Eight households randomly selected were included per EA using simple random sampling after segmentation to yield 240 households per district
- Villages were randomly selected from within the target EAs.
- Where EAs and villages were very big, they were segmented
- Segments were randomly selected for data collection.
- Households were visited at least twice before the teams left the EA
- Households were not replaced
- The assessment utilised the Standardised Monitoring and Assessment of Relief and Transitions (SMART) approach

EAs already selected for the ongoing MICS assessment were excluded to avoid interviewee overburden

Questionnaire Design and Enumerator Training

- The standard SMART data collection tool was adapted to include contextual indicators on Water Sanitation and Hygiene (WASH), childhood illness, Infant and Young Child Feeding (IYCF), growth monitoring and food fortification
- The questionnaire was loaded on an electronic platform; KOBO Collect
- The SMART training package was adapted and a 5 day Enumerator training conducted at a central venue from the 13th to the 17th of February 2019
- Competent enumerators and anthropometrists were selected from the MoHCC at district level
- A standardization test for anthropometry was conducted in collaboration with the City of Harare Health Department to enhance consistency of measurements
- A pilot test was conducted over a day in a rural field setting and feedback was incorporated into the data collection tool before data collection

Data Collection

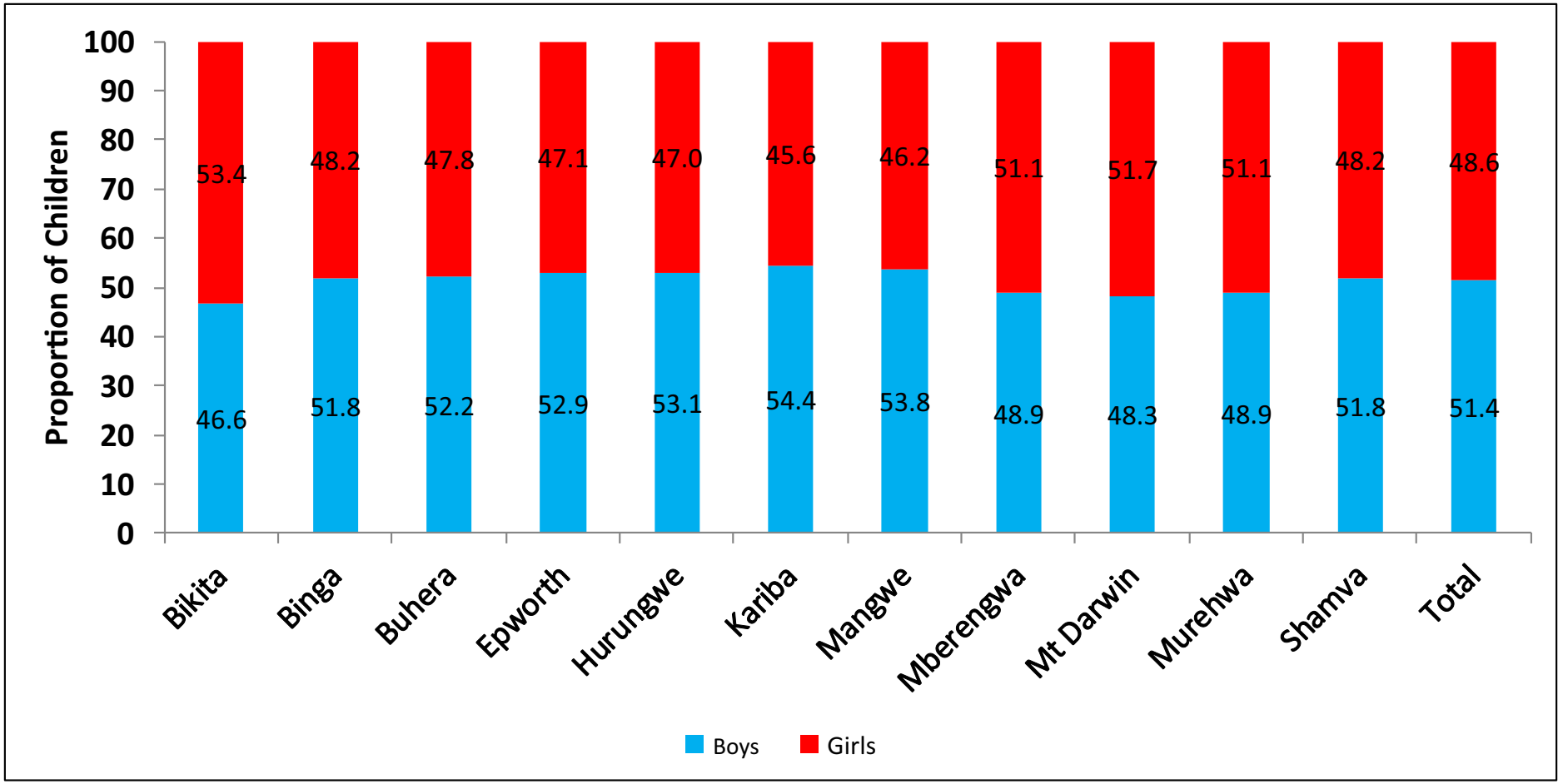
- Data collection was conducted over 10 days from the 19th to the 28th of February 2019 by 2 teams per districts; 2 Enumerators and 2 Anthropometrists
- Data was collected using hand-held electronic mobile devices that were linked to a central server.
- Data was automatically transferred to the central server daily or whenever the device had connection to internet
- Children 6-59 months had their heights, weights, oedema and MUAC assessed for the estimation of GAM basing on WHO 2006 growth standards
- Verbal consent was obtained from all caregivers and respondents and confidentiality was assured
- Children who displayed signs of illness were immediately referred to the nearest health facility
- All oedema cases were verified and confirmed by the Provincial supervisory team

Data Management and Analysis

- The electronic questionnaire had in-built restrictions to enhance quality and avoid outliers for certain variables for example date of birth, weight and height
- ENA for SMART was used for flag checks on anthropometry datasets
- Each Team of Enumerators was supervised by a Provincial Nutritionist in collaboration with a National Supervisor
- Data Analysis was done using ENA for SMART v.2011 and STATA v.13

Household & Children Demographics

Proportion of Children Assessed by Sex



The average proportion of the assessed children was 51.4% male as to 48.6% Female and there was almost a similar trend across most districts

Number of Children Assessed by Age

District	<6month	6 -23 month	24 -59 month	Total
Bikita	11	36	86	133
Binga	17	47	102	166
Buhera	17	62	126	205
Epworth	18	56	117	191
Hurungwe	27	71	115	213
Kariba	28	60	129	217
Mangwe	17	43	111	171
Mberengwa	16	56	110	182
Mt Darwin	13	52	111	176
Murehwa	13	44	76	133
Shamva	24	46	96	166
Total	201	573	1179	1,953

A total of 1, 953 children were assessed during the assessment

Proportion of Children Assessed by Child Living Arrangement

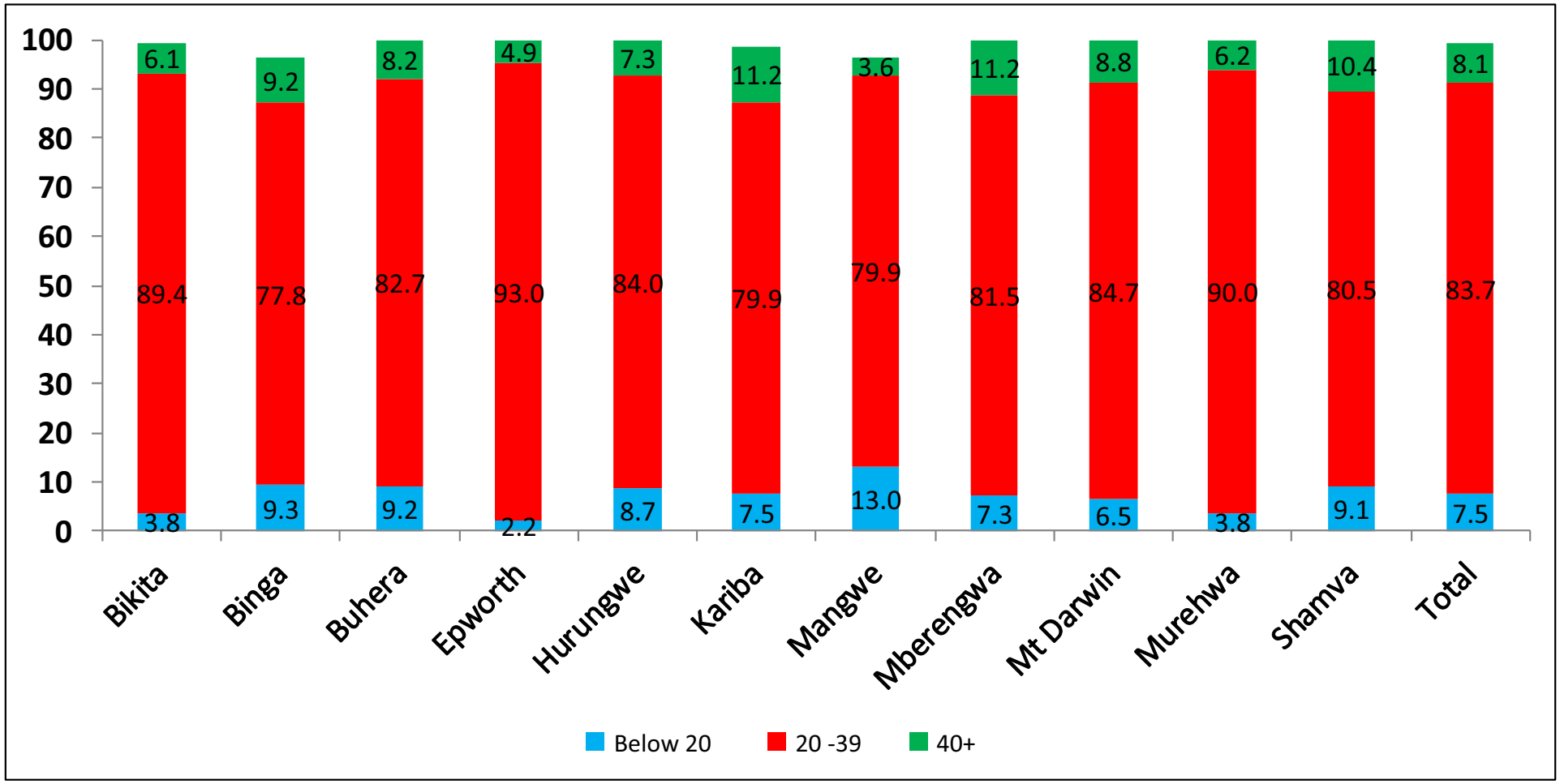
District	Live with both parents	Percentage of children who live with mother and not with father		Percentage of children who live with father and not with mother		Percentage of children not living with both parents				Percentage of children whose father or mother living status unknown	Total
		Father alive	Father is dead	Mother is alive	Mother is dead	Both parents are alive	Father is alive	Mother alive	Both parents are dead		
Bikita	66.1	15.7	2.5	2.5	0.0	10.7	0.0	0.0	0.0	2.5	**121**
Binga	49.7	34.7	1.4	1.4	0.0	8.8	0.7	0.0	0.0	3.4	**147**
Buhera	67.6	10.1	1.6	2.7	0.5	12.8	2.1	1.6	0.5	0.5	**188**
Epworth	79.6	11.4	1.8	0.6	0.0	4.2	0.6	0.0	0.0	1.8	**167**
Hurungwe	79.7	10.4	1.1	1.7	0.0	4.4	1.1	0.6	0.0	1.1	**182**
Kariba	73.8	12.8	4.8	2.1	0.5	4.8	0.0	0.5	0.0	0.5	**187**
Mangwe	31.6	41.5	2.0	0.0	0.0	11.8	0.0	2.0	0.0	11.2	**152**
Mberengwa	68.1	19.6	1.2	1.8	0.0	8.6	0.0	0.6	0.0	0.0	**163**
Mt Darwin	77.2	9.5	1.9	1.9	0.0	7.6	0.0	0.6	0.0	1.3	**158**
Murehwa	60.5	16.8	0.8	2.5	0.0	15.1	0.8	2.5	0.8	0.0	**119**
Shamva	74.7	9.9	2.1	2.8	0.0	4.9	1.4	0.0	0.0	4.2	**142**
Total	66.9	17.1	2.0	1.8	0.1	8.3	0.6	0.8	0.1	2.3	**1726**

The average proportion of children assessed by orphan hood with father dead is 2.0% with Kariba recording the highest proportion(4.8%).

Proportion of Children Assessed by Mother's ; Caregivers' and Fathers Age

	<20 Years	20-39 Years	40-59 Years	60+ Years	Total
Caregiver's age	6.7	71.5	16.9	4.9	1921
Mother's age	7.5	83.7	8.1	0.8	1906
Father's age	0.3	67.7	27.5	4.6	1836

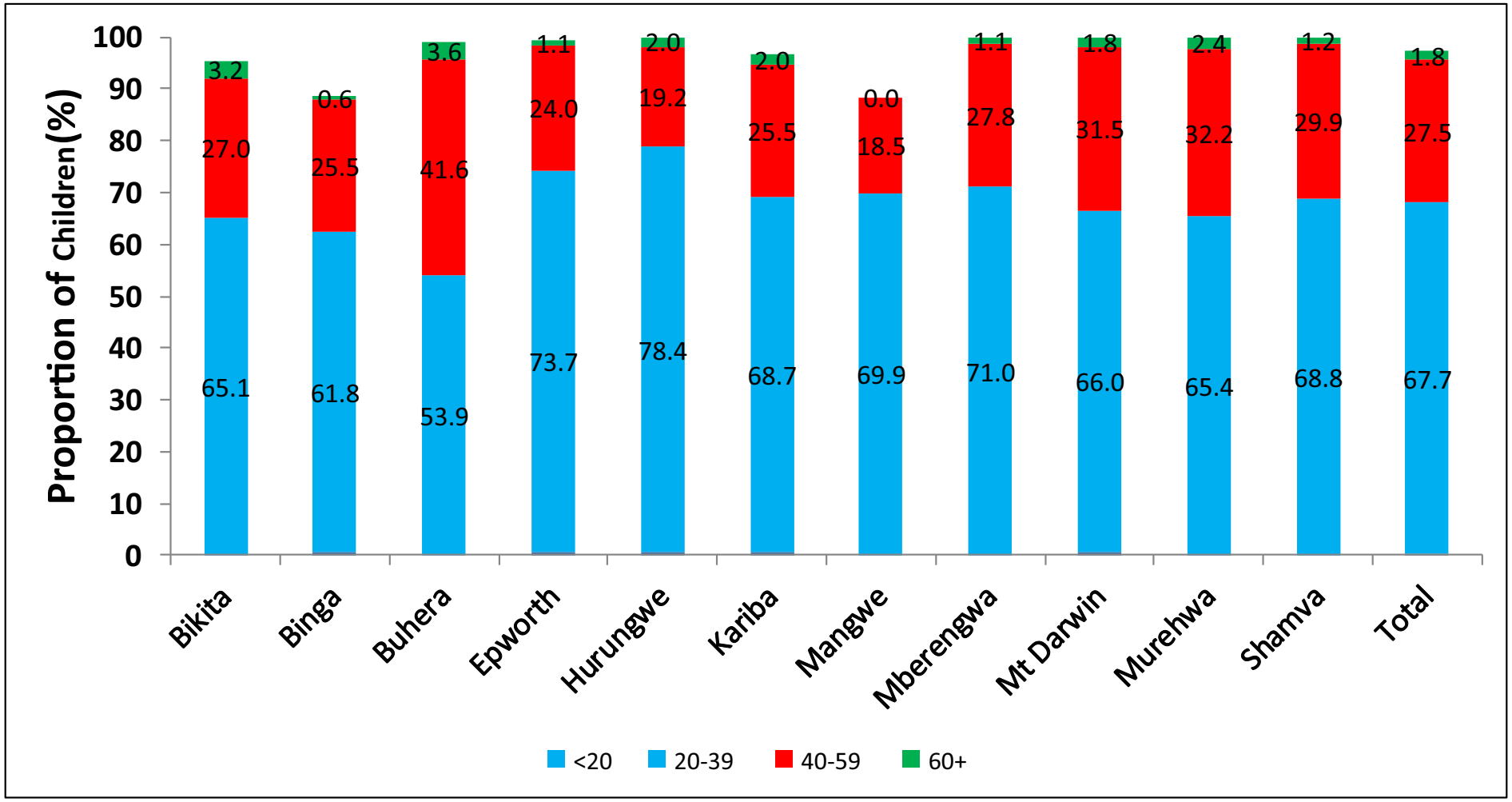
Proportion of Children Assessed by Mother's Age



The highest proportion of the assessed children's mothers were in the 20 -39 age group (71.5%) followed by 40 – 59 age group (16.9%).

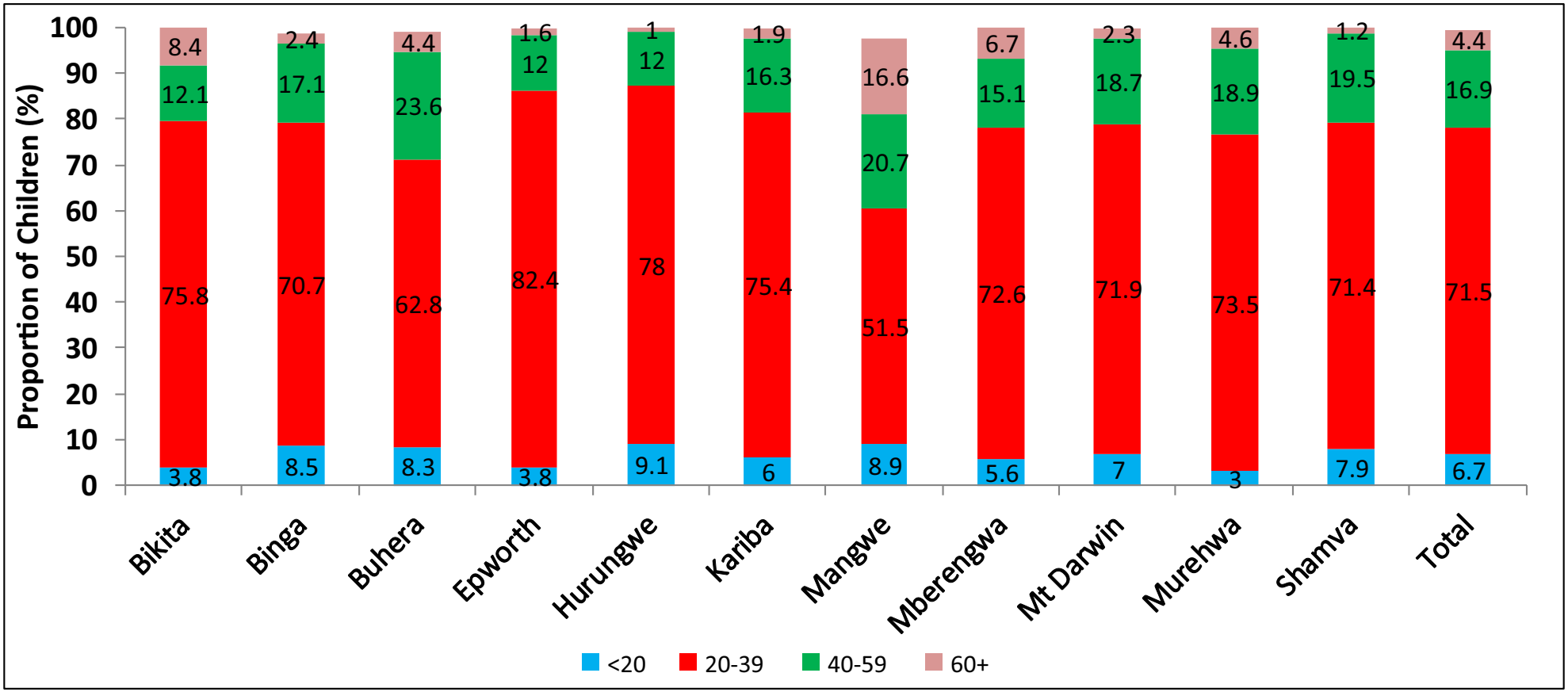
Mangwe had the highest proportion of mothers less than 20 years (13%) followed by Binga (9.3%)

Proportion of Children Assessed by Father's Age



The average proportion of children assessed by fathers age was highest in the 20 – 39 age group (67.7%) and it was also observed that there are elderly men above the age of 60 (1.8%) who had children below the age of five

