



Zimbabwe Livelihoods Assessment Committee (ZimLAC)



2024 Urban Nutrition Assessment Report



Foreword

The national policy documents including the Food and Nutrition Security Policy commit the Government of Zimbabwe to “ensuring a national integrated food and nutrition security information system that provides timely and reliable information on the food and nutrition security situation and the effectiveness of programmes and informs decision making”. In addition, the Multisectoral Food and Nutrition Security Strategy (MFNSS 2023-2025) further affirms the vision to avail credible, timely information for evidence based decision making and programming.

The main purpose of the 2024 Urban Nutrition Survey was to assess nutrition status among the urban population in Zimbabwe and characterize the underlying factors as well as identify key drivers to facilitate evidence based decision making and programming for better nutrition outcomes. The inclusion of subnational analysis provides for targeted programming of interventions aimed at addressing the nutrition outcomes within the devolution agenda. Subnational analysis also strengthens context specific actions leaving no-one and no-place behind. This report focuses on thematic areas which include household demographics; water, sanitation and hygiene; household consumption and coping strategies; food fortification; child health and nutrition; vitamin A supplementation; school feeding; non-communicable diseases and their potential risk factors for adolescents and adults; and provides practical recommendations on each thematic area for action at national and subnational level. Through this report, we endeavour to provide Government and its Development Partners with evidence for planning and decision making as well as effective targeting of interventions and efficient use of resources to address the various forms of malnutrition and the underlying drivers for the urban population in Zimbabwe.

Our sincere appreciation goes to the Zimbabwe Livelihoods Assessment Committee for successfully conducting this survey. The active participation of all food and nutrition security structures at National, Provincial and District level as well as the urban community at large is greatly appreciated. Financial support from the Government of Zimbabwe and its Development Partners provided all the impetus required to meet the cost for this exercise. We submit this report to you all for your use and reference as you champion actions towards addressing priority issues aimed at preventing malnutrition in all its forms and reducing the related risk factors throughout the life cycle.



George D. Kembo (Dr.)

DIRECTOR GENERAL/ ZIMLAC CHAIRPERSON

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- Ministry Public Service, Labour and Social Welfare
- Ministry of Health and Child Care
- Ministry of Local Government and Public Works
- Ministry of Primary and Secondary Education
- Ministry of Women Affairs, Community, Small and Medium Enterprise Development
- Marondera University of Agricultural Sciences and Technology
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- Aquaculture Zimbabwe
- Mercy corps
- SAYWHAT
- Caritas
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- Local Authorities

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Food and Agriculture
Organization of the
United Nations



Acronyms

EA	Enumeration Area
FNSP	Food and Nutrition Security Policy
FCS	Food Consumption Score
HDDS	Household Dietary Diversity Score
HHS	Household Hunger Score
MFNSS	Multisectoral Food and Nutrition Security Strategy (2023-2025)
SAM	Severe Acute Malnutrition
ZimLAC	Zimbabwe Livelihoods Assessment Committee

Overall Survey Purpose

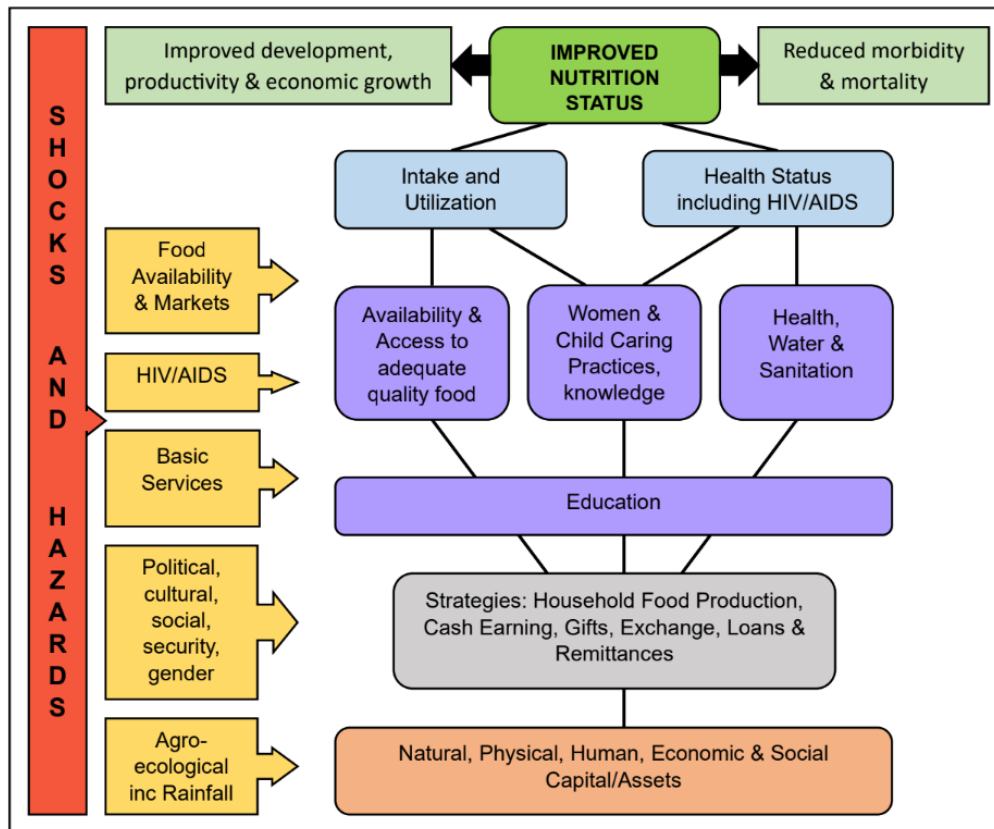
The main purpose of the survey was to assess the nutrition status among the urban population in Zimbabwe and characterize the underlying factors as well as identify its key drivers to facilitate evidence based decision making and programming for better nutrition outcomes.

Survey Objectives

1. To assess the nutritional status (anthropometry) in children 0–59 months of age, school going children, adolescents and adults;
2. To determine the practices related to Infant and Young Child Feeding;
3. To assess the diversity and frequency of consumption of locally available micronutrient rich foods through household dietary diversity assessment and individual dietary diversity assessment of children 0–59 months of age and women of reproductive age;
4. To assess the prevalence of morbidity (cough, fever and diarrhoea) among children 0–59 months of age;
5. To assess uptake of industrially fortified foods;
6. To describe the socio-economic profiles of households with assessed individuals in terms of demographics, access to basic services, hygiene practices and coping strategies;
7. To assess the extent of non-communicable diseases and their associated risk factors such as physical activity, alcohol intake and tobacco use among adolescents and adults.

Assessment Methodology

Survey Conceptual Framework



- In recognition of the multifaceted and multi-dimensional nature of not only the impacts of nutrition status but also its causes, the design of the Nutrition Survey 2024, was guided by the food and nutrition conceptual framework as pronounced in the Food and Nutrition Security Policy as well as the Multisectoral Food and Nutrition Security Strategy (2023-2025).
- This places nutrition as an outcome of multisectoral drivers at various levels and its role in driving the economic development.

Data Collection, Preparation and Analysis

- A multi-sectoral Technical Team undertook a multi-stakeholder consultation process which culminated in the development of the survey design and protocols informed by the assessment objectives, development of data collection tools, pre-testing as well as standardization of data collection instruments and anthropometric measurements.
- The Urban Nutrition Survey Technical Team was made up of members from Government, United Nations, Technical Organisations and Non-Governmental Organisations.
- The survey had a national supervisory team, inclusive of provincial nutritionists.
- The national supervisors underwent training in all aspects of the assessment (background, data collection tools, assessment sampling strategy and assessment supervision).
- The Ministry of Local Government and Public Works, through the Provincial Administrators' offices provided the necessary coordination including the recruitment of district enumerators and mobilisation of vehicles at all levels.
- District enumeration teams comprised of officers from Government and local NGOs.
- Each district enumeration team had 3 enumerators and 1 anthropometrist who had the responsibility of measuring children aged 6-59 months, school-aged children, adolescents and adults in the selected household. Enumerators underwent a 1 day data collection and instrument standardisation training, including a standardisation training to ensure precision and accuracy in anthropometric measurements.
- The assessment used android gadgets for primary data collection and transcription.
- Data analysis and report writing was done by a team of technical experts from the Zimbabwe Livelihoods Assessment Committee under the leadership and coordination of the Food and Nutrition Council.

Methodology- Sampling

- The sample design was such that key nutrition indicators, particularly global acute malnutrition prevalence, could be reported at domain level at least 95% confidence.
- Global Acute Malnutrition prevalence as the chosen key indicator for the survey informed the sample design as well as the sample size.
- The 2022 ZimSTAT master sampling frame was used to draw 30 enumeration areas (EAs) for each domain using the Probability Proportional to Population Size (PPS) method.
- The sample was drawn from 44 reporting domains made up of cities, towns, service centres and growth points.
- It focused on urban households residing in the medium-density, high density, and peri-urban areas of Zimbabwe. It covered Urban Council Areas, Administrative Centers, Growth Points and other Urban Areas.
- 10 households to be enumerated were selected using systematic random sampling from a randomly selected suburbs within the sampled enumeration areas (EAs).
- All members in the households were considered for anthropometric measurements , while adults were considered for non-communicable disease risk factors and individual diets targeted women and children under 5 years.
- Enumerator training was held on the 12th of February 2024. Primary data collection took place from 13 to 28 February 2024. Various secondary data sources and field observations were used to contextualise the analysis and reporting.

Methodology-Sampling and Sample Size

- The sample size was done using ZIMVAC 2022 global acute malnutrition (GAM) rate of 5.1%.
- A total of **13 479** households were interviewed.
- At least 5806 children under 5, 3457 children 5 to 9 years and 20 728 adults were measured.

	Number of Households		Number of Households
Bulawayo North	304	Beitbridge Urban	300
Emakhandeni	303	Gwanda Urban	299
Luveve	297	Plumtree	300
Magwegwe-Pumula	298	Kwekwe Urban	298
Lobengula	300	Gweru Urban	595
Nketa-Emganwini	292	Shurugwi	300
Nkulumane-Tshabalala-Sizinda	301	Zvishavane Urban	297
Mutare Urban	299	Gokwe Centre, Nembudziya	300
Rusape	302	Redcliffe	300
Bindura Urban	300	Masvingo Urban	301
Mazowe, Mvurwi	300	Gutu	293
Marondera Urban	310	Chiredzi Urban	299
Murehwa-Mutoko-Mudzi	300	Bikita-Zaka	297
Chivhu	302	Harare South	300
Ruwa	306	Greater Harare 1	296
		Greater Harare 2	294
Kadoma Urban	300	Greater Harare 3	300
Chegutu Urban	303	Greater Harare 4	297
Chinhoyi Urban	291	Epworth	302
	300	Chitungwiza (Zengeza-Seke)	301
Norton		Chitungwiza	299
Hwange	296	Caledonia	301
Victoria-Falls	305	Hatcliffe	301
National	13479		

Background

- Nutrition must be understood as both an input to, and an outcome of, economic development where improved nutrition is a marker and maker of development. Evidence suggests that an additional dollar invested in quality nutrition programmes will yield an average return of USD 16.
- The UN General Assembly (UNGA) declared a [UN Decade of Action on Nutrition \(2016-2025\)](#), recognizing the role of nutrition in achieving the 2030 Agenda on Sustainable Development and the Sustainable Development Goals (SDGs). The Decade calls for eradicating hunger and preventing all forms of malnutrition worldwide, particularly stunting, wasting, and overweight in children under five years of age; and anaemia in women and children among other micronutrient deficiencies; as well as for reversing the rising trends in overweight and obesity and reducing the burden of diet-related non-communicable diseases (NCDs) in all age groups.
- The many manifestations of malnutrition derive not just from a lack of sufficient and adequately nutritious and safe food, but from a host of interacting processes linking health, care, education, sanitation and hygiene, access to resources, women's empowerment and more. Good nutritional status leads to higher individual earnings and mental acuity, which in turn support macroeconomic and societal growth. Exposure to economic, weather and climatic related shocks can further exacerbate the negative nutrition outcomes.
- In Zimbabwe, the hot and dry conditions associated with the El Nino have been experienced for the greater part of the 2023/2024 season. A delayed commencement of the rains characterised the season. This could have caused limited access to nutritious diverse foods especially green harvest. The food and nutrition security situation are most likely to be impacted, mainly affecting food access and diversity, which may contribute to the deterioration of the nutrition situation due to poor quality of diets.
- The erratic season will likely disrupt water sanitation and healthy food environments supporting nutritious, diverse, safe diets. Some parts of the country experienced some flash floods and these were exacerbated by factors which included poor drainage in cities, settling in low-lying areas and streams passing through residential areas. This led to destruction of shelter and displacement of people. Affected households may become food and nutrition insecure due to the loss of food stockpiles, non-food items and livelihood disruption. All these factors affect food consumption, increase in water diseases and acute respiratory infections which have an effect on nutrition outcomes.

Background

- The country has been experiencing health related epidemics across districts and these include cholera, measles and malaria. These impact differently in individuals of varying nutritional status especially in children like measles exposed children in vitamin A deficiency compromises immunity. The Zimbabwe Cholera Situation Report of 9 March reported that the country recorded the first cholera outbreak in the country in 2023 which started on the 12th of February 2023 in Chegutu town. The suspected and confirmed cases have been reported in 62 districts in all the 10 provinces in the country since the beginning of 2023. As of 9th March 2024, a cumulative total of 27858 suspected cholera cases, 71 laboratory confirmed deaths and 513 suspected cholera deaths and two-thousand seven hundred and six laboratory confirmed cases were reported. However, the Government, through the Ministry of Health and Child Care has commenced the cholera vaccination in selected hotspots throughout the country.
- The exposure to repeated recurring diarrhoeal episodes weakens the body's ability to fight infections and absorption of nutrients in the body, thereby affecting the overall nutritional status of the affected populations. Cholera may result in severe dehydration compromising feeding practices of the affected person and subsequent deterioration of the nutritional status of the individual. There could be suboptimal IYCF practices of children under 5 years when mothers and care givers fall victim to diseases. Moreso if a breadwinner is the affected individual, this can lead to reduced livelihood capacity which may cause limited access to diverse, nutritious, diets resulting from negative coping strategies. When outbreaks occur, the women usually take the role of taking care of the sick hence childcare may be compromised.

Background

- Pursuant of the overarching goal **“to become an empowered and prosperous middle-income society by 2030”**, and to align with the National Development Strategy (NDS) 1 (2021-2025), the Government of Zimbabwe has developed, among other sectoral plans, the Multi-Sectoral National Food and Nutrition Strategy for Zimbabwe 2021-2025 (MFNSS 2021-2025). The NDS1 is the first 5-year Medium Term Plan aimed at realising the country's Vision 2030, while simultaneously addressing the global aspirations of the Sustainable Development Goals (SDGs) and Africa Agenda 2063. These policies express a shared vision and commitment for accelerated action to improve the quality of diets, ensure food safety, improve nutrition for all ages adolescents, women of child bearing and non-communicable diseases among all age groups through the life cycle approach.

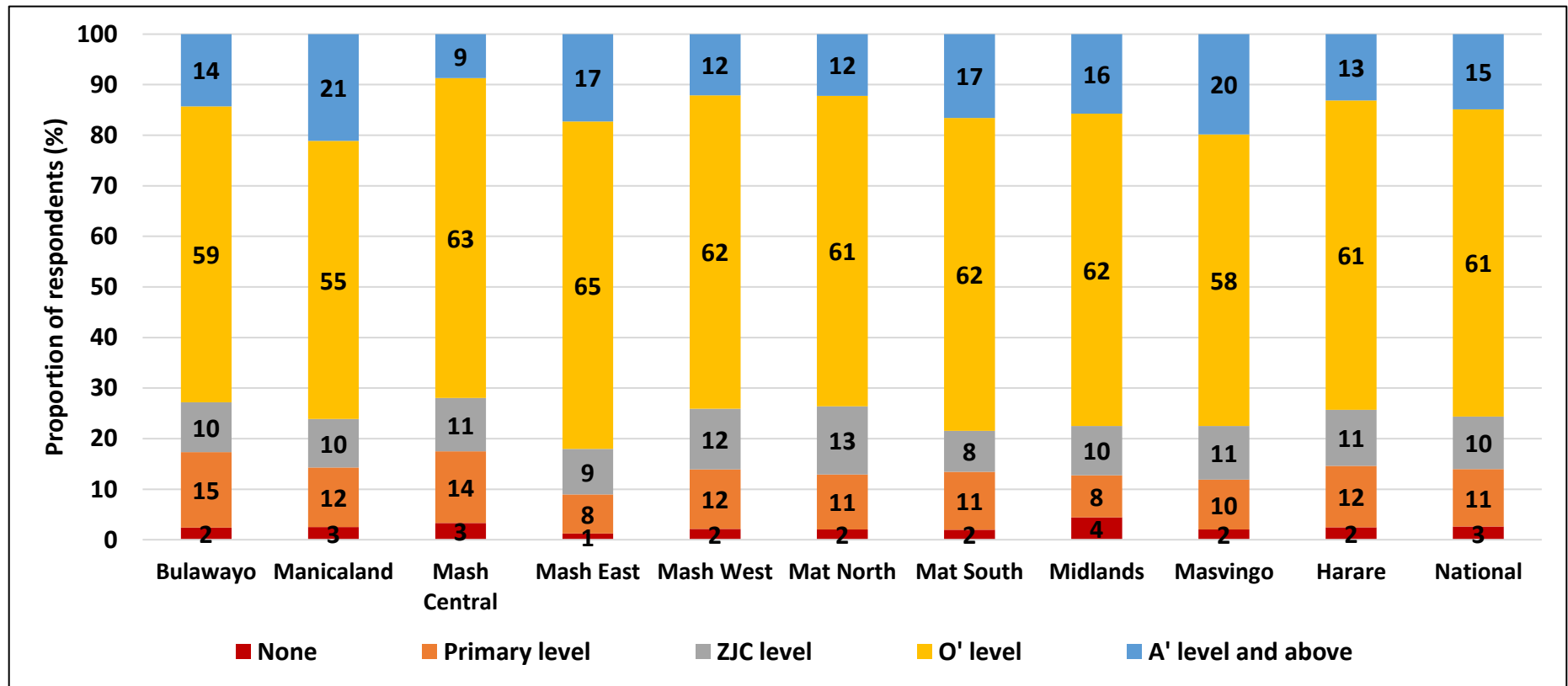
Demographics

Characteristics of Respondents

Province	N	Household size	Respondent Sex		Age Group				
			Male (%)	Female (%)	Average Age of Respondent (years)	12-17 years (%)	18-24 years (%)	25-59 years (%)	60+ years (%)
Bulawayo	2,095	4.1	23.2	76.8	42	1	13	68	18
Manicaland	601	3.8	23.0	77.0	40	1	13	76	11
Mash Central	600	3.9	16.5	83.5	39	1	15	75	10
Mash East	1,218	3.5	21.1	78.9	38	2	17	74	7
Mash West	1,194	4.0	21.4	78.6	40	0	11	78	11
Mat North	601	3.5	20.2	79.8	37	1	14	79	7
Mat South	899	3.5	17.8	82.2	38	1	17	73	9
Midlands	2,090	4.1	19.7	80.3	38	2	16	73	10
Masvingo	1,190	3.7	17.7	82.3	37	1	17	74	8
Harare	2,991	4.2	19.4	80.6	39	1	15	74	10
National	13,479	3.9	20.2	79.8	39	1	15	73	11

- A total of 13,479 households were interviewed and the average age of respondents was 39 years.
- The majority of respondents (79.8%) were female.
- 73% of the respondents were in the 25-59 years age group.

Education Level of Respondents



- The majority of the respondents had received some form of education (97%).

Sample-Household Characterisation

Province	N	Household Size	Average Household Head Age (Years)	Household Head Sex (%)		Orphans (%)
				Male	Female	
Bulawayo	2095	4.1	47.8	52.0	48.0	12.2
Manicaland	601	3.8	44.0	61.9	38.1	12.7
Mash Central	600	3.9	43.4	66.2	33.8	9.4
Mash East	1218	3.5	42.0	64.5	35.5	9.3
Mash West	1194	4.0	44.2	67.5	32.5	13.4
Mat North	601	3.5	42.5	66.3	33.7	10.1
Mat South	899	3.5	42.6	53.6	46.4	7.7
Midlands	2090	4.1	46.3	67.4	32.6	10.4
Masvingo	1190	3.7	46.1	58.0	42.0	10.4
Harare	2991	4.2	44.0	69.0	31.0	9.3
National	13479	3.9	44.8	63.0	37.0	10.5

- The average household size was 4.
- The proportion of households which were male-headed was 63%.

Sample Characteristics by Age

Province	Males	Female	Total	0 to 4 years		5 to 17 years		18 to 59 years		60 years and above		Age groups of nutrition significance				
				N	%	N	%	N	%	N	%	0-23 months	6-23 months	5 to 9 years	10 to 19 years	Females 15 to 49 years
												N	N	N	N	N
Bulawayo	3783	4896	8679	1035	11.9	2563	29.5	4394	50.6	687	7.9	398	327	969	2006	2611
Manicaland	1029	1229	2258	277	12.3	675	29.9	1167	51.7	139	6.2	104	78	261	487	634
Mash Central	1066	1283	2349	340	14.5	682	29.0	1209	51.5	118	5.0	146	117	291	478	653
Mash East	1966	2284	4250	680	16.0	1164	27.4	2233	52.5	173	4.1	278	224	501	795	1290
Mash West	2195	2583	4778	703	14.7	1360	28.5	2472	51.7	243	5.1	245	185	539	977	1363
Mat North	960	1129	2089	243	11.6	546	26.1	1216	58.2	84	4.0	94	77	207	415	697
Mat South	1308	1838	3146	508	16.1	746	23.7	1728	54.9	164	5.2	203	170	323	540	1046
Midlands	3878	4707	8585	1167	13.6	2485	28.9	4447	51.8	486	5.7	521	411	1014	1816	2582
Masvingo	1963	2417	4380	611	13.9	1249	28.5	2293	52.4	227	5.2	243	201	542	896	1368
Harare	5746	6705	12451	2042	16.4	3266	26.2	6431	51.7	712	5.7	837	653	1443	2232	3504
National	23894	29071	52965	7606	14.4	14736	27.8	27590	52.1	3033	5.7	3069	2443	6090	10642	15748

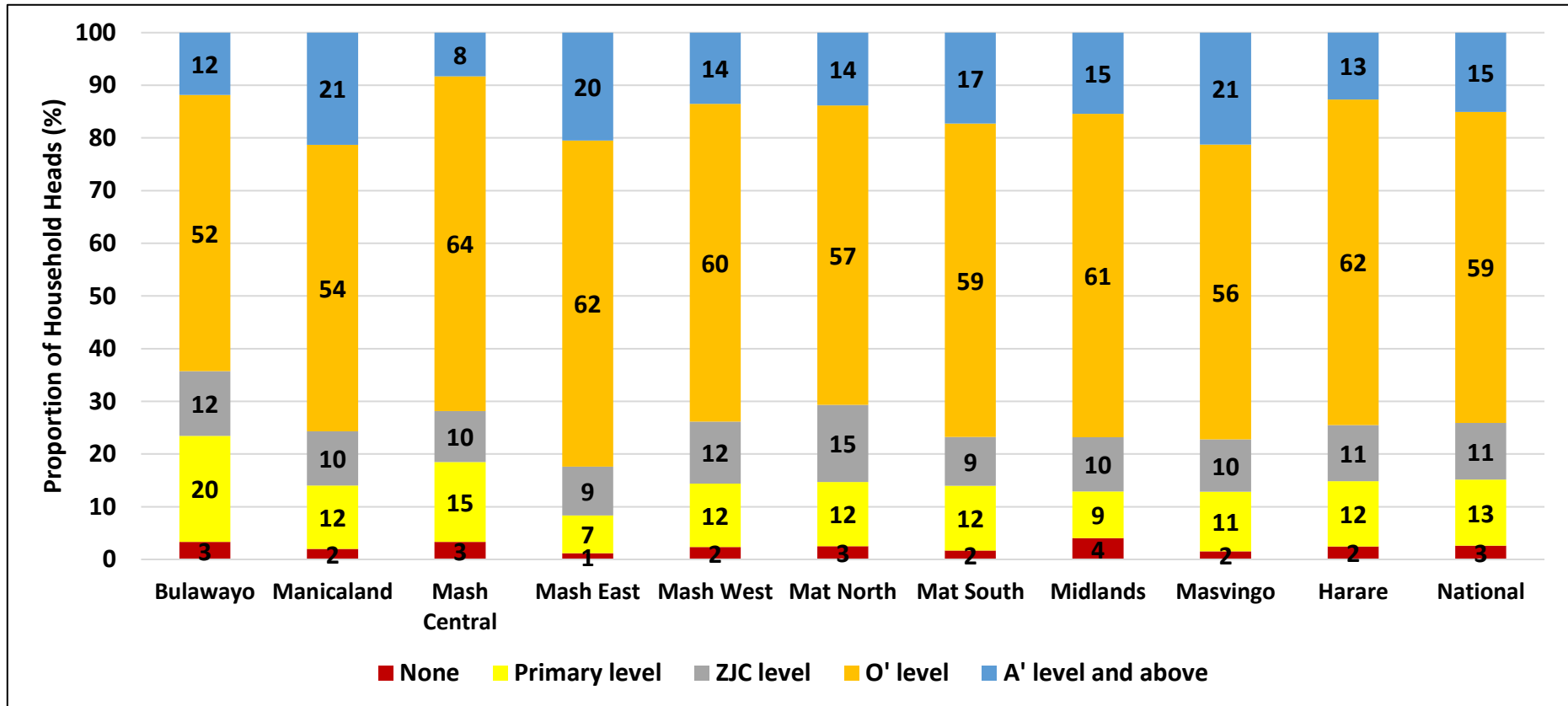
- The sample had 52965 members of which 14.4% were aged 0-4 years, 27.8% aged 5 to 17 years, 52.1% aged 18-59 years and 5.7% aged 60 years and above.

Age and Marital Status of Household Head

Province	Average Age of Household Head (Years)	Married Living Together (%)	Married Living Apart (%)	Divorced/Separated (%)	Widowed (%)	Cohabiting (%)	Never Married (%)
Bulawayo	48	45.3	8.5	11.6	19.8	1.3	13.5
Manicaland	44	55.2	15.6	11.3	12.5	0.2	5.2
Mash Central	43	58.3	13.3	11.7	13.8	0.2	2.7
Mash East	42	56	11.7	14.9	10.3	0.2	6.9
Mash West	44	60.4	5.4	13.9	15.6	0.8	4
Mat North	42	61.7	6.2	9.3	10.5	2.2	10.2
Mat South	43	50.9	12.6	11	12.5	0.4	12.6
Midlands	46	62.6	8.7	13	11.2	0.1	4.4
Masvingo	46	53.8	11.2	15	13.9	0.4	5.6
Harare	44	63.9	5.7	11	13.8	1.5	4
National	45	57.3	8.9	12.3	13.9	0.8	6.8

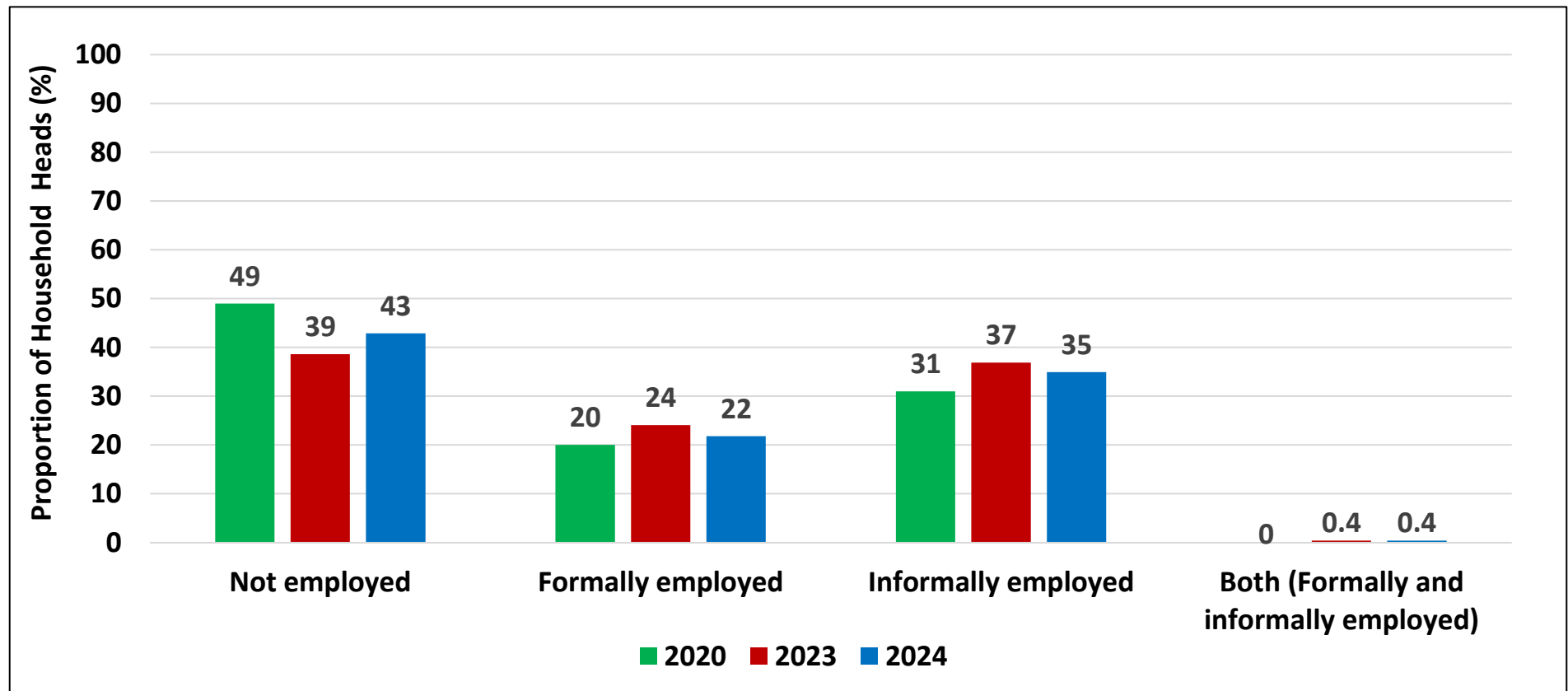
- The average age of household head was 45 years.
- The majority of the household heads were married and living together (57.3%).
- Masvingo (15%) and Mashonaland East (14.9%) had the highest proportion of divorced or separated household heads.

Education Level of Household Head



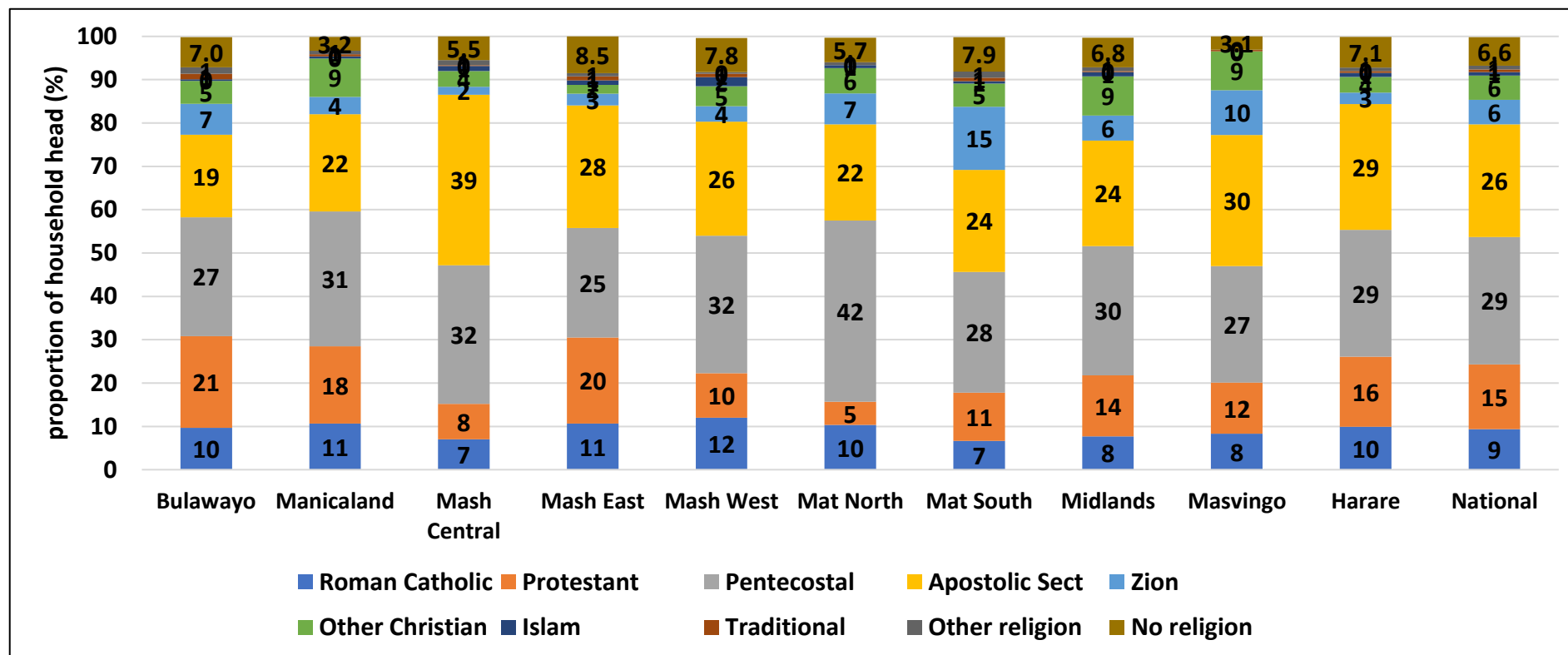
- The majority of household heads (97%) attained some form of education.

Employment Status of Household Head



- There was no significant change in the employment status of household heads compared to 2023.

Religion of Household Head



- Most of the household heads were from pentecostal churches (29%) and apostolic sects (26%). Religion of the household head can influence uptake of key nutrition messages, behaviours and food choices.

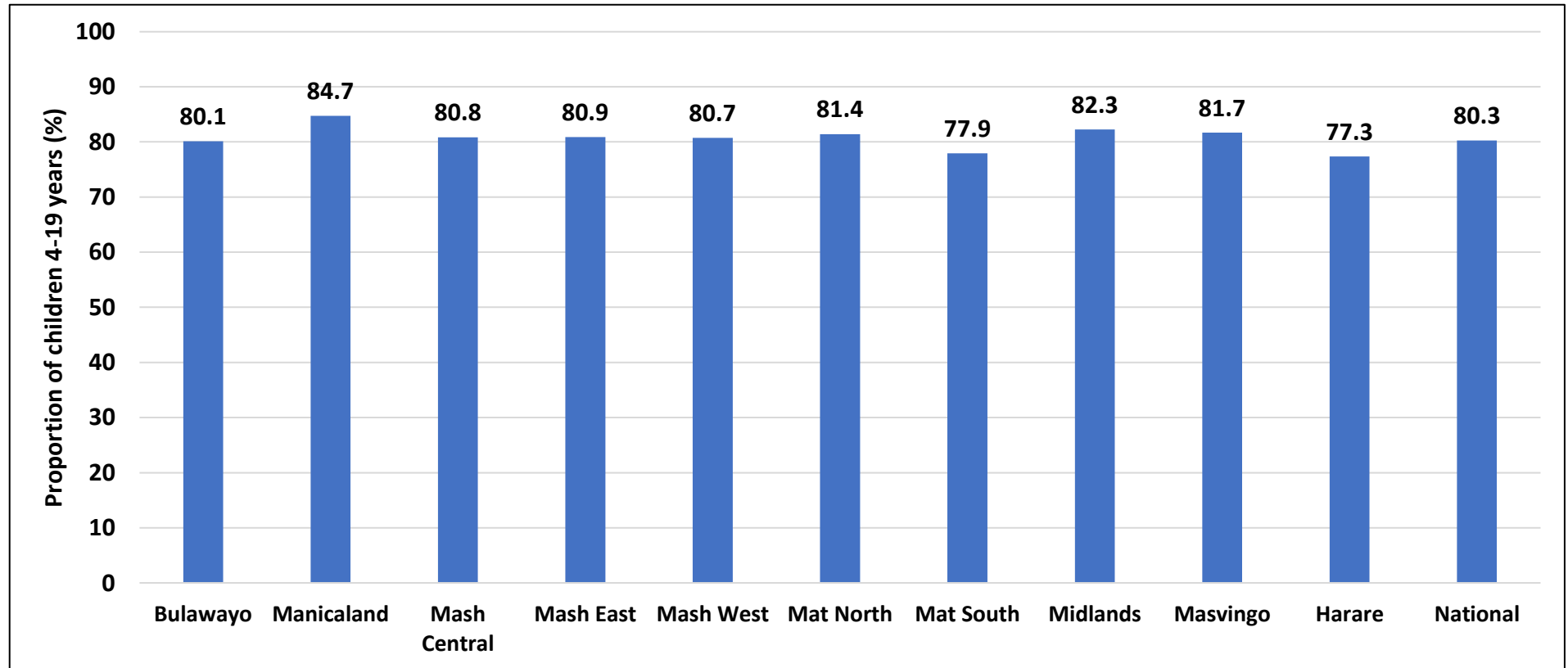
Vulnerability Attributes

Province	Male headed households (%)	Female headed households (%)	Child headed Households (%)	Elderly headed households (%)	Orphan present in household (%)	Households with a member living with at least a Chronic condition (%)	Households with a member living with disability present (%)
Bulawayo	52.0	48.0	0.3	24.3	25.1	45.5	15.8
Manicaland	61.9	38.1	0.3	14.8	25.1	36.1	8.5
Mash Central	66.2	33.8	0.0	12.3	18.2	31.8	4.7
Mash East	64.1	35.2	0.8	10.3	17.7	14.1	6.2
Mash West	67.2	32.4	0.1	14.4	28.5	36.6	9.6
Mat North	66.2	33.6	0.2	10.3	17.0	35.1	8.7
Mat South	53.6	46.4	0.4	12.3	13.8	28.7	4.4
Midlands	67.4	32.6	0.1	14.7	22.4	21.2	10.6
Masvingo	58.0	42.0	0.5	12.4	19.0	27.6	12.0
Harare	68.9	31.0	0.1	14.3	19.1	29.8	12.4
National	62.9	37.1	0.3	15.0	21.0	30.5	10.6

- Nationally, 30.5% of the households had a member who had at least a chronic condition.
- Bulawayo had the highest proportion of households with a member living with at least a chronic condition (45.5%), a member living with disability (15.8%) and elderly headed households (24.3%).

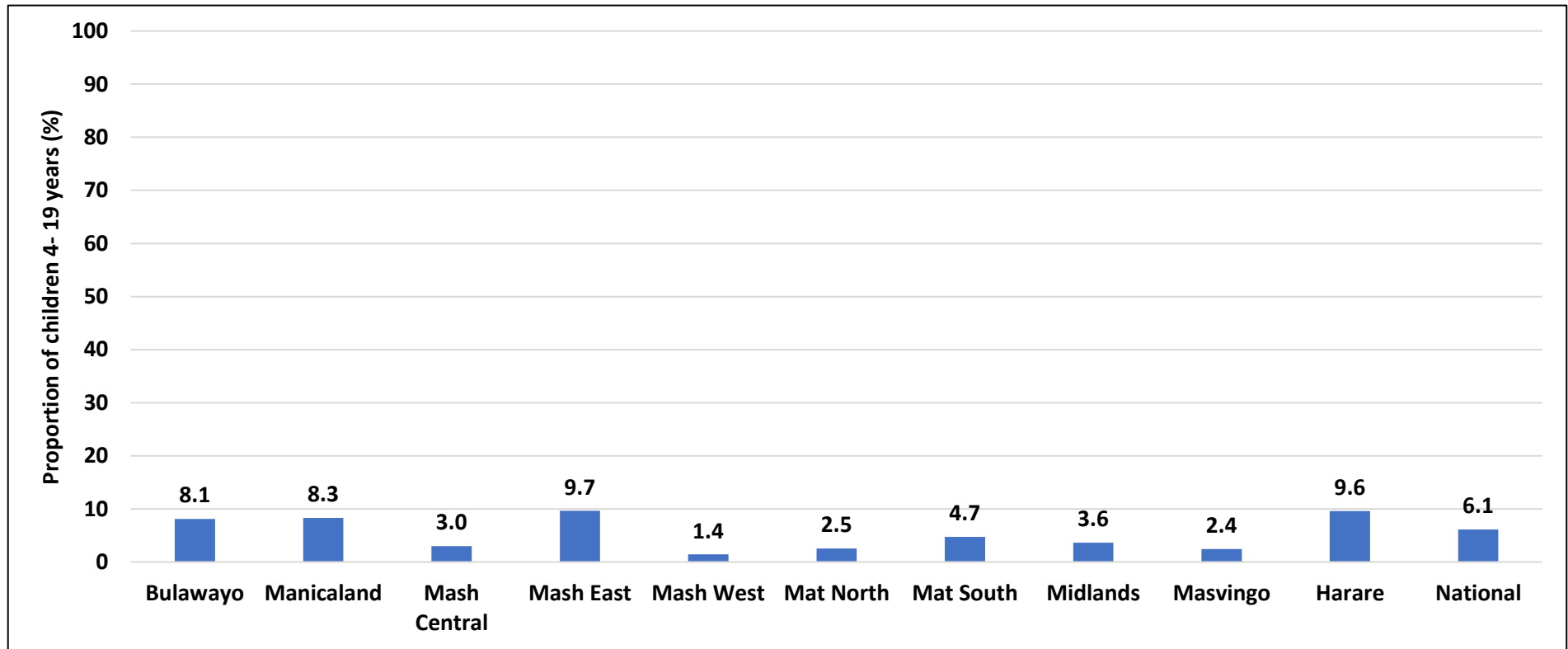
Education

School Attendance



- Nationally, 80.3% of the children aged 4- 19 years were in school at the time of the assessment.

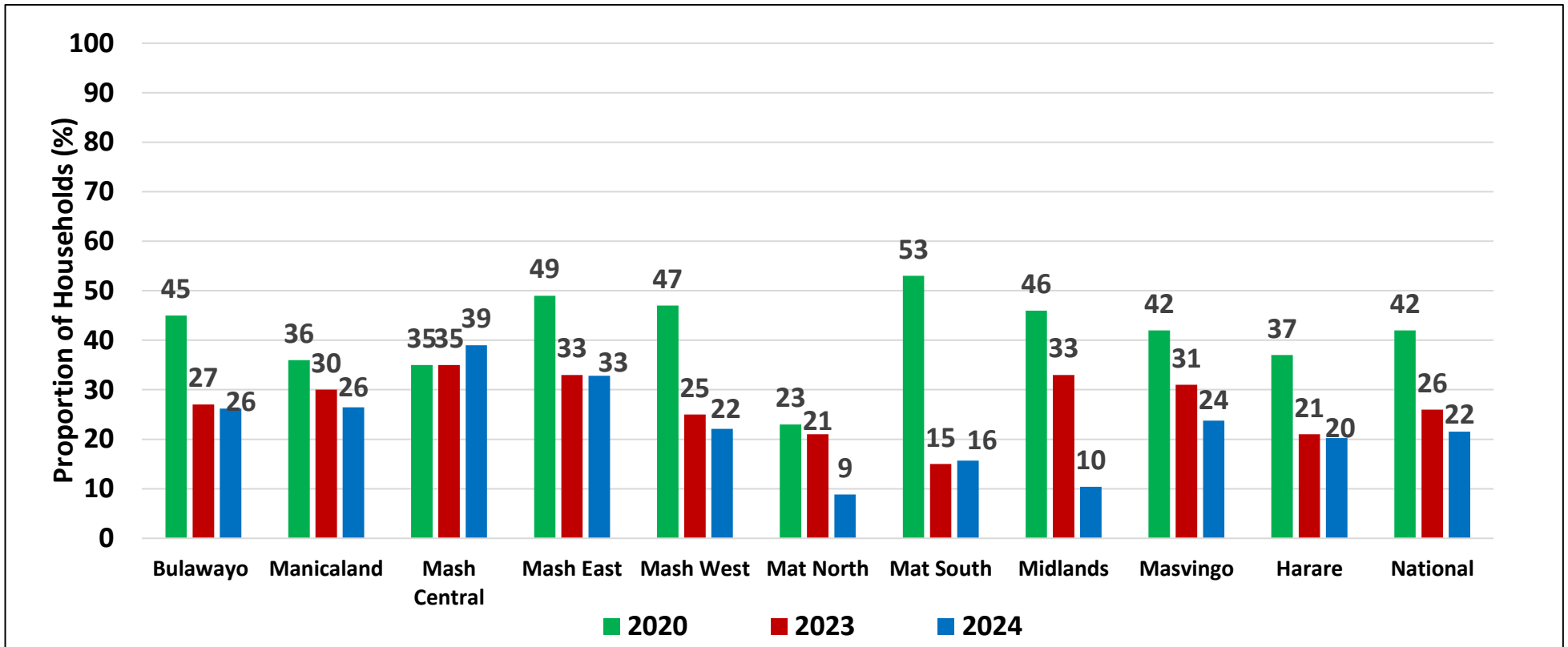
Proportion of Children Receiving Hot Meals at School



- A child or young person who is hungry does not learn well. A healthy diet in sufficient quantity is essential for learning and development.
- About 6.1% of school going age children were receiving hot meals at school.

Social Protection

Social Support from Any Source



- Social support has declined since 2020 from 42% to 22% in 2024. The decline in social support is a positive reflection of economic performance for the period under review. An improvement in the economy is anticipated to improve household economy thereby reducing the number of needy households

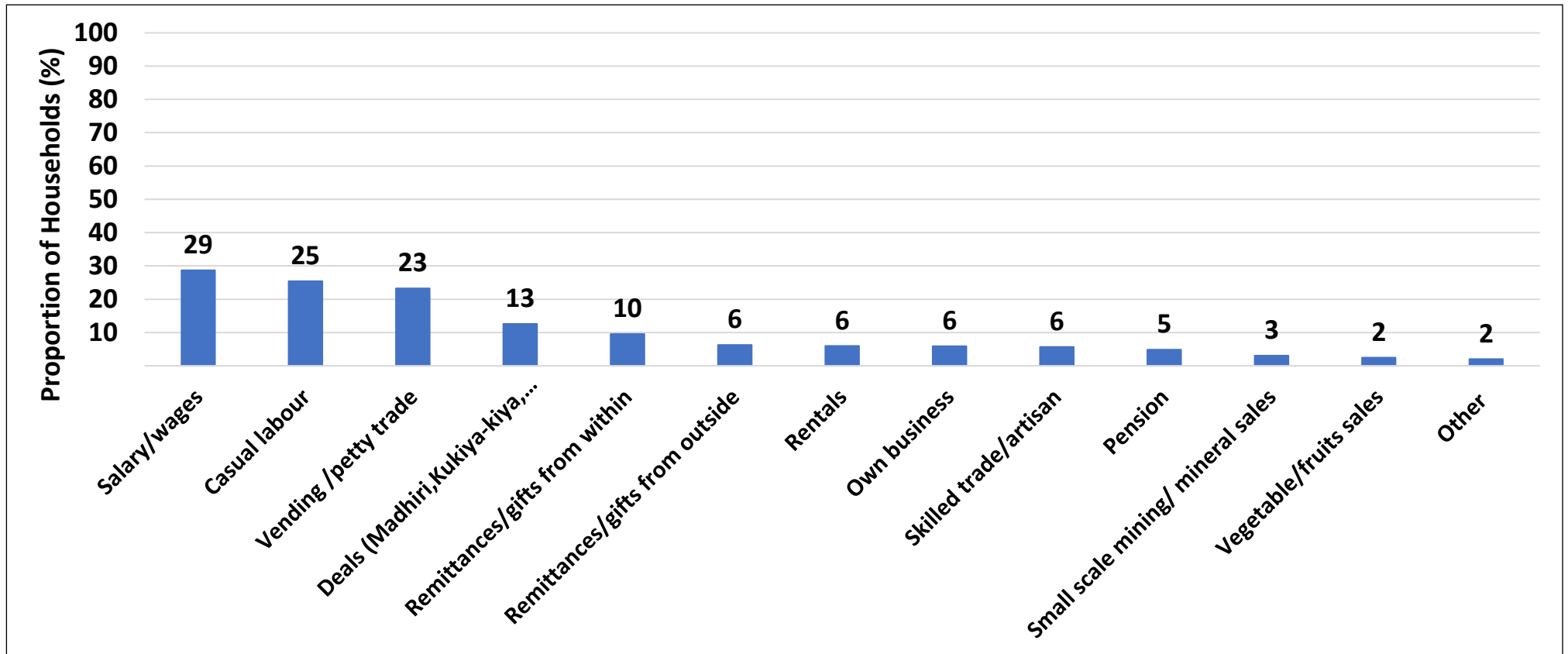
Sources of Support

Province	Government (%)	Relatives Within Urban Areas (%)	UN/NGO (%)	Relatives in Rural Areas (%)	Mutual Groups (%)	Relatives in the Diaspora (%)	Churches (%)
Bulawayo	6.5	4.6	6.8	4.5	0.7	8.1	2.1
Manicaland	15	8.8	3	9.5	0.2	4.5	1.7
Mash Central	31.3	4.3	0.7	2.2	0.3	4.3	2
Mash East	20.1	9.8	0.8	9.8	0.2	4.5	2.1
Mash West	4.5	8.2	1.8	6.5	0.3	3.9	2.4
Mat North	2.3	2.2	1.2	2	0	1.7	1.8
Mat South	1.6	3.1	5.2	2.4	1	5.3	1.2
Midlands	2.7	2.4	1.6	2.7	0.5	1.9	1.1
Masvingo	5.7	3.4	8	5.3	0.5	4.2	1.8
Harare	4.4	4.7	4.4	3.9	0.6	5.4	2.8
National	7.4	5	3.8	4.7	0.5	4.7	2

- The positive performance of social capital effect as reflected by support from relatives (14.4%) is noted. Government is encouraged to continue with progressive economic initiatives that build the capacity of households. Added to this is Government's (7.4%) social support.

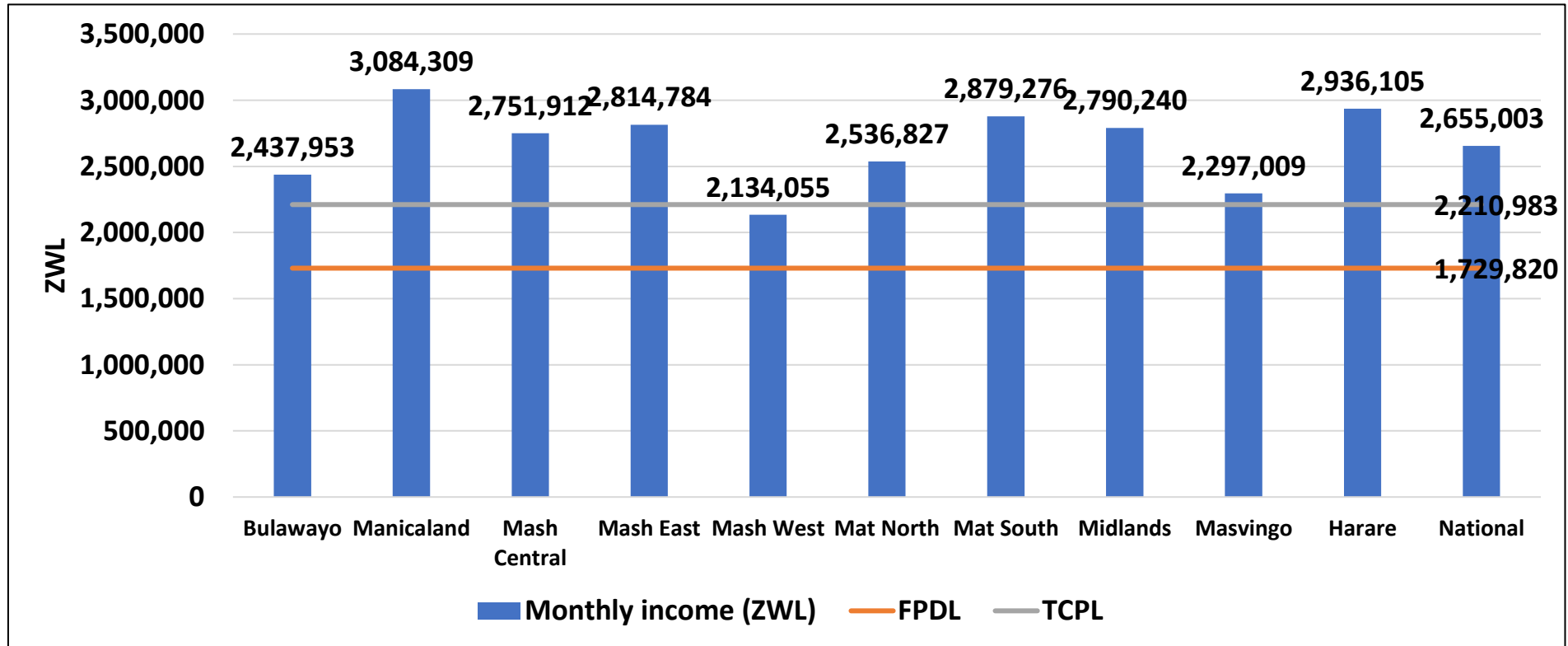
Income and Expenditure

Household Main Income Sources



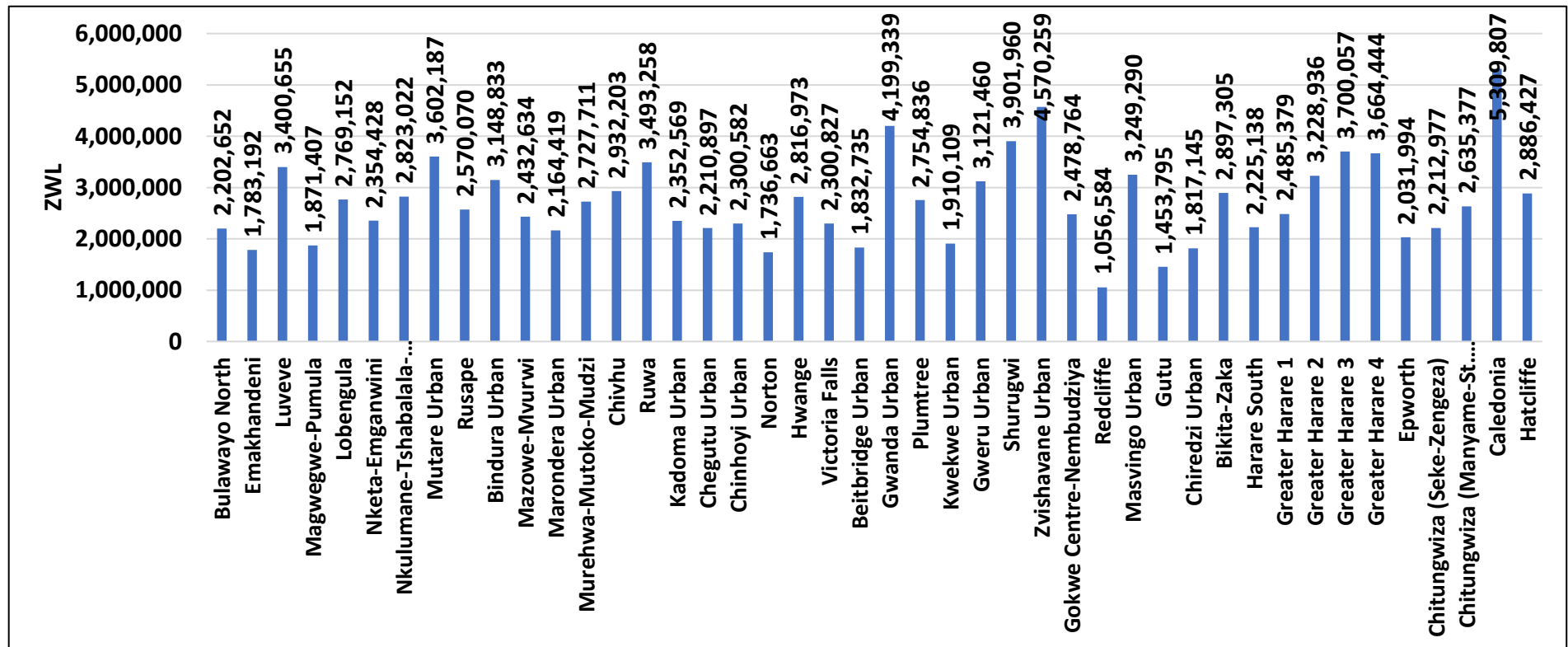
- Salaries/wages (29%), casual labour (25%) and vending (23%) were the main household income sources

Average Household Monthly Income (ZWL)



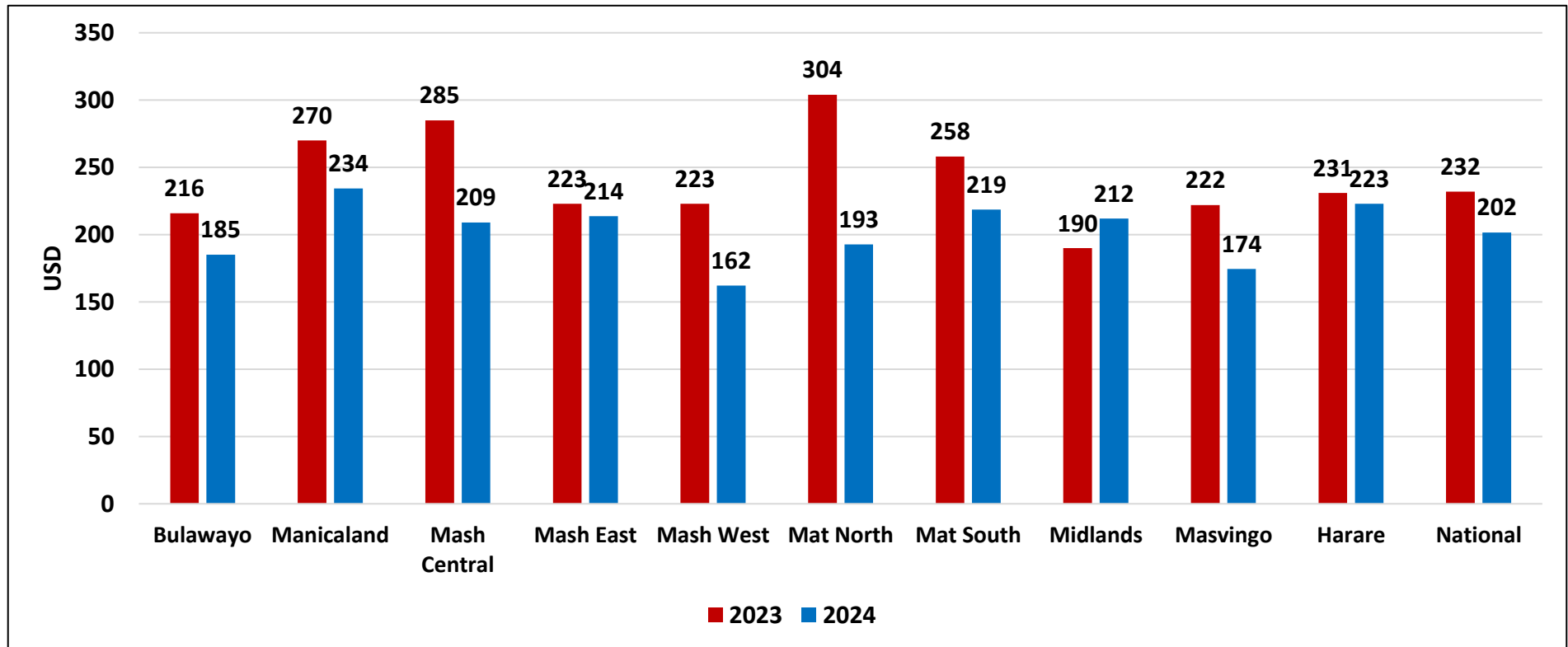
- Manicaland had the highest average household monthly income at ZWL3,084,309. Government is complimented for maintaining an enabling economic environment.

Average Household Monthly Income by Domain (ZWL)



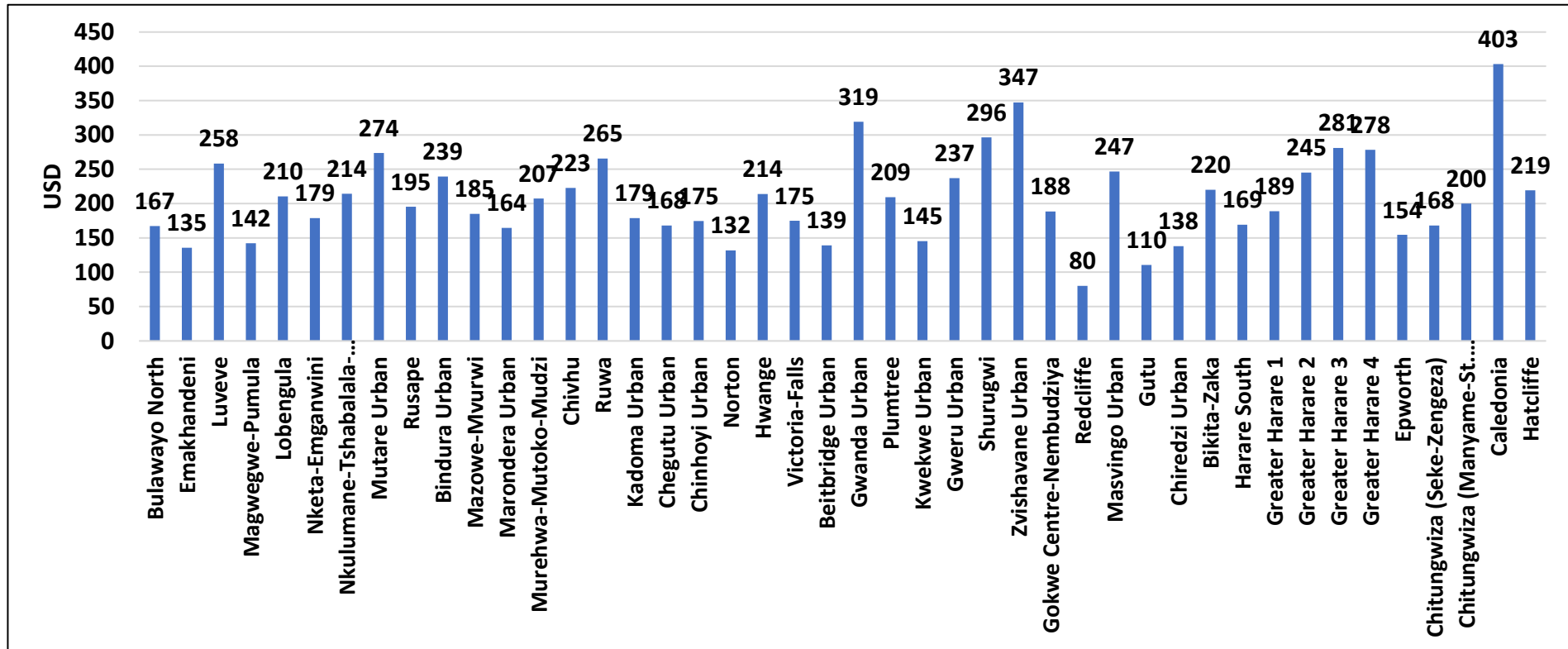
- Caledonia (ZWL 5,309,807) had the highest average household monthly income in ZWL.

Average Household Monthly Income (USD)



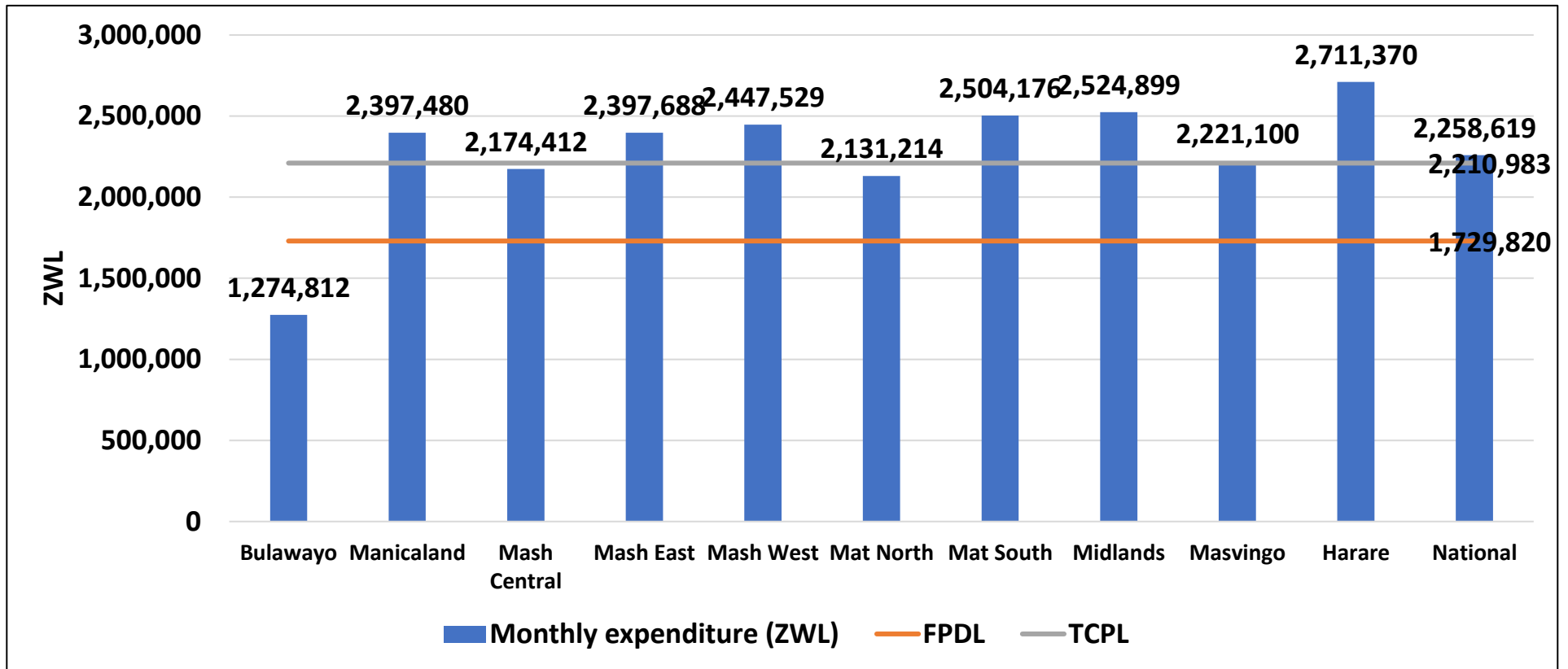
- National average household monthly income decreased from USD232 in 2023 to USD 202 in 2024.
- Manicaland (USD 234) had the highest average household monthly income.
- **NB: The USD monthly income and expenditure was calculated using the RBZ Auction rate of Tuesday 20 February 2024.**

Average Household Monthly Income by Domain (USD)



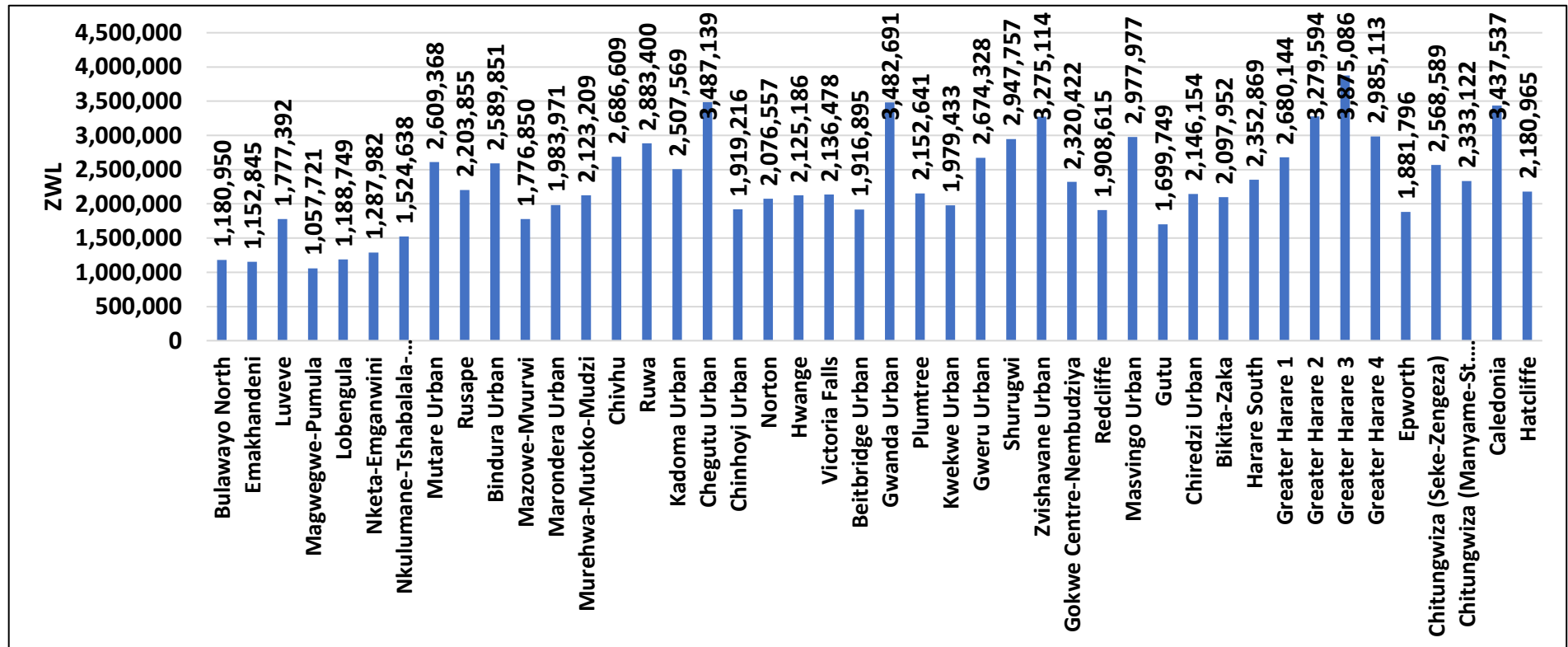
- Caledonia (USD 403), Zvishavane (USD 347) and Gwanda (USD 319) had the highest average monthly incomes in 2024.

Average Household Monthly Expenditure (ZWL)



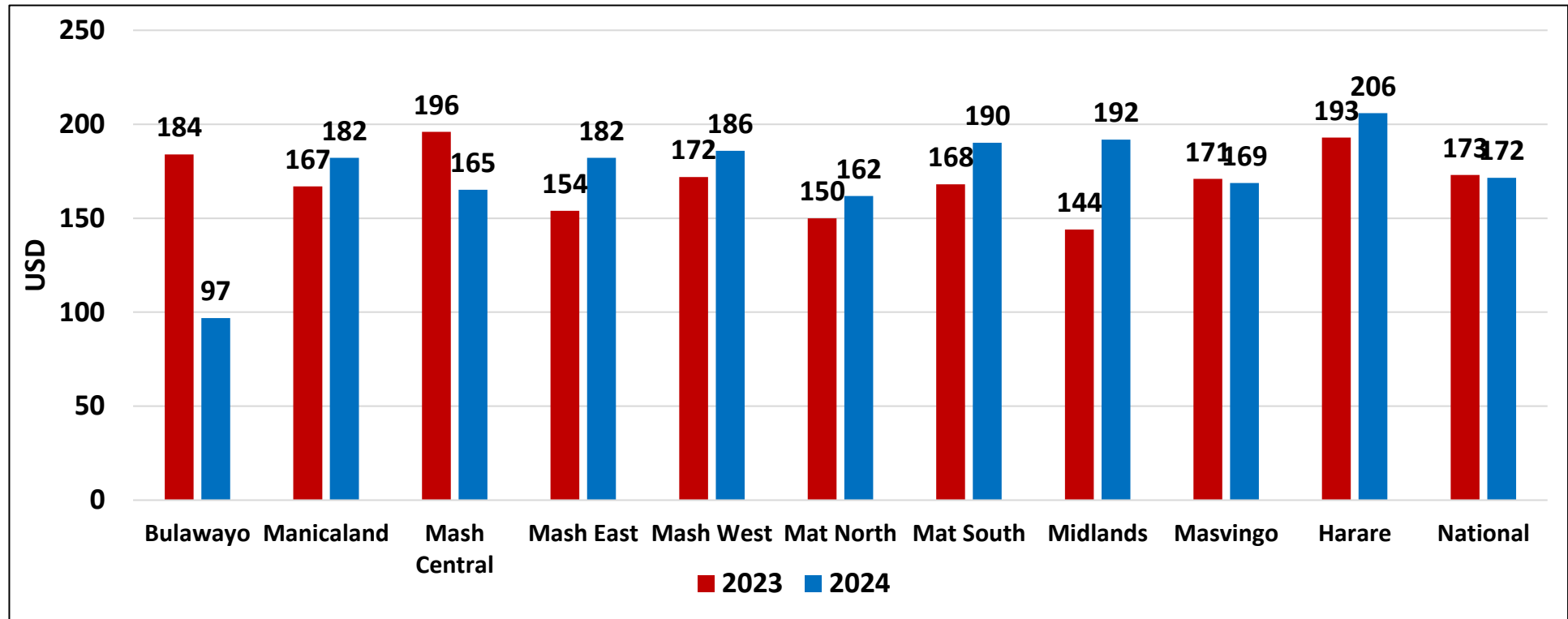
- Harare (ZWL 2,711,370) had the highest average household monthly expenditure.

Average Household Monthly Expenditure (ZWL) by Domain



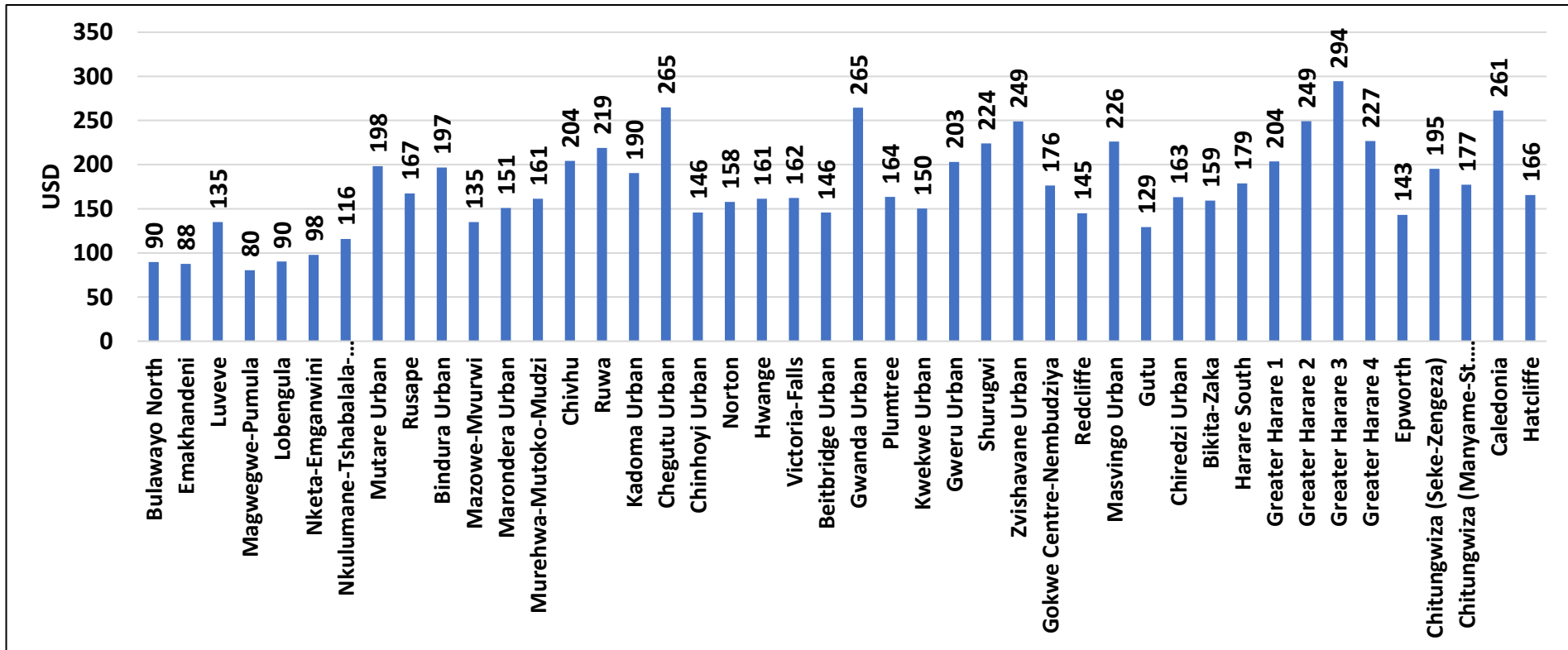
- Greater Harare 3 had the highest monthly expenditure (ZWL 3,875,086).