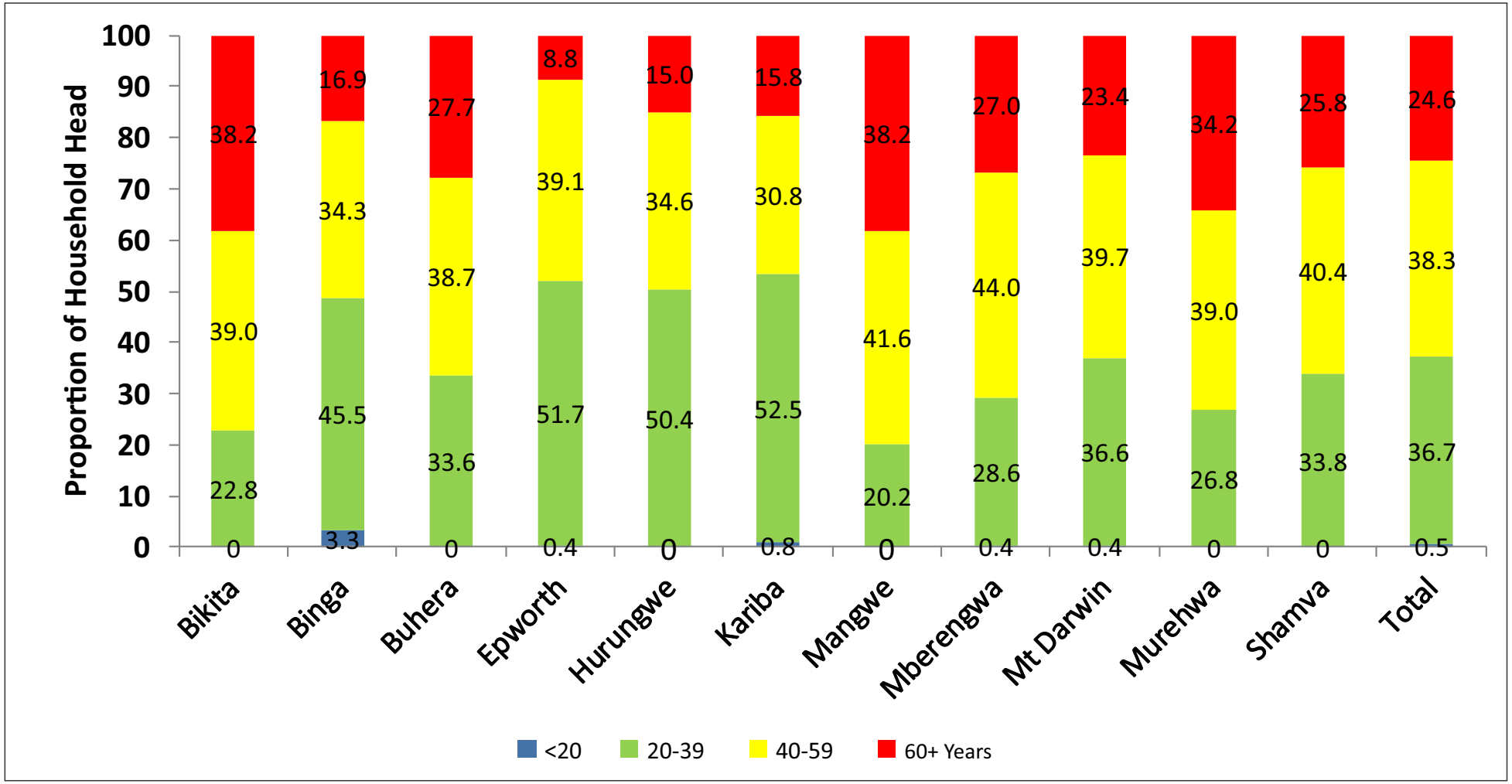
Proportion of Children Assessed by Caregiver's Age



The average proportion of children assessed by caregivers ' age were highest in the 20 -39 age group (71.5%) followed by 40 – 59 age group(16.9%) . Of note is the proportion of the elderly (4.4%) who are also principle care givers of the children under five.

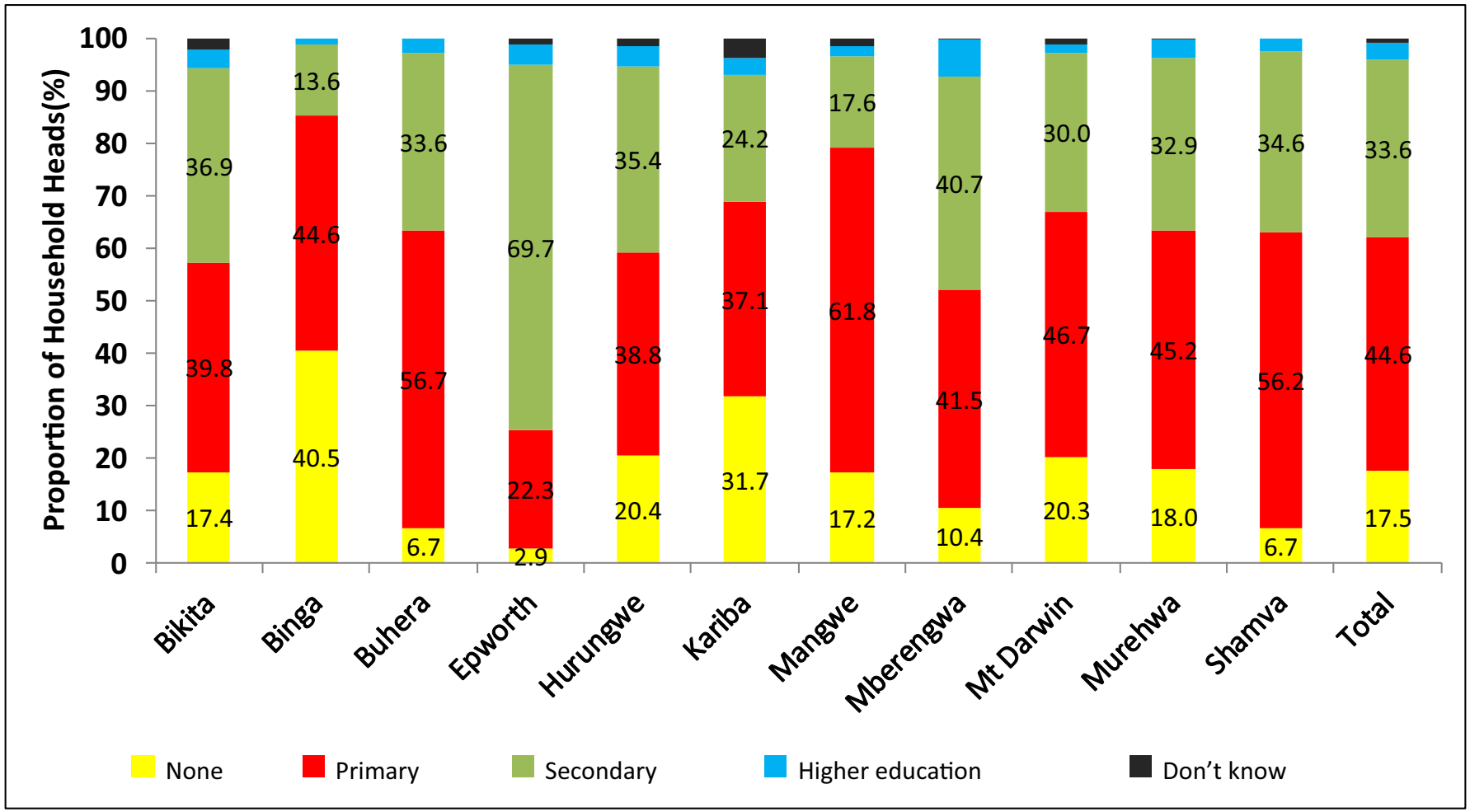
Mangwe (16.6%) had the highest proportion of children being taken care of by elderly caregivers

Proportion Household Head by Age



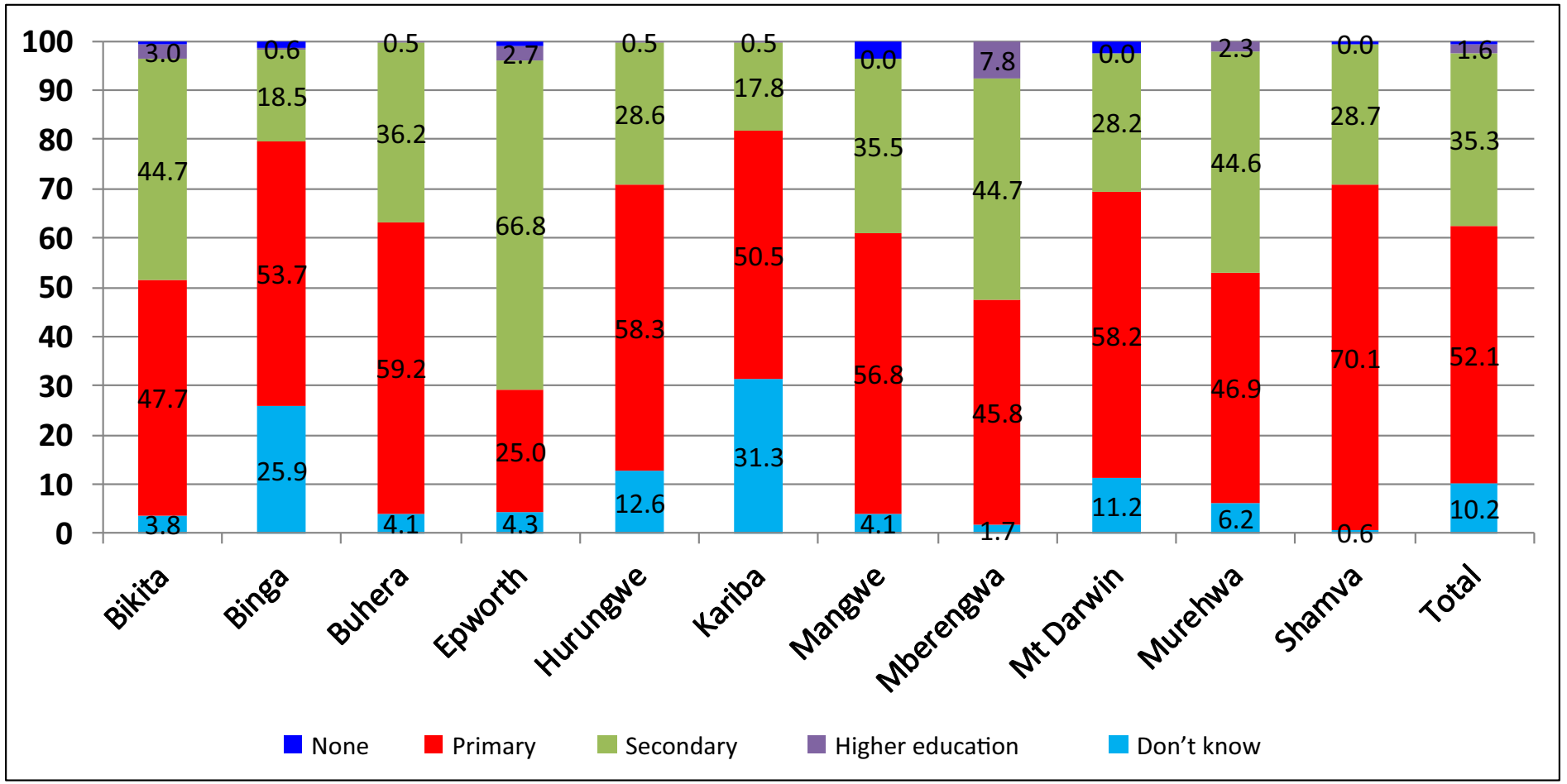
Most of the household head were in the 40-59 years (38.3%) and 20-39 years (36.7%) age groups .
Binga had the highest proportion of household head under 20years.

Education of Household Head in Households with Children Under five



The surveyed households with children under five had at least 81.4% household heads who have attained primary level and above

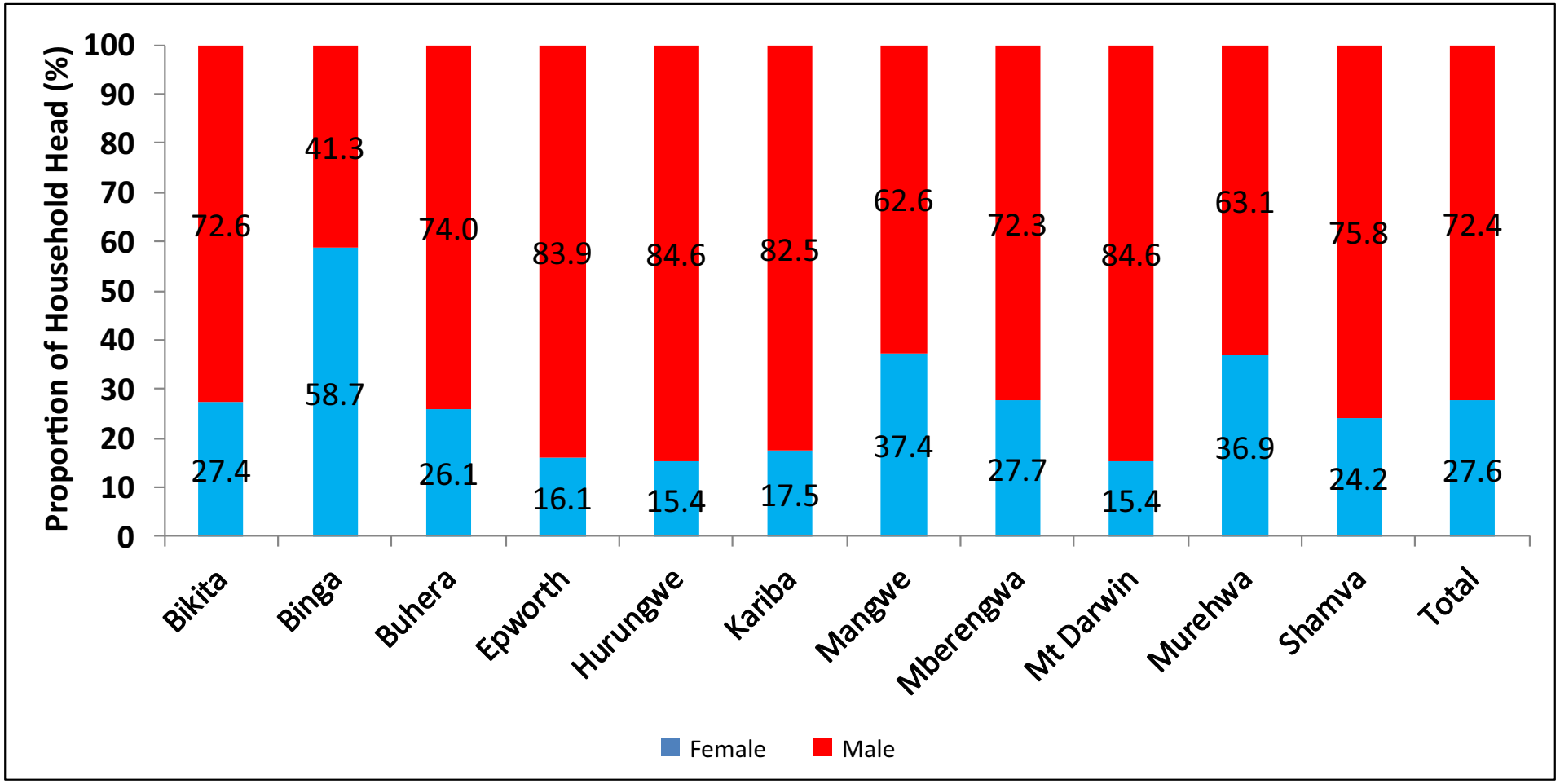
Education of Mother of Children Under five



The average assessed households with children under five had at least 89% mothers who have attained primary level and above

Kariba (31.3%) and Binga (25.%) districts had the highest proportion of mothers who have not attained any level of education

Proportion of Household Head by Sex



The majority of the households were male headed (72.4%)

The trend is similar across all districts save for Binga which had 58.7% of the households being female headed.

Infant and Young Child Feeding Practices

Definitions

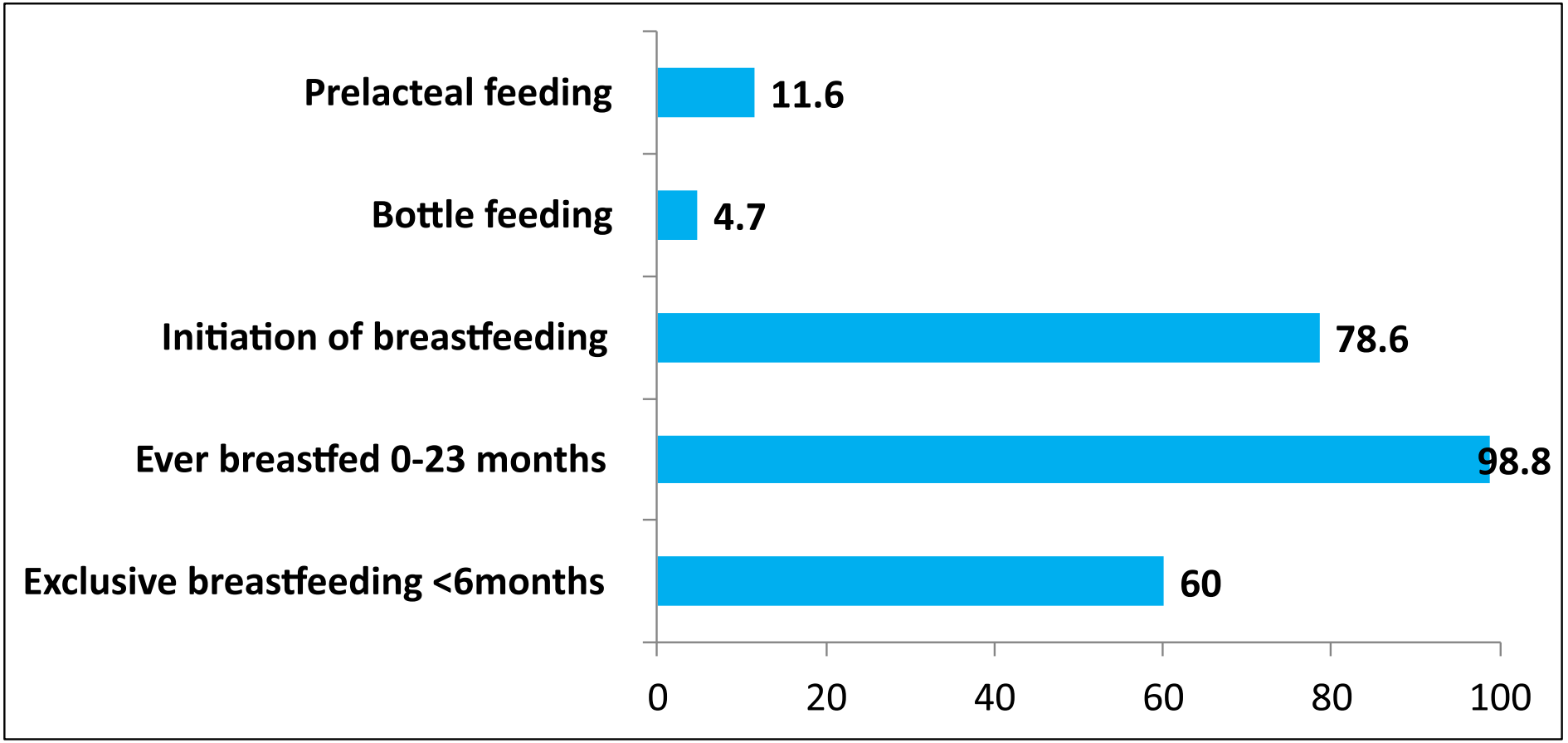
Exclusive breastfeeding

- Exclusive breastfeeding means giving a baby only breast milk, and no other liquids or solids, not even water. Drops or syrups consisting of vitamins, mineral supplements or medicines (including ORS) are permitted. (WHO, 2012)

Prelacteal feeds

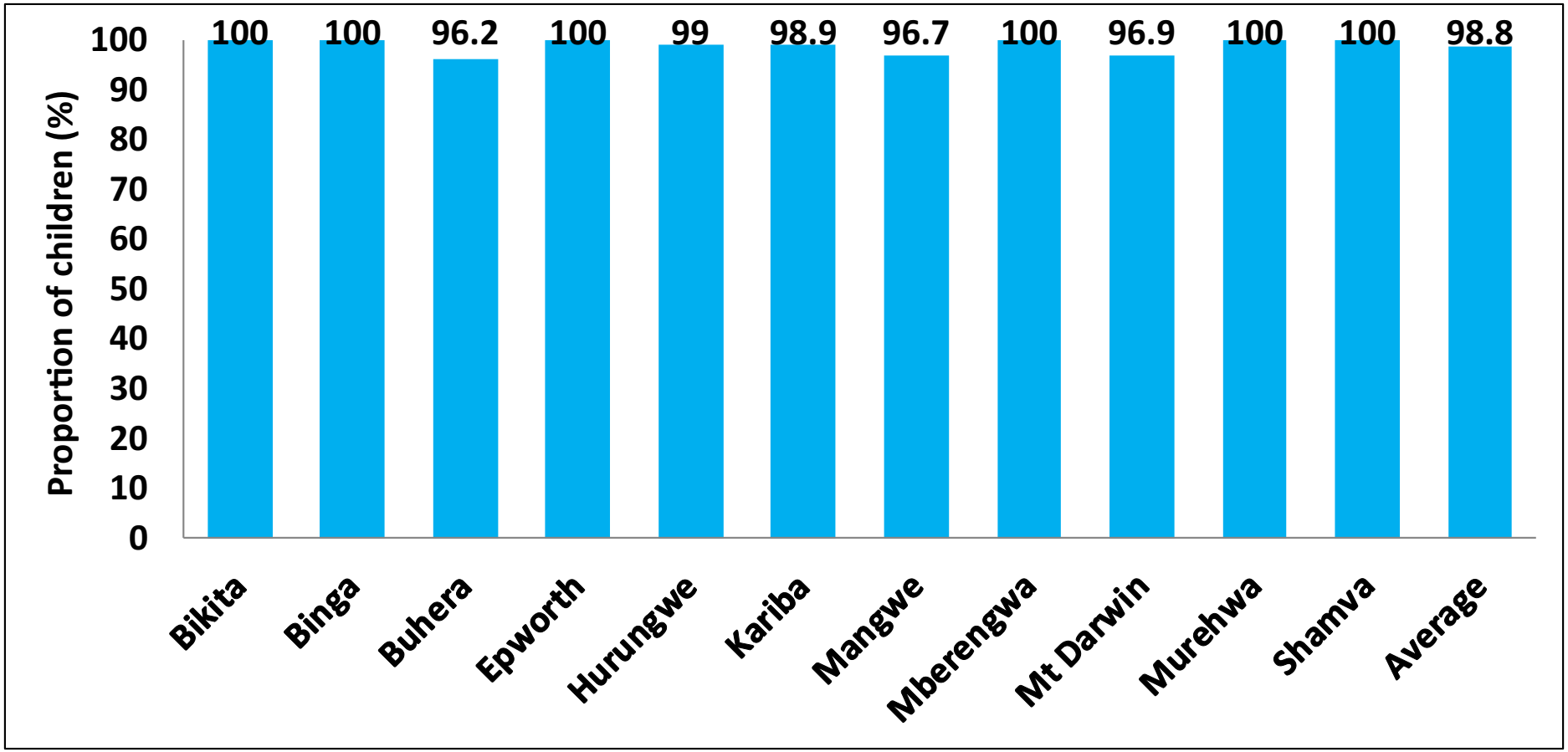
- These are foods other than breast milk given to children within 3 days of birth

Summary of Breastfeeding Practices



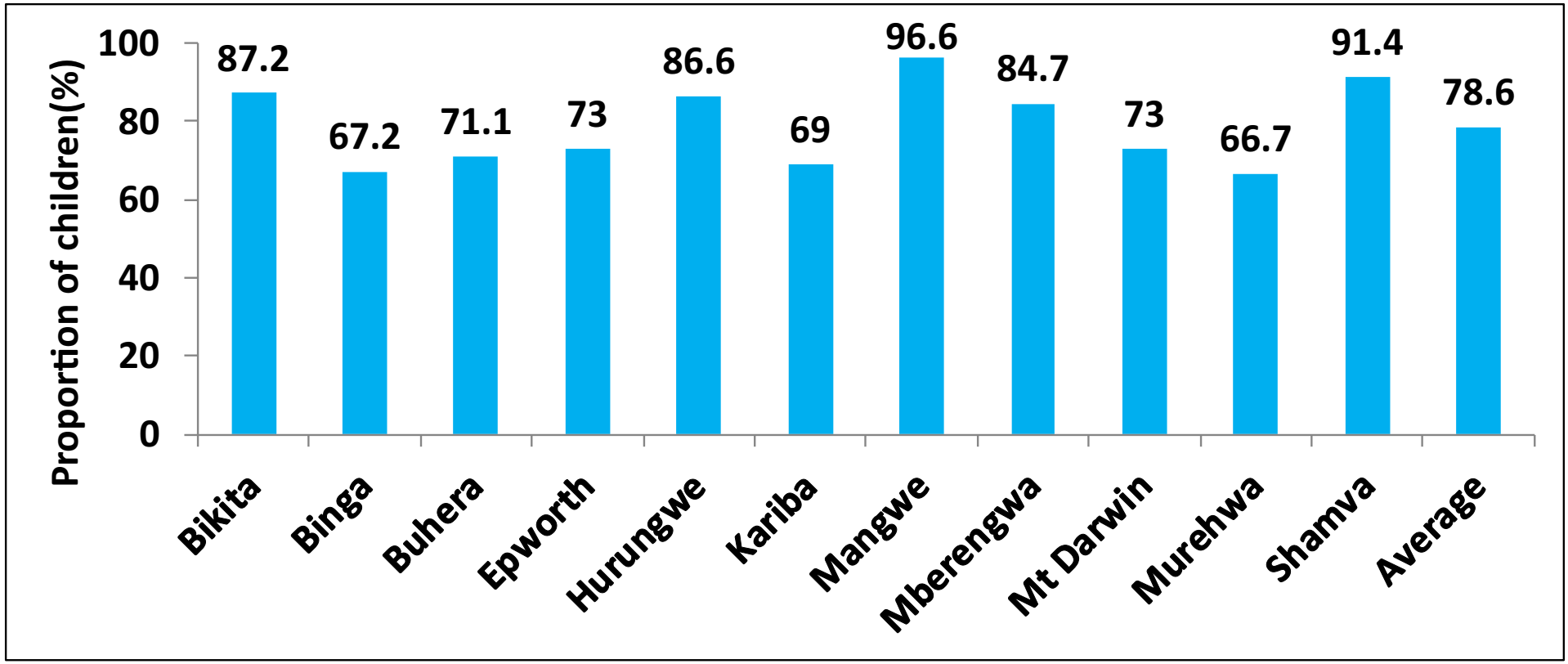
- About 60% of children less than 6 months were exclusively breastfed and this surpassed the WHA target of 50%.

Proportion of Children 0-23 Months Ever Breastfed



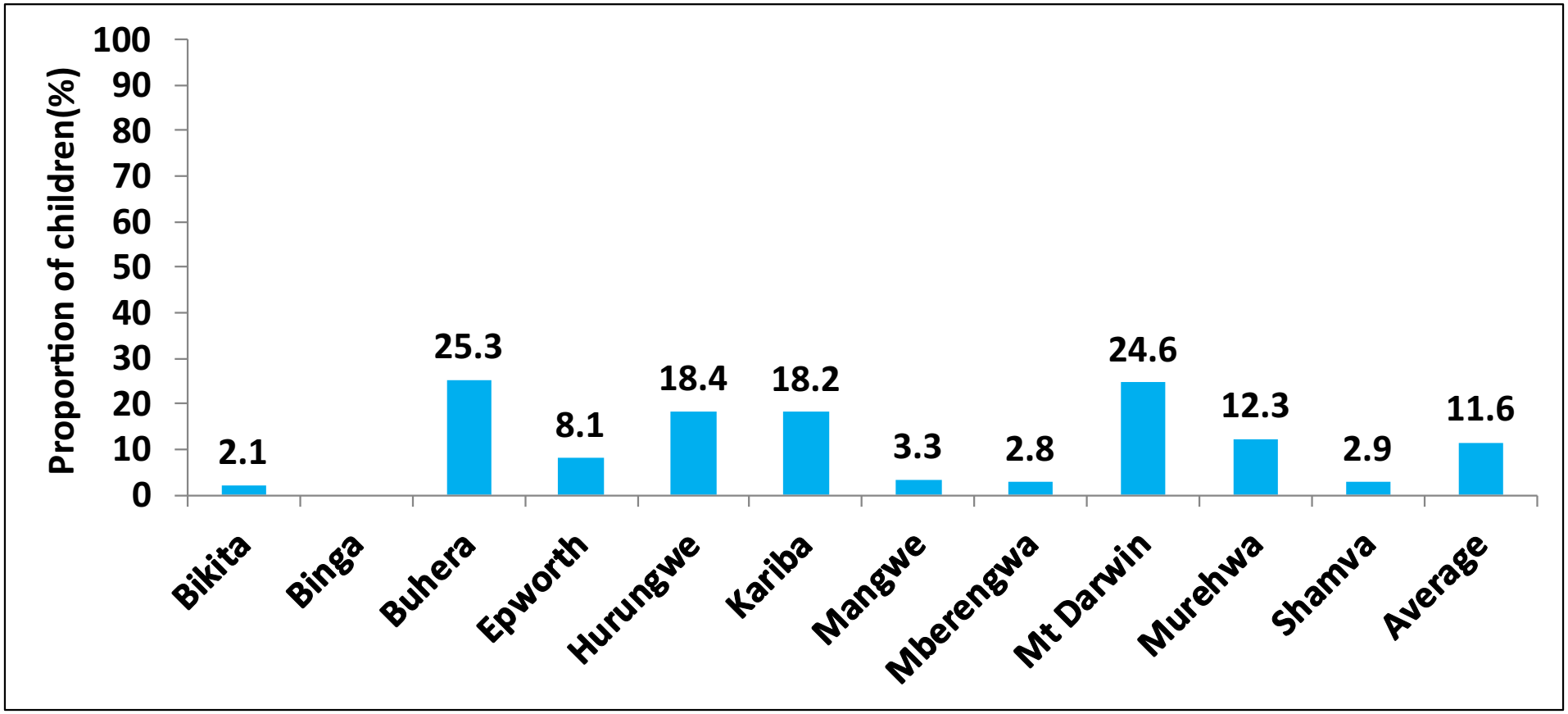
- Breastfeeding was practised across all the 11 districts with more than 96% of children being breastfed at some point in time of their life
- In six out of eleven districts 100% of the children were breasted at some point of their life

Proportion of Children Breastfed Within 1 hour of Birth



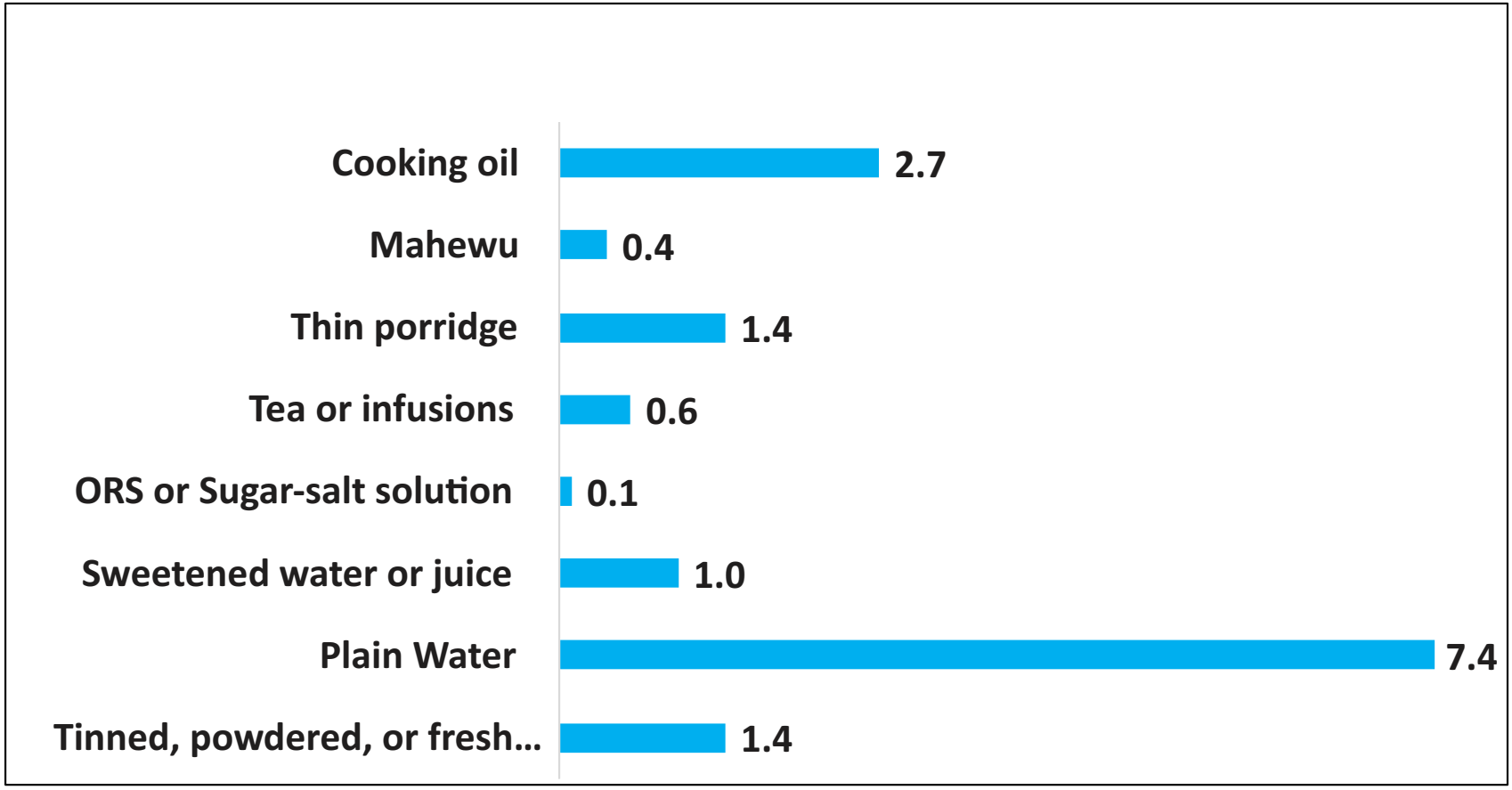
- The average number of children initiated on breastfeeding within the first hour of birth was 78.6%
- Mangwe and Shamva are the districts that surpassed the national target of 90% for children initiated on breastfeeding within the first hour of birth.
- Murehwa, Binga and Kariba had the least proportion of children initiated on breastfeeding within the first our which was less 70%

Proportion of Children given Foods Other than Breast milk Within 3 days of Birth



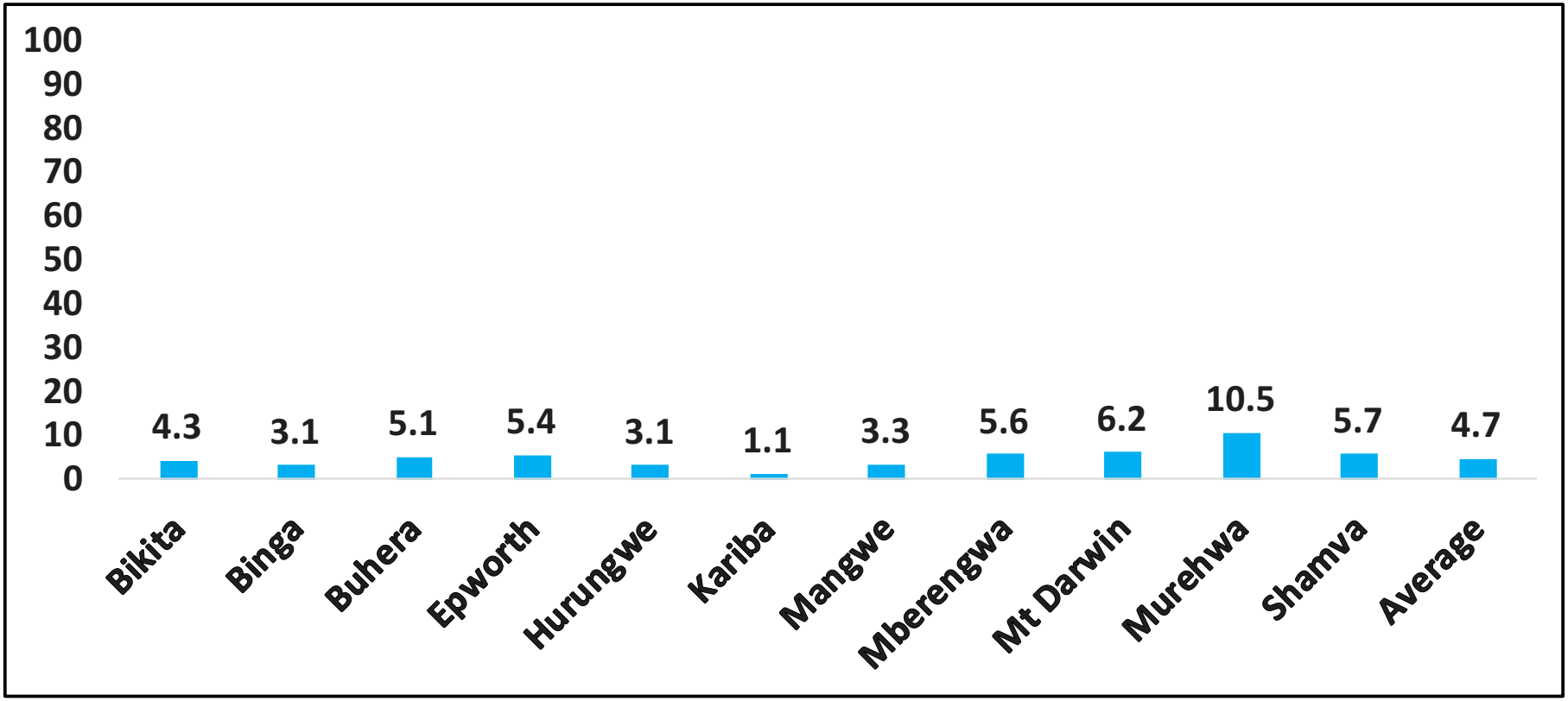
- Binga has no children introduced to prelacteal feeds within 3 days of birth
- Buhera (25.3%) and Mt Darwin (24.6%) had highest proportion of children introduced to prelacteal feeds within 3 days of birth

Common Prelacteal Feeds Introduced Within 3 Days of Birth



- Water, cooking oil, thin porridge, tinned, powdered of fresh or infant formula and sweetened water or juice were the most common foods used as prelactael feeds

Proportion of Children Fed from a Bottle With a Teat



- Murehwa (10.5%) had highest proportion of children fed using a bottle with a teat.
- Other districts with high figures are Mt Darwin (6.2%), Shamva (5.7%), Mberengwa (5.6%), Epworth (5.4%) and Buhera (5.1%).
- Kariba (1.1%) had the least proportion of children fed from a bottle with a teat

Complementary Feeding

- **Minimum dietary diversity (MDD)** is defined as receiving foods from at least 5 of 8 food groups: 1) breastmilk, 2) grains, roots and tubers, 3) legumes and nuts, 4) dairy products (milk, infant formula, yogurt, cheese), 5) flesh foods (meat, fish, poultry and liver/organ meats), 6) eggs, 7) vitamin-A rich fruits and vegetables, and 8) other fruits and vegetables.

- **Minimum meal frequency (MMF)** among currently breastfeeding children is defined as children who also received solid, semi-solid, or soft foods 2 times or more daily for children age 6-8 months and 3 times or more daily for children age 9-23 months. For non-breastfeeding children age 6-23 months it is defined as receiving solid, semi-solid or soft foods, or milk feeds, at least 4 times.