Average Household Monthly Expenditure (USD)



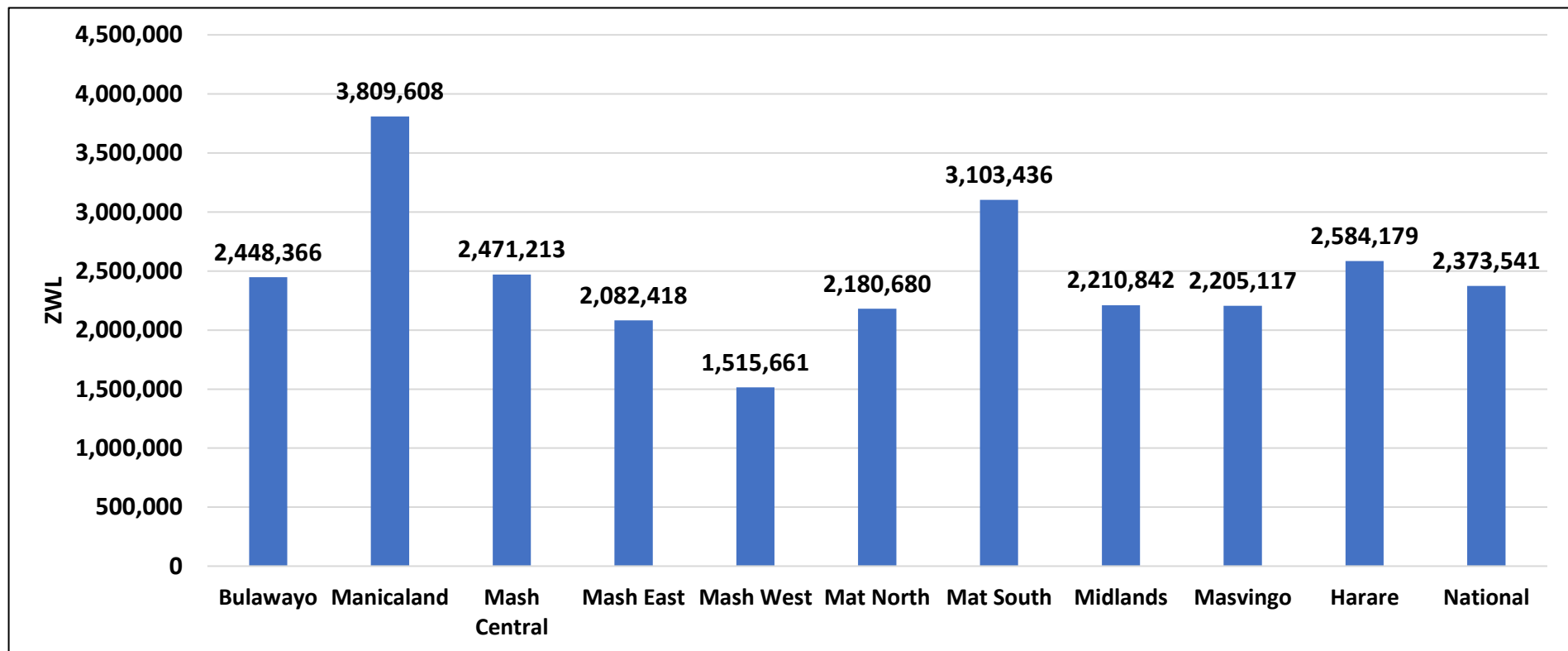
- Government's success in maintaining a stable economic environment (Income vs Expenditure) is noted as evidenced by stable national average household monthly expenditure of USD 172.
- Harare (USD 206) had the highest average monthly expenditure while Bulawayo had the least (USD 97).

Average Household Monthly Expenditure (USD) by Domain



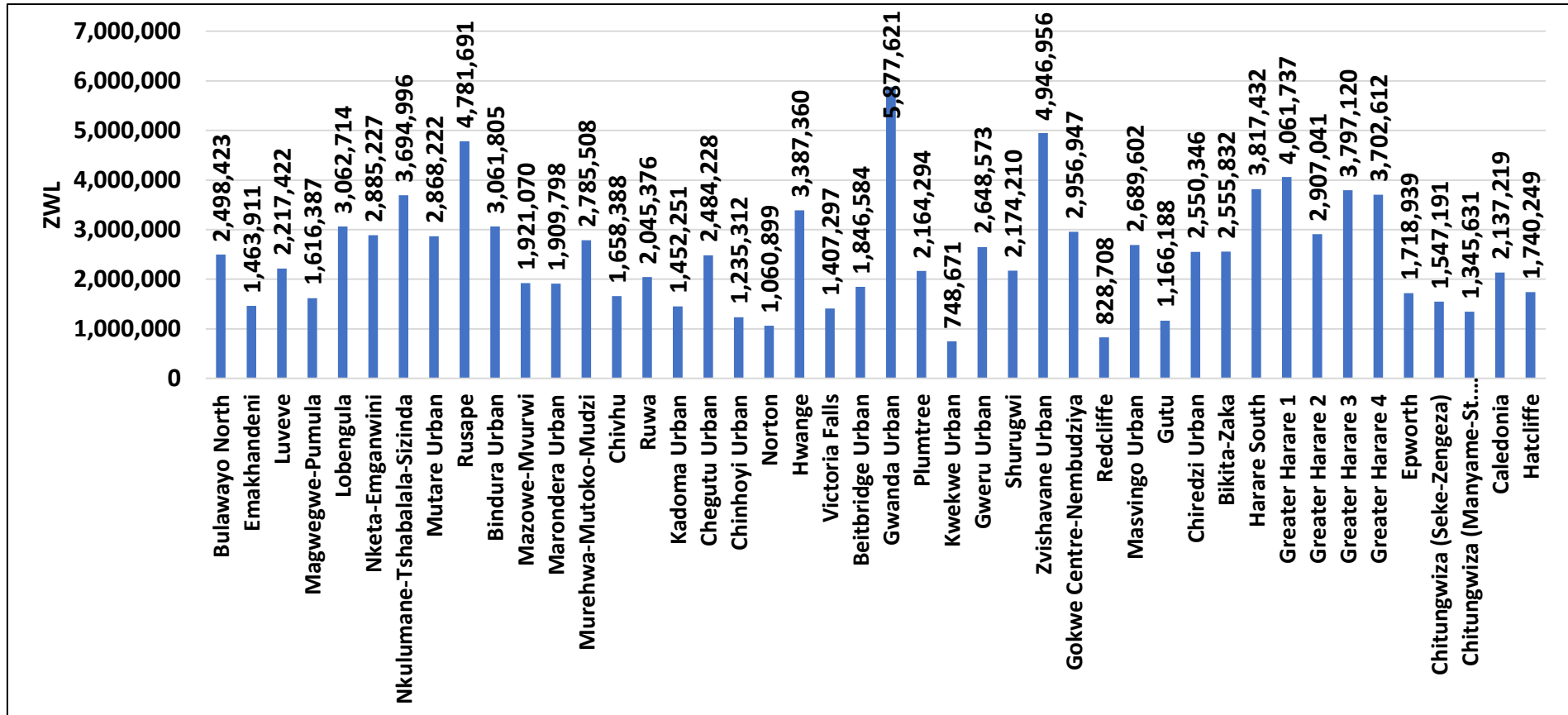
- Greater Harare 3 had the highest average monthly expenditure of USD 294 while Magwegwe-Pumula (USD80) had the lowest.

Average Household Expenditure (ZWL) for 6 Months



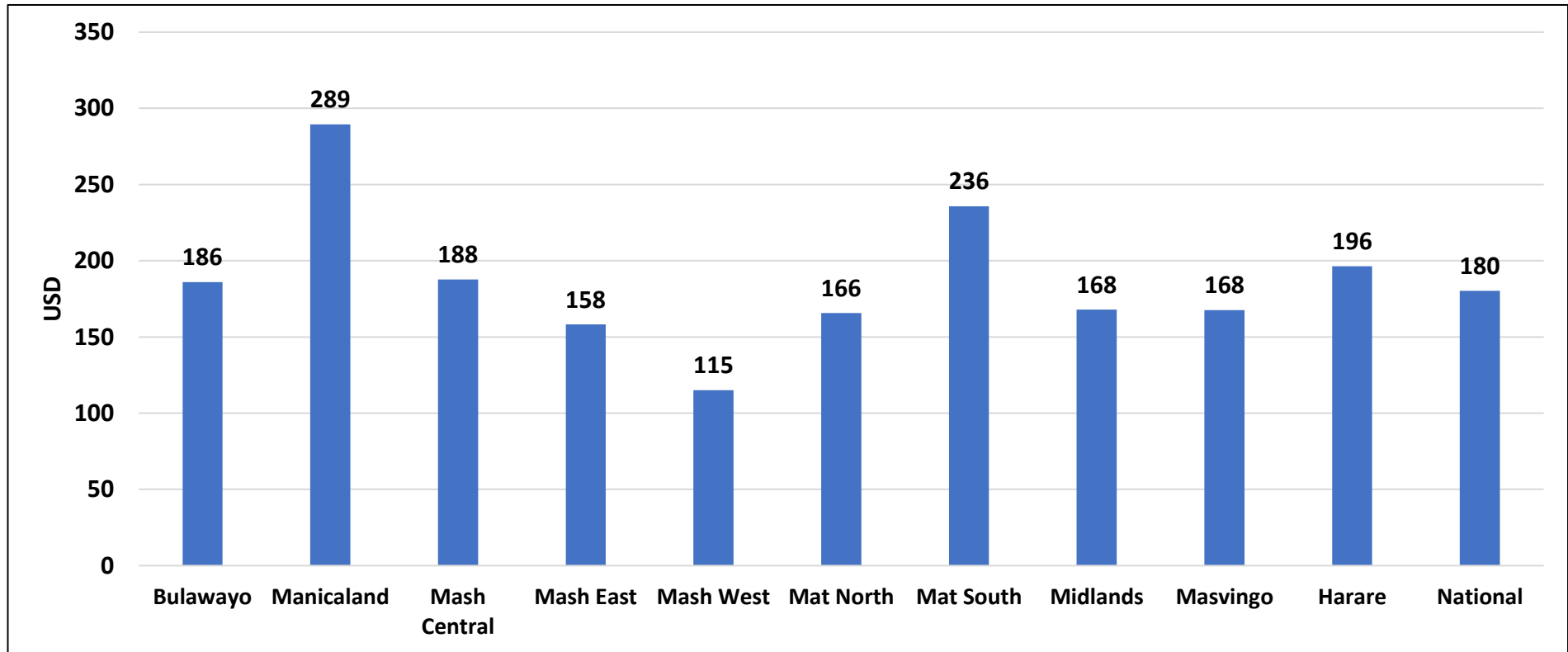
- National average household expenditure for 6 months was ZWL 2,373,541.
- Manicaland (ZWL 3,809,608) had the highest average household expenditure for 6 months.

Average Household Expenditure for 6 Months (ZWL)



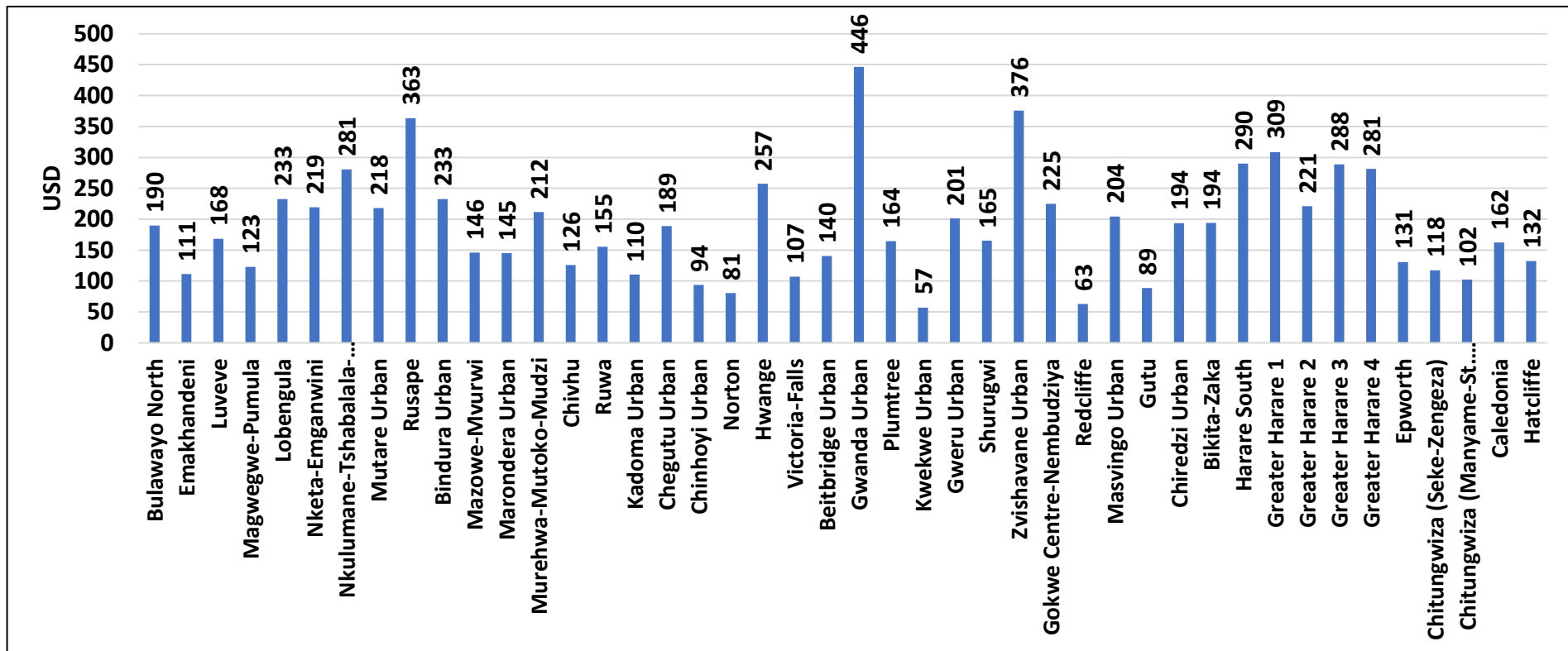
- Gwanda Urban (ZWL 5,877,621) had the highest average household expenditure for 6 months.

Average Household Expenditure for 6 Months (USD)



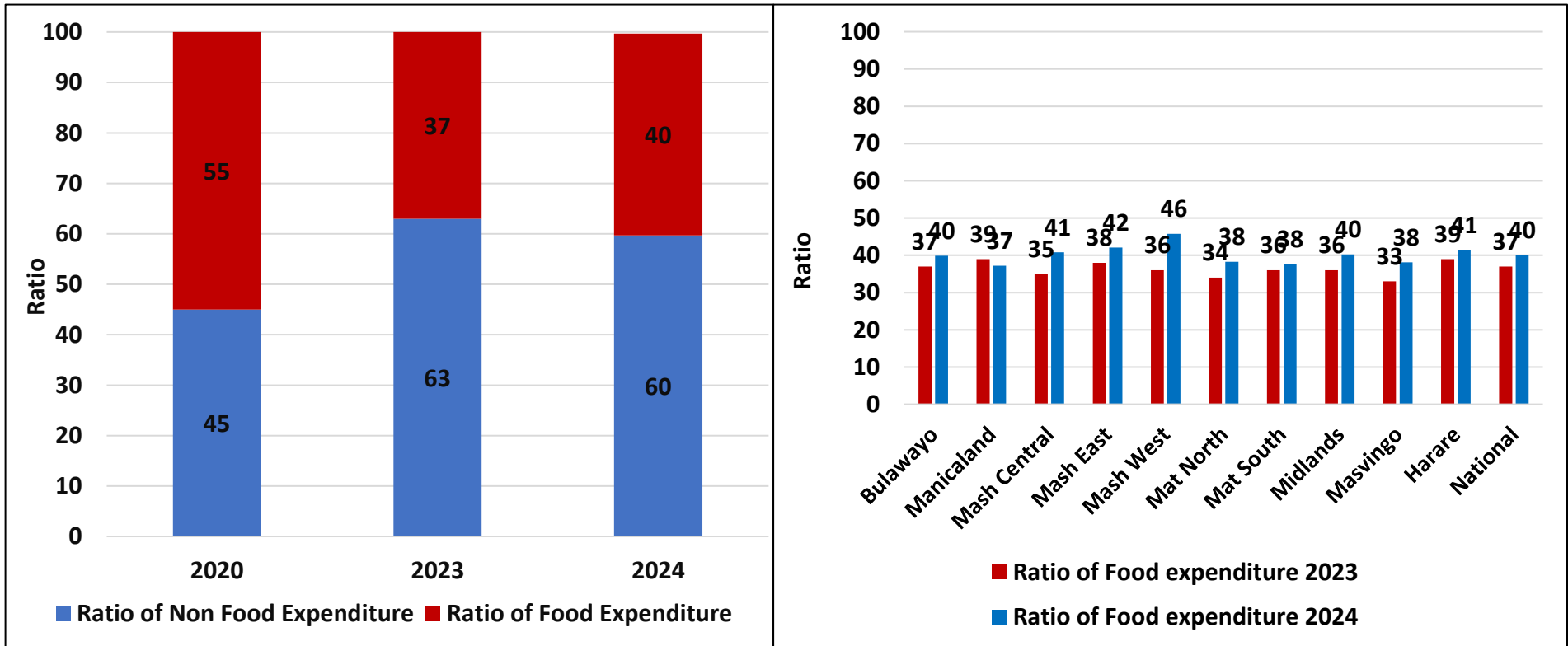
- The national average six months expenditure was USD 180. Manicaland (USD 289) had the highest, while Mashonaland West (USD 115) had the least.

Average Household Expenditure for Six Months by Domain (USD)



- Gwanda (USD 446) had the highest expenditure while Kwekwe (USD 57) had the least.

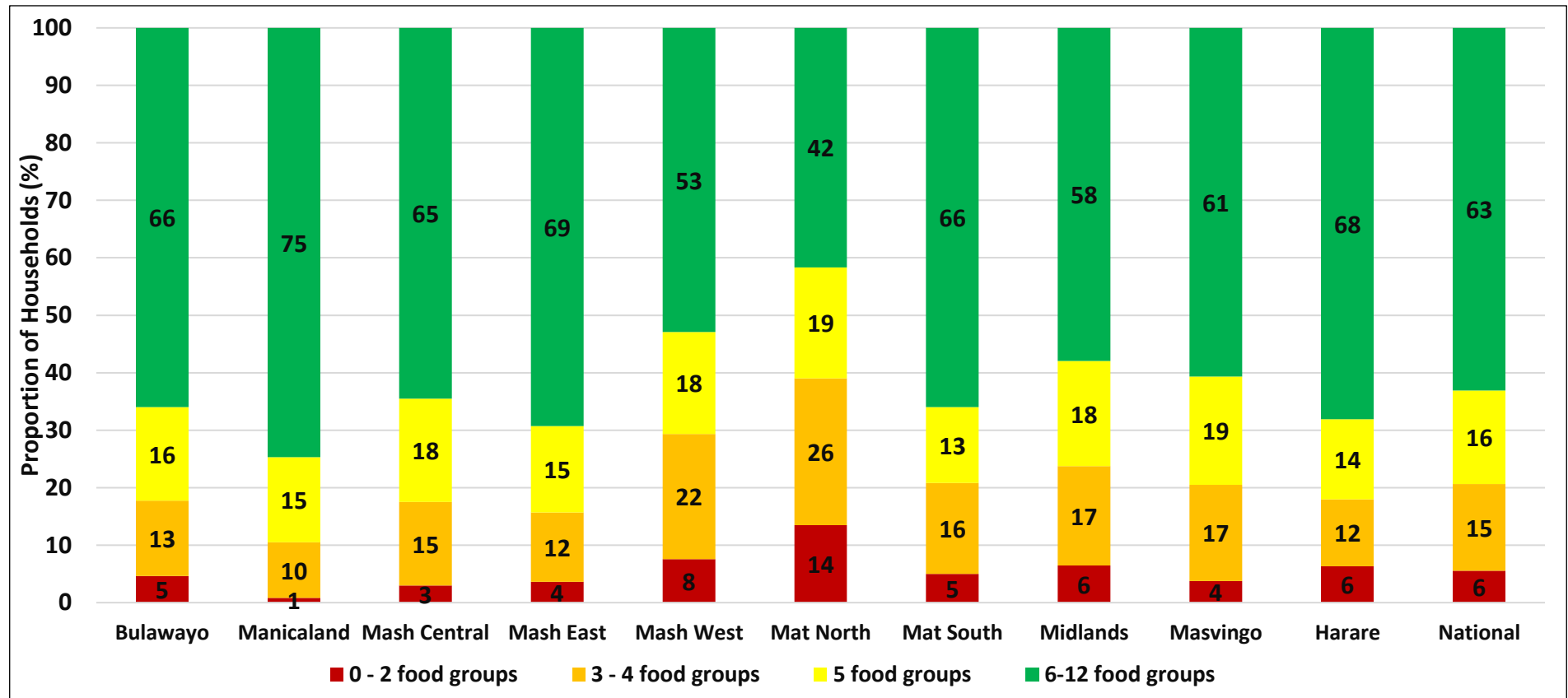
Food Expenditure Ratio by Year



- Food Expenditure ratio increased to 40% in 2024 compared to 37% in 2023.
- Mashonaland West (46%) had the highest food expenditure share while Manicaland (37%) had the least.

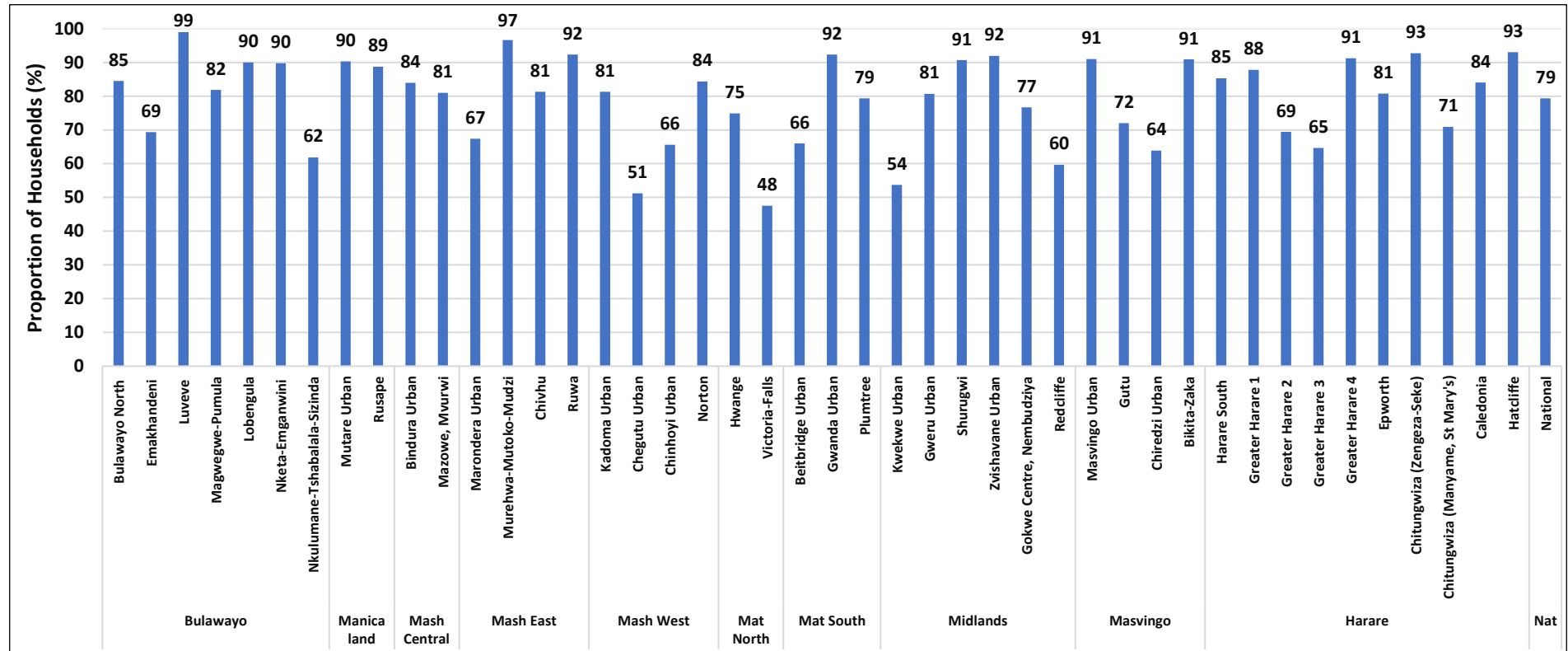
Household Consumption Patterns

Household Dietary Diversity Score (HDDS)



- Household Dietary Diversity Score was high across the provinces with 79% of households at the national level consuming 5 or more food groups. There is need to continue implementing high impact economic measures that have resulted in high food access.

Households Consuming ≥ 5 Food Groups



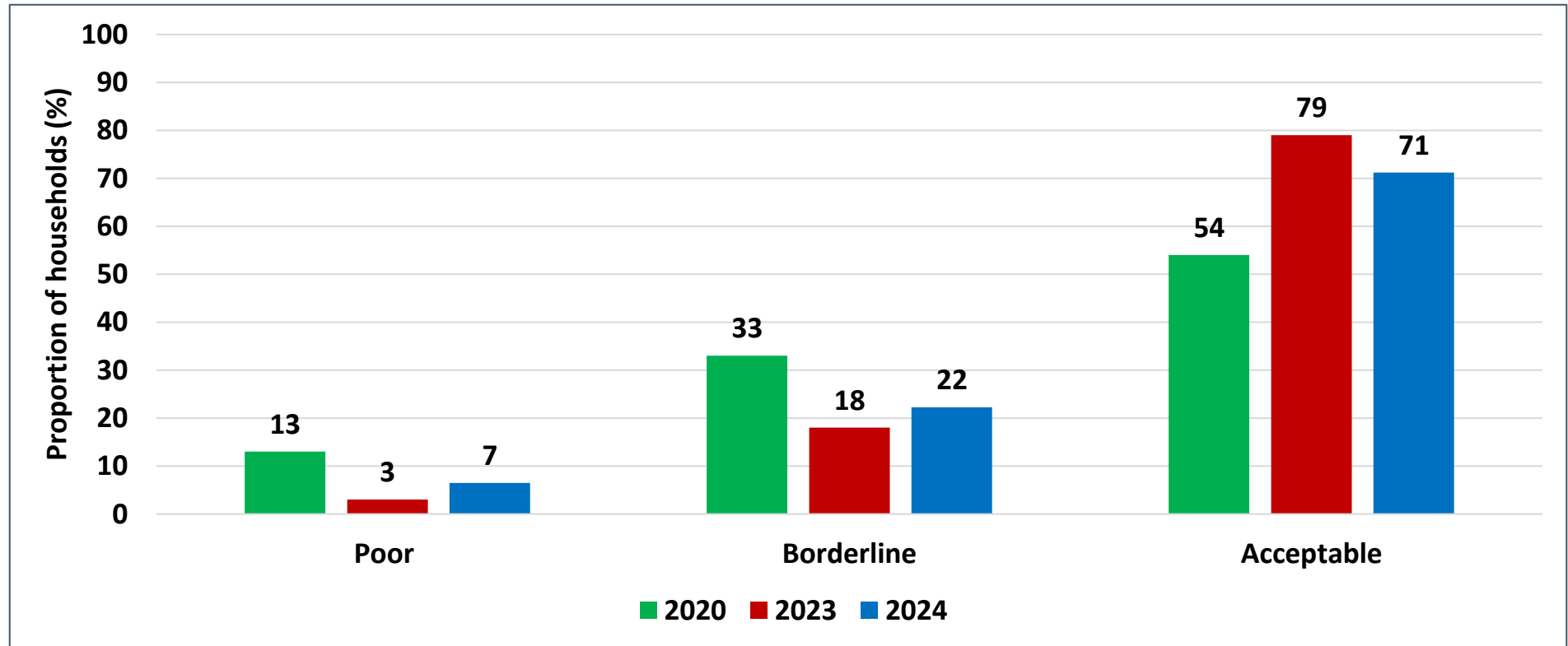
- All domains, (except Victoria Falls 48%) had over 50% of their households consuming at least 5 food groups.

Food Consumption Score-Nutrition

Food Consumption Score Groups

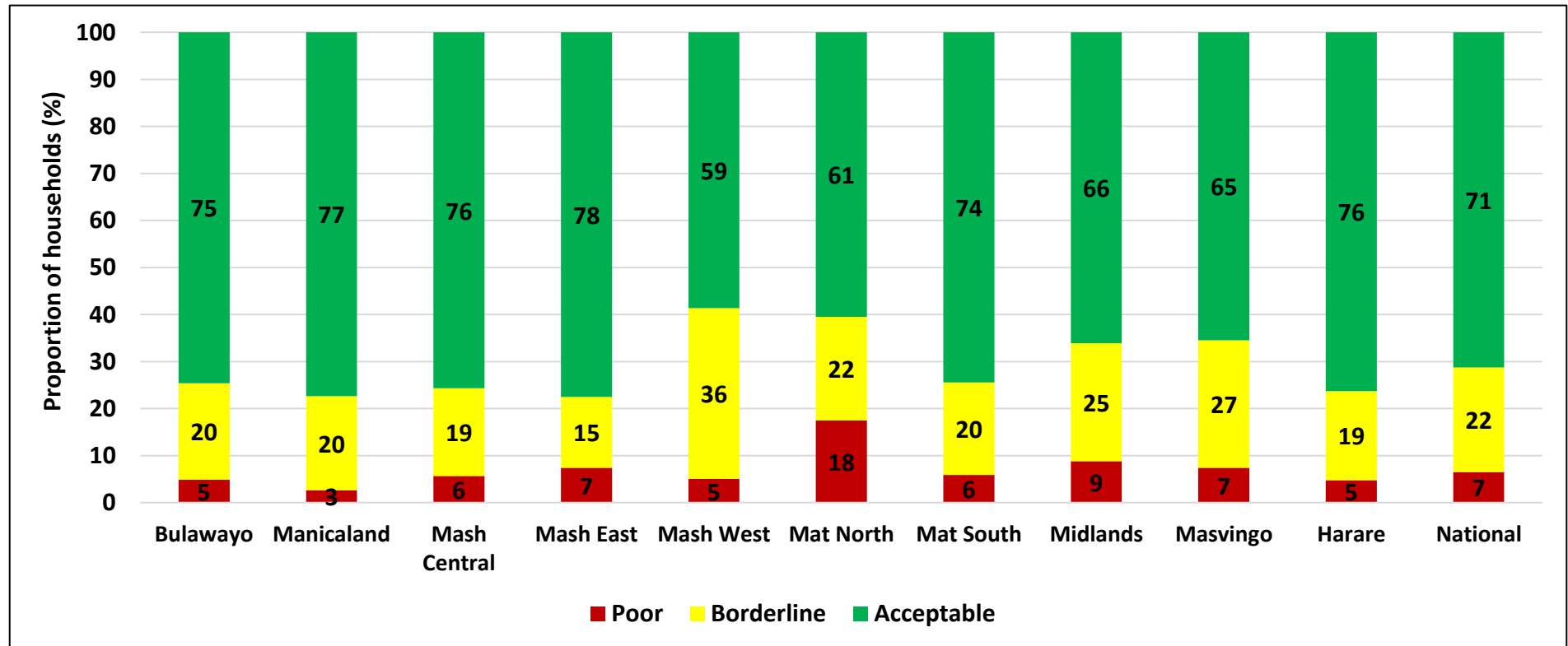
Food Consumption Score Groups	Score	Description
POOR	0-21	An expected consumption of staple 7 days, vegetables 5-6 days, sugar 3-4 days, oil/fat 1 day a week, while animal proteins are totally absent
BORDERLINE	21.5-35	An expected consumption of staple 7 days, vegetables 6-7 days, sugar 3-4 days, oil/fat 3 days, meat/fish/egg/pulses 1-2 days a week, while dairy products are totally absent
ACCEPTABLE	>35	As defined for the borderline group with more number of days a week eating meat, fish, egg, oil, and complemented by other foods such as pulses, fruits, milk

Food Consumption Score



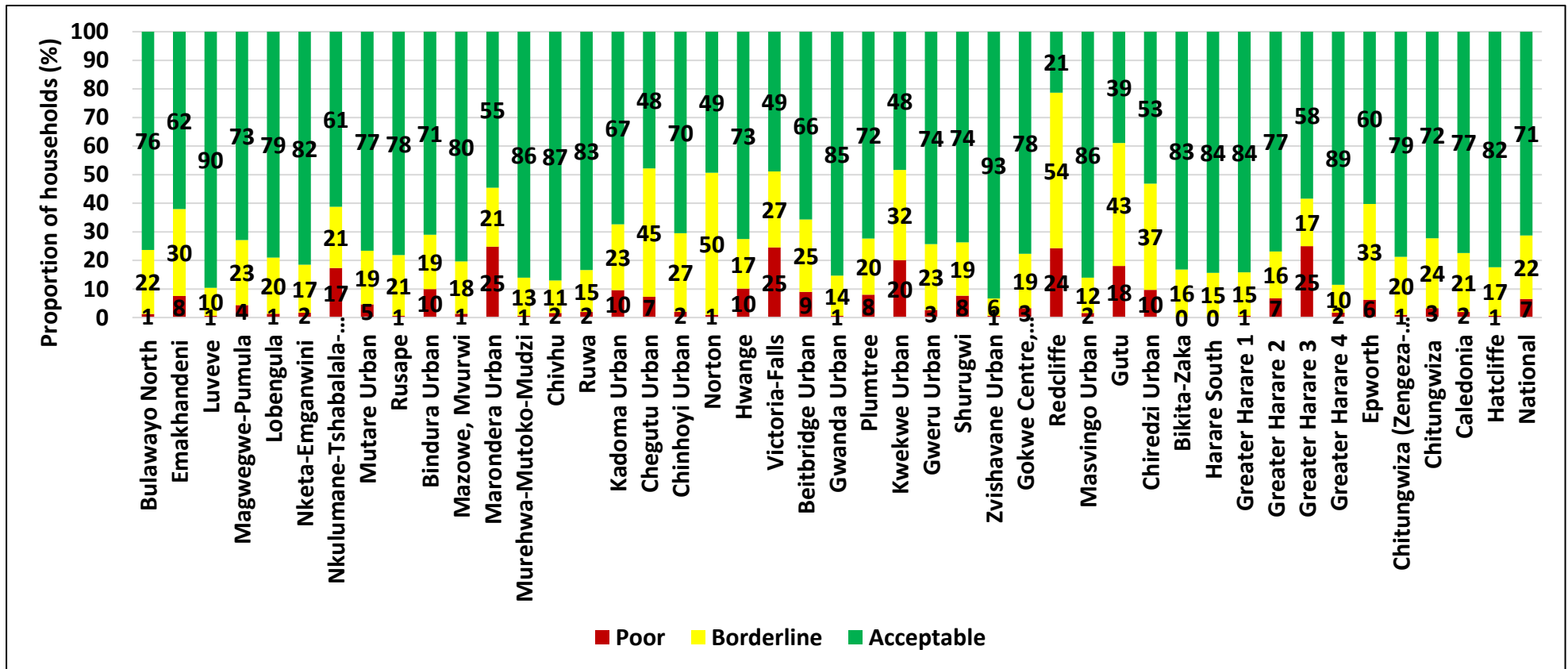
- Nationally, 71% of urban households consumed acceptable diets which include meat, fish, egg, oil, and complemented by other foods such as pulses, fruits and milk.

Food Consumption Score by Province



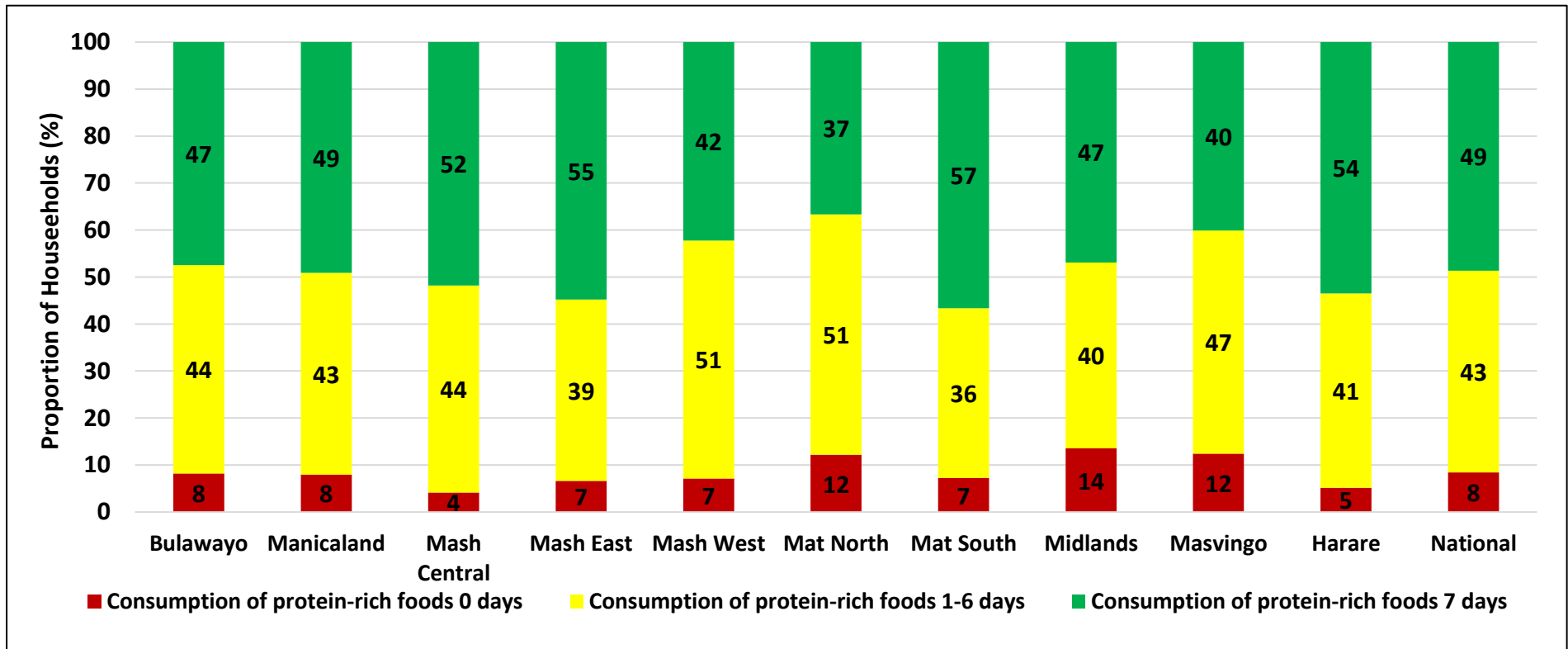
- Mashonaland East (78%) and Manicaland (77%) had the highest proportion of households consuming acceptable diets.
- Mashonaland West (59%) and Matabeleland North (61%) had the least proportion of households consuming acceptable diets.
- Matabeleland North had the highest proportion of households (18%) consuming poor diets.