- **The minimum acceptable diet (MAD)** for breastfed children age 6-23 months is defined as receiving the minimum dietary diversity and the minimum meal frequency, while it for non-breastfed children further requires at least 2 milk feedings and that the minimum dietary diversity is achieved without counting milk feeds. (UNICEF/WHO 2017)

Complementary Feeding Practices for Children 6-23 Months

District	Minimum Meal frequency	Minimum Dietary Diversity	Minimum Acceptable Diet
Bikita	48.5	3.0	3.0
Binga	22.7	2.3	0.0
Buhera	47.5	1.7	0.0
Epworth	63.0	14.8	11.1
Hurungwe	64.3	7.1	5.7
Kariba	35.1	1.8	1.8
Mangwe	83.3	0.0	0.0
Mberengwa	85.2	27.8	27.8
Mount Darwin	47.9	25.0	20.8
Murehwa	52.3	2.3	2.3
Shamva	51.2	9.8	9.8
Average	54.8	9.1	7.8

- The average minimum acceptable diet for the 11 district was7.8% while the average minimum dietary diversity was 9.1% and the minimum meal frequency was 54.8%.
- Districts with high minimum acceptable diets were Mberegwa (27.8%) and Mt Darwin (20.8%).

Food Fortification and Micronutrient Supplementation

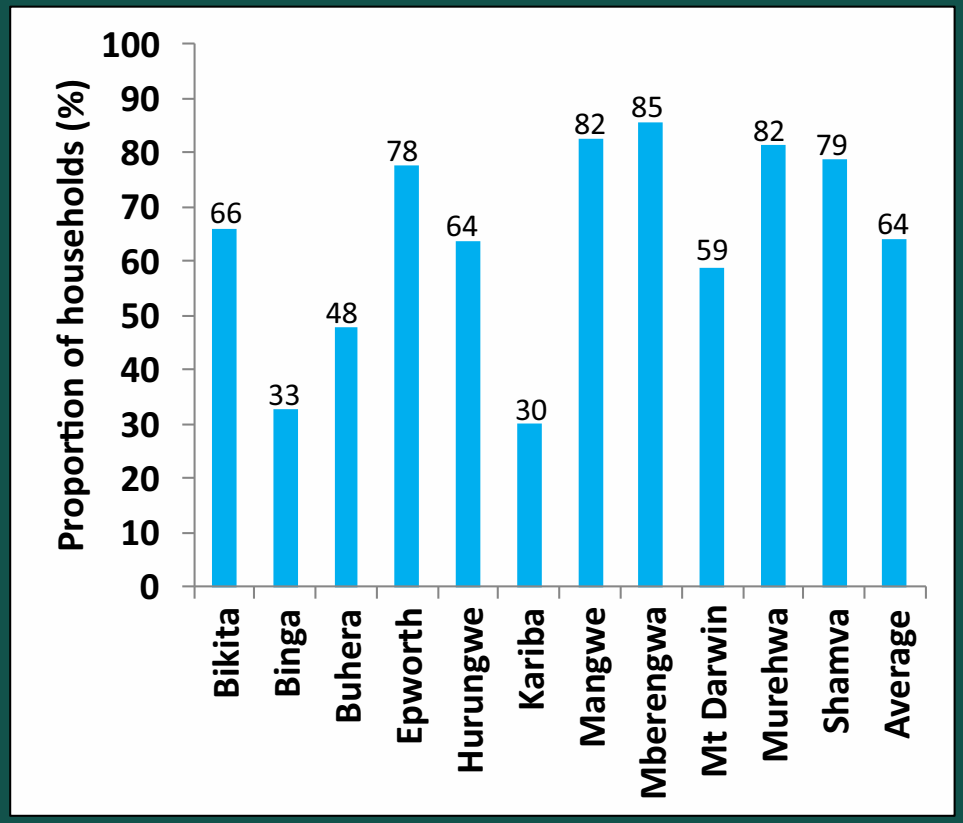
Food Fortification

- Food Fortification is the process of adding minute levels of vitamins and minerals to foods, regardless of whether the micronutrient was present or not in that food.
- This is done to address micronutrient deficiencies.
- In line with the Zimbabwe National Food Fortification Programme, the country made industrial fortification mandatory for sugar, cooking oil, maize meal and wheat flour.
- This was an addition to mandatory salt iodization which commenced in the early 1990s.
- Mandatory industrial food fortification for the four food vehicles was initiated on the 1st of July 2017.
- In this report the presence of a national food fortification logo on a food item identified in the household was a proxy used to indicate that the food item was fortified.

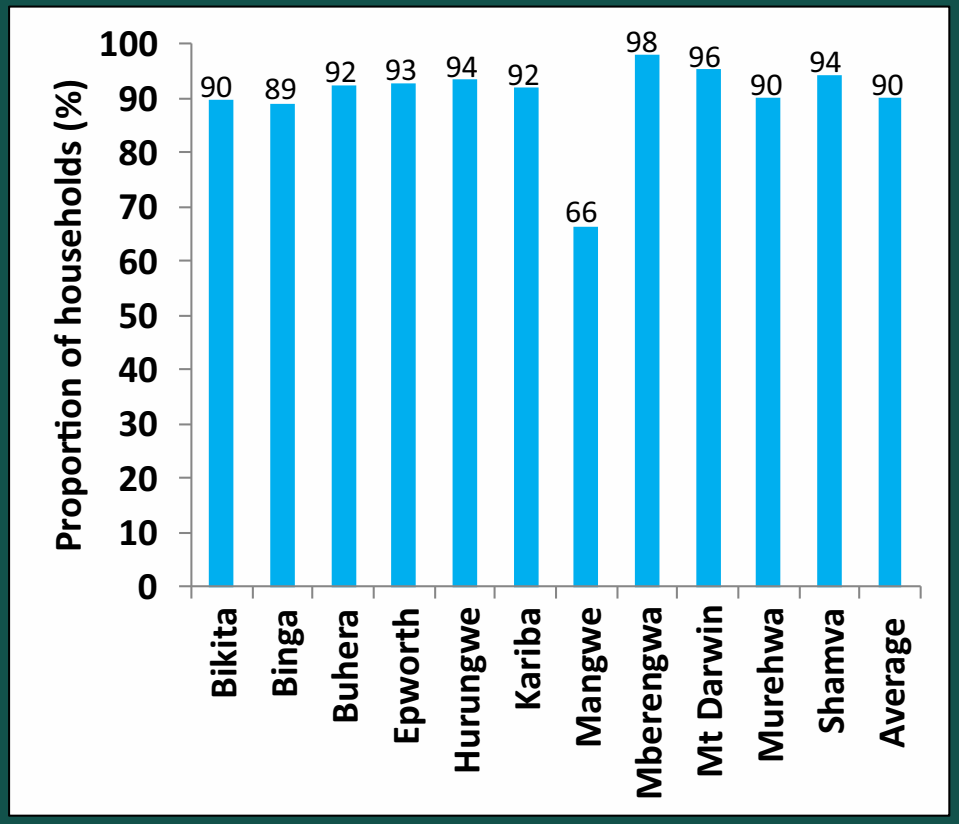
National Food Fortification Logo

Access to Fortified Sugar

Proportion of households with sugar available



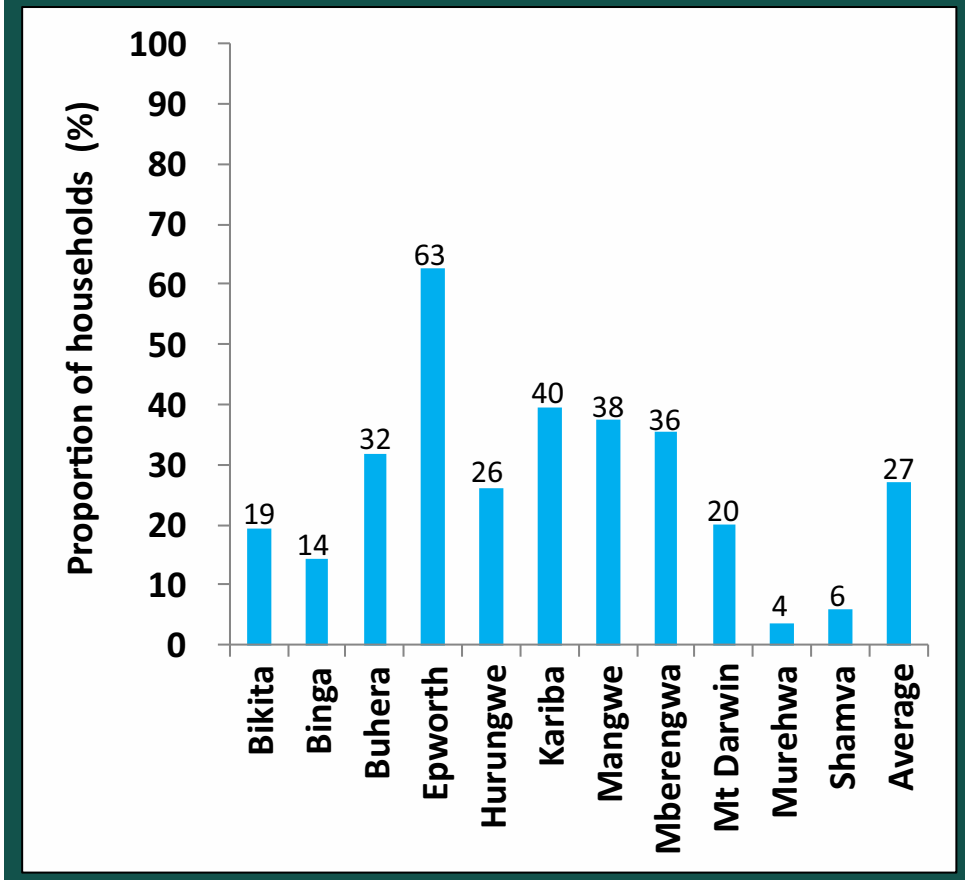
Proportion of households using sugar with fortification logo



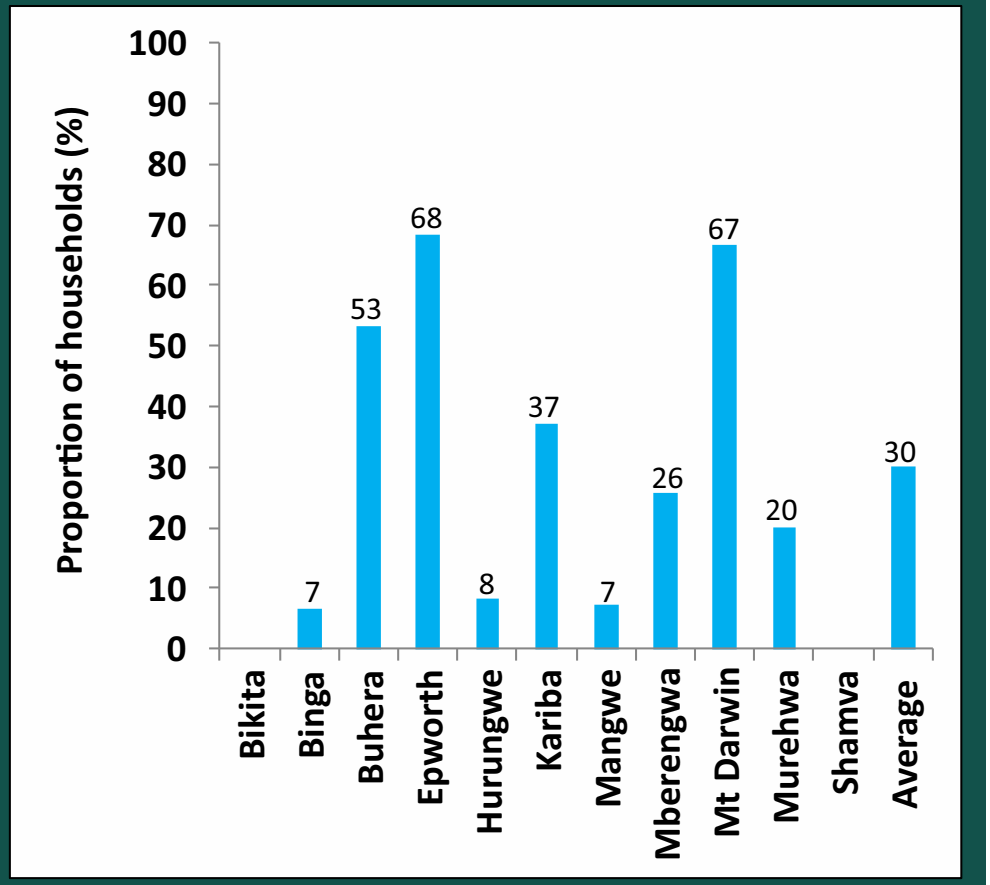
- Binga (33%) and Kariba (30%) had the lowest proportion of children living in households with sugar
- Of those households with access to sugar, an average of 90% had access to fortified sugar with the national food fortification logo, with the least recorded in Mangwe (66%)
- Access to fortified sugar with a local food fortification logo was almost universal in Mberengwa (98%) and Mt Darwin (96%)

Access to Fortified Mealie-Meal

Proportion of households who purchased mealie-meal



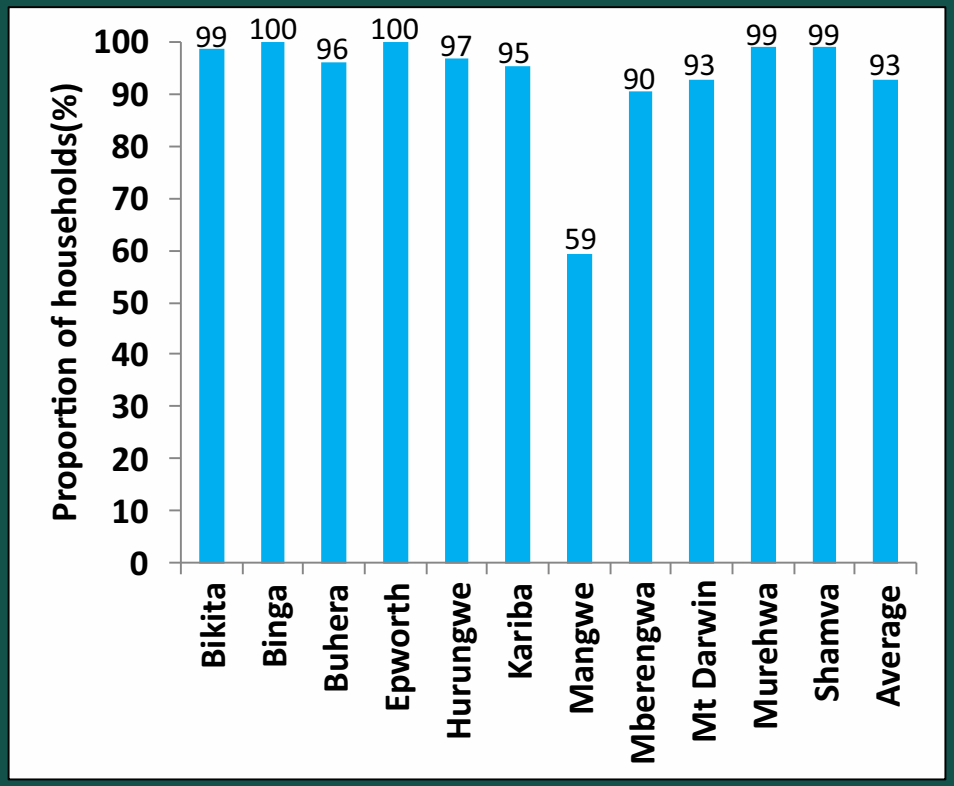
Proportion of households using mealie-meal with fortification logo



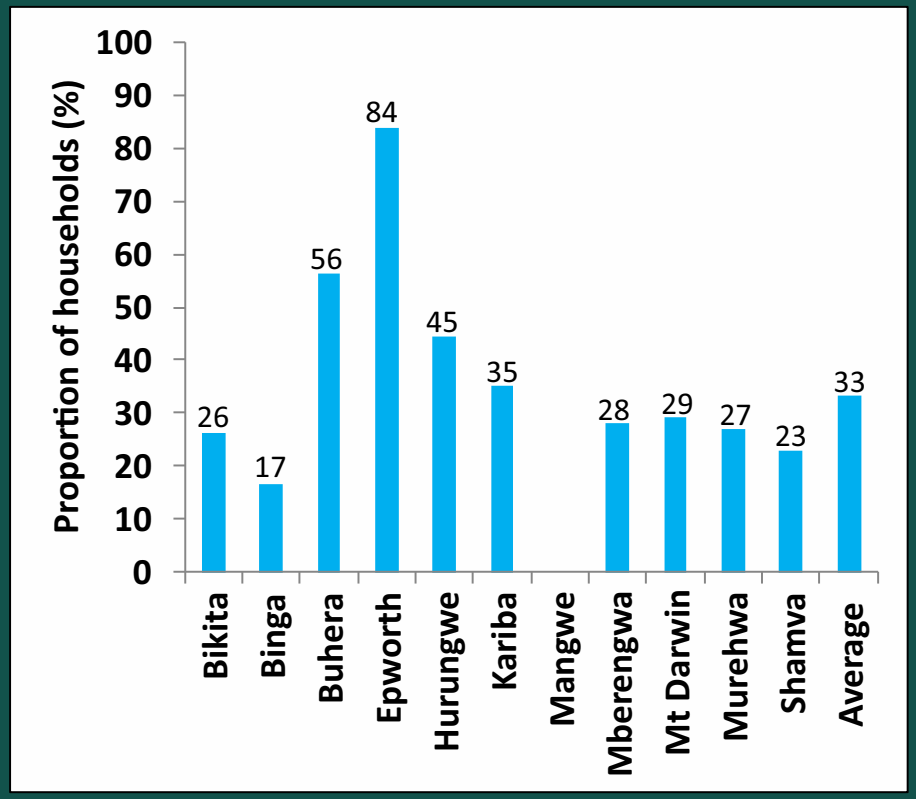
- Only in Epworth does the national food fortification logo has potential of reaching more than half of households (63%)
- Murehwa(4%) and Shamva (6.%) had the lowest proportion of households who purchased mealie-meal.
- Bikita and Shamva had no households that purchased mealie-meal with logo whilst Epworth (68.%) and Mt Darwin (67%) had the highest households purchasing fortified mealie meal with the national food fortification logo

Access to Fortified Wheat Flour

Proportion of households who purchased wheat flour



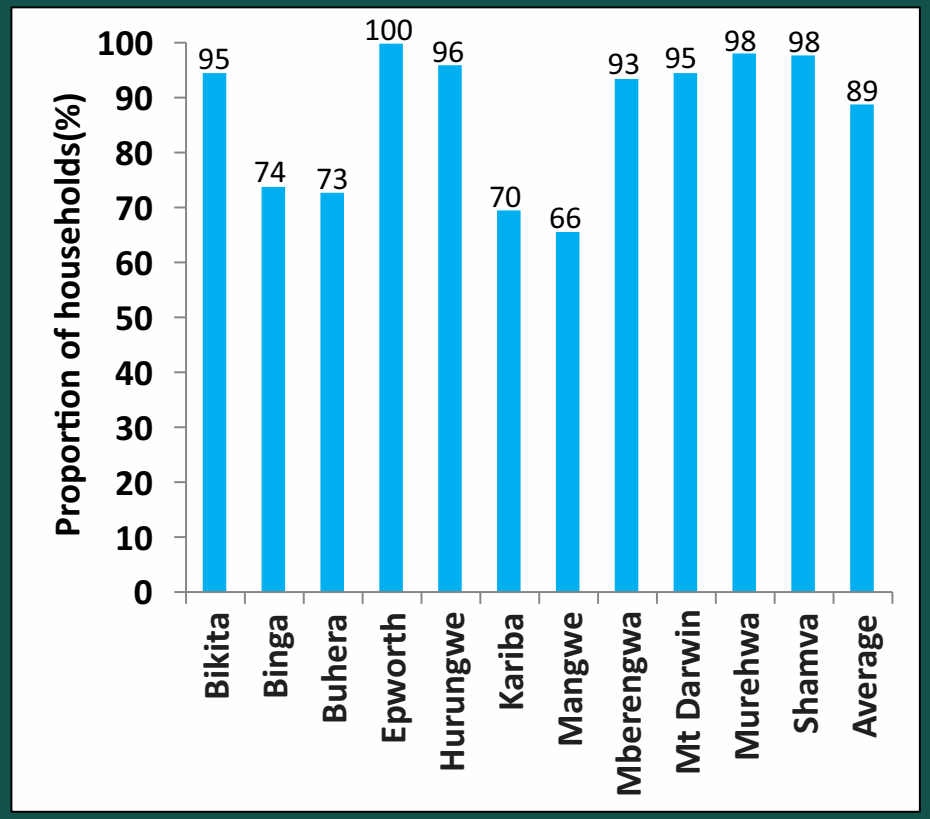
Proportion of households using wheat flour with fortification logo



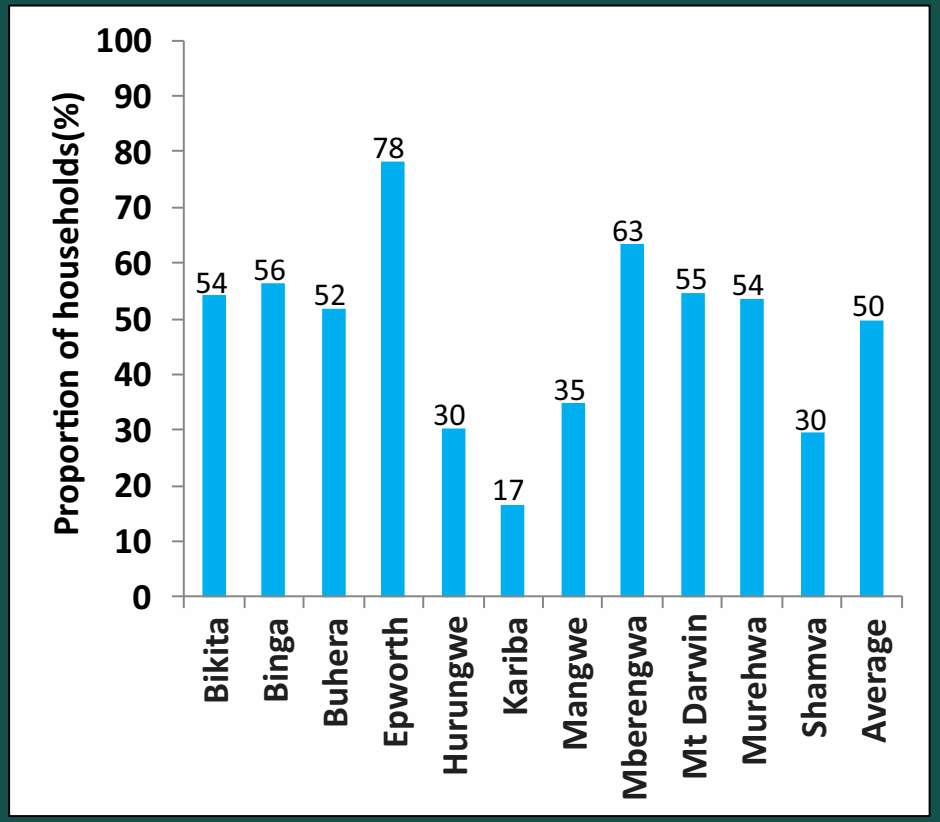
- Mangwe (59.%) had the least proportion of households who had purchased flour and all had no national fortification logo.
- On average, 33.% of the households were using purchased wheat flour with national fortification logo.
- In Hurungwe among households that purchased wheat flour, no household was accessing fortified flour with a national food fortification logo

Access to Fortified Cooking oil

Proportion of households purchasing cooking oil

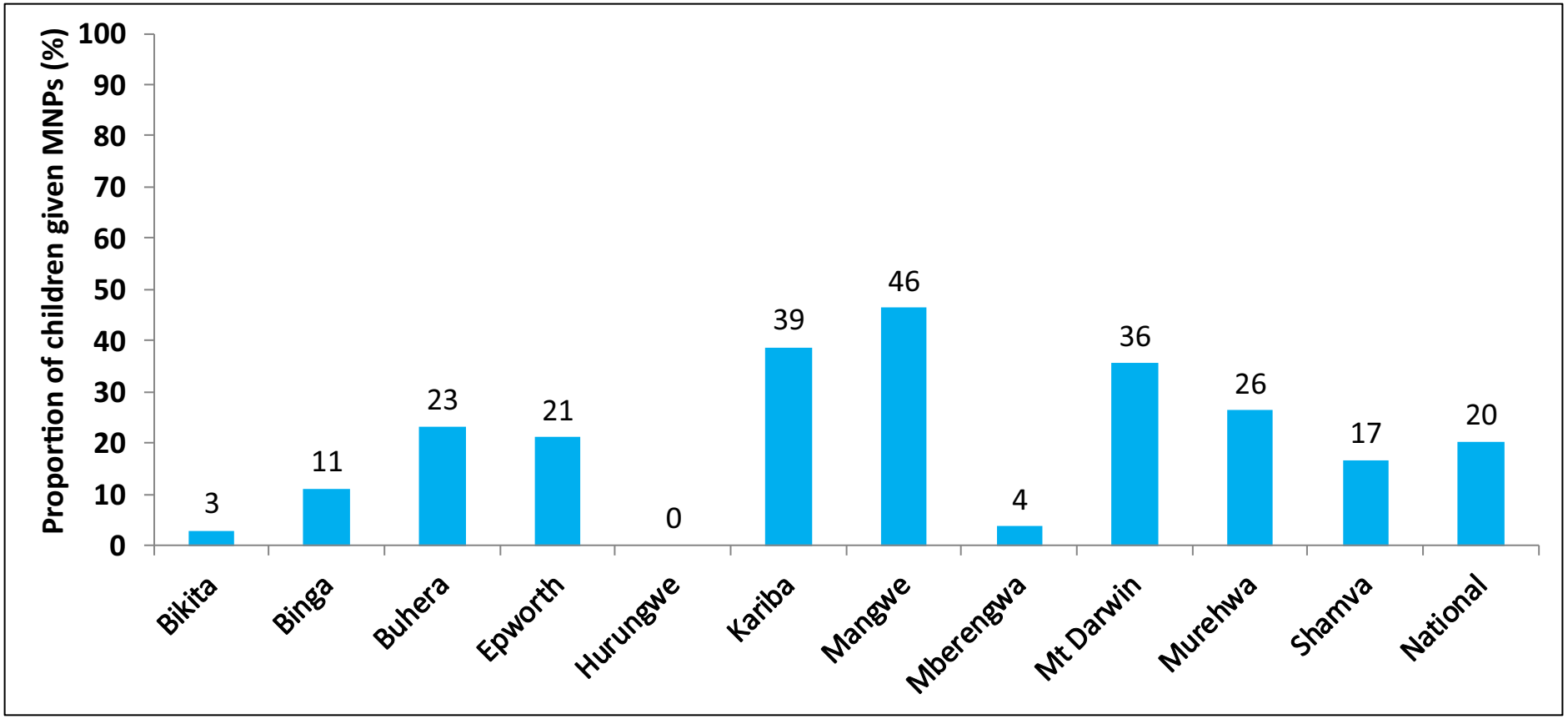


Proportion of households using cooking oil with fortification logo



- There is potential to reach more than two-thirds of the households with fortified cooking oil in all the 11 districts.
- Of the households that had cooking oil, an average of 89% of the households reported to have purchased.
- About half of the households were using purchased cooking oil with a national food fortification logo,
- Kariba, Hurungwe, Mangwe and Shamva had less than 50% of Households purchasing cooking oil with the national food fortification logo.

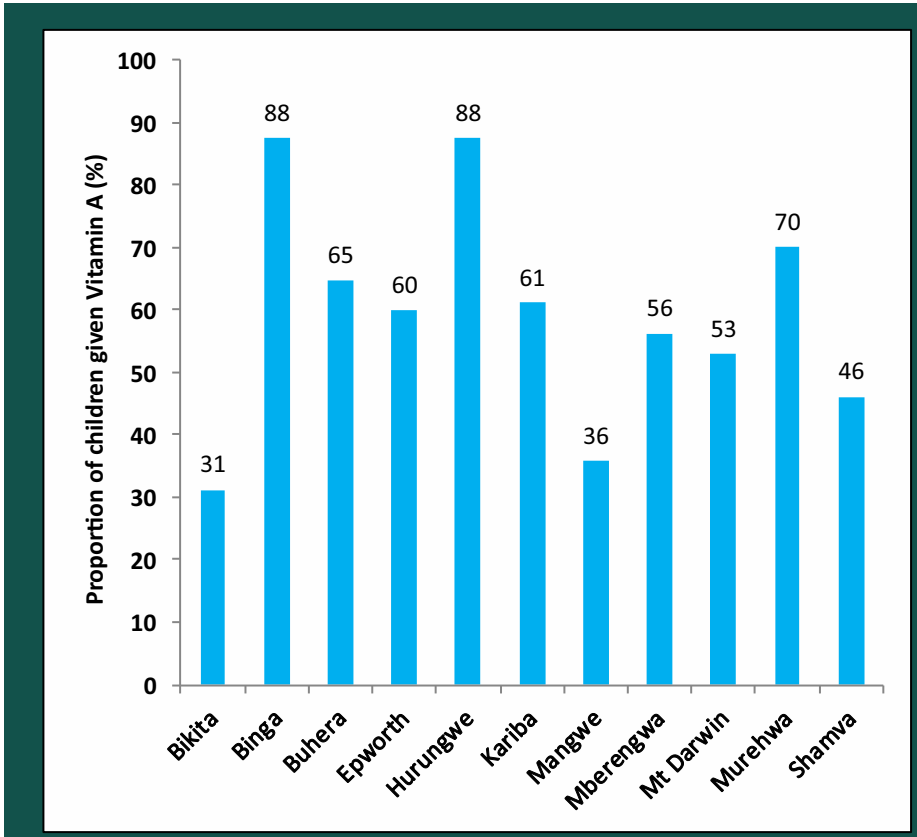
Proportion of Children Given Food with Micronutrient Powders



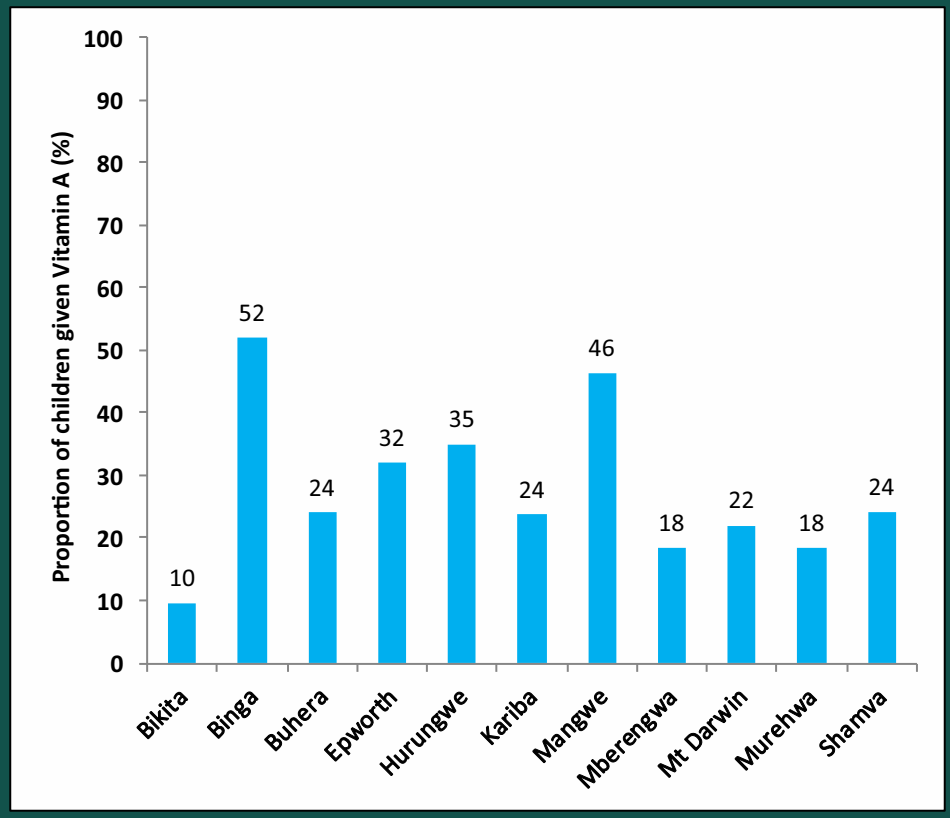
- On average, 20% of the children had consumed food with MNPs within 7 days prior to the survey
- Mangwe (46%) had the highest proportion of children who consumed food with MNPs.
- In Hurungwe the progamme of MNP supplementation had not started and Kariba started during the fourth quarter of 2017. Four of the districts started the program in April 2018 and 4 in November 2018

Vitamin A Supplementation Coverage

Percentage of children 6-11 months who received one dose in the past 12 months

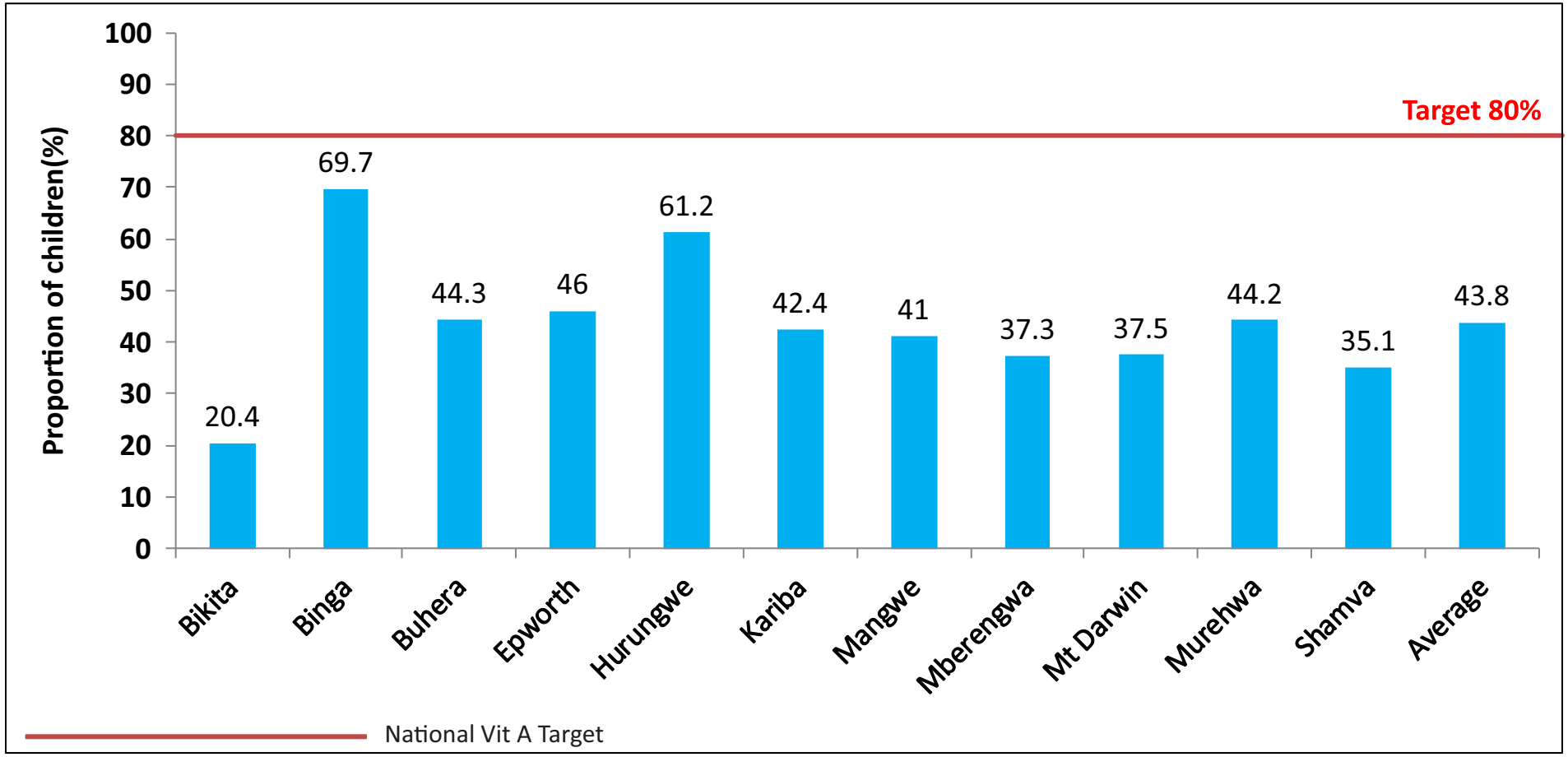


Percentage of children 12-59 months who received two doses in the past 12 months



- Vitamin A coverage for children 6-11months was higher than that for 12 – 59months for all the districts except Mangwe
- Binga and Hurungwe had a coverage of 88% surpassing the vitamin A supplementation target of 80%

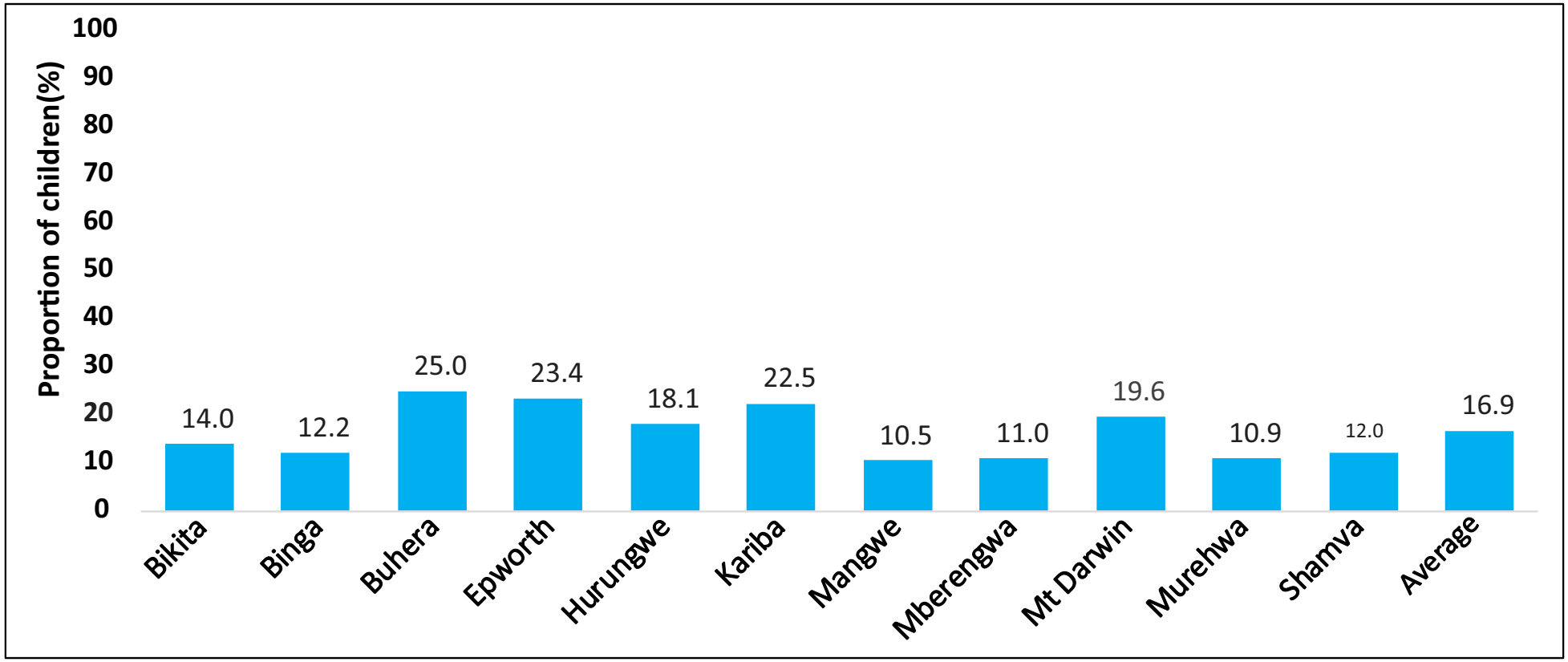
Vitamin A Supplementation for Children 6-59 Months



- Binga (69.7%) and Hurungwe (61.2%) had the highest proportion of children that had received the recommended dose of Vitamin A for a year and Bikita (20.4%) had the least
- All the districts had Vitamin A coverage lower than the target of 80%.