Food Consumption Score by Domain



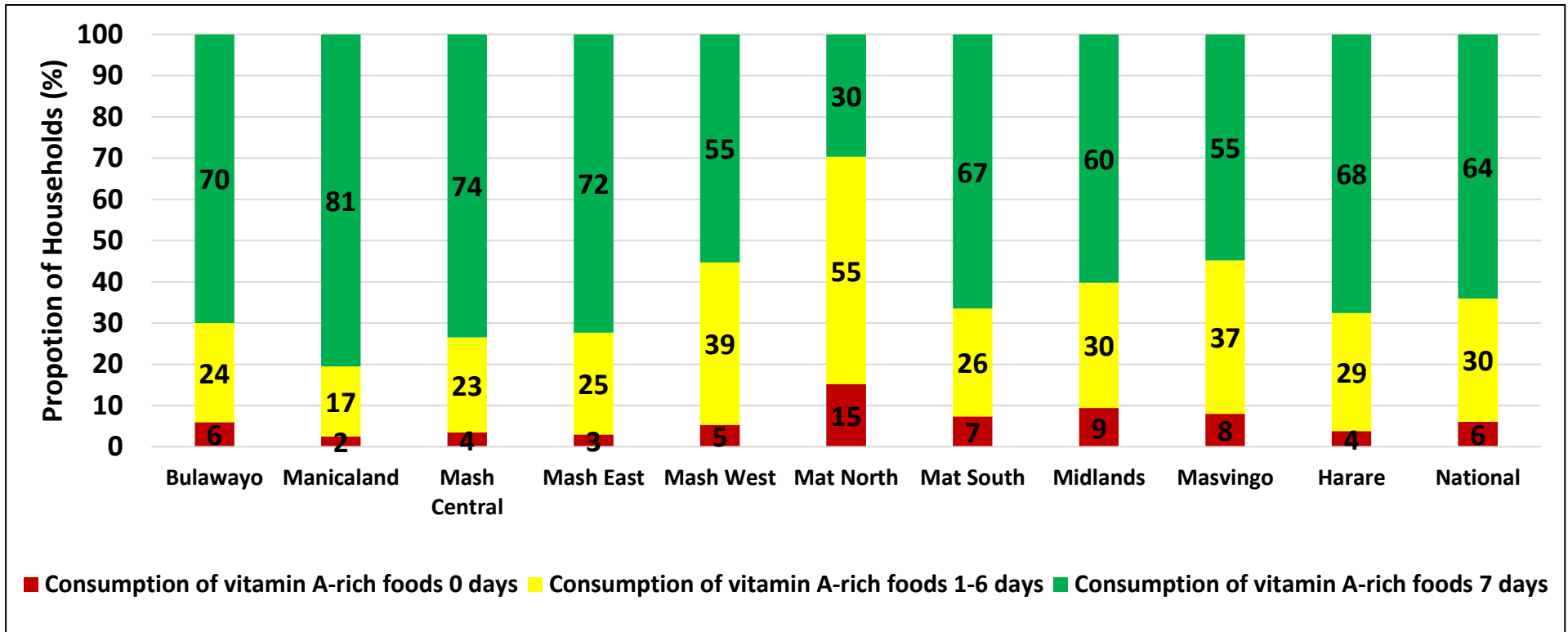
- Attention should be given to Greater Harare 3, Redcliffe, Victoria Falls and Marondera (all above 20%), which had the highest proportion of households that consumed poor diets.

Consumption of Protein Rich Foods by Province



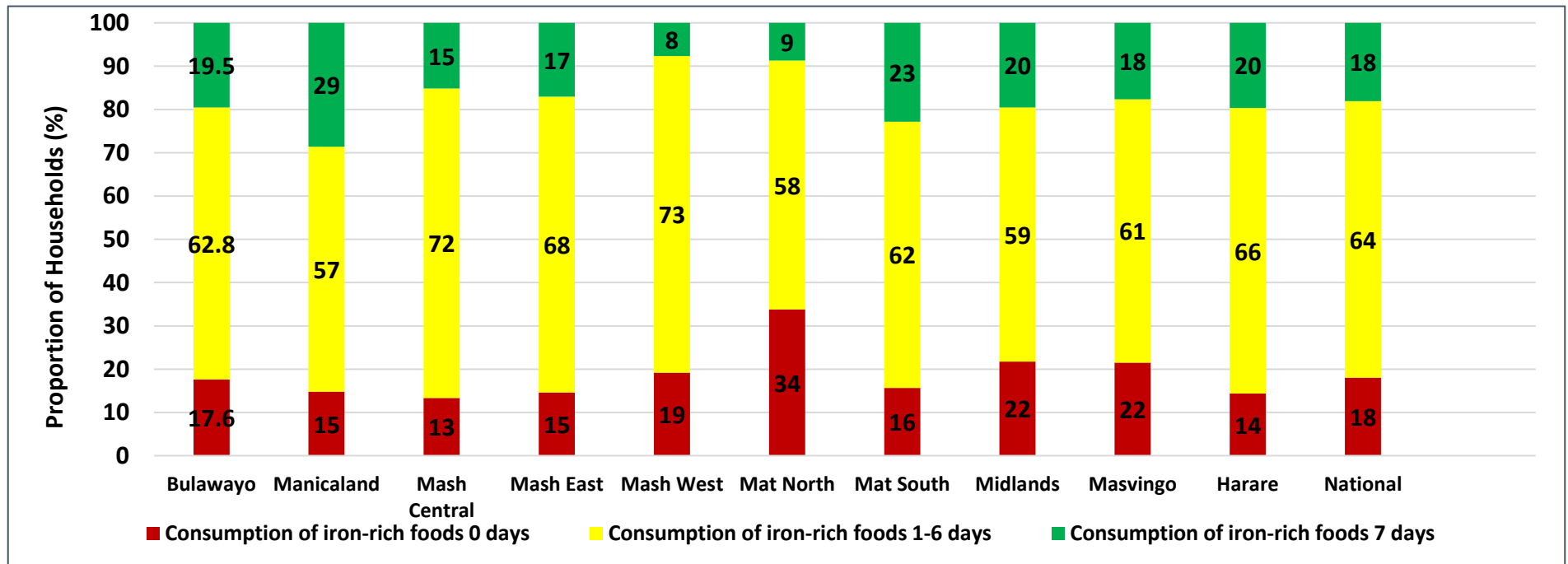
- Nationally, 92% of urban households consumed protein-rich foods between 1 to 7 days prior to the survey.
- About 49% of urban households consumed protein rich foods for the seven days prior to the survey.
- Matabeleland South (57%) had the highest proportion of households that consumed protein rich foods for the seven days prior to the survey.
- Midlands (14%) had the highest proportion of households that did not consume any protein rich foods in the seven days prior to the survey.

Consumption of Vitamin A Rich Foods by Province



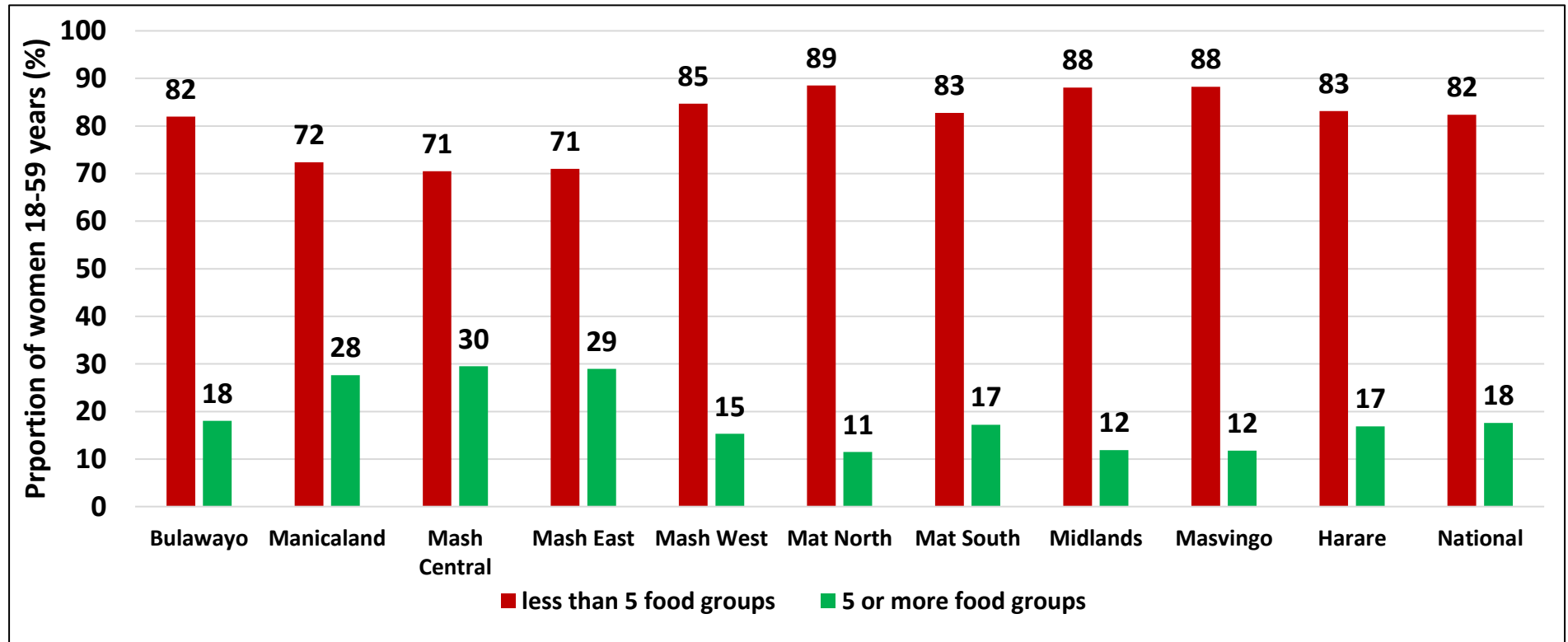
- At least 94% of the households consumed Vitamin A rich foods for 1 to 7 days prior to the survey. Sixty four percent of the households consumed Vitamin A rich foods for the 7 days prior to the survey.
- Manicaland (81%) had the highest proportion of households that consumed Vitamin A rich foods for the 7 days prior to the survey.
- Matabeleland North (15%) had the highest proportion of households that did not consume vitamin A rich foods.

Consumption of Iron Rich Foods by Province



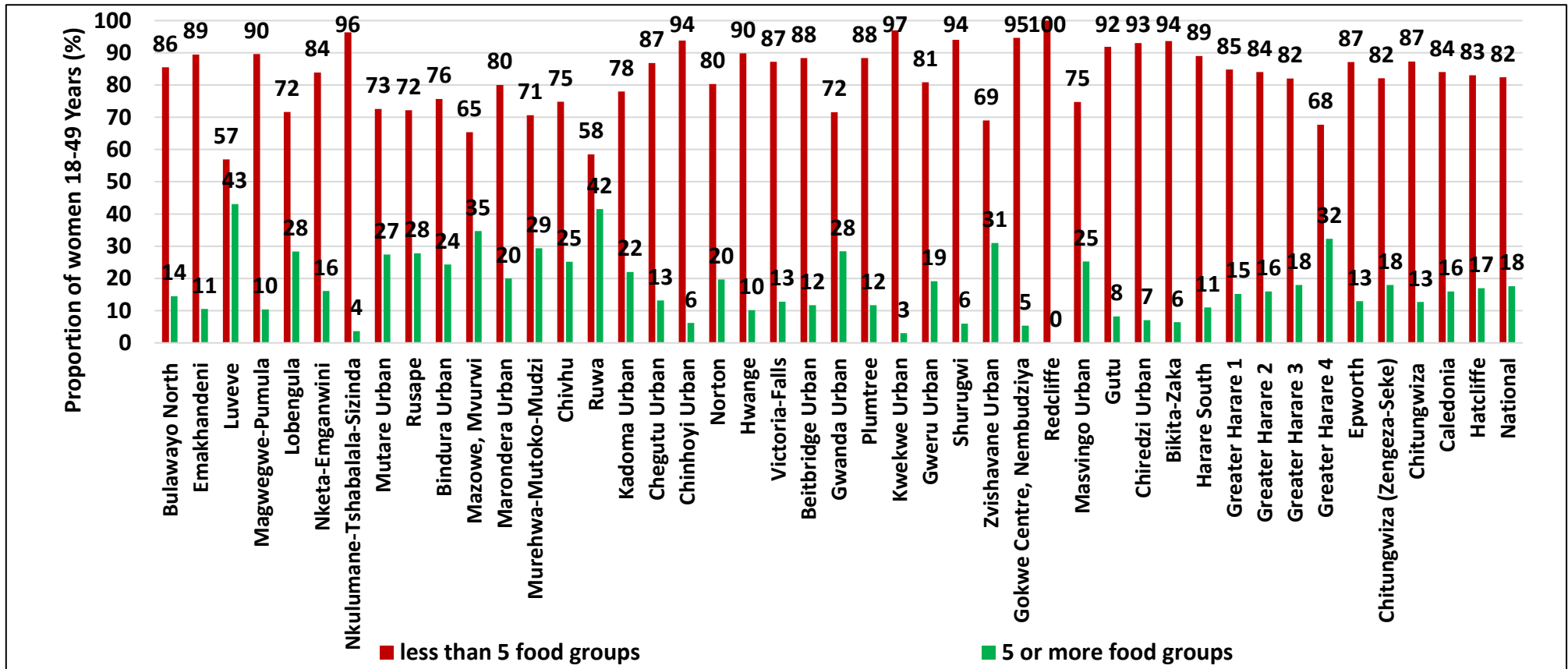
- Eighty two percent of the households consumed iron rich foods for 1 to 7 days prior to the survey. A small proportion of the households (18%) had consumed iron rich foods for 7 days prior to the survey.
- Matabeleland North (34%) had the highest proportion of households that did not consume iron rich foods at all.
- Over half of households across all provinces consumed iron rich foods 1-6 days in a week.
- Mashonaland Central (72%) and Mashonaland West (73%) had the highest proportion of households that consumed iron rich foods for 1-6 to days compared to the national average of 64%.

Women Minimum Dietary Diversity (MDD-W)



- Nationally, 18% of women consumed foods above the recommended five food groups within the 24-hour recall period of the survey.
- The majority of women of child bearing age consumed food from less than 5 food groups within a 24-hour recall and that is a cause for concern.
- Mashonaland Central had the highest proportion of women who consumed food from five or more food groups.

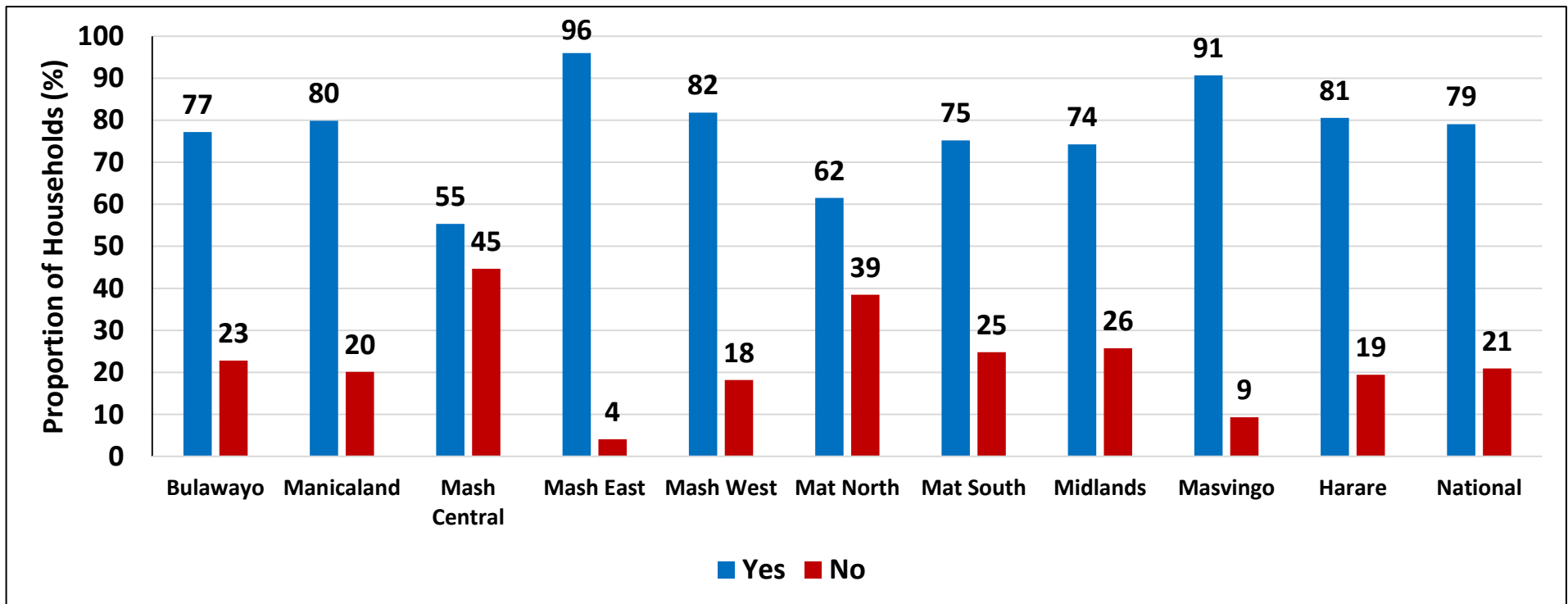
Women Minimum Dietary Diversity by Domain



- Across all the domains, the majority of women consumed food from less than 5 food groups and that is a cause for concern.
- Redcliffe (100%) had the highest proportion of women who consumed food from less than five food groups.
- Luveve (43%) and Ruwa (42%) had the highest proportion of women who consumed food from five or more food groups.

Iodisation

Proportion of Households With Iodised Salt



- Iodised salt is an important source of iodine. Iodine is a key nutrient in promoting growth, metabolism and prevention of goitre.
- One in every five households had salt that had a negative result upon testing.

Sources of Salt Without Iodine

	No Iodine Present	
	Locally Packaged Brands	Imported Brands
Bulawayo	22.12	0.88
Manicaland	20.00	0.00
Mash Central	44.13	0.17
Mash East	3.86	0.14
Mash West	17.19	0.81
Mat North	38.15	0.85
Mat South	21.70	3.30
Midlands	24.40	0.60
Masvingo	8.45	0.35
Harare	17.95	1.05
National	21.80	0.81

- Nationally, 21% households had salt that had a negative result upon testing, of which 21.8% of the households had salt which was from locally packaged brands and 0.81% from a foreign source.

Child Health

Vitamin A Supplementation for Children 6-59 Months

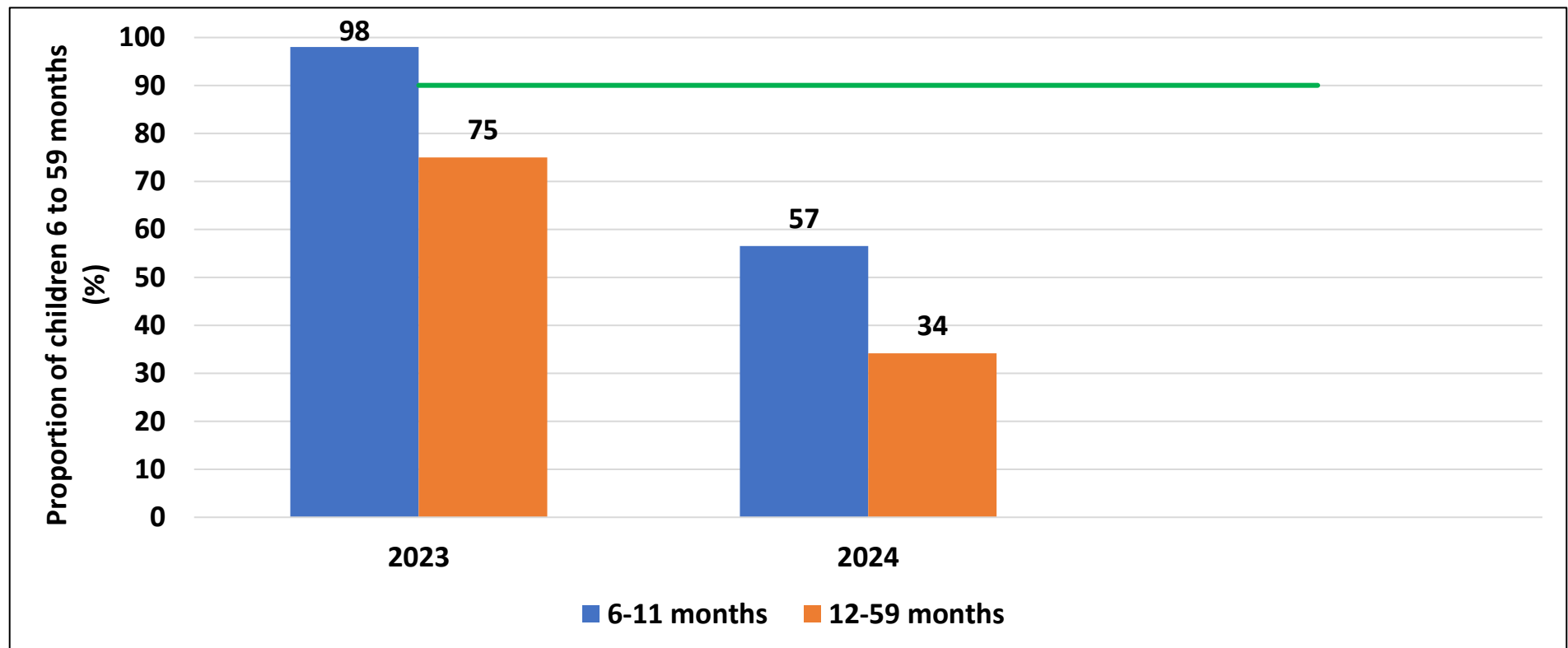
The Zimbabwe VAS schedule is presented below:

Age Group	Vitamin A Dosage	Timing for Administration
Below 6 months	Do not give	N/A
6-11 months	100 000 IU	Once at age 6 months
12-59 months	200 000 IU	Once every 12 months from age 6 months, until child reaches 5 years

The World Health Organization recommends Vitamin A Supplementation (VAS) once every six months for children in the age group of 6-59 months.

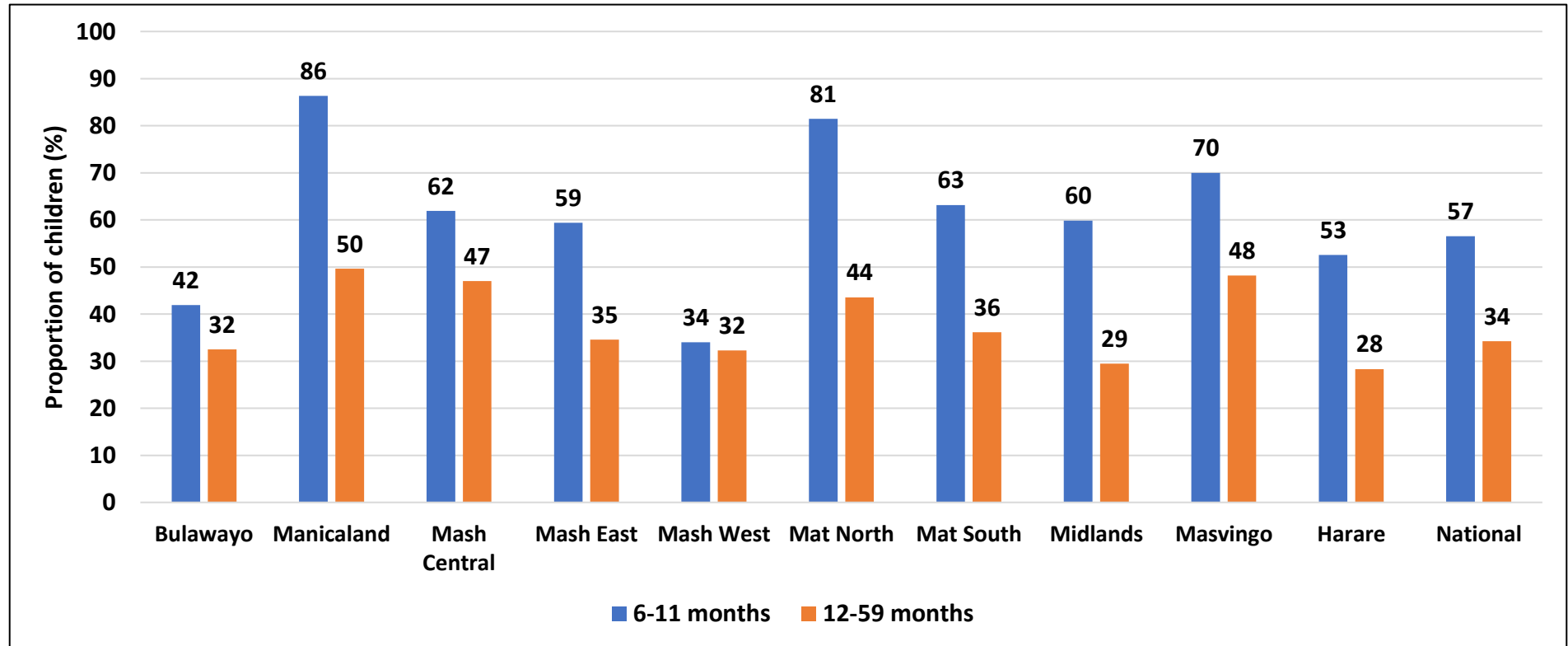
VAS is proven to reduce all cause mortality, incidence of diarrhea and measles in children.

Vitamin A Supplementation for Children 6-59 Months



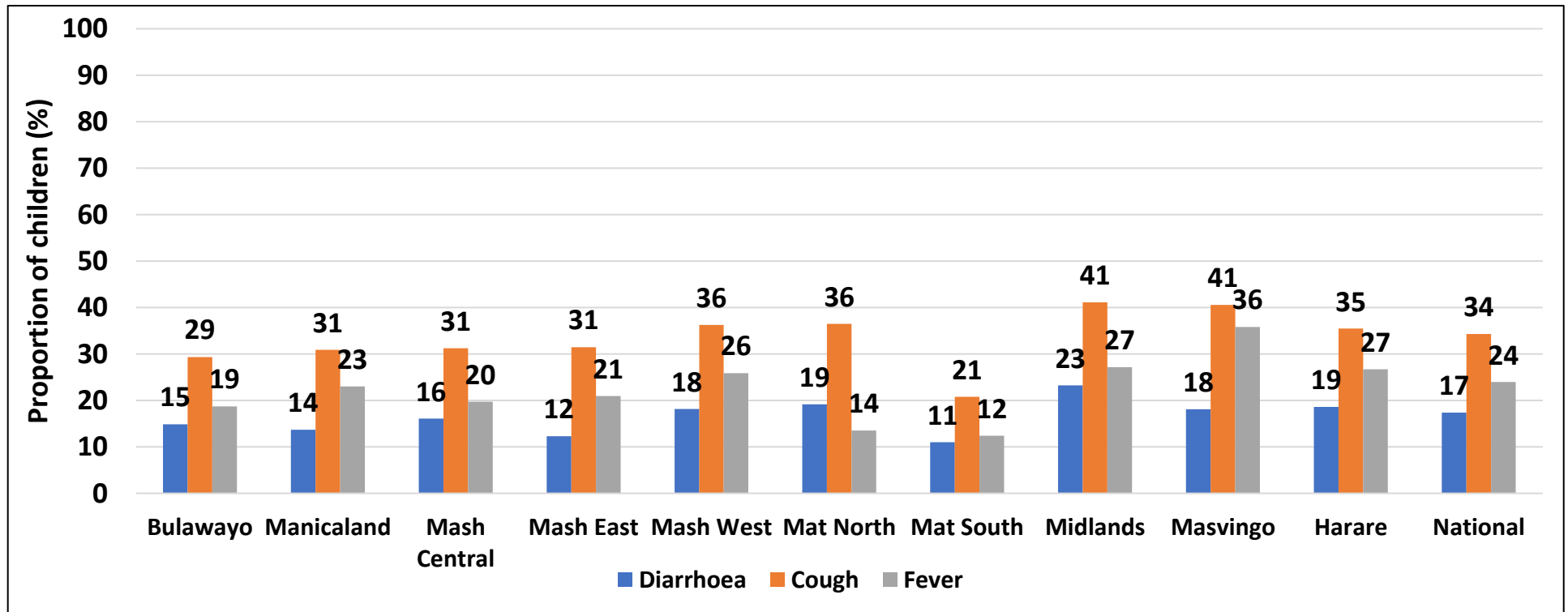
- Overall, Vitamin A supplementation for children decreased for the two age categories.

Vitamin A Supplementation



- Nationally, 57% and 34% of children 6-11 months and 12-59 months received the required one and two doses of Vitamin A, respectively.
- Manicaland (86%) and Matabeleland North (81%) had the highest proportion of children 6-11 months who received the required dose of Vitamin A.
- Low Vitamin A supplementation coverage for both age groups is a cause for concern. This is below the 90% coverage target for the national intervention.

Child Illness (6-59 Months)



- Cough was the most reported illness for children across all the provinces.
- Midlands and Masvingo (41%) had the highest proportion of children with cough two weeks prior to the survey.
- Masvingo (36%) had the highest proportion of children with fever while Matabeleland South (12%) had the lowest. Diarrhoea was highest in Midlands (23%).

Child Illness (6-59 Months) by Domain

Domain	Diarrhoea (%)	Cough (%)	Fever (%)	Domain	Diarrhoea (%)	Cough (%)	Fever (%)
Bulawayo North	18.2	33	20.5	Gwanda Urban	6.8	20.3	21.5
Emakhandeni	26.6	30.8	22.5	Plumtree	5.9	17	7.8
Luveve	8.4	8.2	8.2	Kwekwe Urban	18.2	21	5.7
Magwegwe-Pumula	15.7	27.2	21.6	Gweru Urban	19.7	45.7	27.8
Lobengula	11.3	44.7	28	Shurugwi	22.8	36.1	29.1
Nketa-Emganwini	13.1	20.8	8.5	Zvishavane Urban	18.4	61.5	32.7
Nkulumane-Tshabalala-Sizinda	10.3	35.2	18.2	Gokwe Centre, Nembudziya	29.9	45.5	37.4
Mutare Urban	18.7	26	17.3	Redcliffe	33.5	36.4	32.4
Rusape	7.9	36.7	29.7	Masvingo Urban	10.1	49.1	42.2
Bindura Urban	14.6	40.2	29.2	Gutu	34.7	59.8	50
Mazowe, Mvurwi	17.8	21.2	9.1	Chiredzi Urban	24	42.5	41.4
Marondera Urban	14.9	37.8	20.2	Bikita-Zaka	4.7	9.8	7.6
Murehwa-Mutoko-Mudzi	9.4	30.4	22.8	Harare South	19.4	62.1	55.8
Chivhu	13.6	15.9	22.2	Greater Harare 1	21.9	56.2	22.8
Ruwa-Domboshava-Goromonzi	11.5	36.8	19.2	Greater Harare 2	18.1	41.7	27.8
Kadoma Urban	14.9	5	1.4	Greater Harare 3	6.8	18.4	15.5
Chegutu Urban	24.6	52.4	38	Greater Harare 4	10.6	25.2	13.3
Chinhoyi Urban	21.3	33.5	20.4	Epworth	24.6	41.7	31.4
Norton	12.6	46.6	36.9	Chitungwiza (Zengeza)	15.6	33.1	31
Hwange	17.3	28.8	13.7	Chitungwiza (St. Mary's, Manyame)	43.5	27.6	32.5
Victoria-Falls	21.3	44.9	13.4	Caledonia	9.6	22.8	16.9
Beitbridge Urban	20	24.7	7.1	Hatcliffe	14.8	17.5	15.8
				National	17.4	34.3	24

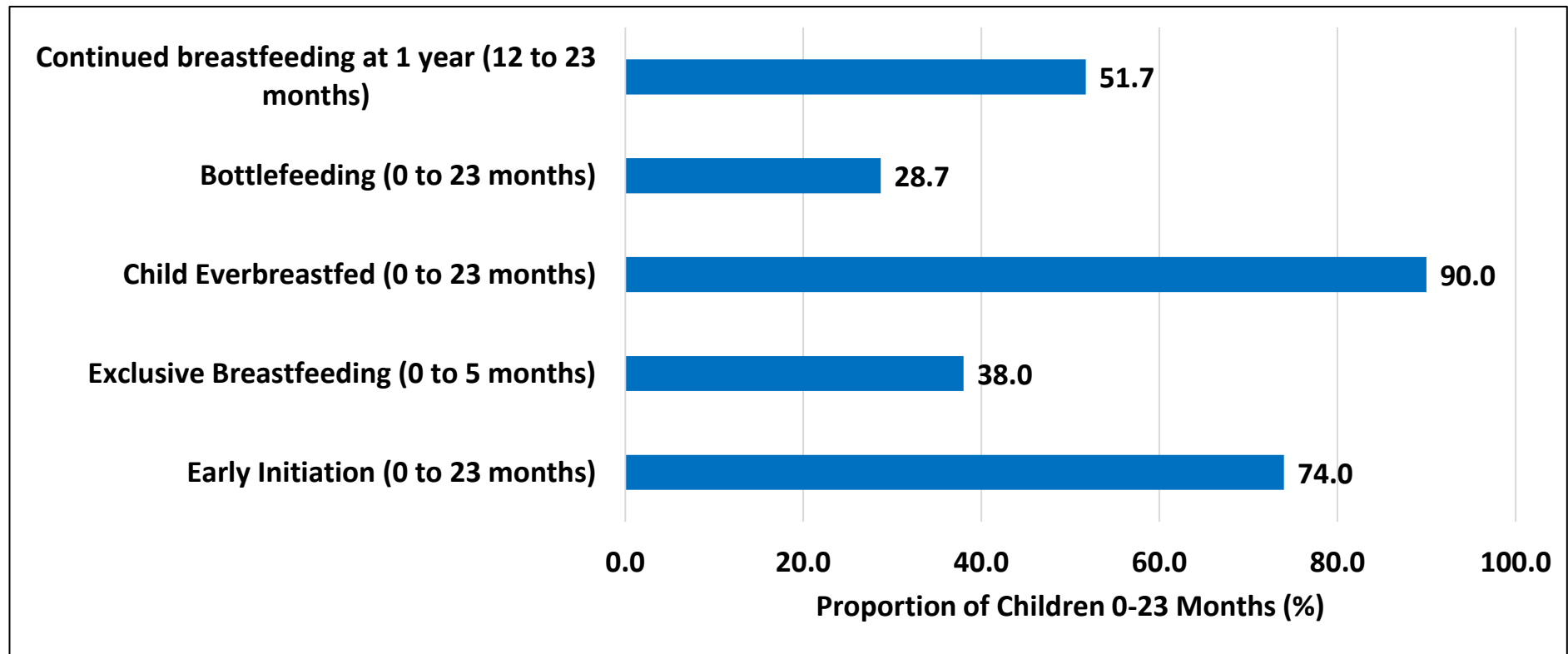
- Cough was the most common illness across most domains except Chitungwiza (St Mary's-Manyame).
- Harare South (62.1%), Zvishavane (61.5%) and Gutu (59.8%) had the highest proportion of children who had cough two weeks prior to the survey.

Infant and Young Child Feeding Practices

Infant and Young Child Feeding

- Infant and young child feeding (IYCF) practices directly affect the health, development and nutritional status of children less than two years of age and ultimately, impact child survival. Improving IYCF practices in children 0–23 months of age is therefore critical to improved nutrition, health and development.
- The World Health Organization (WHO) recommends breastfeeding practices that consist of early initiation of breastfeeding within one hour of birth, exclusive breastfeeding for six months, and continued breastfeeding with complementary feeding for at least two years.
- WHO recommends that children aged 6–23 months be fed a variety of foods to ensure that nutrient needs are met. Food group diversity is associated with improved linear growth in young children. A diet lacking in diversity can increase the risk of micronutrient deficiencies, which may have a damaging effect on children’s physical and cognitive development.
- Poor-quality diets are one of the greatest obstacles to children’s survival, growth, development and learning. During the first two years of life, diets lacking in essential vitamins and minerals can irreversibly harm a child’s rapidly growing body and brain and increase the risk of stunting, wasting and micronutrient deficiencies. Meanwhile, foods high in sugar, fat or salt can set children on the path to unhealthy food preferences, overweight and diet-related diseases.

Summary of Breastfeeding Practices



- The proportion of children (0 to 23 months) who were ever breastfed was 90%.
- Early initiation of breastfeeding was 74%.
- The exclusive breastfeeding rate was 38%. This rate is less than the World Health Assembly target of 50%.
- The proportion of children being bottle fed was 28.7% while continued breastfeeding at 1 year was 51.7%.

Notes

EGG AND/OR FLESH FOOD CONSUMPTION 6–23 MONTHS (EFF)

- WHO guiding principles for feeding breastfed and non-breastfed children state that “meat, poultry, fish or eggs should be eaten daily, or as often as possible”
- There is evidence that children who consume eggs and flesh foods have higher intakes of various nutrients important for optimal linear growth. Consuming eggs is associated with increased intakes of energy, protein, essential fatty acids, vitamin B12, vitamin D, phosphorus and selenium, and with higher recumbent length
- Introduction of meat as an early complementary food for breastfed infants was associated with improved protein and zinc intake. There is also evidence of low prevalence of egg and flesh food intake across many countries.

Indicator definition: percentage of children 6–23 months of age who consumed egg and/or flesh food during the previous day.

SWEET BEVERAGE CONSUMPTION 6–23 MONTHS (SwB)

- WHO guiding principles for complementary feeding advise against giving sweet drinks, such as soft drinks, as they contribute no nutrients other than energy and may displace more nutritious foods.
- Higher intakes of sugar-sweetened beverages (SSBs) have been associated with an increased obesity risk among children of all ages. Early introduction of SSBs (before 12 months of age) is associated with obesity at six years of age. SSB consumption during the complementary feeding period is associated with an increased risk of obesity in childhood.

Indicator definition: percentage of children 6–23 months of age who consumed a sweet beverage during the previous day.

Notes

UNHEALTHY FOOD CONSUMPTION 6–23 MONTHS (UFC)

- In many low- and middle-income countries, diet patterns are shifting towards higher intakes of added sugars, unhealthy fats, salt and refined carbohydrates.
- A variety of guidance documents indicate the need to avoid or limit these types of foods when feeding IYC.
- Recent national guidance for feeding IYC advises avoidance of foods such as candies, chocolate, chips, French fries, cakes and cookies: Consumption of such foods may displace more nutritious foods and limit the intake of essential vitamins and minerals.
- Recently, unhealthy snack food and beverage consumption has been associated with a higher risk of nutrient inadequacy, and lower length-for-age among one-year-olds (43).
- Food preferences that begin early in life track into later childhood and adolescence. Such practices, if continued throughout adolescence and adulthood, can increase the risk of becoming overweight or obese, and of related chronic diseases later in life.

Indicator definition: percentage of children 6–23 months of age who consumed selected sentinel unhealthy foods during the previous day.