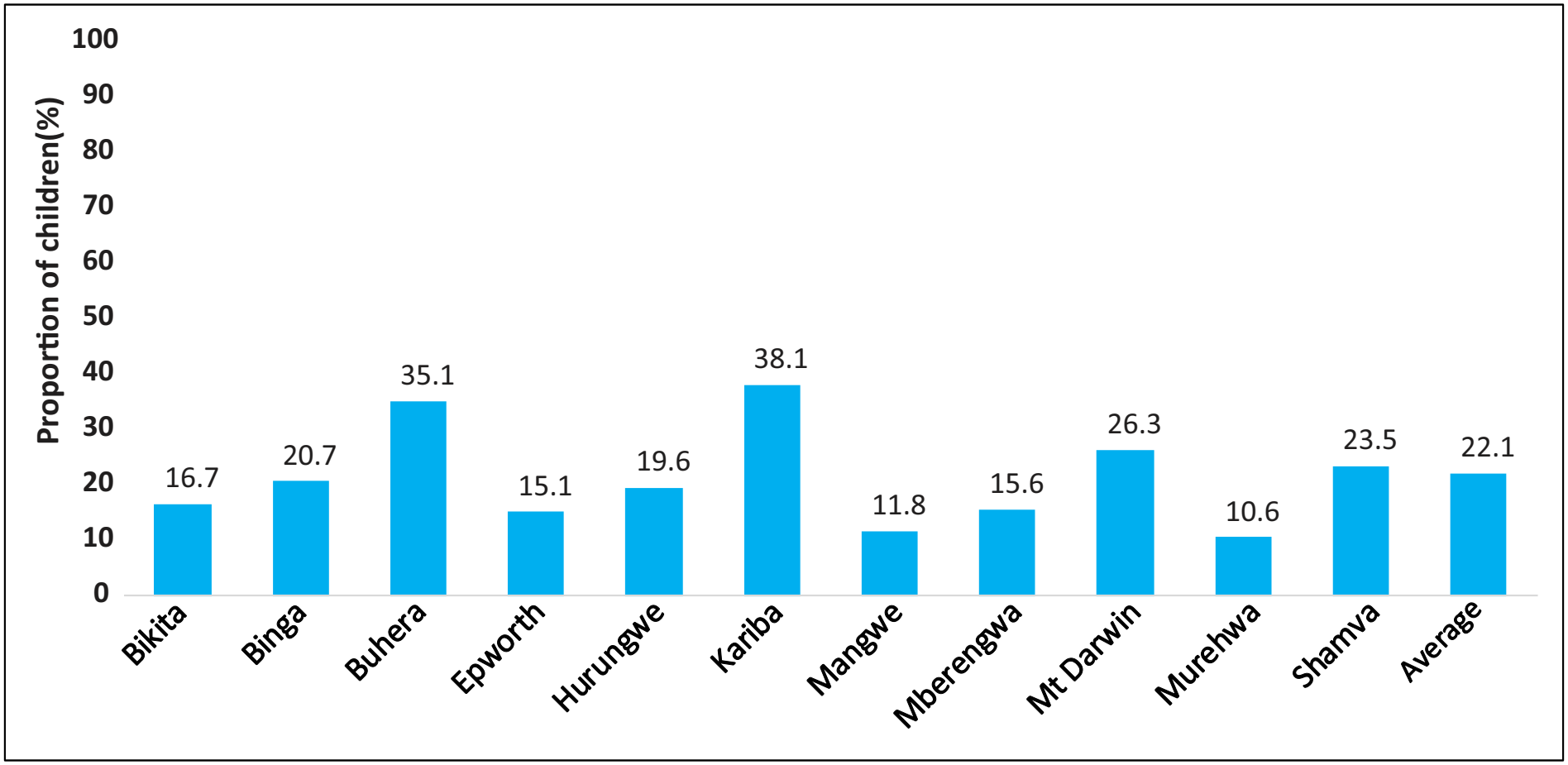
Childhood Illness

Proportion of Children 6-59 Months who had Diarrhoea in the Past 2 Weeks



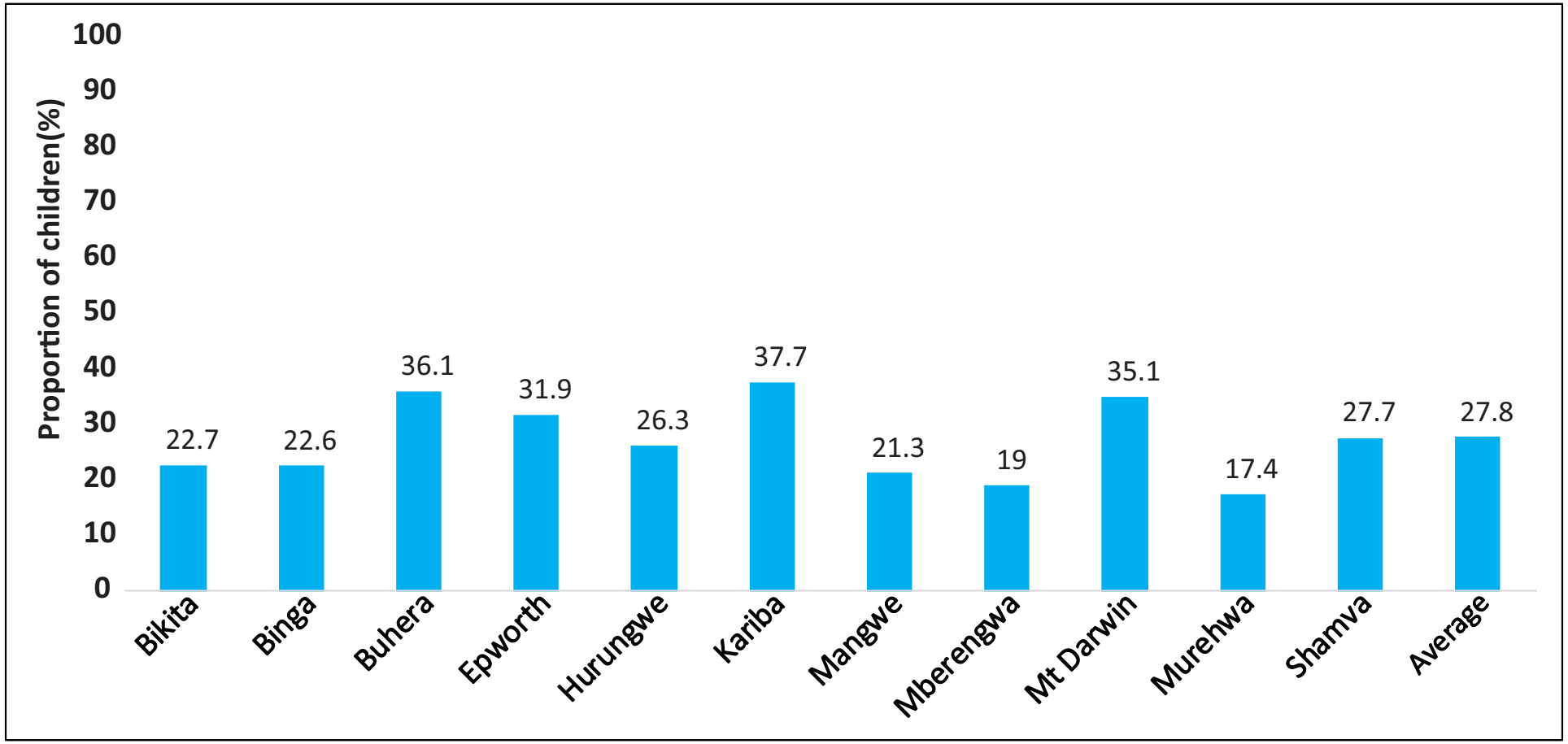
- The district with the highest proportion of children with diarrhoea was Buhera (25%) which was above the average of 16.9%
- Mangwe had the least proportion of children with diarrhoea at 10.5%

Proportion of Children 6-59 Months who had Fever in the Past 2 Weeks



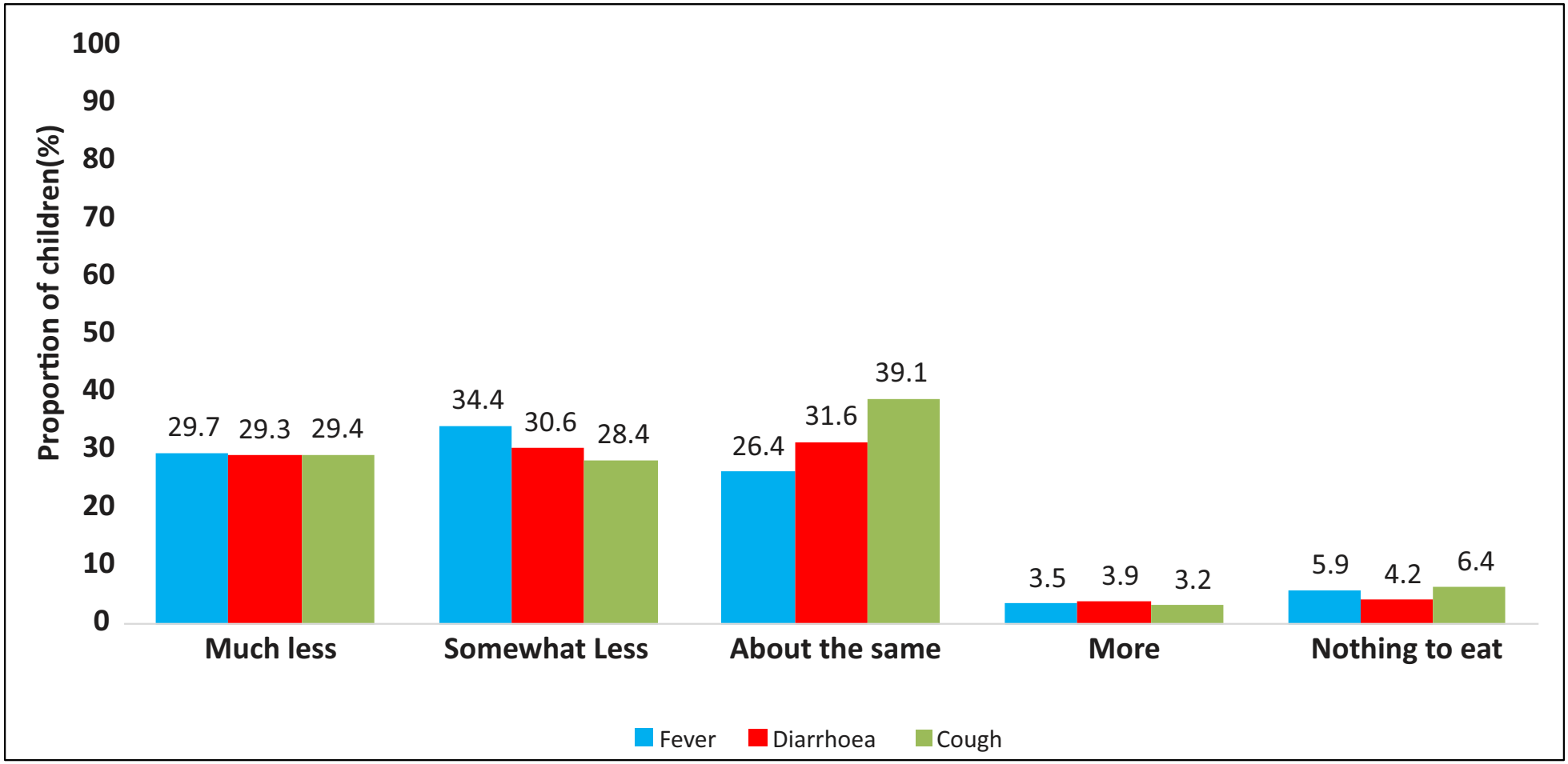
- Highest proportion of children who had fever in the previous 2 weeks was recorded in Kariba (38.1%) and the least(10.6%) was recorded in Murehwa .

Proportion of Children 6-59 Months who had Cough in the Past 2 Weeks



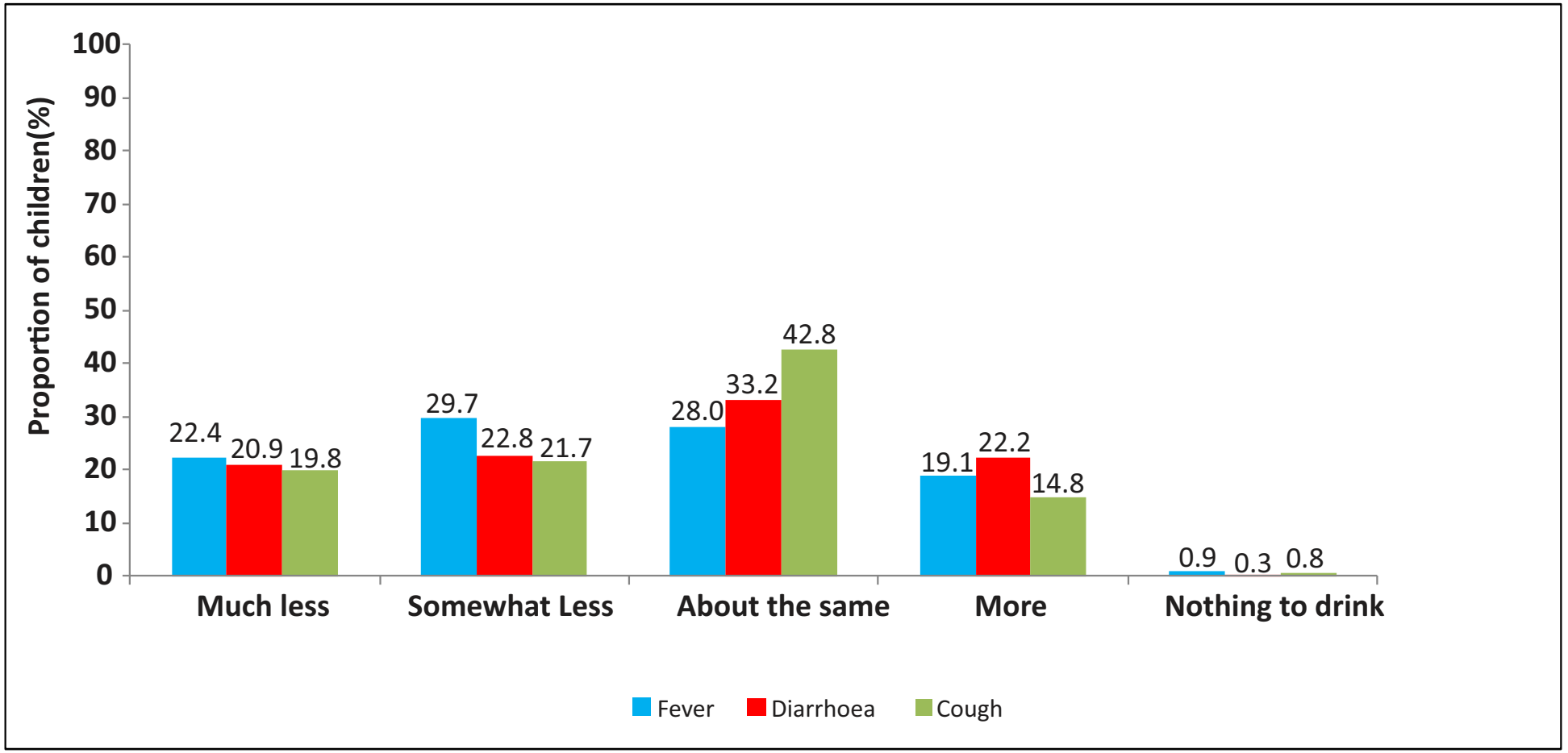
- Kariba and Buhera had the highest proportion of children who had a cough in the previous 2 weeks, recording 37.7 % and 36.1% respectively.
- The least proportion was found in Murehwa (17.4%)

Feeding Practices During Illness



- Generally children who were suffering from diarrhoea and fever were offered less food than those suffering from cough.
- Children who were suffering from diarrhoea (4.2%), fever (5.9%) and cough(6.4%) were given nothing to eat during illness.

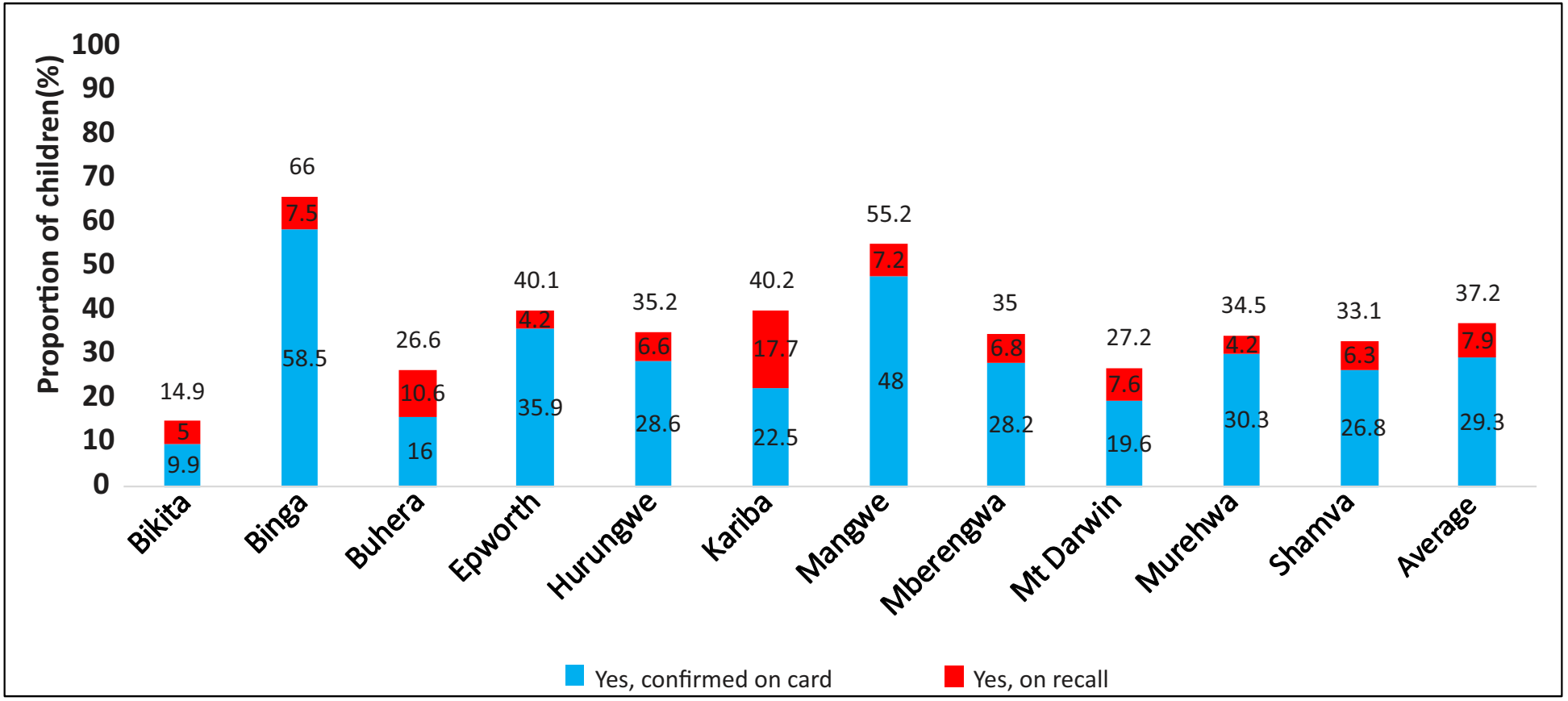
Feeding Practices During Illness



- About 28.0% of the children suffering from fever, 33.2% from diarrhoea and 42.8% from cough were given about the same amount of liquids to drink during illness.

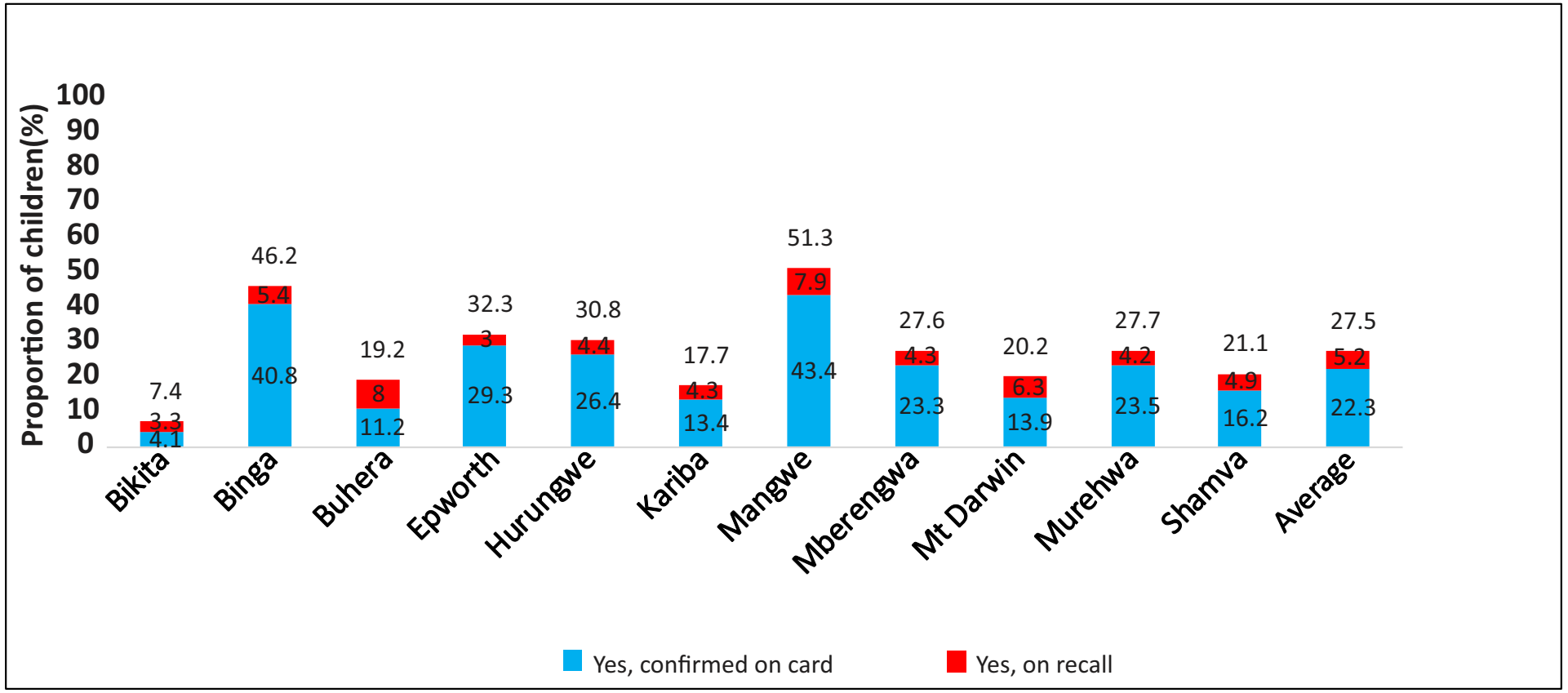
Child Anthropometry

Proportion of Children Weighed in the Past 30 Days



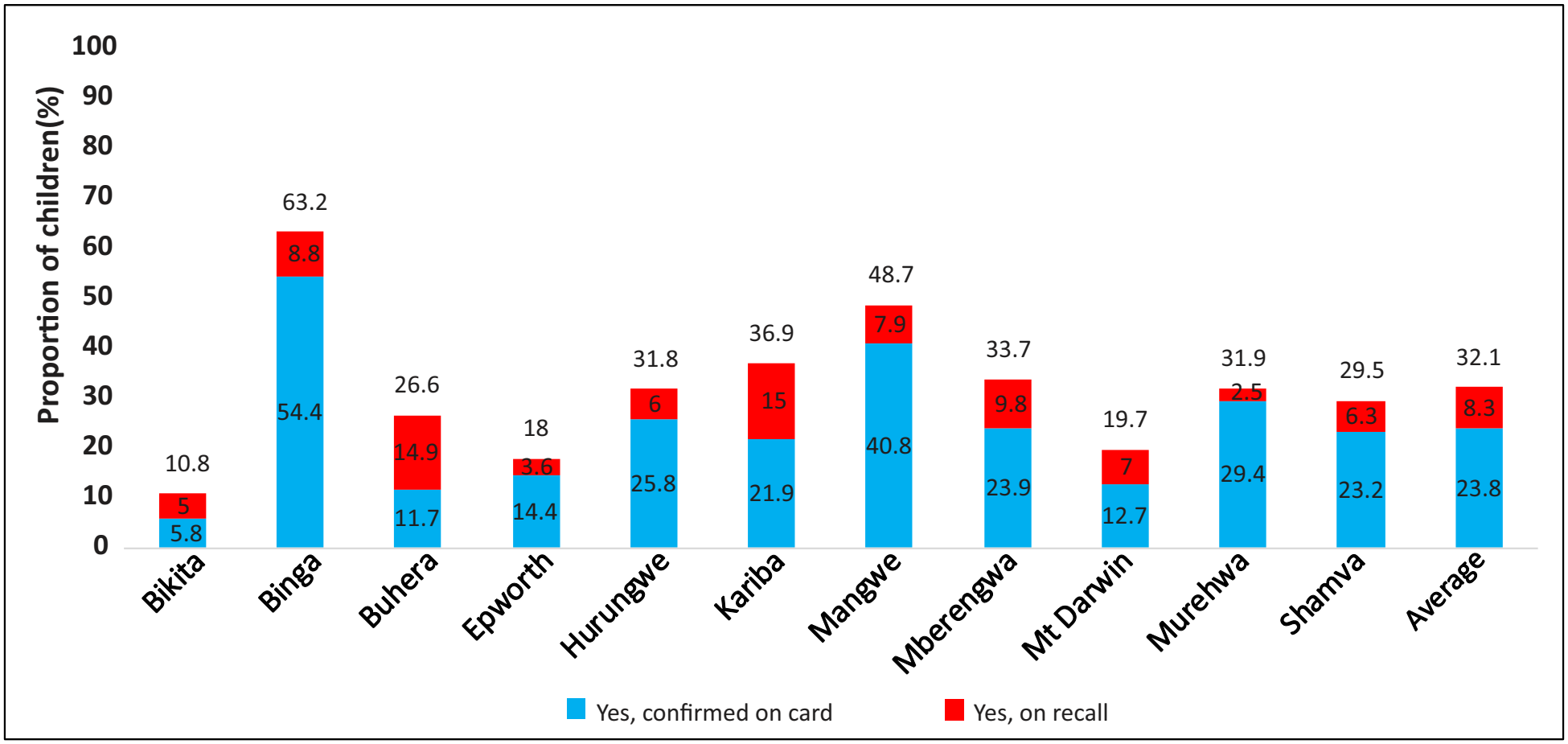
- Binga (66%) and Mangwe (55.2%) had the highest proportion of children who had been weighed in the previous 30 days .
- Bikita district recorded the least proportion(14,9%) of children who had been weighed in the previous 30 days .

Proportion of Children 6-59 Months Measured Height in Past 30 days



- Generally all the 11 districts had less than 50% of the children reported(confirmation by the child health card) to have been taken height measurements in the previous 30 days .
- The least number of children taken height was recorded in Bikita district(7.4%).

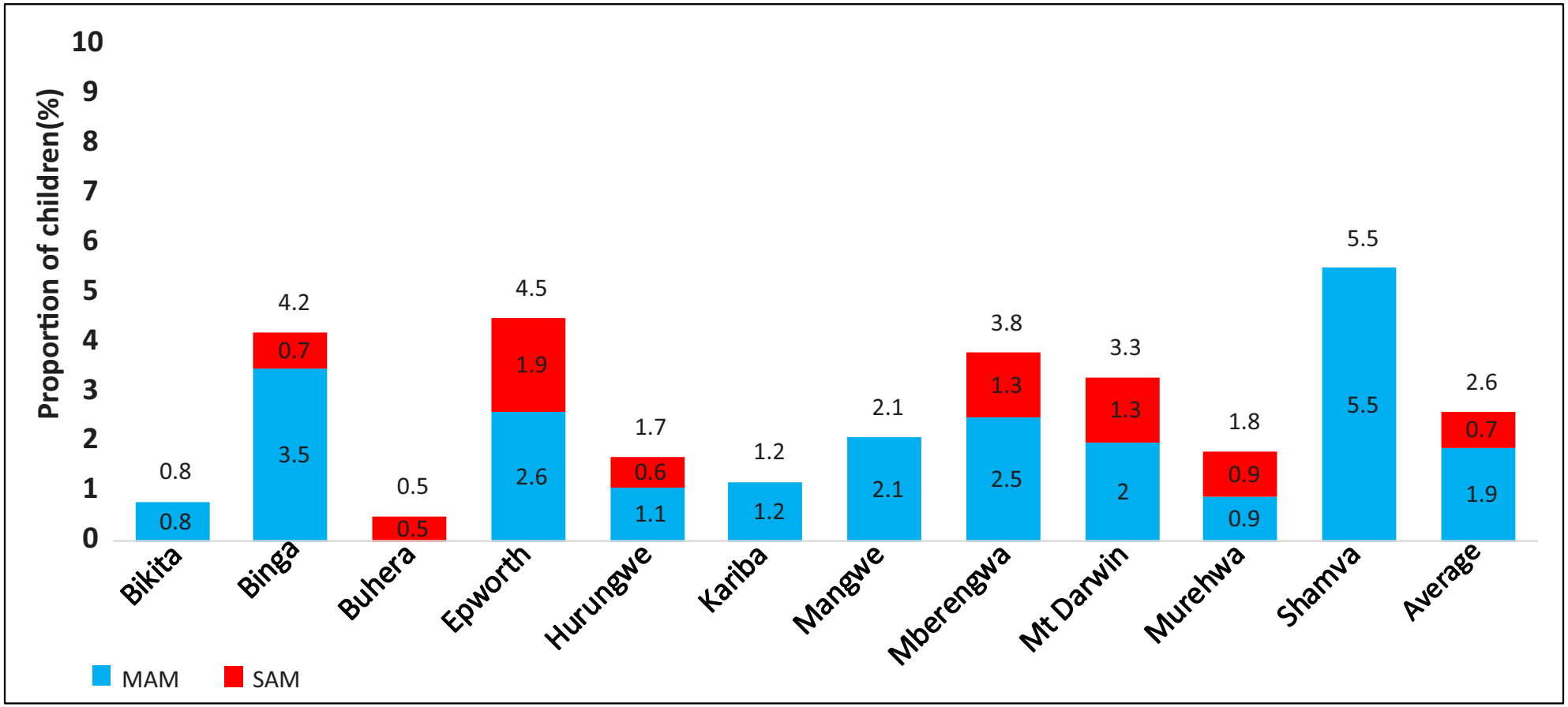
Proportion of Children 6-59 Months with MUAC measured in the Past 30 Days



A total of 10 out of 11 districts recorded less than 50% of the children who were measured MUAC in the last 30 days

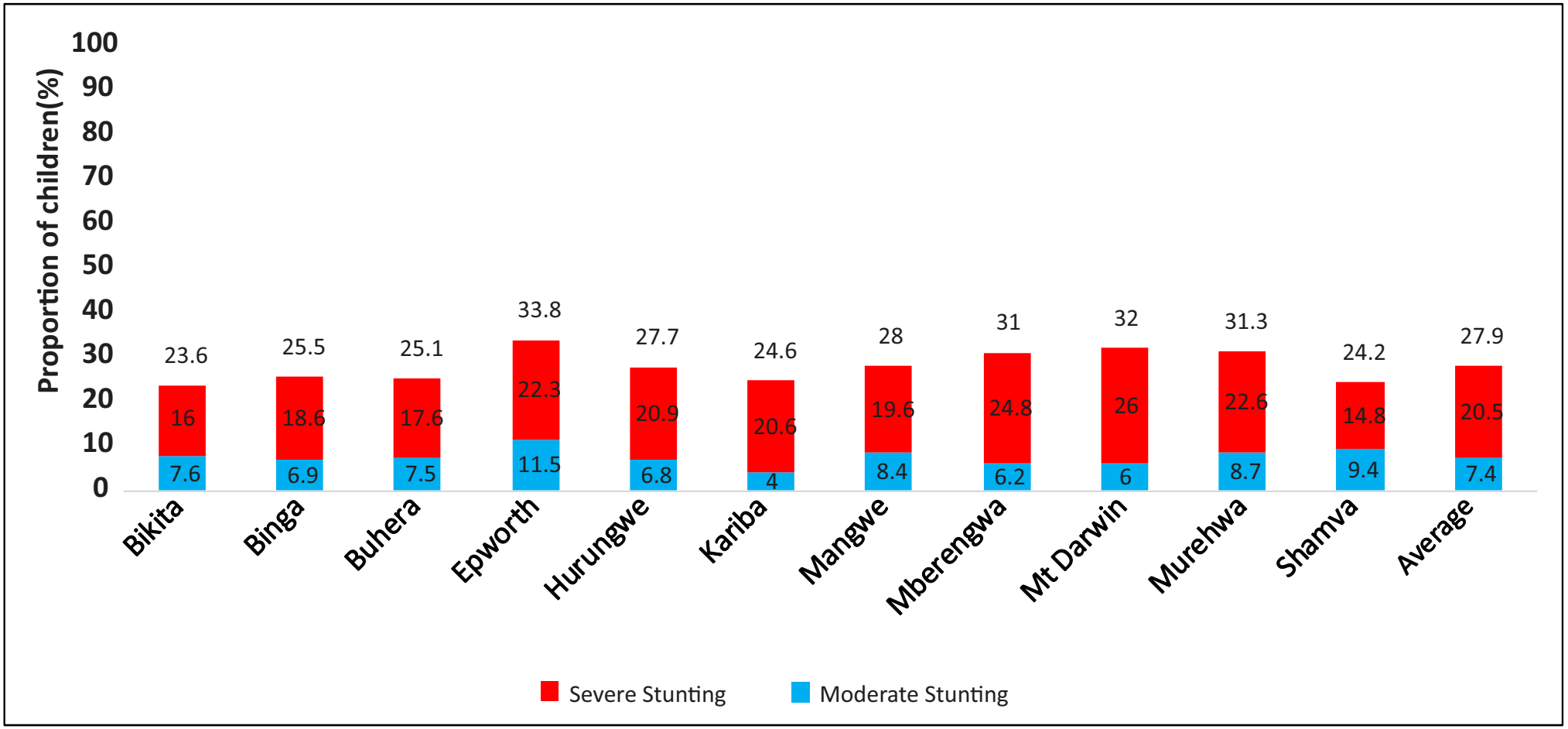
Only 1 district, Binga recorded 63.2% of the children to have been measured MUAC in the last 30 days .

Proportion of Children with Acute Malnutrition by District (WHO Standards)



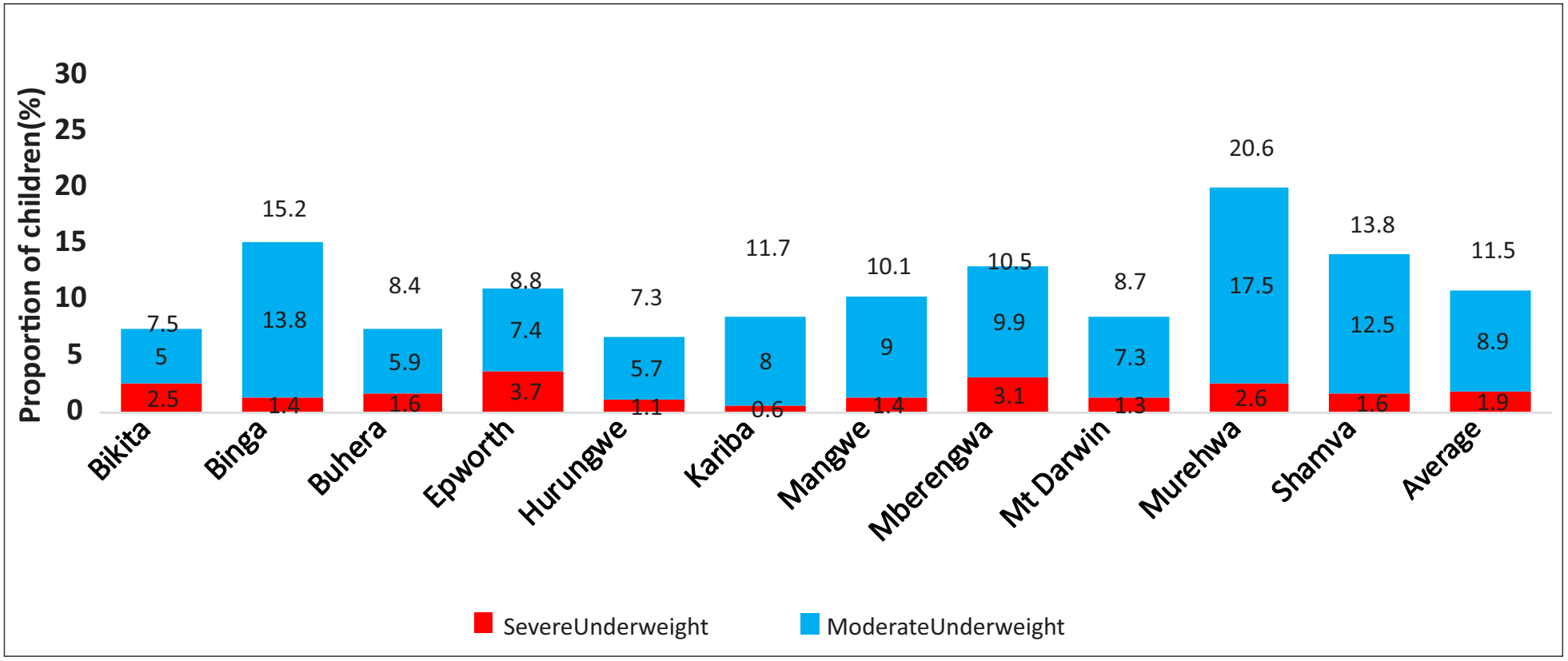
- Global Acute Malnutrition (GAM) ranged from 0.5 % to 5.5 %.
- Majority of the districts had a prevalence of Global Acute Malnutrition of less than 5% except for Shamva which recorded 5.5%.

Proportion of Children with Stunting



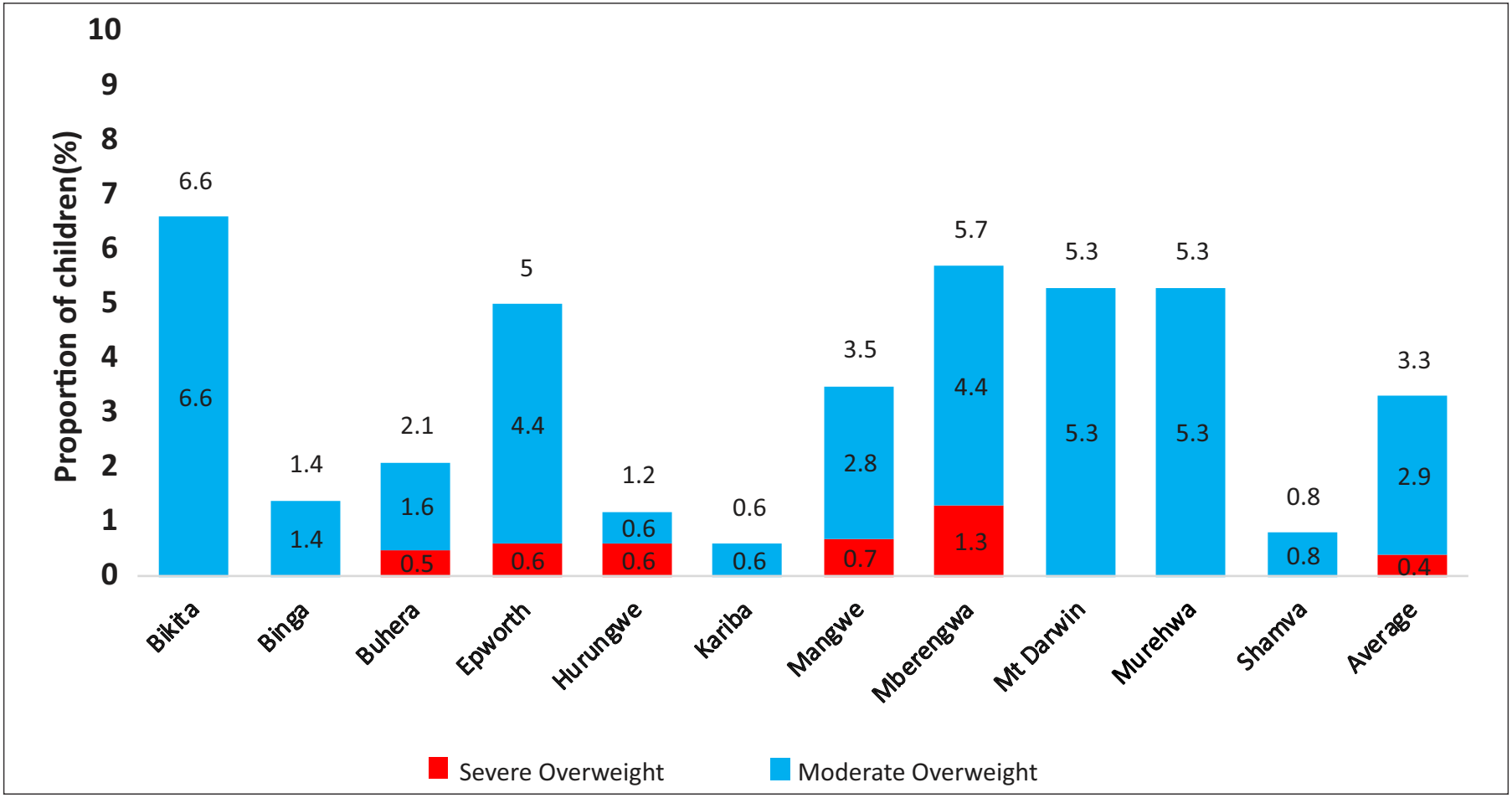
- All 11 districts had high stunting rates of above 20%.
- The highest was Epworth with 33.8% and the least was Bikita with 23.6%.