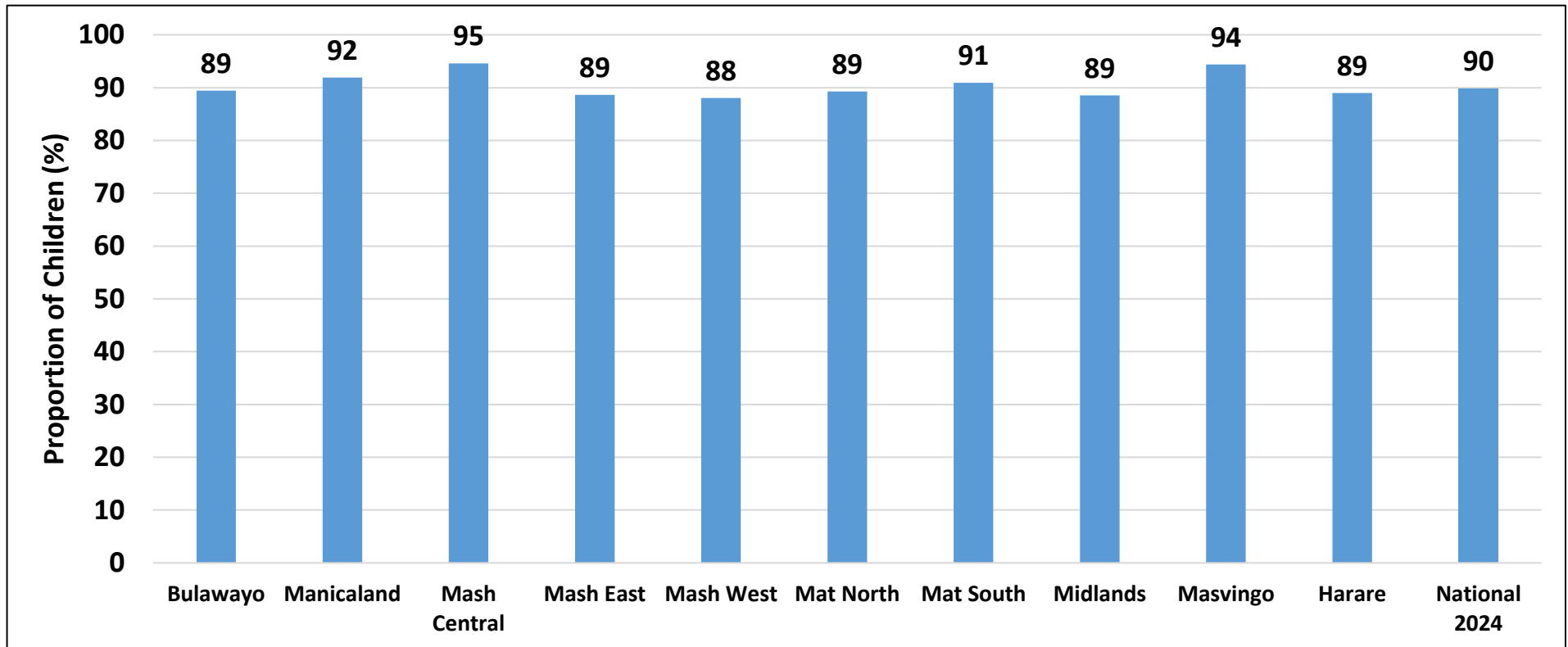
- *“sentinel unhealthy foods” are foods or categories of foods (e.g. “sweets” or “candies”) that are likely to be consumed by IYC and are high in sugar, salt and/or unhealthy fats.*

ZERO VEGETABLE OR FRUIT CONSUMPTION 6–23 MONTHS (ZVF)

- WHO indicates that low vegetable and fruit consumption is associated with increased risk of noncommunicable diseases (NCDs).
- Consumption of zero vegetables or fruits on the previous day represents an unhealthy practice.

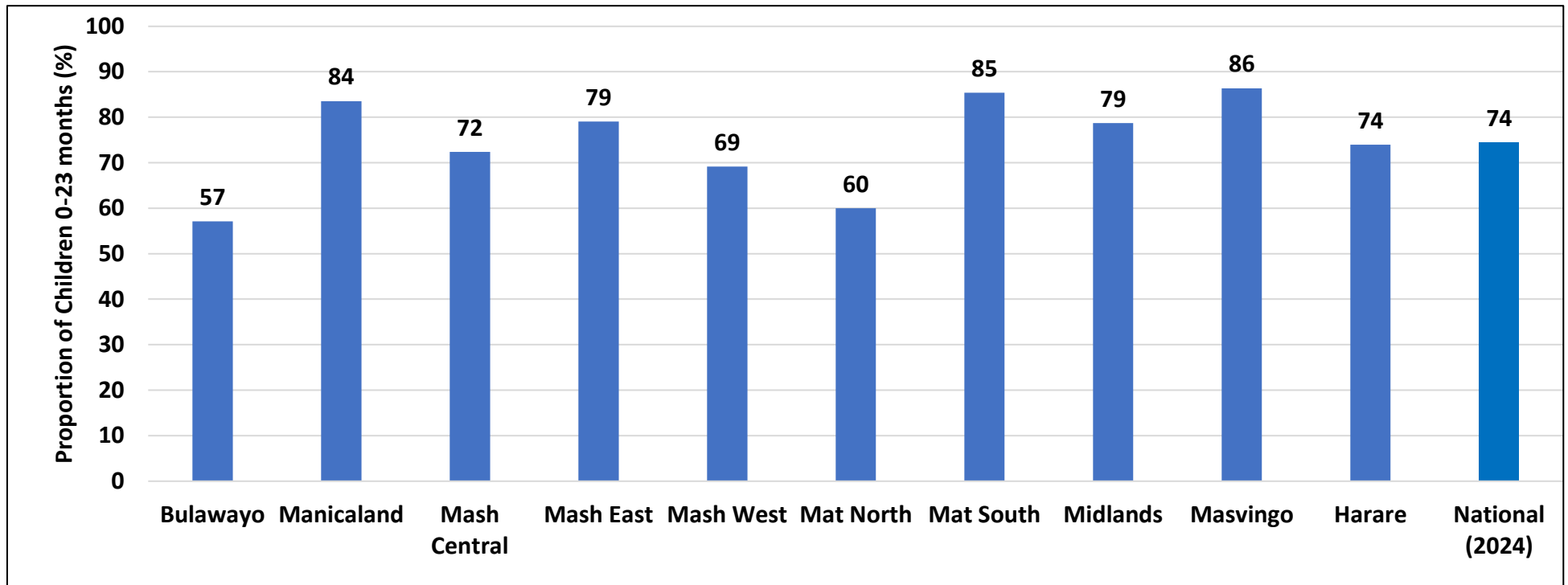
Indicator definition: percentage of children 6–23 months of age who did not consume any vegetables or fruits during the previous day.

Children Ever Breastfed



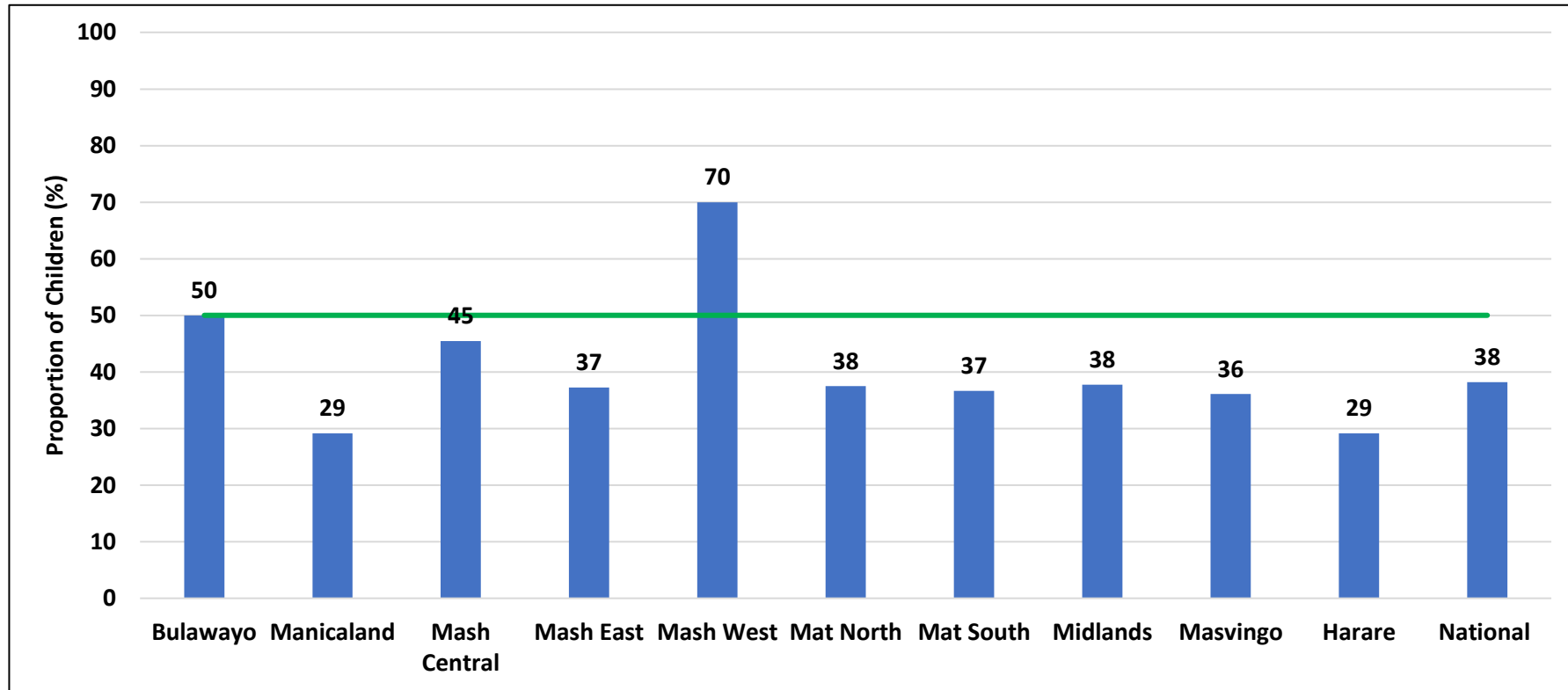
- The proportion of children who were ever breastfed was 90%. The recommendation is to have children exclusively breastfed for the first 6 months and continue breastfeeding for at least 2 years.

Early Initiation of Breastfeeding by Province



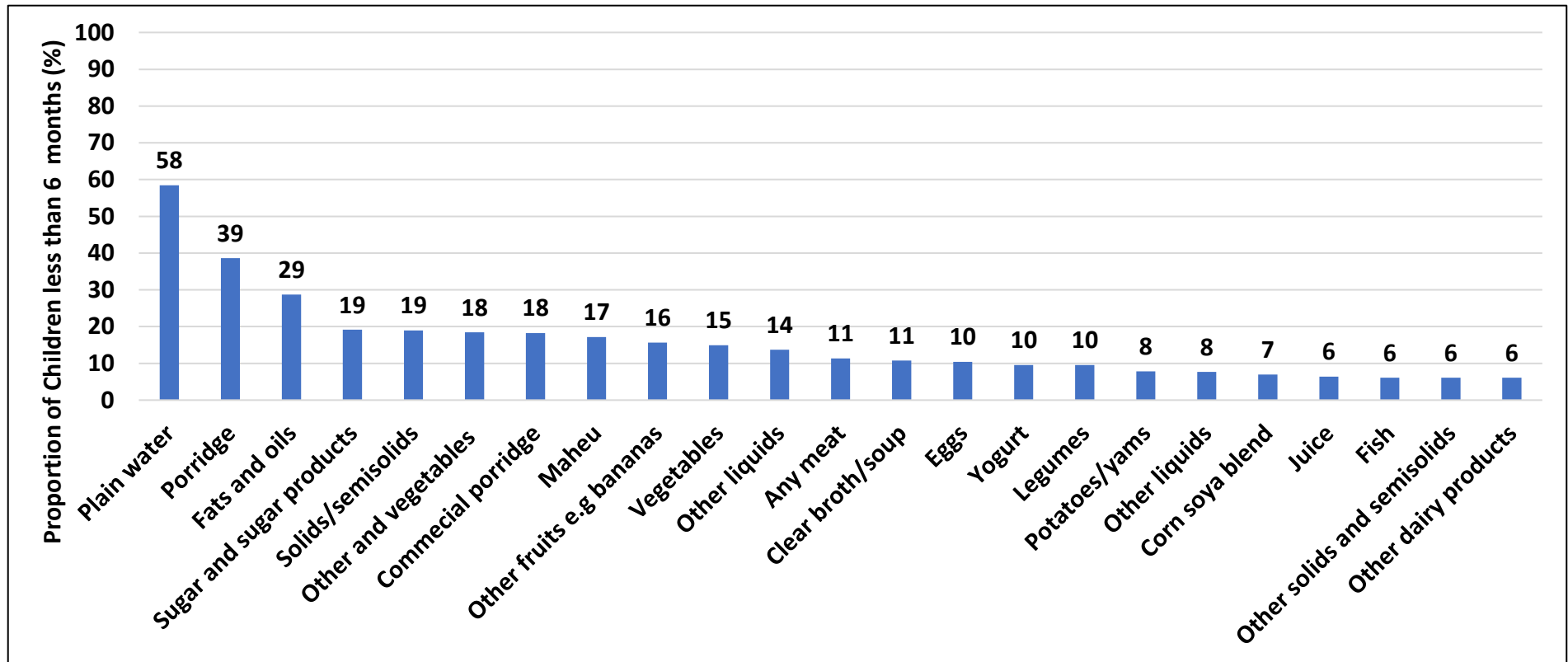
- About 74% of children were initiated to breastfeeding within the first hour of birth.
- Bulawayo (57%) and Matabeleland North (60%) had the least proportion of children who were initiated to breastfeeding within the first hour of birth and need some attention regarding this indicator.

Exclusive Breastfeeding



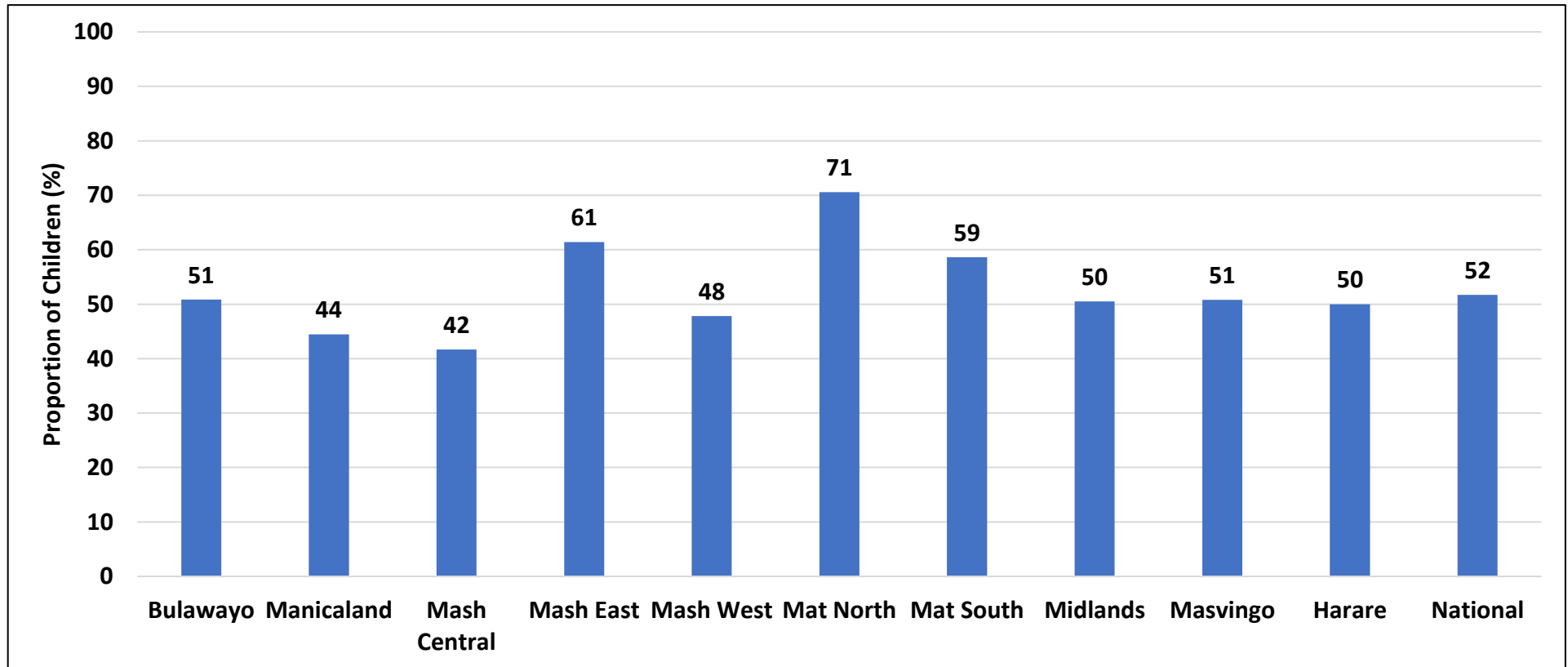
- Exclusive breastfeeding is a low cost, life-saving child survival intervention.
- The proportion of children who were exclusively breastfed was 38%.

Foods Given to Children Less than 6 months in Addition to Breastfeeding



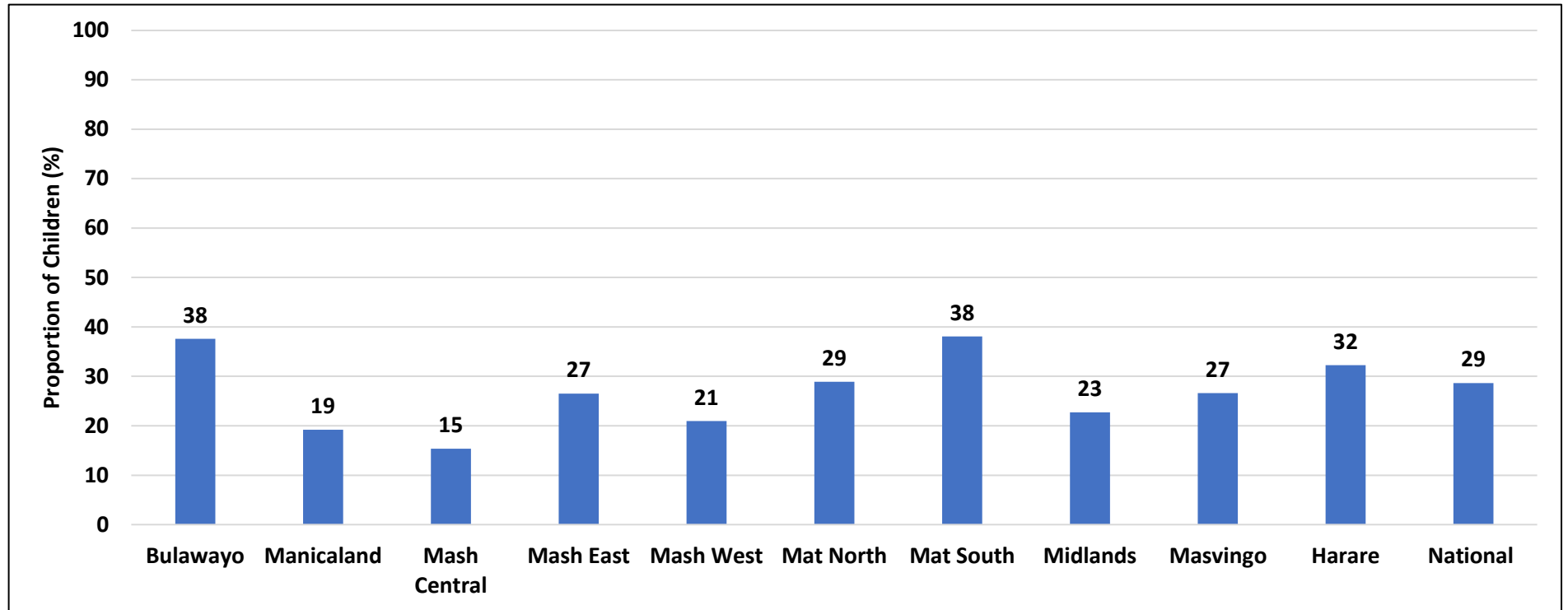
- Plain water (58%), porridge (39%), fats and oils (29%) were the most common foods given to children less than 6 months during the 24 hours preceding the survey.

Continued Breastfeeding at 1 Year



- The proportion of children who continued breastfeeding beyond 1 year was 52%.
- Mashonaland Central (42%) and Manicaland (44%) had the least whilst Matabeleland North (71%) and Mashonaland East (61%) had the highest rates across the provinces.

Bottle Feeding

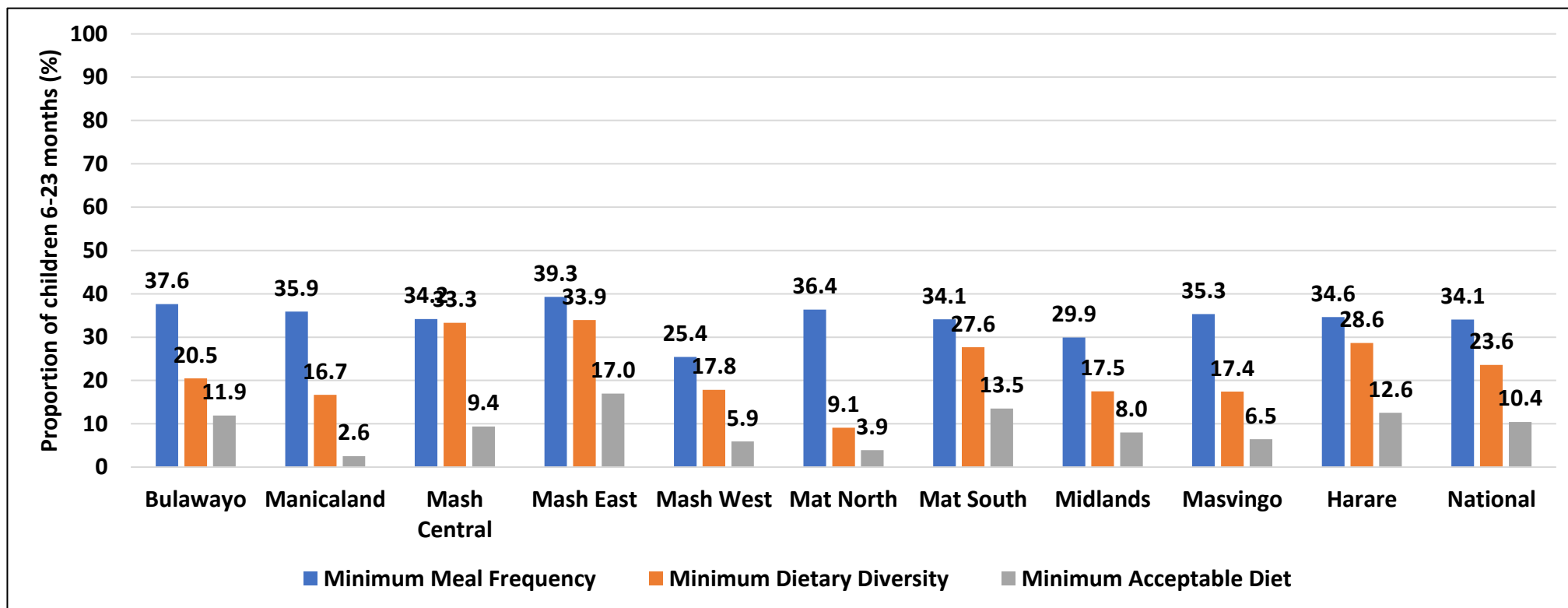


- Bottle feeding interferes with breastfeeding and predisposes infants to diarrheal diseases, especially in an environment with compromised WASH services. Matabeleland South and Bulawayo reported the highest rates of bottle feeding (38%).

Complementary Feeding

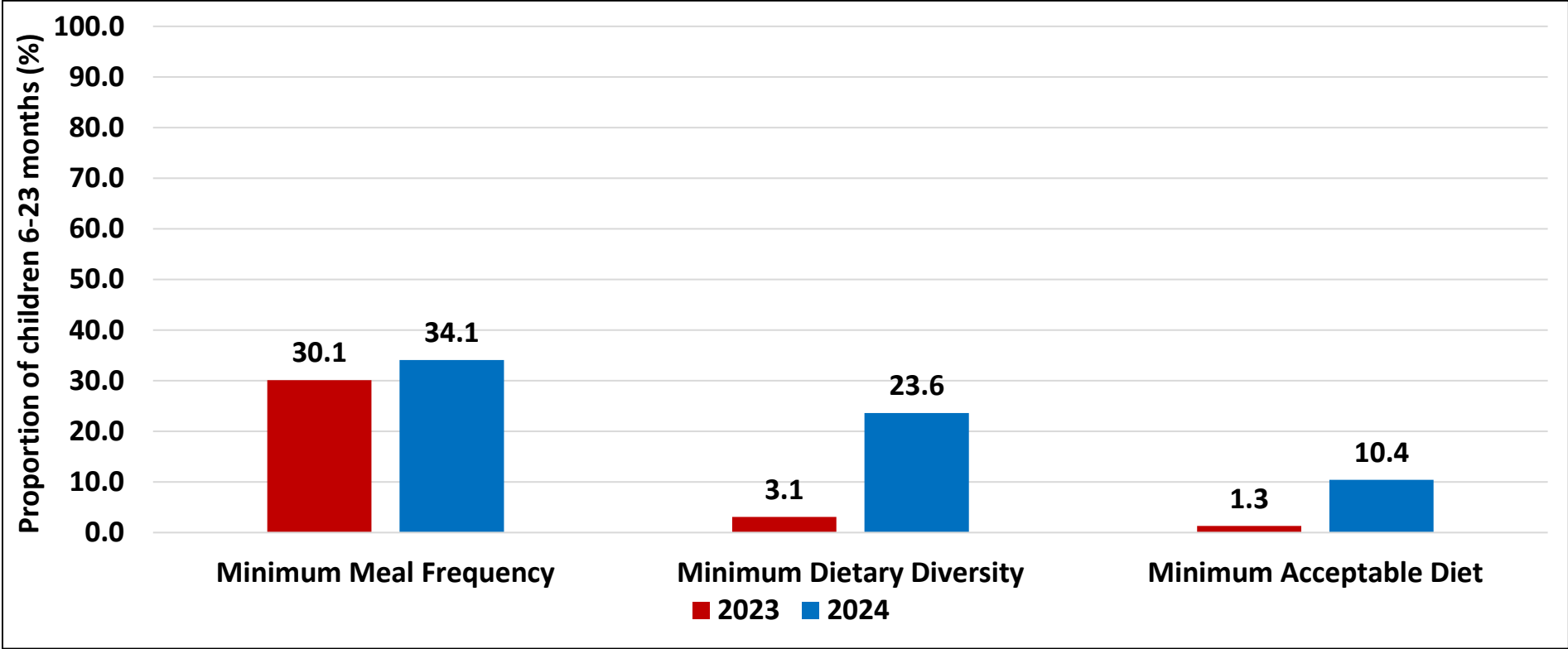
- Minimum Dietary Diversity (MDD) is a proxy indicator for adequate micronutrient density. Both breastfed and non-breastfed infants are expected to consume at least five of the seven food groups that are recommended by the World Health Organisation.
- Minimum Meal Frequency (MMF) is a proxy for a child's energy requirements and is the proportion of breastfed and non-breastfed children 6 to 23 months of age who receive solid, semi-solid, or soft-foods or milk feeds the minimum number of times or more.
- Minimum Acceptable Diet (MAD) is a composite indicator of minimum meal frequency and dietary diversity. It represents minimum standards of IYCF practices.

Infant and Young Child Feeding Diet Quality



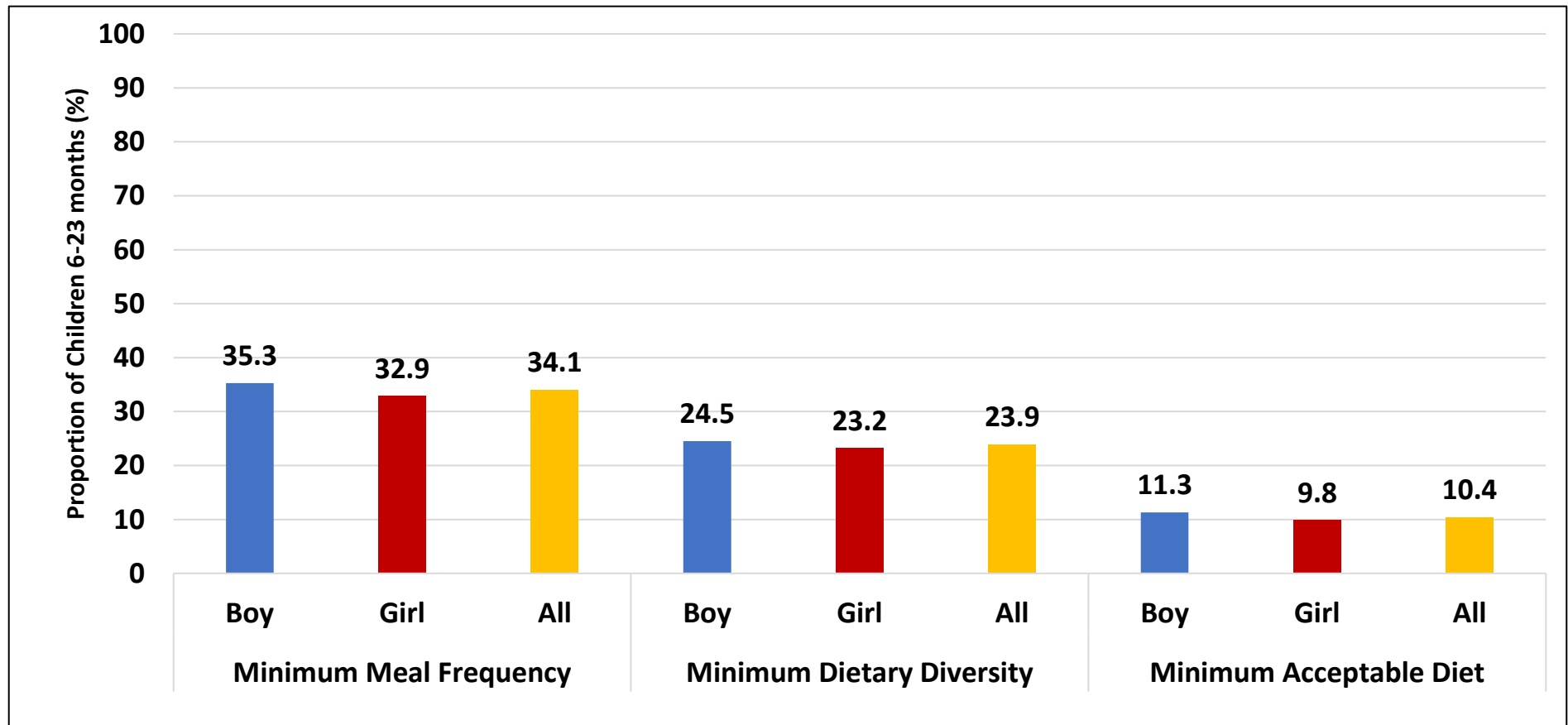
- About 10.4% of children received adequate diverse age appropriate diets.
- Only 23.6% of children were consuming a minimum diversified diet.
- Attention should be given to infant and young child feeding practices to improve nutrition outcomes in urban areas.

Infant and Young Child Feeding Diet Quality



- Nationally, only 10.4% of children achieved a minimum acceptable diet, an increase from 1.3% in 2023. However, this remains below the national target of 25%.

Infant and Young Child Feeding Diet Quality: By Sex

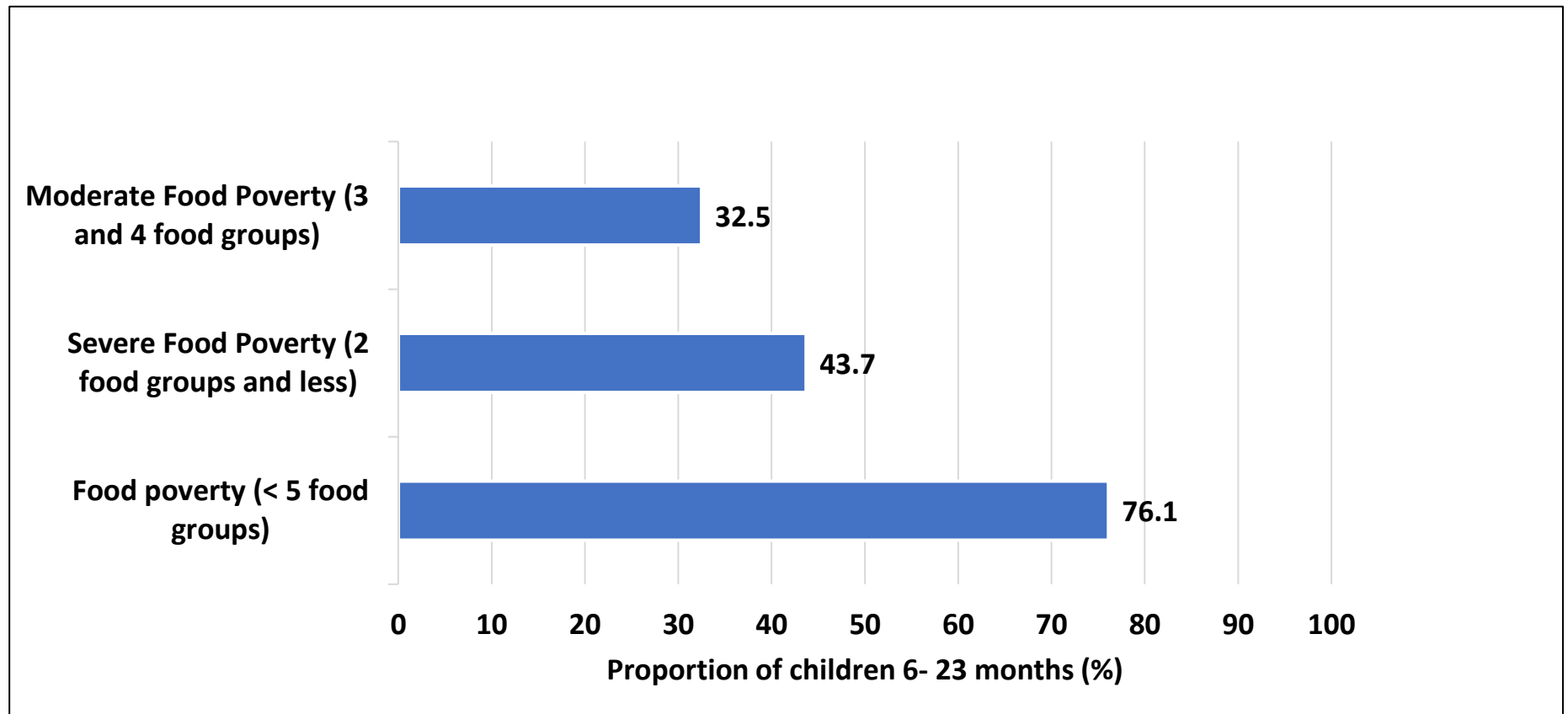


- There was no significant difference in diet quality by sex.

Child Food Poverty

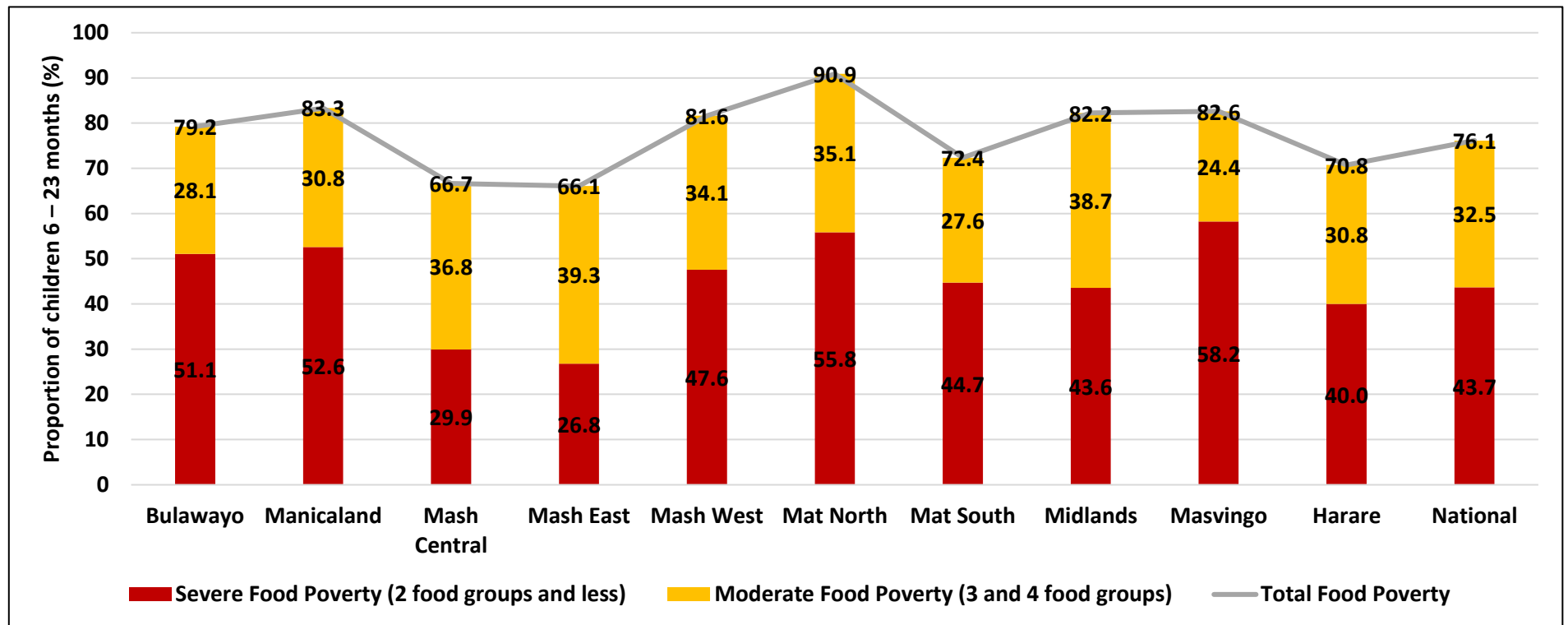
- **Children living in food poverty** is defined as the proportion of children under five years of age consuming foods and beverages from four or fewer of the eight defined food groups.
- **Severe child food poverty** refers to the proportion of children under 5 consuming foods and beverages from zero, one or two out of eight defined food groups during the previous day.
- **Moderate child food poverty** refers to the proportion of children under five 5 consuming foods and beverages from three or four out of eight defined food groups during the previous day.

Child Food Poverty



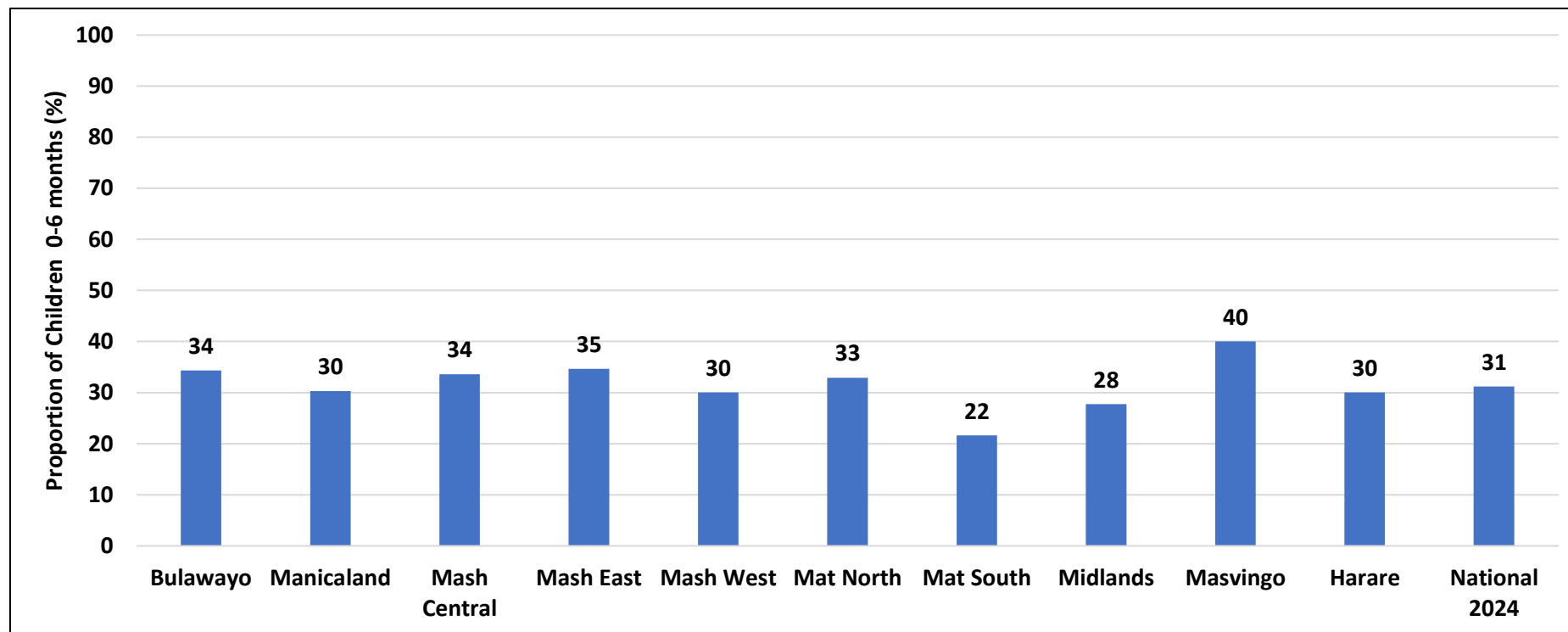
- Seventy six percent of the children 6 to 23 months consumed a meal which did not meet minimum dietary diversity in the 24 hours prior to the survey.
- Attention needs to be given to the 43.7% of children who were in severe food poverty.

Child Food Poverty



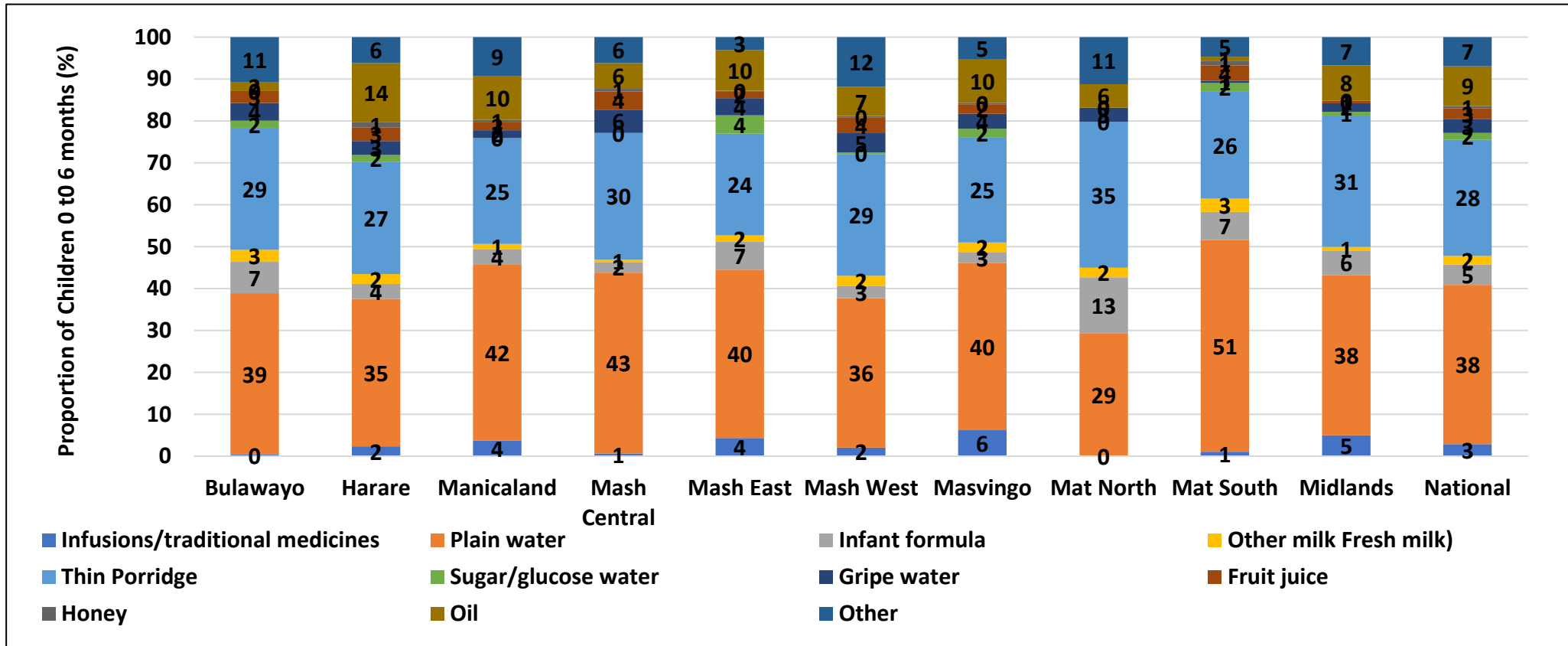
- Masvingo (58.2%) and Matabeleland North (55.8%) had the highest proportion of children aged 6 to 23 months who had severe food poverty.

Children Given Anything other than Breastmilk Within the First 3 Days after Birth



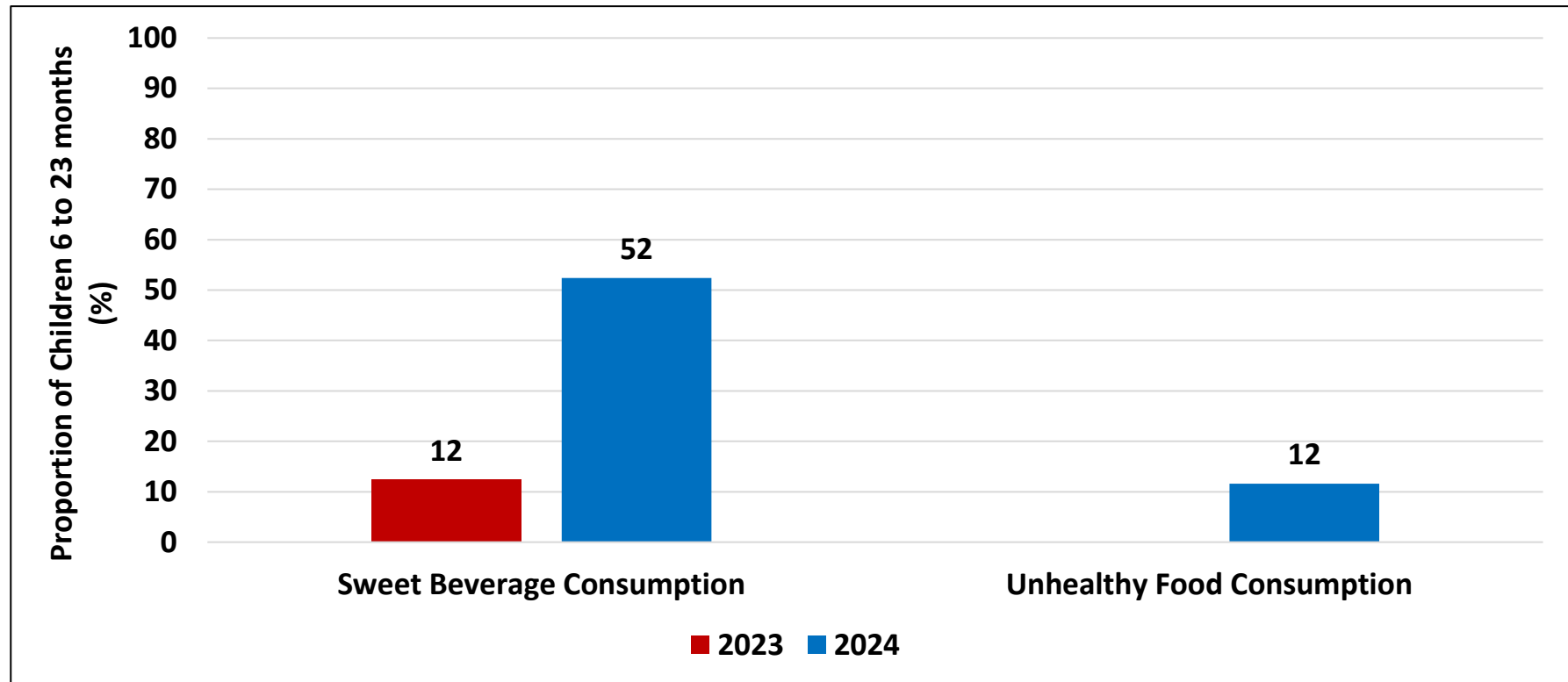
- Nationally, 31% of children had consumed other foods within the first three days after birth.
- Masvingo (40%) and Mashonaland East (35%) reported the highest proportions of children who consumed other foods within the first 3 days.

Common Liquids Given to Infants Under 6 months



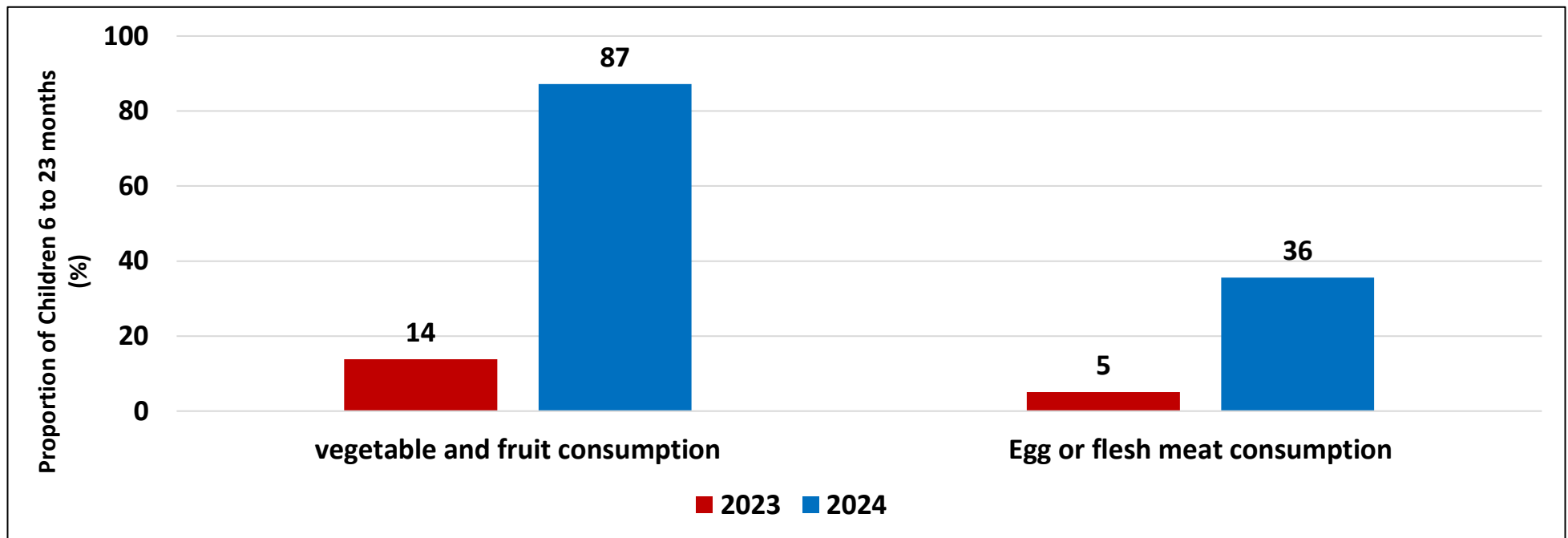
- Children below six months should not be given anything other than breastmilk because it interferes with exclusive breastfeeding.
- Children were mainly being given plain water during their first 6 months of life (38%), followed by thin porridge (28%).
- Oil, infant formula and gripe water were commonly given to children across the provinces.

Infant and Young Child Feeding Diet Quality Indicators by Year



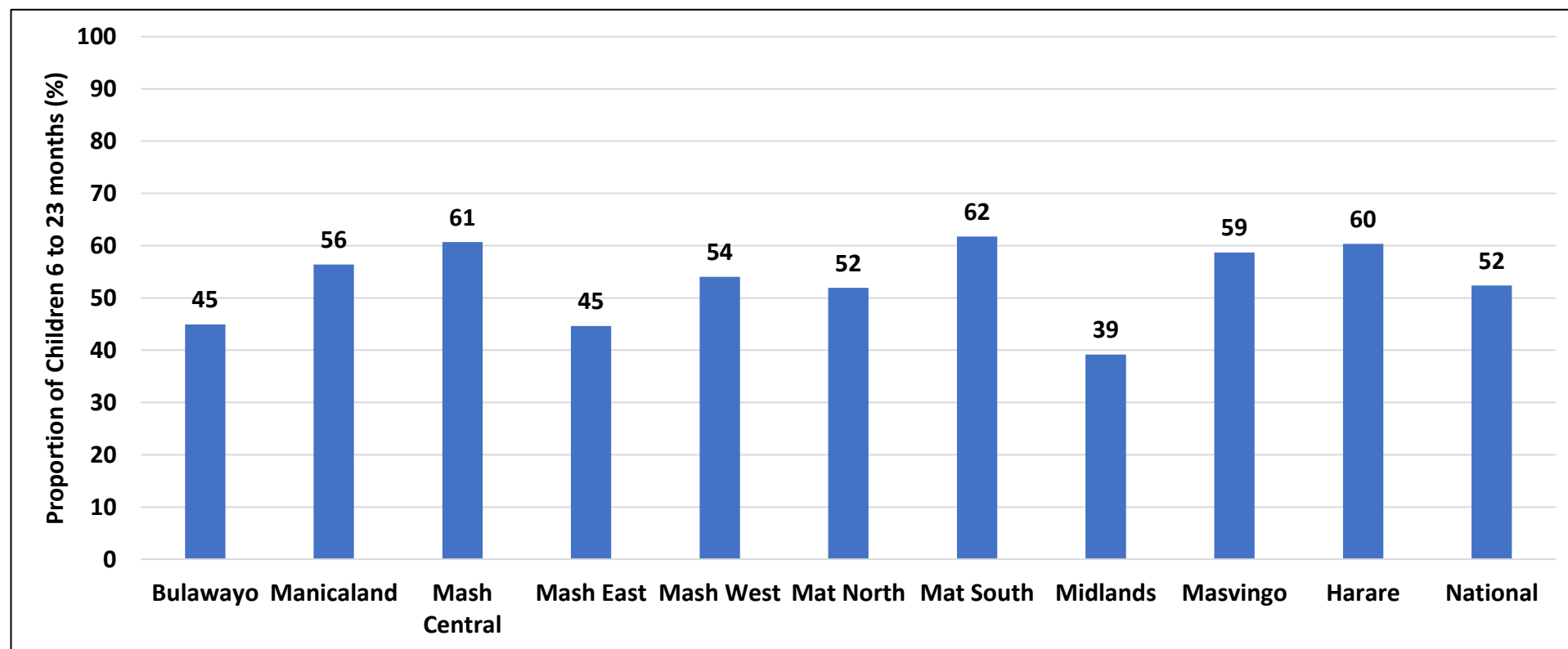
- Feeding children sweet beverages and unhealthy foods such as corn snacks and sweets interferes with the consumption of diverse nutritious diets.
- The proportion of children 6 to 23 months who were fed sweet beverages in the 24 hours prior to the survey was 52%.

Infant and Young Child Feeding Diet Quality Indicators by Year



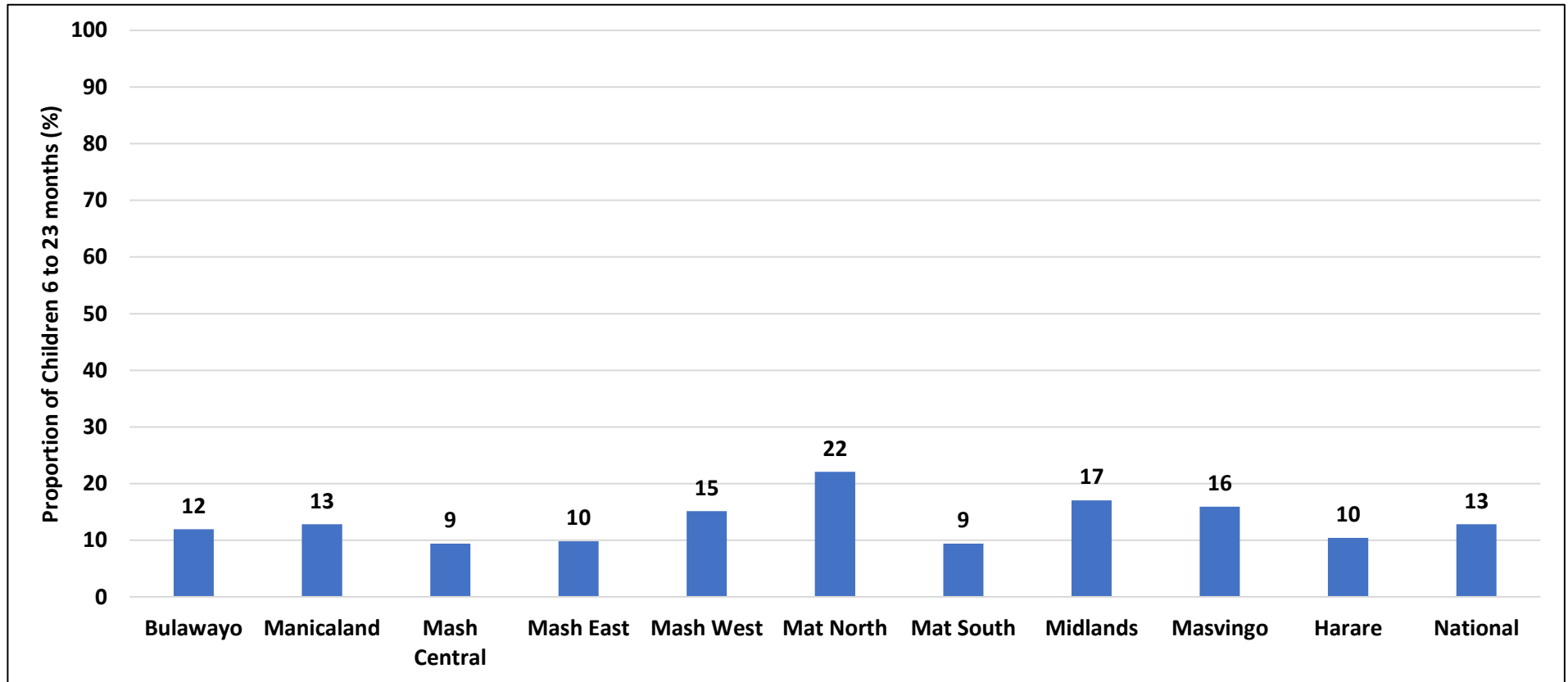
- Vegetable, fruit, egg and flesh meat consumption provides the much needed nutrients required for optimum growth and development during this window of opportunity (first 1 000 days).
- About 87% of the children 6 to 23 months consumed vegetables and fruits 24 hours prior to the survey.
- There was an improvement in the proportion of children who consumed eggs or flesh meat from 5% to 36%.

Sweet Beverage Consumption 6–23 Months (SwB)



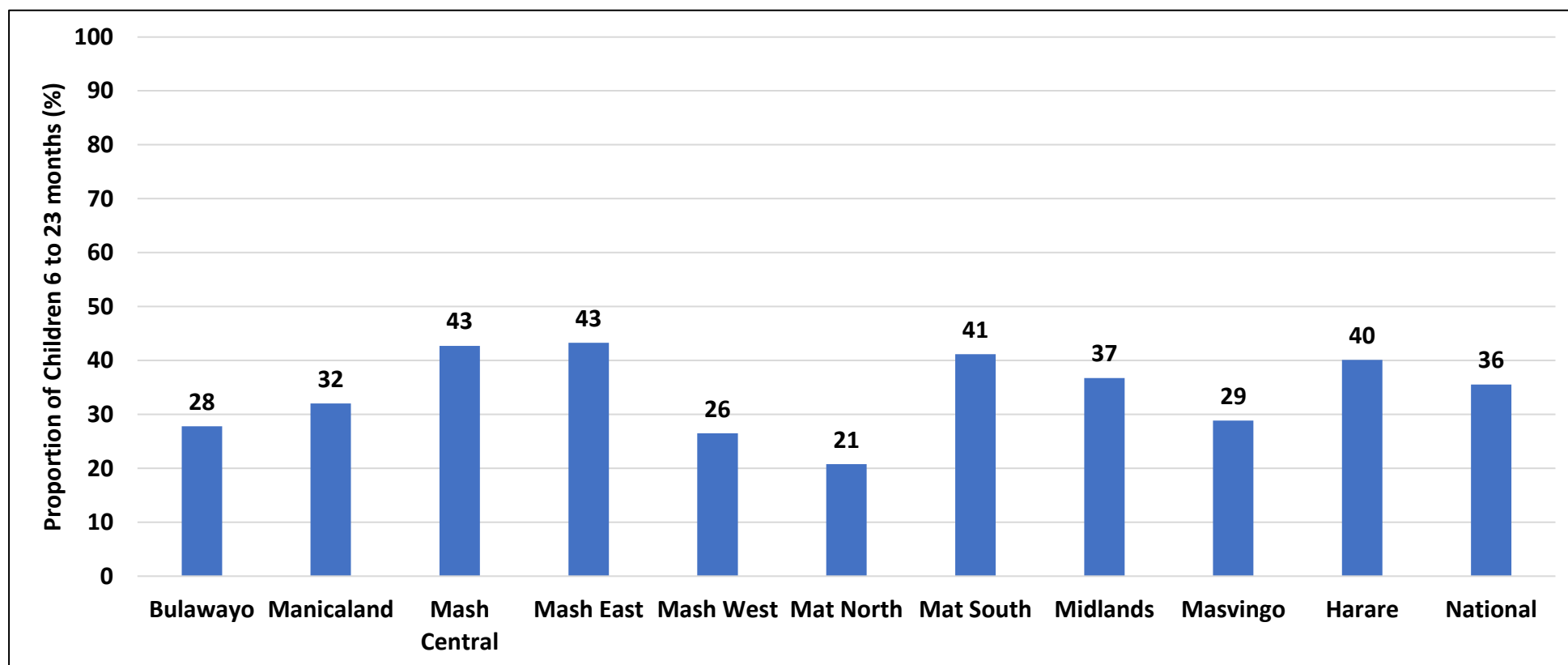
- Nationally, an estimated 1 in two children 6-23 months in urban areas were consuming sweet beverages, with Matabeleland South (62%), Mashonaland Central (61%) and Harare (60%) recording the highest.

Non Vegetable or Fruit Consumption 6–23 Months (ZVF)



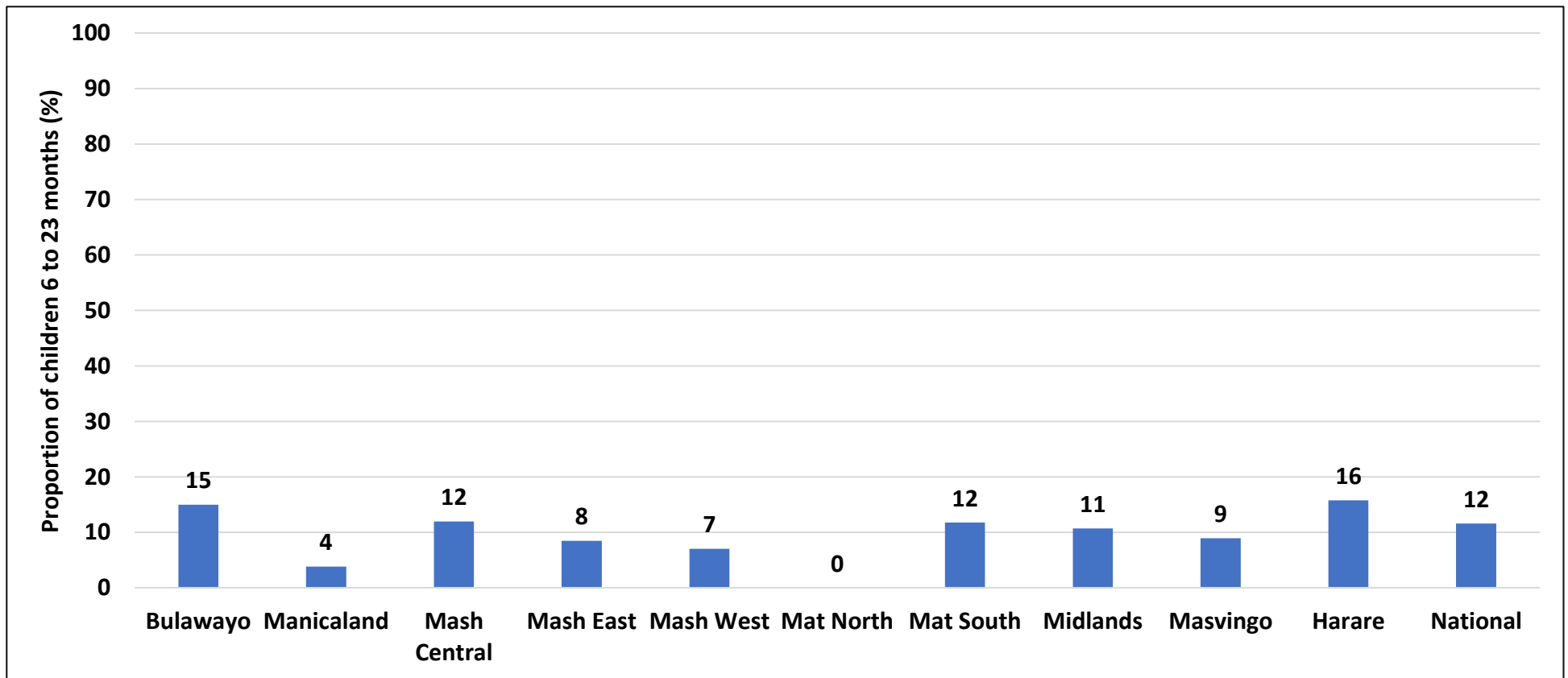
- Nationally, an estimated 13% of children 6-23 months in urban areas were neither consuming vegetables nor fruits, with Matabeleland North (22%), Midlands (17%), Masvingo (16%) and Mashonaland West (15%) recording proportions above the national average.

Egg and or Flesh Meat Consumption 6–23 Months (EFF)



- Nationally, only 36% of children 6-23 months in urban areas were consuming egg and or flesh meat with Matabeleland North and Matabeleland South recording the least (21% and 26% respectively).

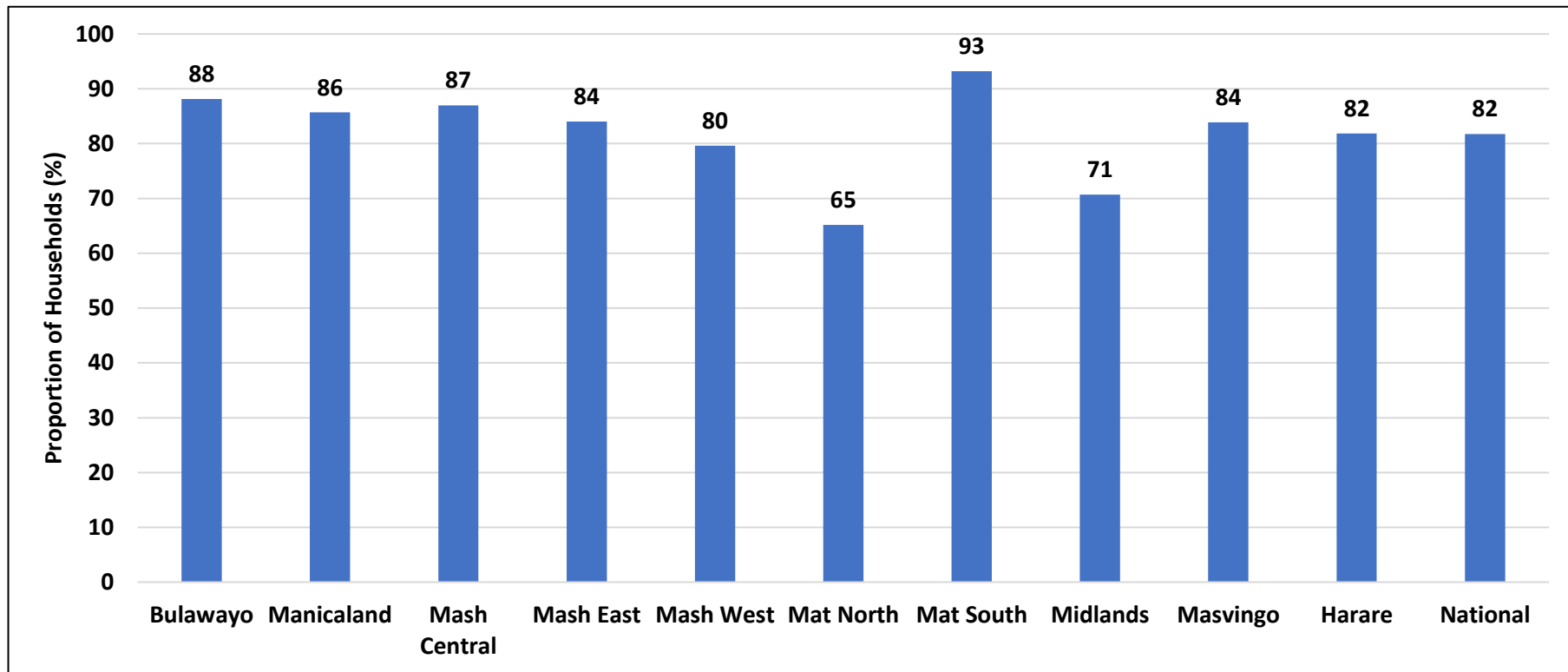
Unhealthy Food Consumption 6–23 Month (UFC)



- An estimated 12% of children 6-23 months in urban areas were consuming unhealthy foods, with Harare (16%) and Bulawayo (15%) recording the highest.

Water, Sanitation and Hygiene (WASH)

Connection to Council or ZINWA



- Eighty-two percent of urban households had their dwelling units connected to Council or ZINWA water.
- Availability of infrastructure that supports provision of safely managed services is a positive starting step for the country to meet the SDG target 6.1 that calls for universal and equitable access to safe and affordable drinking water

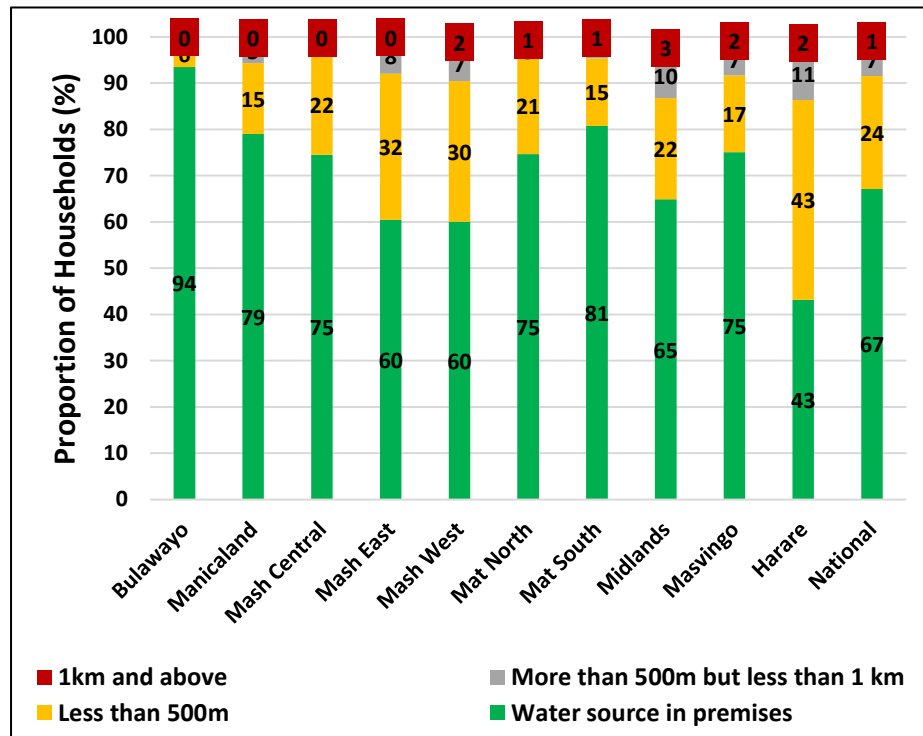
Main Drinking Water Sources

Province	Piped into dwelling (%)	Piped into yard or plot (%)	Piped into public tap or standpipe (%)	Piped into neighbour's yard (%)	Borehole /Tube well (%)	Protected well (%)	Unprotected well (%)	Protected spring (%)	Unprotected spring (%)	Surface water (%)	Tanker-truck (%)	Cart with small tank (%)	Water Kiosk (%)	Bottled/sachet water (%)	Other (%)
Bulawayo	77.1	20.6	1.3	0.1	0.4	0	0.3	0	0	0	0	0	0.1	0.1	0.1
Manicaland	55.7	26.0	2.0	2.0	4.8	8.0	1.0	0	0	0.3	0.2	0	0	0	0
Mash Central	38.8	15.0	3.8	1.2	11.7	29.3	0.2	0	0	0	0	0	0	0	0
Mash East	27.6	18.1	0.4	0.4	18.7	33.8	0.7	0.2	0	0	0	0	0	0	0.1
Mash West	48.1	2.5	5.1	0.8	20.8	19.9	1.9	0.1	0.1	0.2	0	0	0	0.1	0.4
Mat North	73.7	3.8	20.2	0.3	1.5		0	0	0	0.2	0	0	0	0	0.3
Mat South	59.1	27.1	0.9	1.3	6.8	0.3	0	0	0.1	0.1	1.7		0.8	0	1.8
Midlands	50.8	14.9	11.9	2.4	15.5	3.4	0.1	0	0	0.1	0	0.1	0.3	0	0.6
Masvingo	49.2	21.0	2.3	2.5	8.4	15.3	0.8	0.3	0	0	0	0	0.1	0	0.2
Harare	18.5	5.0	1.7	0.3	29.4	36.6	4.6	0.5	0.1	0.0	0.5	0.1	2.0	0.4	0.3
National	46.5	14.1	4.3	1.0	14.5	16.5	1.4	0.2	0.0	0.1	0.2	0.0	0.6	0.1	0.4

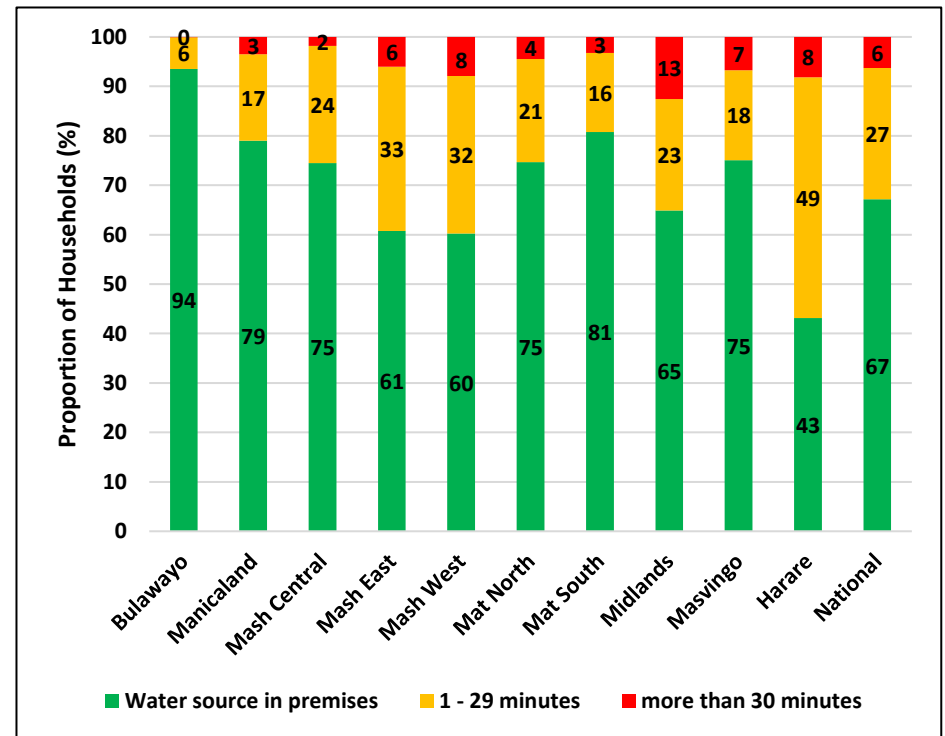
- The main source of drinking water for urban households was piped into dwelling (46.5%), protected wells (16.5%) and boreholes (14.5%).

Distance and Time Taken to Main Drinking Water Source

Distance Travelled



Time taken



- The majority of urban households (91%) travelled less than 500m to the nearest main drinking water source.
- Reducing distance and time taken to fetch water increases the quantity of water available for consumption and hygiene whilst water fetching times greater than 30 minutes increase risk of diarrheal disease and ultimately impacts on nutrition outcomes.