Proportion of Underweight Children



- Moderate underweight was above 5% in all the districts with Murehwa having a high of proportion of 17.5%.
- Severe underweight was below 5% in all the districts.
- The highest prevalence of underweight amongst children was in Murehwa district at 20.1% and least in Hurungwe at 6.8%.

Proportion of Overweight Children



- The prevalence of overweight was high in Bikita district at 6.6% and least in Kariba district at 0.6%.
- A total of 6 out 11 districts recorded 0% severe overweight.

Water, Sanitation and Hygiene (WASH)

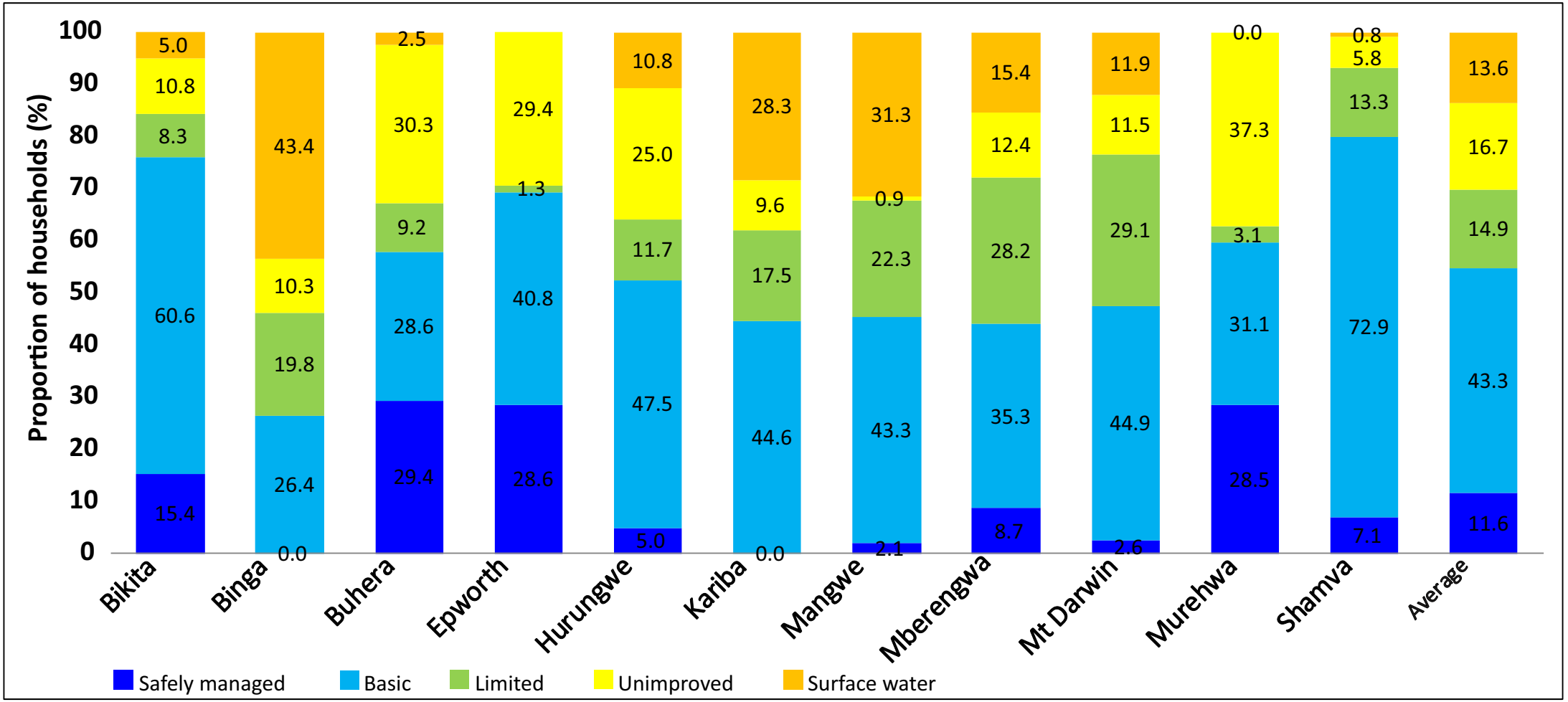
Ladder for Drinking Water Services

Service level	Definition
Safely Managed	Drinking water from an improved water source that islocated on premises, available when needed and free from faecal and priority chemical contamination
Basic drinking water	Basic drinking water services are definedas drinking water from an improved source, provided collection time is not more than 30minutes for a roundtrip including queuing.
Limited drinking water services	Limited water services are defined as drinking water from an improved source, where collection time exceeds 30 minutes for a roundtrip including queuing.
Unimproved water sources	Drinking water from an unprotected dug well or unprotected spring.
Surface Water sources	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation channel.

Note :
Improved" drinking water sources are further defined by the quality of the water they produce, and are protected from fecal contamination by the nature of their construction or through an intervention to protect from outside contamination. Such sources include: piped water into dwelling, plot, or yard; public tap/standpipe; tube well/borehole; protected dug well; protected spring; or rainwater collection. This category now include packaged and delivered water, considering that both can potentially deliver safe water.

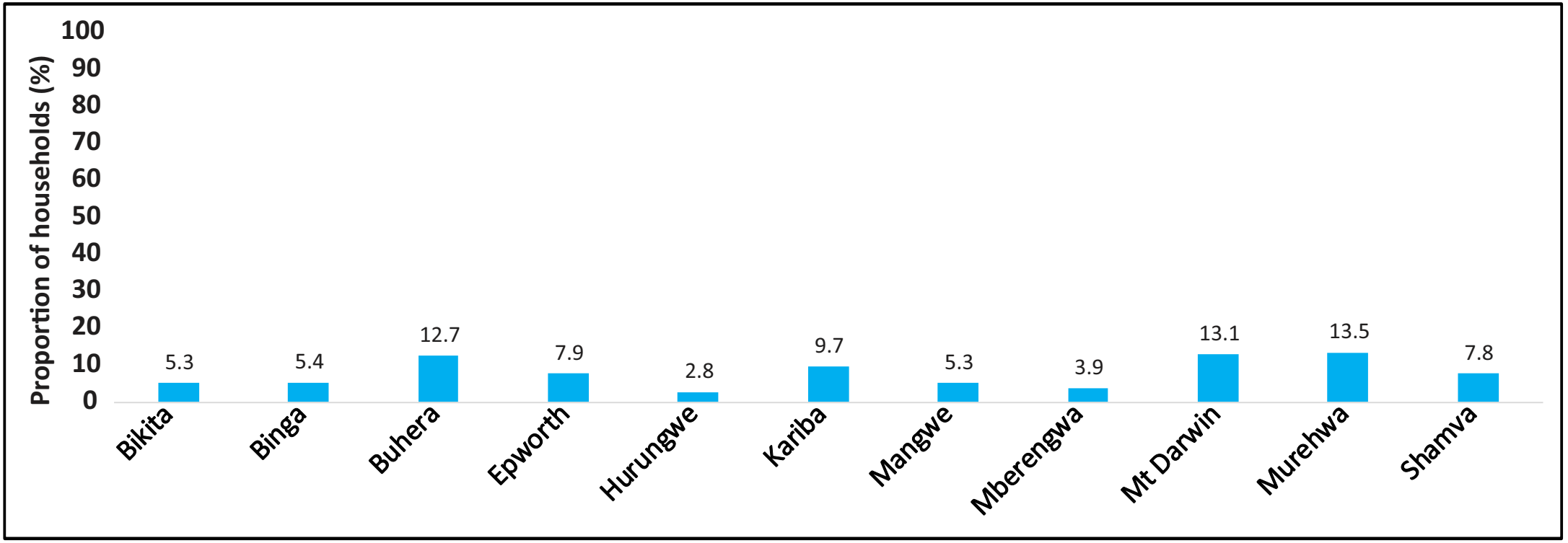
Source: UNICEF and WHO

Access to Drinking Water



- Buhera district (29.4%) had the highest proportion of households drinking water from water sources that were located on premises though tests for feacal and chemical contamination of these water sources were not carried out.
- Binga district (43.4%) had the highest proportion of households drinking water from surface water sources such as dams and rivers. On average only 69.8% households from the assessed districts were drinking water from Improved water

Proportion of House holds who treat Drinking water



- The proportion of households that treat their drinking water was between 2.8% and 13.5% with Murehwa having the highest and Hurungwe the least.

Type of Water Treatment

District	Type of Water Treatment			
	Boil	Add bleach or chlorine (Jik)	Let stand and settle	Add water treatment tablet
Bikita	1.7	1.7	0.0	0.8
Binga	2.9	0.0	0.4	0.0
Buhera	8.4	2.9	0.0	2.1
Epworth	4.2	3.4	0.0	0.0
Hurungwe	4.2	0.0	0.0	0.0
Kariba	7.5	0.0	0.0	0.8
Mangwe	5.2	0.0	0.0	0.0
Mberengwa	5.0	0.4	0.0	0.8
Mt Darwin	6.2	5.7	0.4	3.5
Murehwa	6.1	3.5	0.0	6.1
Shamva	0.8	1.7	0.0	5.0
Average	4.7	1.8	0.1	1.7

- The most common type of water treatment was boiling (4.7%) and the least was sedimentation (0.1%)

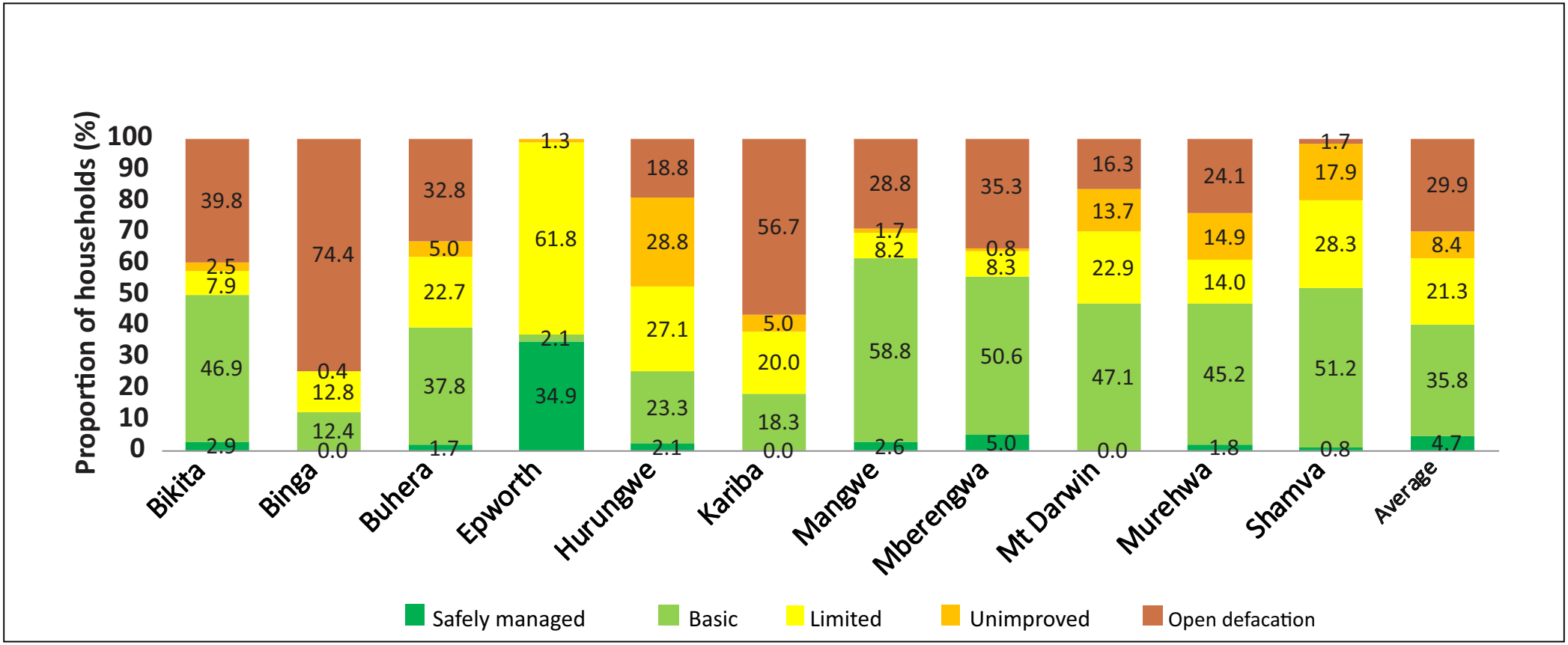
Sanitation Ladder

SERVICE LEVEL	DEFINITION
SAFELY MANAGED	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
BASIC	Use of improved facilities that are not shared with other households
LIMITED	Use of improved facilities shared between two or more households
UNIMPROVED	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
OPEN DEFECATION	Disposal of human faeces in fields, forests, bushes or with solid waste

Note: improved facilities include flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs

Source: UNICEF and WHO

Proportion of House hold by Level of Sanitation Services



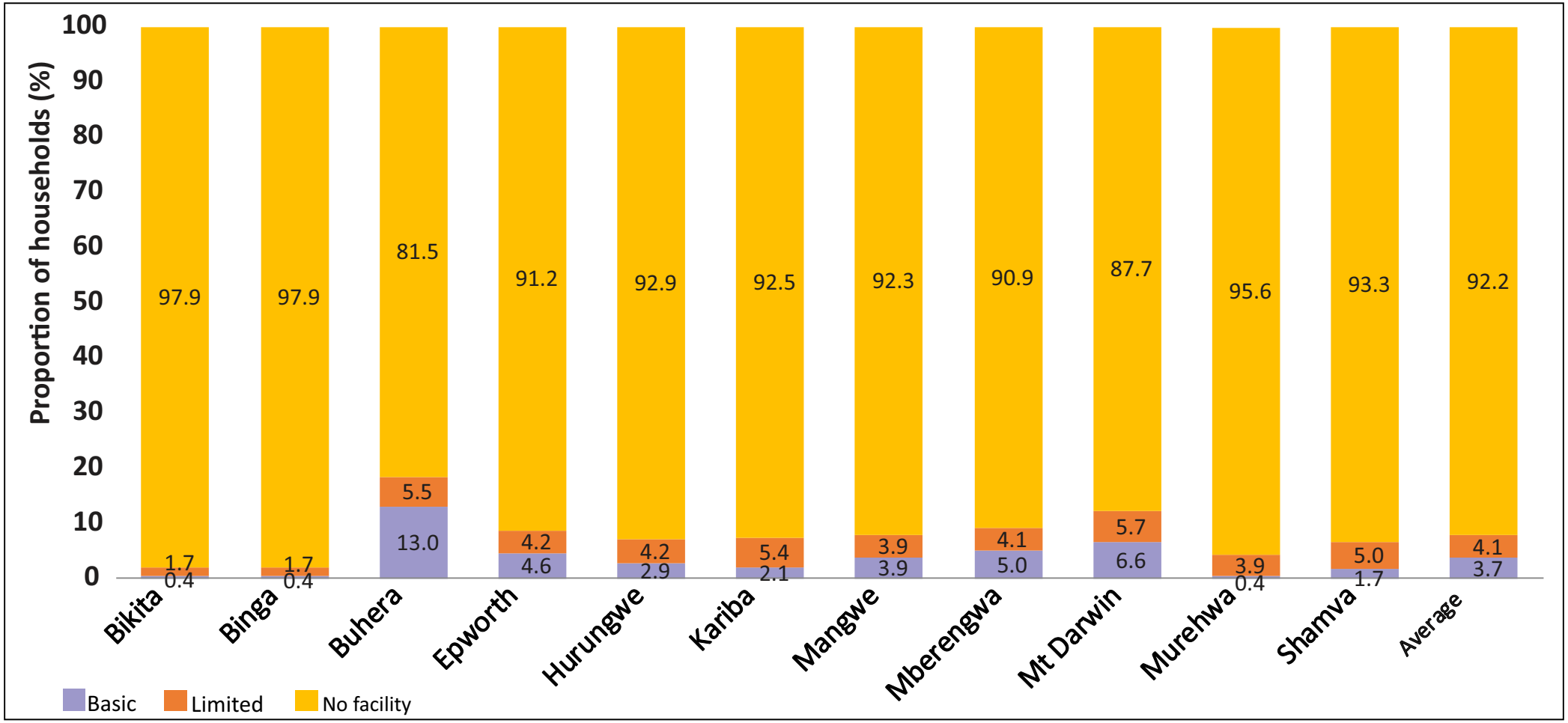
- On average, one in three households use improved sanitary facilities and Epworth district had the highest proportion of households using safely managed sanitation facilities(34.9%).
- Binga district had the highest proportion of households practicing open defacation.
- On average 29.9%households from the assessed districts were practicing open defacation.

Hygiene Ladder

SERVICE LEVEL	DEFINITION
BASIC	Availability of a handwashing facility on premises with soap and water
LIMITED	Availability of a handwashing facility on premises without soap and water
NO FACILITY	No handwashing facility on premises

Source: UNICEF and WHO

Proportion of House hold by Hand Washing Facilities



- About 92.2% of households across the 11 assessed districts had no hand washing facilities.
- Buhera district had the highest proportion of households with basic hand washing facilities.
- Mount Darwin district had the highest proportion of households with limited hand washing facilities

Conclusions and Recommendations

- The prevalence of GAM across the 11 domains ranged between 0.5%-5.5% .A total of 3 districts had GAM above 4 % namely Binga, Epworth and Shamva. The Ministry of Health and Child Care needs to strengthen identification and referral of children with acute malnutrition for treatment in these 3 districts.

- The monthly coverage of growth monitoring ranged from 7.4%-51.3% for height, 14.9%-66.0% for weight and 10.8%-63.2% for MUAC across the 11 domains. Therefore there is need to improve community and health centre based growth monitoring in the all districts.

- All the assessed eleven domains had high stunting levels above the acceptable global threshold of 20%. The Government of Zimbabwe need to scale up high impact nutrition interventions.

- The proportion of children meeting the minimum acceptable diet was very low ranging from 0% to 28%. There is need to strengthen community based nutrition specific and sensitive interventions to improve the nutrition outcomes.

- The vitamin A supplementation coverage for children 6-59 months was very low ranging from 20.4% to 69.7%. There is need to strengthen community based vitamin A supplementation

- The coverage for micronutrient powders distribution was below 50% across all the 11 districts. There is need to increase resource allocation at sub national level for advocacy and programme logistics

Conclusions and Recommendations

- Three districts that are namely Binga, Kariba and Mangwe had a high proportion of households that are fetching drinking water from surface sources and the same districts including Buhera, Bikita, Mberengwa and Murehwa have high proportion of households practicing Open Defecation. Therefore there is need to capacitate communities on the importance of hygiene through various platforms such as Participatory Health and Hygiene Education (PHHE) services prioritising districts with low water and sanitation coverages

- There is need to design behavior- change interventions and by-laws that enforce the construction of appropriate sanitation facilities at each household and installation of community piped water schemes from the Zambezi river.

- They were no hand washing facilities at most households. WASH activities should be mainstreamed into all departments and social gatherings.

- There is need for the Ministry of Health and Child Care to continue engaging stakeholders particularly producers of maize meal and wheat flour on the need to comply with the food fortification legislation.

- The majority of children across the 11 domains were not fed appropriately during illness. The Ministry of Health and Child Care need to improve on IYCF counselling and education for caregivers during childhood illness.

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