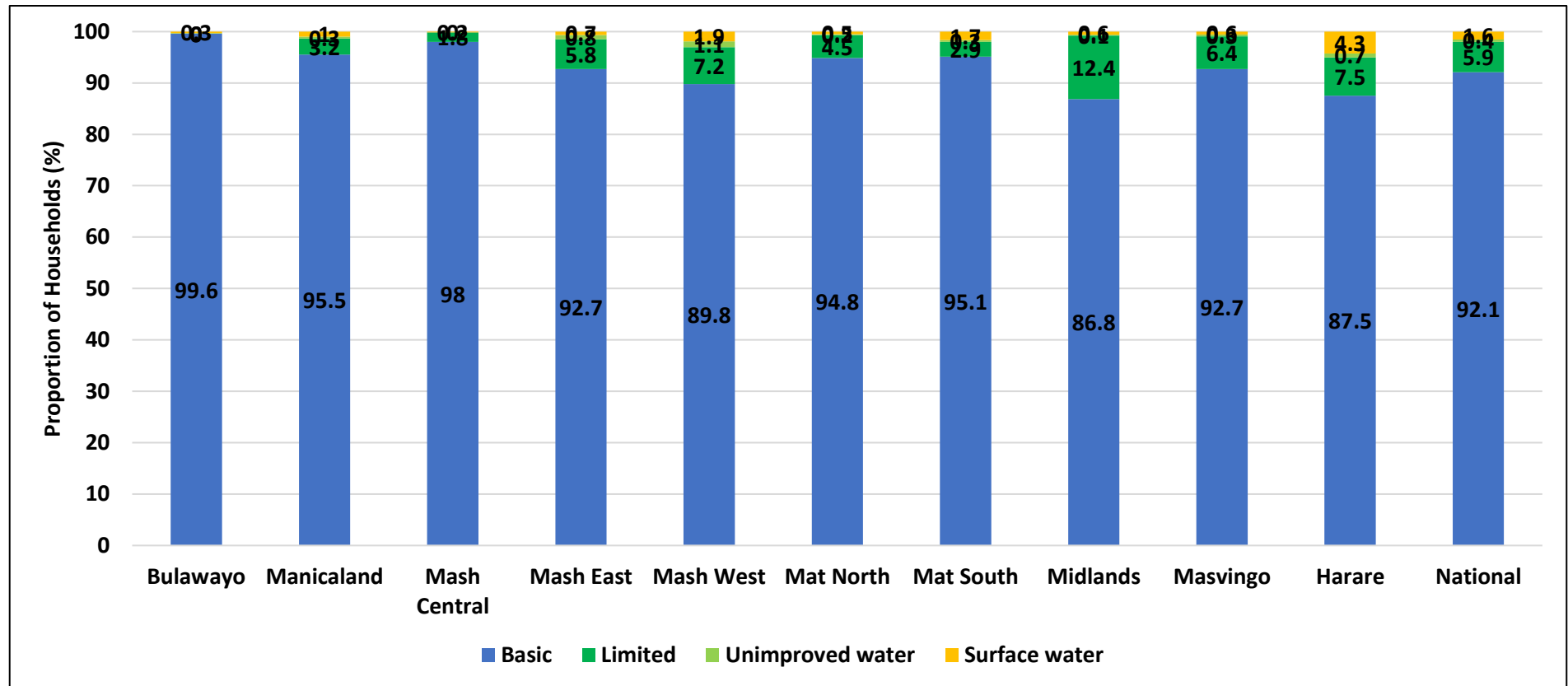
Ladder for Drinking Water Services

Service Level	Definition
Safely Managed	Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination.
Basic Drinking Water	Basic drinking water services are defined as drinking water from an improved source, provided collection time is not more than 30 minutes 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 faecal 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 includes packaged and delivered water, considering that both can potentially deliver safe water.

Main Drinking Water Services



- The proportion of households which accessed basic drinking water services was 94%, while 4% accessed limited services.
- Of concern is the 1.9% of households in Mashonaland West drinking surface water.

Ladder for Sanitation

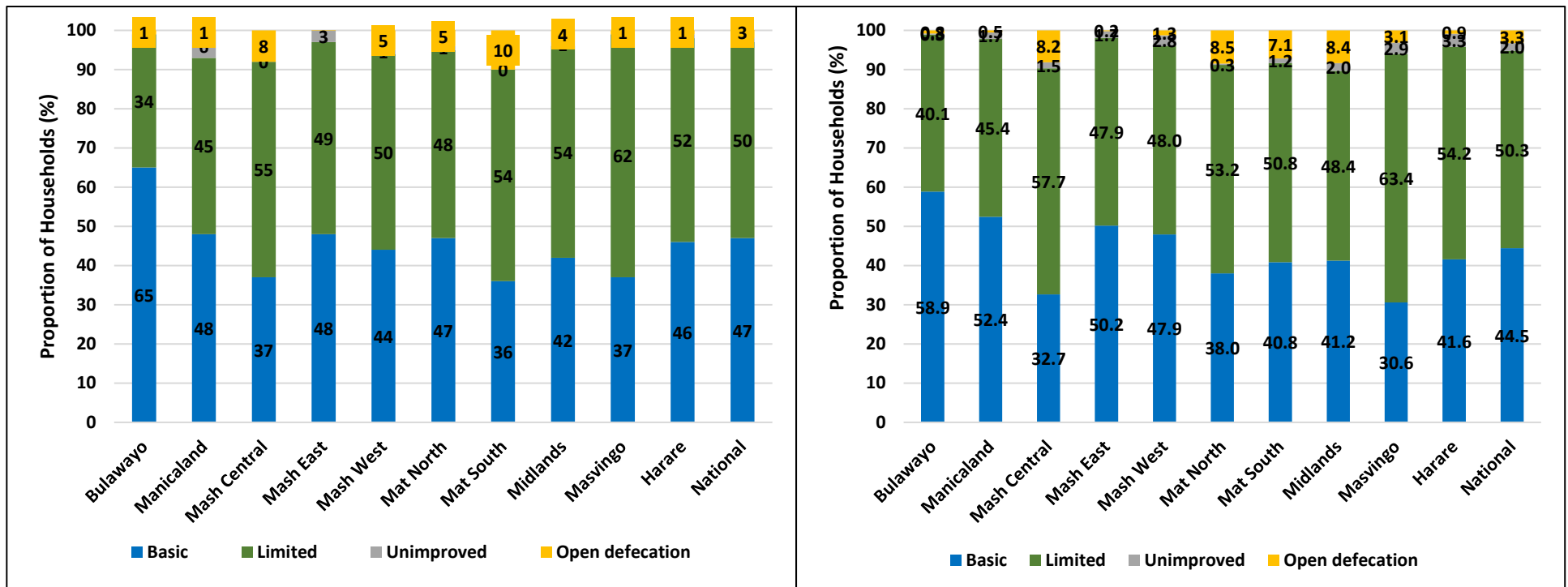
Service level	Definition
Safely Managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite.
Basic Sanitation Facilities	Use of improved facilities which are not shared with other households.
Limited Sanitation Facilities	Use of improved facilities shared between two or more households.
Unimproved Sanitation Facilities	Facilities that do not ensure hygienic separation of human excreta from human contact. Unimproved facilities include pit latrines without a slab or platform, hanging latrines and bucket latrines.
Open Defecation	Disposal of human faeces in fields, forest, bushes, open bodies of water, beaches or other open spaces or with solid waste.

Note: Improved sanitation facilities: Facilities that ensure hygienic separation of human excreta from human contact. They include flush or pour flush toilet/latrine, Blair ventilated improved pit (BVIP), pit latrine with slab and upgradeable Blair latrine.

Access to Sanitation Services

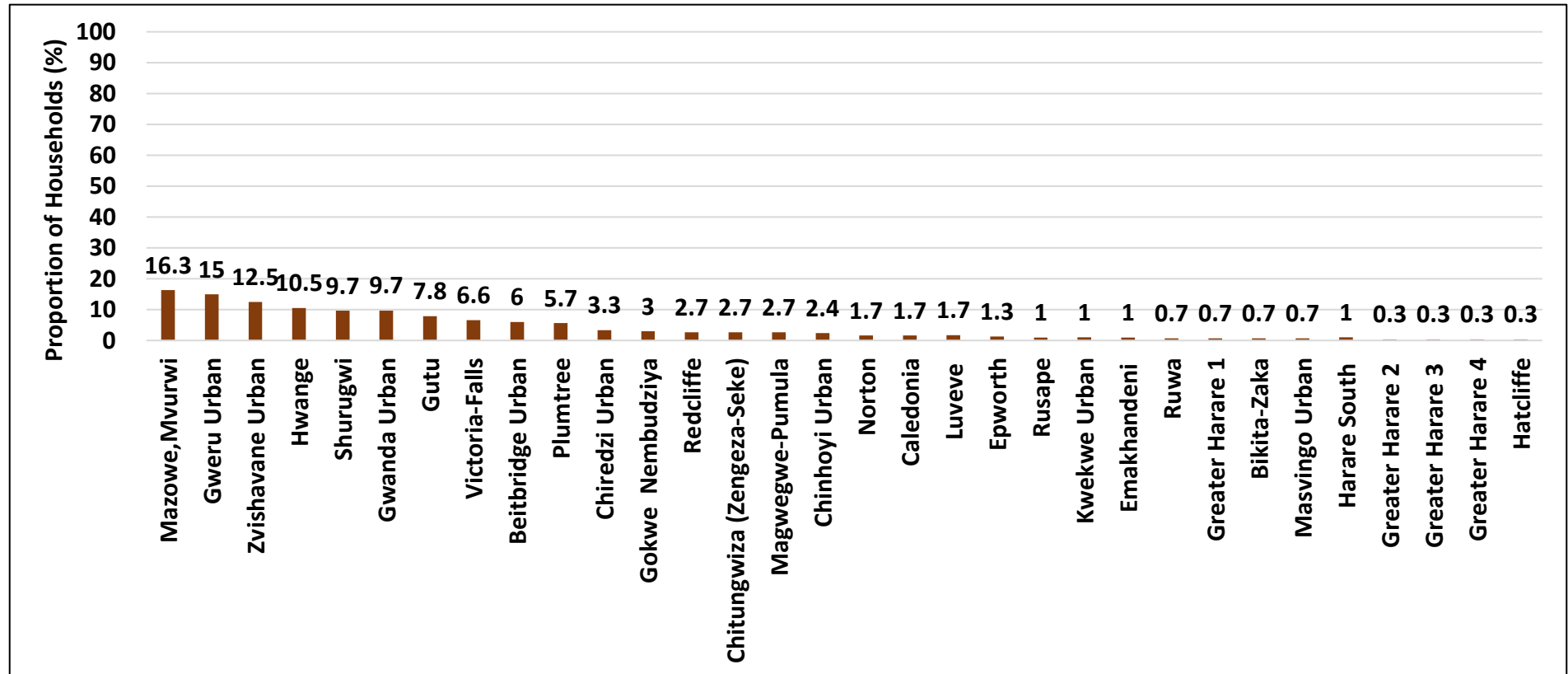
2023

2024



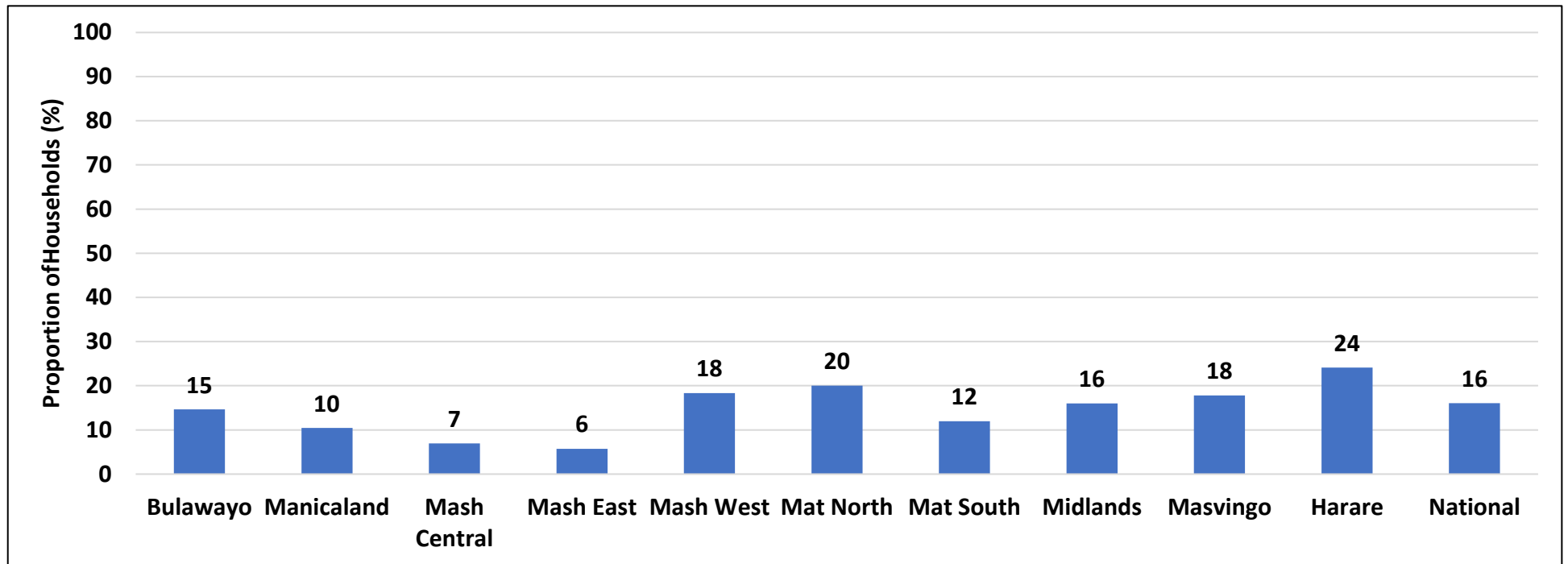
- Ninety five percent of the urban households had access to basic and limited sanitation services.
- About 3% of the urban households were practicing open defecation.
- Open defecation enables the absorption of fecal pathogens that leads to intestinal worms and diarrhea, disturbing the absorption of nutrients, and eventually leading to malnutrition.
- Zero Open Defecation environments have positive health and nutrition benefits.

Open Defecation by Domain



- Mazowe-Mvurwi domain (16.3%), had the highest proportion of households which practised open defecation.

Sewer System Failure



- Provision and use of facilities and services that safely dispose of human urine and faeces, thereby preventing contamination of the environment impacts positively on nutrition outcomes.
- At national level, 16% of households in urban domains reported that their sewer system had failed to function properly during the four weeks prior to the day of interview.

Days Taken to Have Sewer System Fixed

Province	Within 24 hrs	2 days	3 days	4 days	5 days	6 days	7+ days	Total Fixed	Not yet fixed
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Bulawayo	6	10	9	8	3	2	36	75	25
Manicaland	4	12	6	12	10	4	35	84	16
Mash Central	18	29	11	7	0	4	14	82	18
Mash East	47	21	16	8	0	0	8	100	0
Mash West	25	7	9	4	9	9	25	88	12
Mat North	12	27	10	8	1	2	21	82	18
Mat South	28	34	10	6	0	2	10	90	10
Midlands	4	10	4	3	2	2	31	55	45
Masvingo	29	30	13	4	5	2	17	98	2
Harare	7	10	8	6	4	2	33	70	30
National	13	15	9	6	4	3	28	77	23

- Delayed sewer system fixing creates an unhygienic environment, conducive for enteric pathogens that cause diarrhoeal diseases which can impair nutritional status.
- Midlands (45%), Harare (30%) and Bulawayo (25%) reported that their dysfunctional sewer systems had not yet been fixed.

Number of Times Refuse Was Collected

Province	Number of Times Refuse Was collected in January 2024				
	At Least One Time	At Least Two Times	At Least Three Times	At Least Four Times	Never Collected
Bulawayo	96	21	19	18	4
Manicaland	90	10	9	7	10
Mash Central	86	33	13	9	14
Mash East	66	14	10	4	33
Mash West	80	33	29	11	20
Mat North	66	9	7	4	34
Mat South	95	8	4	2	5
Midlands	68	29	24	17	32
Masvingo	92	17	13	6	8
Harare	37	27	25	20	63
National	72	22	19	13	28

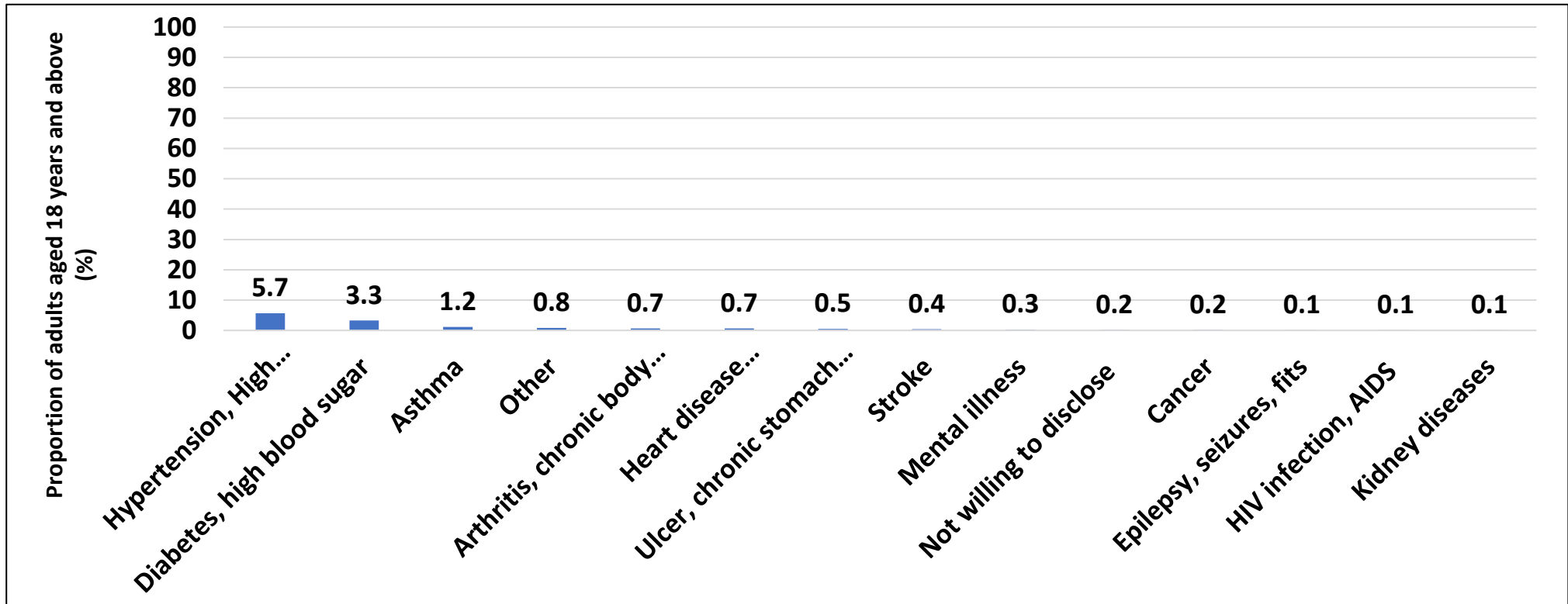
- Nationally, 72% of urban households reported that their refuse had been collected at least once.
- Of concern is the 28% that reported that refuse was never collected in January 2024.
- Children living in poor sanitary conditions are exposed to a high load of pathogens, especially between 6 months and 2 years of age and this can predispose them to impaired nutritional status.

Physical Activity and Non Communicable Diseases

Physical Activity, Tobacco and Alcohol Use

- Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure and can be performed at a variety of intensities, as part of work, domestic chores, transportation or during leisure time, or when participating in exercise or sports activities.
- Regular physical activity is a known protective factor for the prevention and management of noncommunicable diseases such as cardiovascular disease, type-2 diabetes, breast and colon cancer.
- Physical activity also has benefits for mental health , delays the onset of dementia , and can contribute to the maintenance of healthy weight) and general well-being.
- Together with smoking, diet and physical inactivity, consumption of alcohol is among the four most important risk factors for non-communicable disease (NCD). Alcohol consumption, especially heavy consumption, impacts on cancer, liver cirrhosis and stroke.

Chronic Conditions



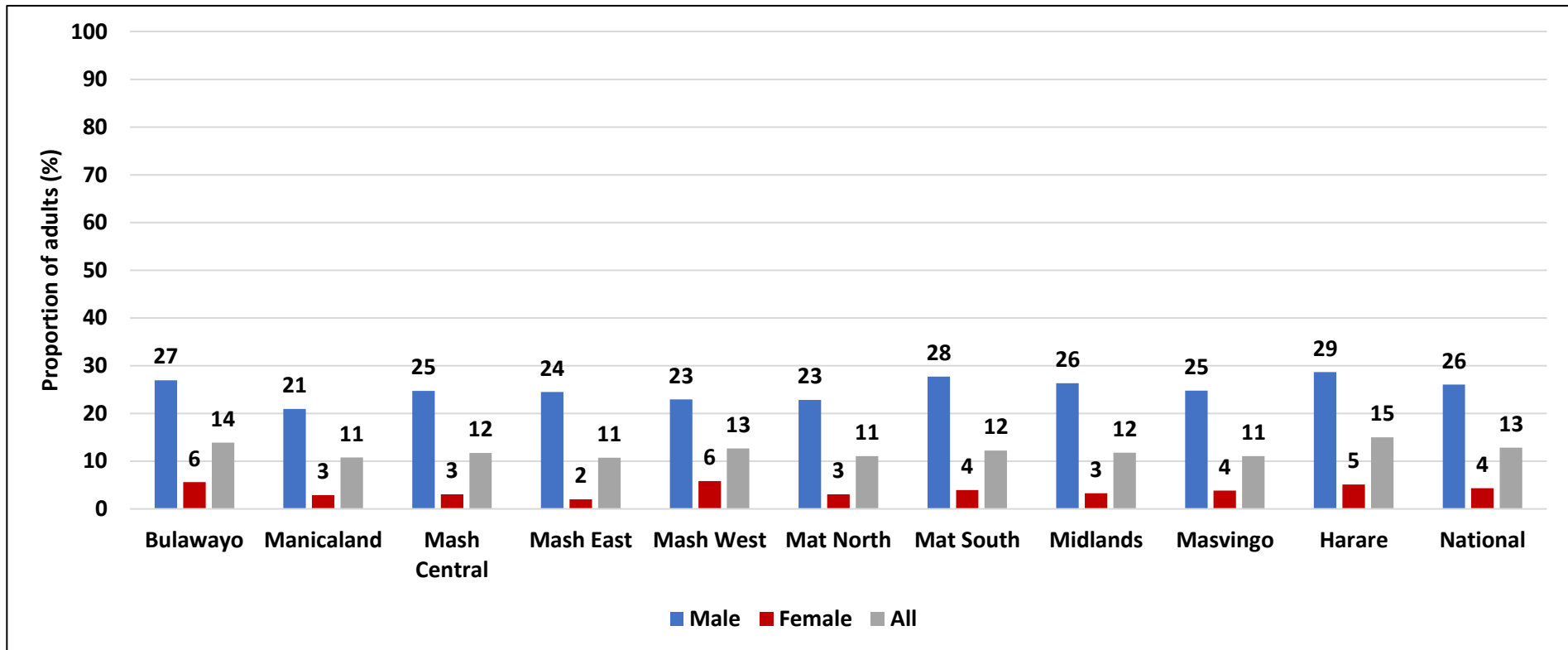
- The most common chronic condition among household members aged 18 years and above was hypertension (5.7%) confirmed by a medical practitioner.

Type of Physical Activity by Age Group

Type of Physical Activity	5 to 9 years	10 to 19 years	Females 15-49 years	18 to 60 years	60+ years
Walking	60.8	60.6	59.0	59.2	54.1
Other similar activities	26.4	23.2	27.9	26.1	33.8
Jogging and running	23.5	21.6	7.4	10.9	3.4
Some gardening activities,	8.4	15.4	25.9	23.1	20.6
Dancing	6.5	5.0	3.6	3.3	1.6
Volleyball	6.2	6.9	5.0	5.5	3.8
Soccer	4.7	7.9	0.8	3.2	0.8
Aerobic exercise classes	1.9	1.9	1.2	1.6	0.5
Swimming or Water aerobics	1.2	0.9	0.6	0.7	0.2
None/Did not engage in any exercise or physical activity	0.9	1.1	1.1	1.1	1.7
Bicycle riding (stationary or on a path)	0.7	0.7	0.4	0.9	1.1
Basketball	0.2	0.6	0.2	0.2	-

- The main physical activity engaged by different age groups within a household was walking.
- Regular physical activity such as walking and jogging is proven to help prevent and manage non-communicable diseases such as heart disease, stroke, diabetes and several cancers.

Consumption of Alcohol



- More males (26%) than females (4%) above 18 years in urban domains reported to have ever consumed alcohol.
- Harare (29%) and Matabeleland South (28%) had more males reporting to have ever consumed alcohol.

Frequency Consumption of Alcohol (Males)

	Rare (1-4 days/month) (%)	Sometimes (1-4 days /week) (%)	Often (more than 5 days a week) (%)
Bulawayo	9	8	3
Manicaland	8	5	3
Mash Central	11	4	2
Mash East	7	7	4
Mash West	9	5	3
Mat North	12	4	2
Mat South	10	10	2
Midlands	8	8	4
Masvingo	8	6	4
Harare	10	9	3
National	9	7	3

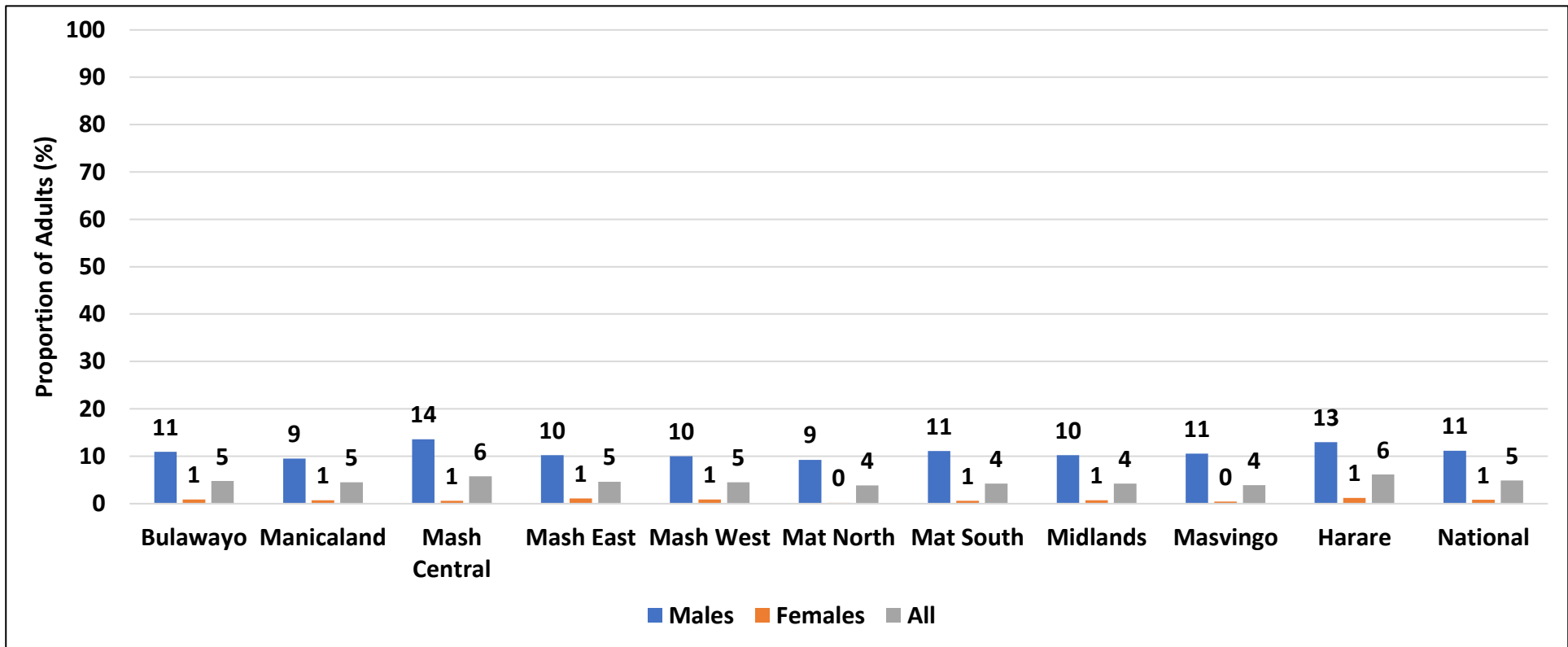
- About 9% of adult males aged above 18 years rarely consumed alcohol, 7% consumed alcohol 1 to 4 days in a week and 3% consumed alcohol more than 5 days in week.
- Alcohol consumption frequency may represent a sizable risk factor for weight gain and obesity amongst adults and adolescents.

Frequency Consumption of Alcohol (Females)

	Rare (1-4 days/month) (%)	Sometimes (1-4 days /week) (%)	Often (more than 5 days a week) (%)
Bulawayo	3	1	0
Manicaland	1	0	1
Mash Central	2	0	0
Mash East	1	0	0
Mash West	2	1	1
Mat North	2	0	0
Mat South	3	0	0
Midlands	2	1	0
Masvingo	2	1	0
Harare	3	1	0
National	2	1	0

- About 2% of adult females aged above 18 years rarely consumed alcohol and 1% consumed alcohol 1 to 4 days in a week.
- There is an increasing risk of adverse birth outcomes, particularly pre-term delivery and low birth weight, with increasing levels of alcohol intake amongst females.





Use of Tobacco Products and Smoking



- Tobacco use and smoking as a lifestyle habit is a major risk factor for non-communicable diseases such as chronic respiratory diseases, cancer, diabetes, heart disease and stroke.
- About 11% percent of adult males and 1% of females reported to be smoking or using tobacco products.

Nutrition Status

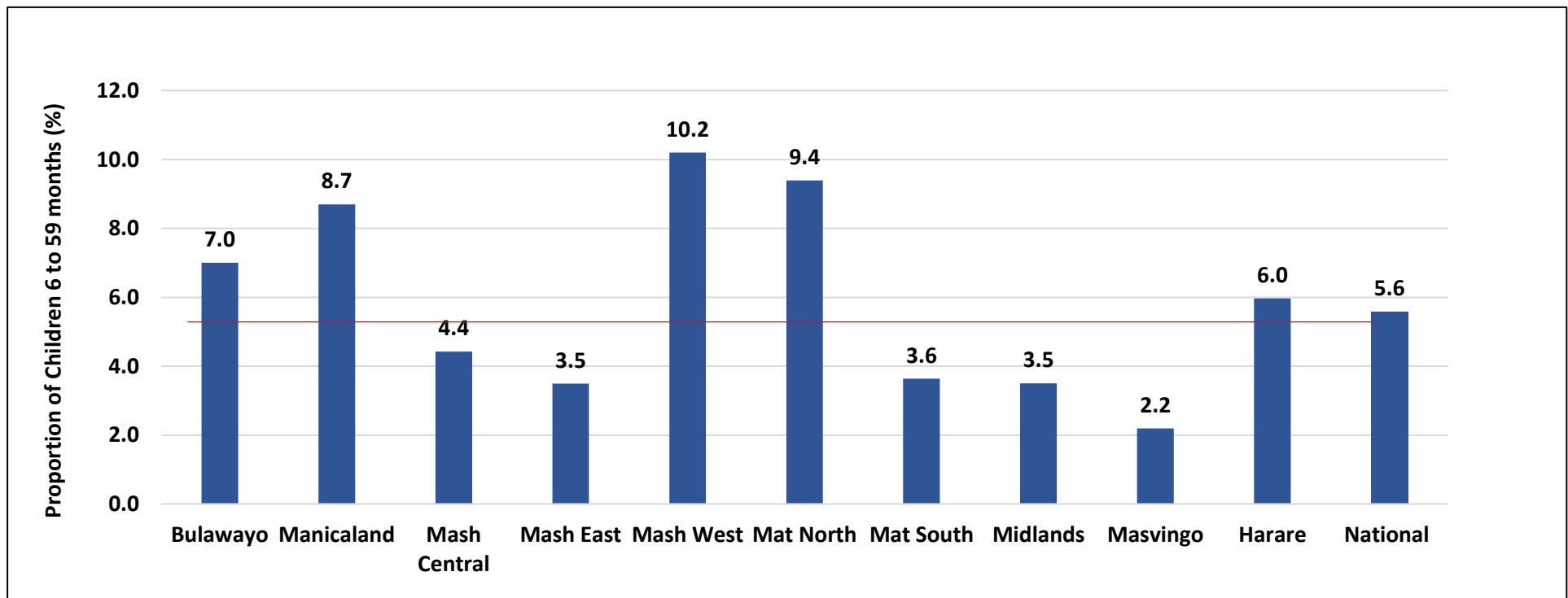
Child Nutrition Status

Child Stunting		The share of children under the age of five who are short for their age (having a low height-for-age), reflecting chronic undernutrition.
Child Wasting		The share of children under the age of five who are too thin for their height (low-weight-for-height), reflecting acute undernutrition.
Child Underweight		The share of the children under the age of the five who are too thin for their age (low weight-for-age).
Overweight /Obesity		The share of children under the age of five who are too heavy for their height (high weight-for-height).

Child Nutrition Status

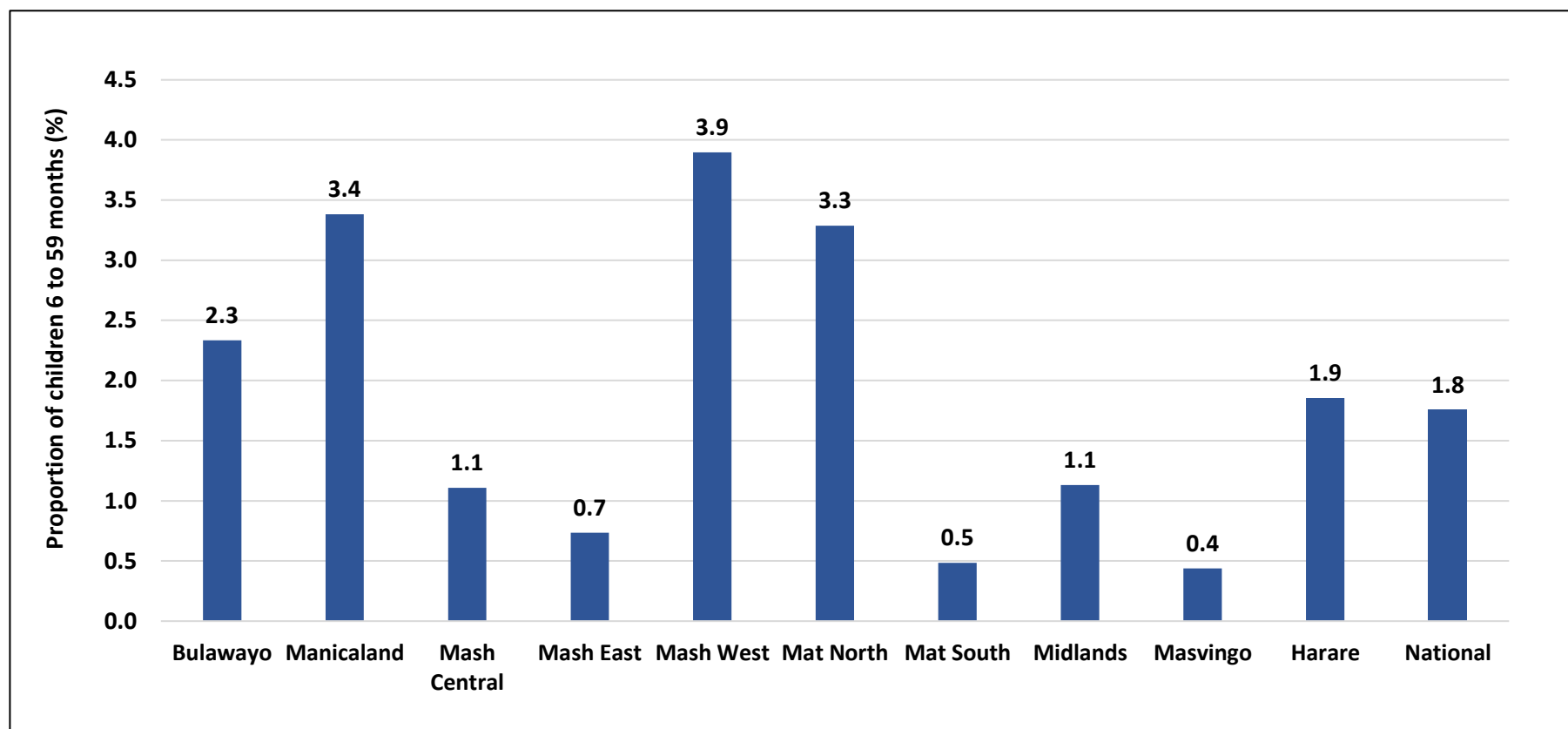
Indicator	Indicator definition (WHO standards, 2006)	National prevalence (%)	Prevalence cut-off values for public health significance
Stunting	Height/Length for age <-2 SD of the WHO Child Growth Standards median	23.2	<2.5%: Very Low 2.5- $<10\%$: Low 10- $<20\%$: Medium 20- $<30\%$: High $\geq 30\%$: Very High (DeOniset al., 2019)
Global Acute Malnutrition	Weight for height <-2 SD of the WHO Child Growth Standards median and/oedema	5.6	<5% Acceptable 5-9.9%: Poor 10-14.9%: Serious >15%: Critical
Severe Acute Malnutrition	Weight for height <-3 SD of the WHO Child Growth Standards median	1.4	0% = acceptable >0%: Unacceptable
Underweight	Weight for age <-2 SD of the WHO Child Growth Standards median and/oedema	9.1	
Overweight	Weight for height $>+2$ SD of the WHO Child Growth Standards median	5.2	<2.5%: very low 2.5 to $<5\%$: low 5 to $<10\%$: medium 10 to $<15\%$: high $\geq 15\%$: very high
obesity	Weight for height $>+3$ SD of the WHO Child Growth Standards median	1.6	

Prevalence of Global Acute Malnutrition for Children Aged 6-59 Months (WHO)



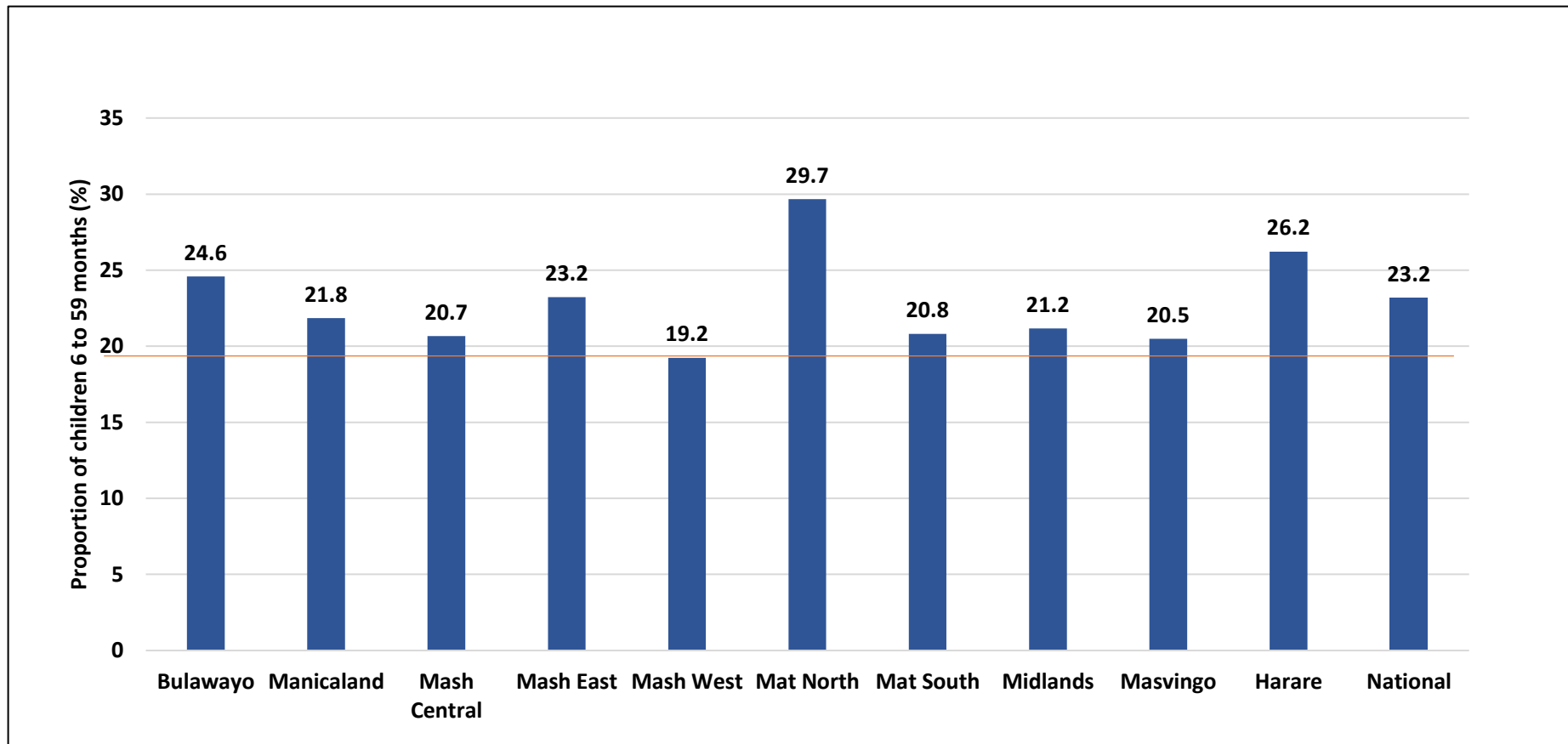
- Nationally, prevalence of GAM was 5.6%.
- Bulawayo, Manicaland, Mashonaland West, Mashonaland East and Harare had GAM levels above the acceptable threshold of 5%.

Prevalence of Severe Acute Malnutrition (WHO)



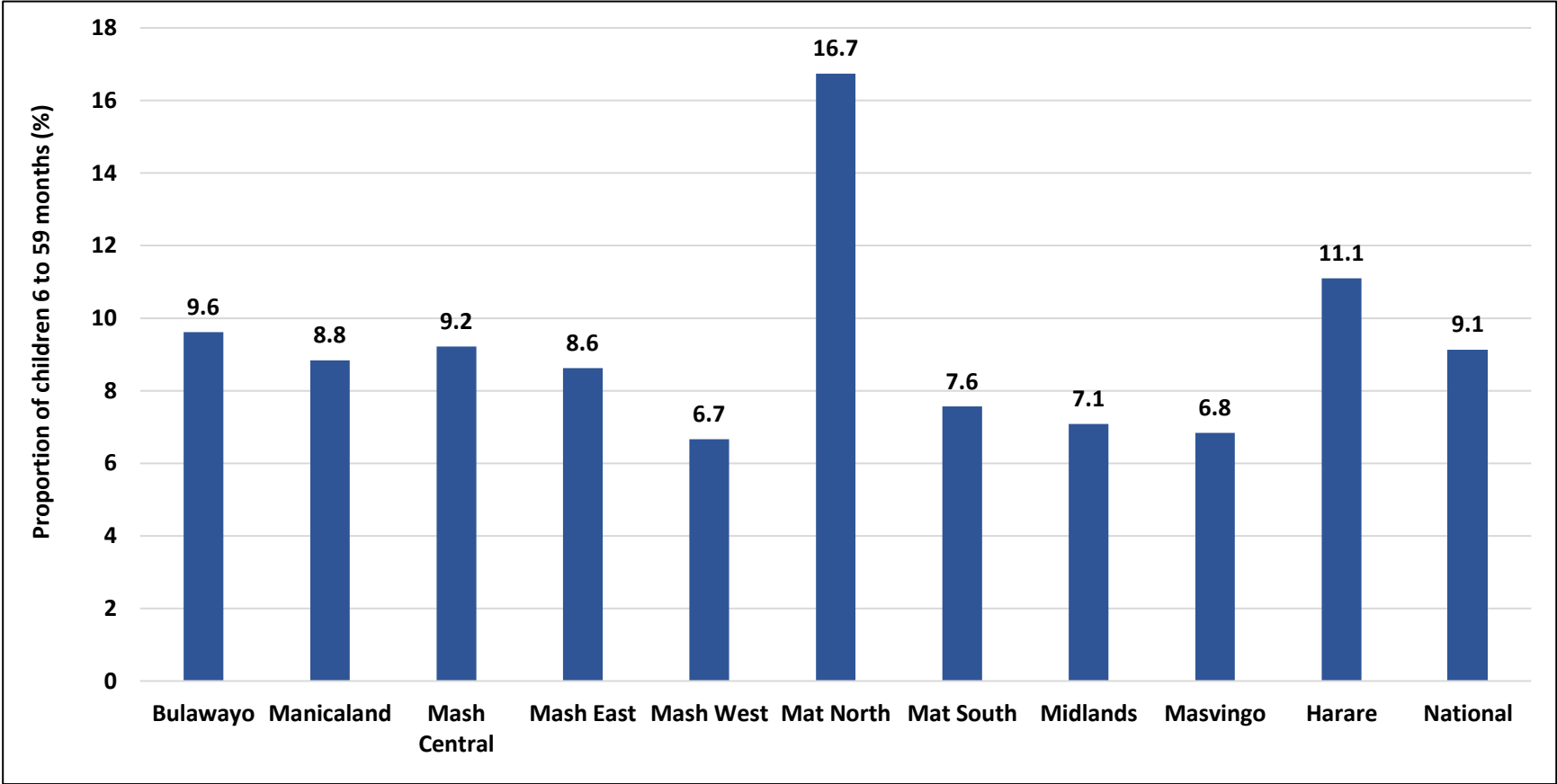
- The national prevalence for SAM was 1.8%, with Mashonaland West, Manicaland and Matebeleland North having the highest proportion of affected children at 3.9%, 3.4% and 3.3% respectively.

Prevalence of Stunting for Children 6-59 Months (WHO)



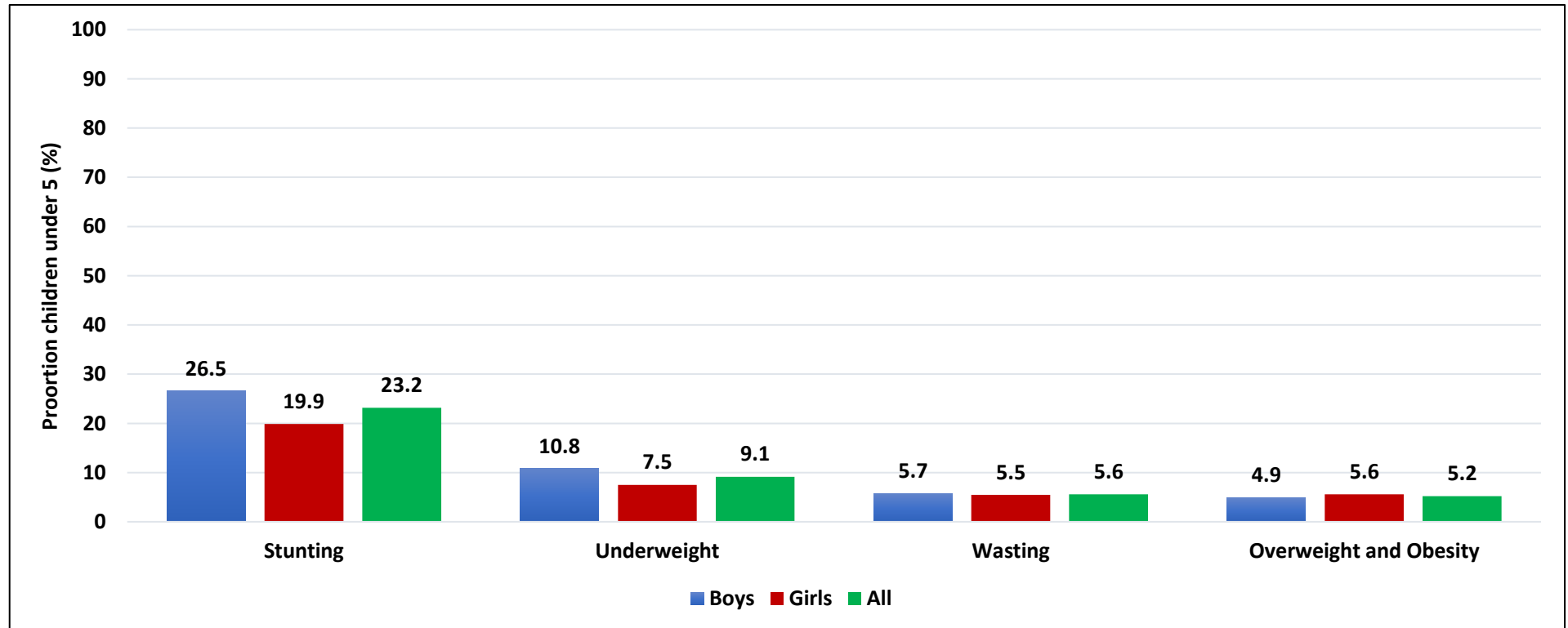
- The national proportion of children 6-59 months who were stunted was 23.2%.
- Stunting levels were highest in Matabeleland North (29.7%), with Harare, Bulawayo and Mashonaland East provinces with high stunting levels at 26.2%, 24.6% and 23.2% respectively.

Prevalence of Underweight in Children aged 6-59 Months



- The national average for underweight was 9.1%, with more children presenting with underweight in Matabeleland North at 16.7%.

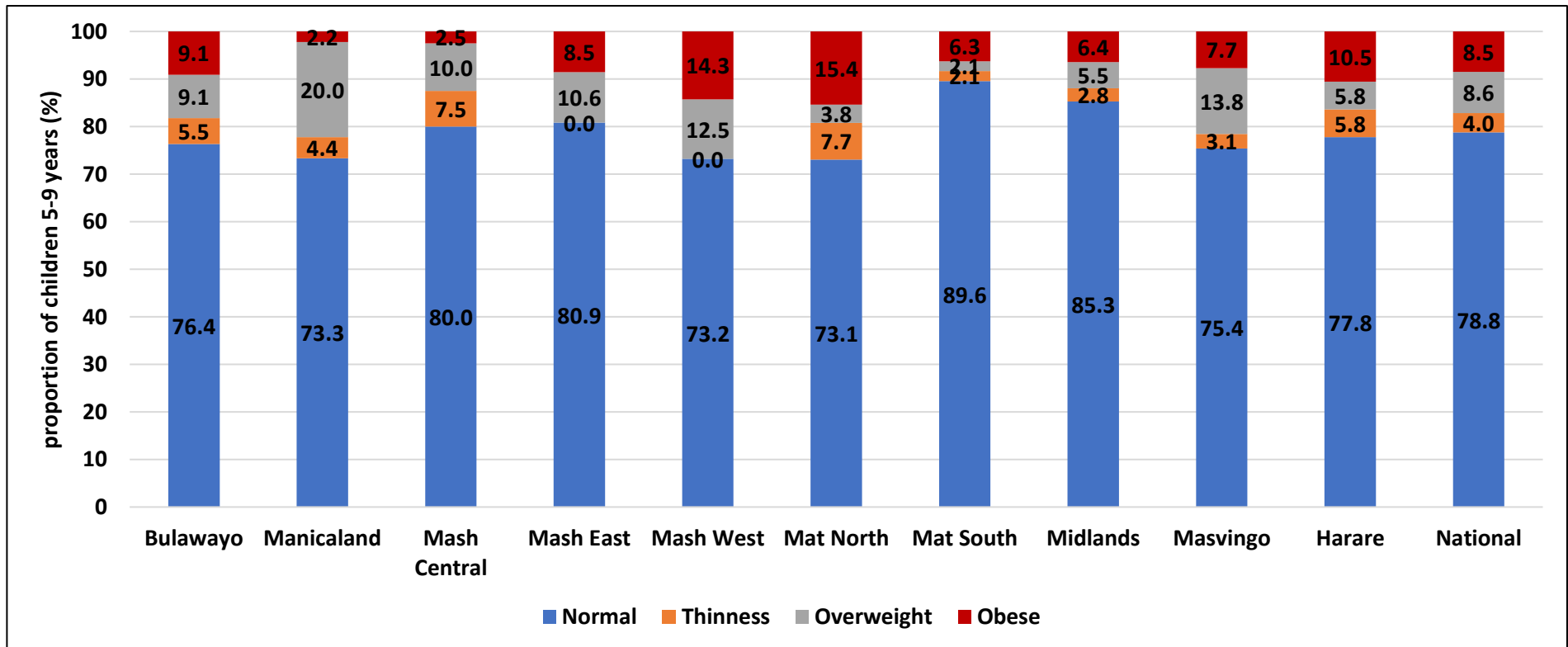
Nutrition Status by Sex of Children 6-59 months



- The proportion of children 6-59 months who were stunted, underweight and wasted was higher within boys than within girls.
- The proportion of children who were overweight and obese was higher within girls compared to within boys.

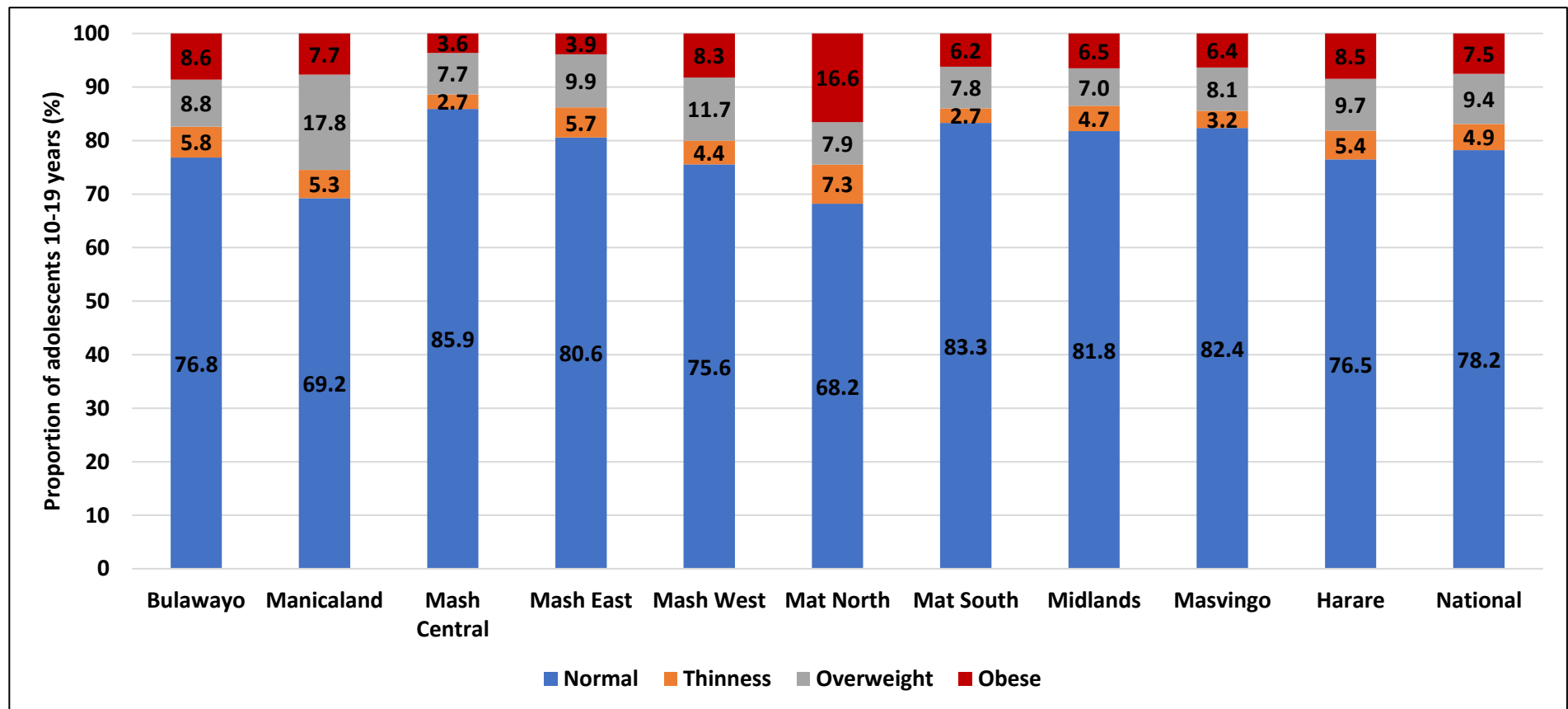
Nutrition Status: 5 to 19 Years

Nutrition Status of Children 5-9 Years



- Nationally, 8.5% of the children aged 5 to 9 years were obese and 8.6% were overweight.

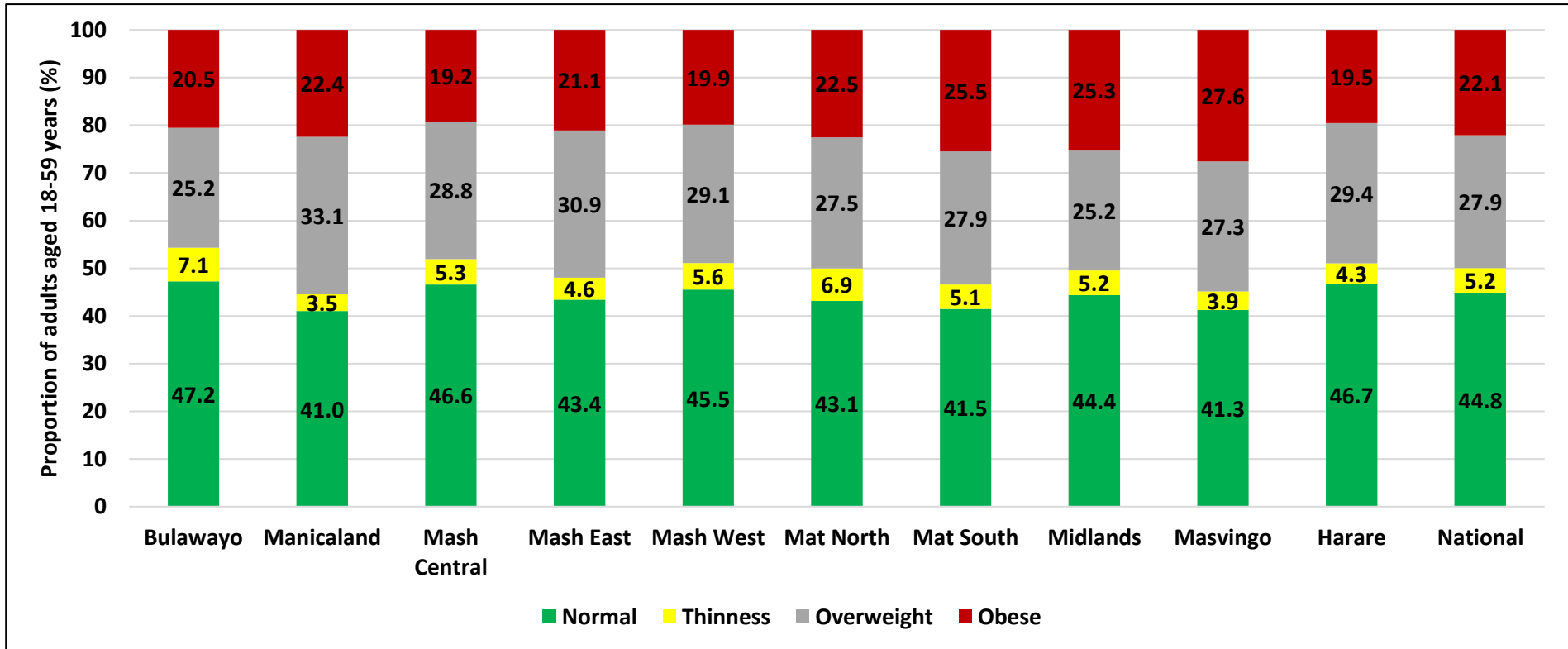
Nutrition Status of Adolescents 10-19 years



- At least 9.4% of the adolescents were overweight.

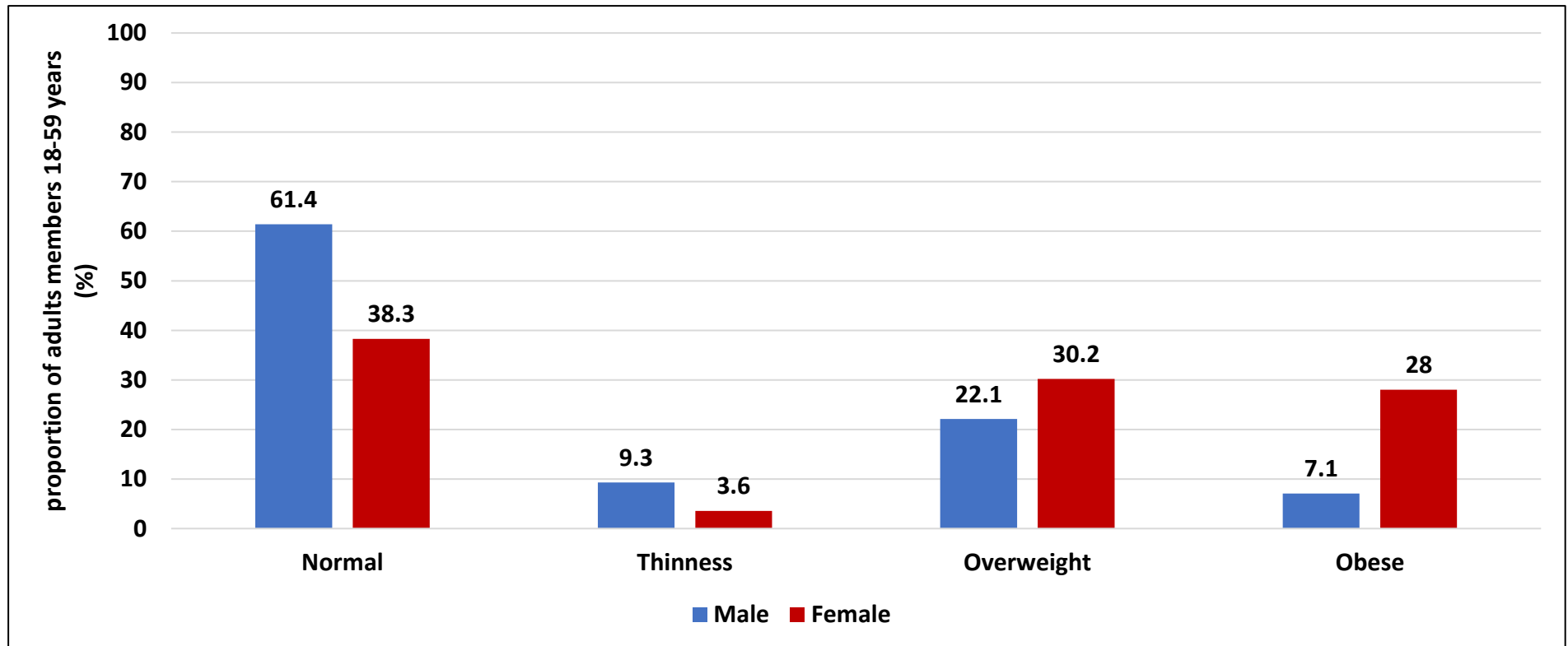
Adult Nutrition Status

Nutrition Status for Adults 18-59 Years by Province



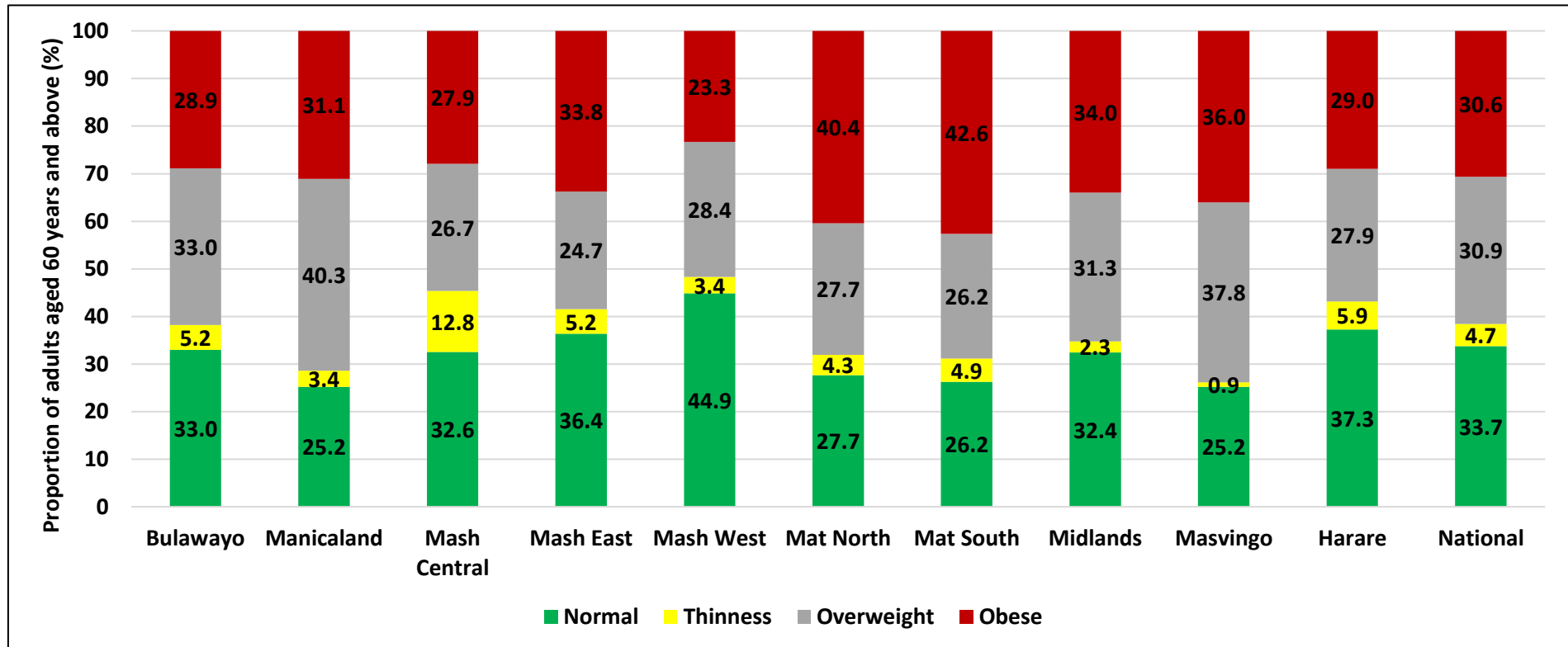
- Body mass index was used to classify adults aged 18 years and above. Having excess fat deposits in the body leads to serious health consequences such as cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis and some cancers (endometrial, breast and colon).
- Nationally, 50% of the adults aged 18-59 years were overweight and obese.

Nutrition Status for Adults 18-59 Years by Sex



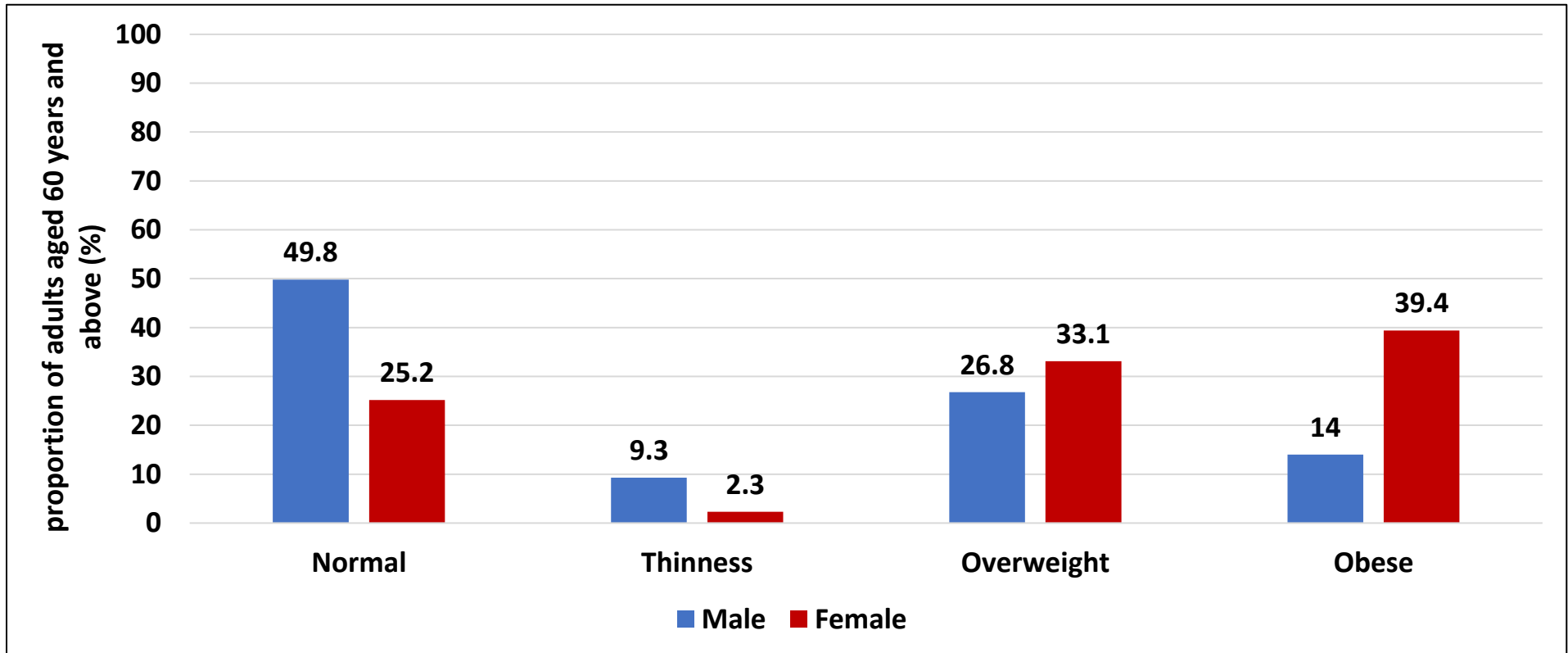
- About 22.1% of the males aged 18-59 years were overweight whilst 7.1% were obese.
- The proportion of women aged 18-59 years who had a normal Body Mass Index was 38.3% whilst 28% were obese.

Nutrition Status for Adults 60 Years and above by Province



- The proportion of adults aged 60 years and above who had normal nutrition status was 33.7%.

Nutrition Status for Adults 60 Years and Above by Sex



- The proportion of adults 60 years and above who had normal nutrition status was 49.8% among males and 25.2% among females.

Conclusions and Recommendations

Conclusions and Recommendations

Infant and Young Child Feeding (IYCF)

- According to the results, the national average prevalence of stunting was high at 23.2%. Although obesity levels were still relatively low at 5.2%, they are a cause for concern. While a high proportion of children (89.8%) were breastfed, only 40.9% of infants under six months of age were exclusively breastfed, falling short of the World Health Assembly's target of 50% by 2025. Additionally, early introduction of complementary foods within the first three days of birth (31.2%) is an unhealthy and not recommended practice. Therefore, efforts to address childhood undernutrition, micronutrient deficiencies and overnutrition need to be integrated to achieve global nutrition targets.
- Early initiation of breastfeeding is one of the high impact child survival strategies. About 74% of the children born within the 2 years preceding the survey were breastfed within the 1st hour of birth. Innovative Baby Friendly Hospital Initiatives) such as localised on job mentorship, should be expanded to cover all institutions offering delivery services to improve optimal breastfeeding practices. In addition, strengthening of community care groups, community synergies initiatives and attendance of anti-natal care sessions initiatives is recommended to ensure continuum of care. This should be augmented by task-sharing with other relevant Ministries such as those responsible for gender and women affairs, bringing in the multisectoral approach to realise optimal IYCF practices at community level.
- The Minimum Acceptable Diet (MAD) remained low at 10%, below the national target of 25%. Only 23% of children were consuming diversified diets. In addition, the proportion of children consuming sweet beverages (52%), unhealthy foods (12%) and those not consuming fruits and vegetables (13%) further impacts negatively on children diet quality outcomes. Through collaborative efforts by the Ministries responsible for ICT, higher and tertiary education as well as the Private Sector, there is need to come up with innovative ways of disseminating nutrition messaging such as digitalising urban messaging targeting the urban population. In India, the use of digital platforms to share information on diets (what, how, when) was proven to be effective.

Conclusions and Recommendations

Water, Sanitation and Hygiene (WASH)

- The findings reflected that 82% of urban households were connected to council or Zinwa piped water system. The Government of Zimbabwe is commended for maintaining the piped water system infrastructure in all urban areas. It is however recommended that Government through fora such as the Water Taskforce chaired by the Ministry responsible for Agriculture must strengthen the systems to support regular access and availability of safe treated water. Literature has shown that piped water systems provide the highest service level for water supplies and are associated with improved health, particularly reduced risk of diarrhoeal diseases.
- Twenty eight percent of households reported that their refuse was not being collected. Local Authorities in urban domains should consider addressing refuse collection and disposal infrastructural deficiencies through close partnerships with public and private organizations. Moreover, a number of critical actions need to be taken at household, commercial enterprise, neighborhood, town and national levels. Robust public awareness campaigns on the need to properly dispose waste need to be explored. Urban authorities can draw lessons from Rwanda garbage collection systems. There is need for collective buy-in from all players (households, local authorities, Government and private players for better waste management and clean environment.

Conclusions and Recommendations

Education

- About 80% of the children aged 4-19 years were going to school at the time of the survey, of which 6.1% were receiving hot meals at school. A child or young person who is hungry does not learn well! A healthy diet in sufficient quantity is essential for learning and development. In addition, without quality education, children are less likely to be healthy. The Ministry responsible for education ought to intensify enforcement and follow up on strategies aimed at keeping children in school. Furthermore, the sector has to intensify rollout and operationalisation of the school health and nutrition programme. In South Africa, School Feeding programmes have had a significant effect on improving illness, school attendance, and academic achievement. There is need for the Government of Zimbabwe to consider adapting new strategies from other countries which seem to have a sustainable Home Grown School Feeding Programme (HGSFP) eg Zambia which has implemented the HGSFP in 39 districts covering all 10 provinces targeting 1,000,000 pupils in approximately 2,800 schools. Through the Ministry of Primary and Secondary Education, schools with reliable water sources should be supported to have nutrition gardens to promote the sustainability of the home grown school feeding programme.

Nutrition Status

- The nutrition sector needs to remain alert and set up sentinel site surveillance mechanisms in provinces with high Global Acute Malnutrition (GAM) rates to define and monitor early warning indicators and trigger levels that will facilitate implementation of anticipatory actions and an appropriate timely response in the event of a continued deterioration of the nutritional status in children under-five. Government and partners need to invest in and implement Integrated Management of Acute Malnutrition (IMAM) programmes that will focus on community screening, early detection and referral of Severe Acute Malnutrition. Implementation of an integrated approach to address the underlying causes of malnutrition as well as for the prevention, treatment and management of acute malnutrition is recommended.

Conclusions and Recommendations

- In the face of high overweight (27.9%) and obesity (22.1%) in adults, there is a gradual convergence in dietary patterns in urban areas, including the consumption of highly processed foods. Policies and legislation are needed to promote healthy food environments, both formal and informal, and to empower consumers to make nutritious food choices. This needs to be coupled with local initiatives to create healthier retail food environments which include restricting advertising of energy-dense foods high in fats, sugars and/or salt.
- The assessment revealed that the quality of diets consumed by all three age groups (children, adolescents, and adults) was poor. The ministry responsible for health needs to take aggressive action in nutrition education and awareness to prevent increased rates of non-communicable diseases (NCDs). Nutrition education can raise awareness about the consequences of poor dietary behaviours. More nutrition education campaigns and awareness efforts are needed to educate the urban population about healthy nutritional behaviours.
- The findings have shown that only 21% of household members above 5 years of age engaged in exercise or physical activity on a daily basis. The health benefits of physical activity include reduced chronic illness and cancers. The Ministry responsible for health should explore the implementation of a group of interventions that work in synergy to promote healthy behaviours and adoption of regular physical activity.
- About 3% of urban adolescents and adults were reported to be currently smoking. Tobacco use is the leading cause of preventable deaths and is estimated to kill more than 5 million people each year worldwide. To address tobacco use's complex set of negative determinants on health, the government of Zimbabwe should consider enforcing finance tools that promote investment in the prevention of NCDs induced by use of tobacco products.

Conclusions and Recommendations

- Given the sedentary lifestyles by the urban population, efforts should be intensified to increase physical activity levels among children and adults to reduce overweight and obesity—one of the key risk factors for non-communicable diseases (e.g., hypertension). Illustrative interventions for adolescents and school aged children include:
 - Formulation and enforcement of policies and guidelines that ensure creation of a supportive school environment that prohibits the marketing and sale of unhealthy foods and beverages in and around the school premises.
 - Health and nutrition education through various social media platforms. Children and adolescents spend a lot of their time on social media which is the best place to find them and reach them with targeted messages that promote healthy lifestyles and good nutrition.
 - Promoting physical education in schools combined with nutrition education (Doak et al., 2005) such as increasing knowledge on the importance of good nutrition on Physical Activity Levels (PALs) at all levels of the school's education system.
 - Reduced screen time (Doak et al., 2005). This entails working with parents and caregivers through nutrition education programmes to encourage them to limit and regulate screen time for their young children and adolescents and promote physical activity at the levels.

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