A Community Based Multi-Sectoral Approach to Address Food and Nutrition Insecurity in Selected Vulnerable Districts of Zimbabwe with a Special Focus on System Strengthening

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Acronyms

FNSCs	Food and Nutrition Security Committees
IYCF	Infant and Young Child Feeding
MUAC	Mid-Upper Arm Circumference
WFNSCs	Ward Food and Nutrition Security Committees
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

1. Introduction/Context

Preventing and reducing stunting, especially during the first 1000 day period; from conception to 2 years of age has emerged as one of the most critical national priorityies to Zimbabwe. This is reflected in the Government's new economic turnaround blue-print, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET)'s cluster number one. In addition to the ZIMASSET, the Government of Zimbabwe has endorsed a multi-sectoral Food and Nutrition Security Policy and Implementation Matrix in 2013-2014, that calls for stakeholders in agriculture, social protection, health, nutrition, education, water and sanitation sectors to address food and nutrition insecurity using a multi-sectoral approach. Stunting has adverse effects on children's cognitive and behavioural development, through mechanisms that are still not fully understood. Being stunted was also found to be associated with less schooling, which was a partial reason for the poor cognition found. Findings from the recent Zimbabwe MICS 2014 indicate prevalence of stunting at 27.6% with noted Stunting remains high in rural areas (30%) compared to (20%) urban areas. The high prevalence of stunting in rural areas, therefore, calls for a more targeted approach in the highly vulnerable rural districts of the country.

2. ZIMASSET Priorities 2015-2018

The operationalization of ZIMASSET is a top priority of the Government of Zimbabwe. In 2014, the Government made further commitment to ensuring the ZIMASSET is operationalized in 2015-2018, through establishment of a revamped implementation and coordination structure. These structures were put in place to support sustainable, results-oriented socio-economic growth and performance. To address current socio-economic challenges and help steer the economy towards rapid recovery and sustained growth, the following strategic areas have been prioritised for the ZIMASSET 2015-2018 period:

- Effective and efficient public service delivery;
- Agricultural value chain development;
- Mineral development and beneficiation;
- Energy development and expansion;
- Making the necessary reforms to improve the 'Doing Business' environment;
- The enhancement of Food and Nutrition Security; and
- Enhanced social protection programmes to protect vulnerable groups.

In the critical area of food and nutrition security, under cluster 1, the ZIMASSET aims to achieve and sustain higher agricultural production and productivity, market access, increased incomes, stunting reduction and improved nutrition. The Government plans to achieve this through implementation of evidence-based food and nutrition interventions which are integrated within a broader multi-sectoral collaboration framework. The Food and Nutrition Security cluster seeks to build a prosperous, diverse and competitive food sector which makes a significant contribution to national development by providing an enabling environment for sustainable economic empowerment and social transformation, with close linkages to value addition and beneficiation activity.

3. Goal of the Food and Nutrition Security Policy

The goal of the Food and Nutrition Security Policy is to:

"***Promote and ensure adequate food and nutrition security for all people at all times in Zimbabwe, particularly amongst the most vulnerable and in line with our cultural norms and values and the concept of rebuilding and maintaining family dignity.***"

The Food and Nutrition Security Policy recognizes that: The food and nutrition insecurity problem Zimbabwe faces is multi-dimensional. Addressing it requires a coordinated multi-sectoral approach. It calls for not only a shared vision on understanding the causes of the food and nutrition insecurity, but also sheds light on a shared vision on how to tackle the problem. The policy emphasizes the need to ensure synergy while minimizing duplication and inefficient deployment of scarce resources.

4. Rationale For the Multi-Sectoral Community Based Approach

The multi-sectoral community based approach is based on the Food and Nutrition Security Policy's Guiding Principles:

- **Principle 4:** strengthening collaboration across sectors, minimising duplication and fostering collective accountability towards a shared goal.
- **Principle 5:** reinforcing the central role and responsibility that communities and civil society have in ensuring food and nutrition security.

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

Consistent with global patterns, chronic malnutrition in Zimbabwe begins *in utero* and peaks at 24 months of age. According to the 2012 Micronutrient survey, 10% of babies in Zimbabwe, are born stunted which reflects a need for pre-conception, maternal and adolescent nutrition interventions. Stunting results from a complex web of household, environmental, socioeconomic and cultural influences. The problem therefore requires that direct nutrition interventions be integrated and implemented in tandem with nutrition-sensitive interventions to achieve maximal benefits. Stunting before age two predicts poorer cognitive and educational outcomes in later childhood and adolescence and has important education and economic consequences at the individual, household and community levels. In the past 2 years, efforts have been made to establish sub-national Food and Nutrition Security Committees (FNSCs), but the coordination structures still require the prominent leadership of Local Government to ensure results. In addition, the FNSCs need to be further established at the village and ward levels to link policy to implementation with the communities on the ground.

The currently established FNSCs have been provided with broader coordination mandates, without a specific focus on stunting reduction as an outcome of their work. Food and nutrition insecurity reduction however, is prioritized as the main outcome of the nutrition component of the food and nutrition security cluster of the ZIMASSET, hence the work of the FNSCs must be targeted at tackling food and nutrition insecurity. In addition, capacitating and improving functionality and effectiveness of the multi-sectoral committees at national and subnational levels will help ensure sustainability of all food and nutrition security efforts being spearheaded by various actors in the country. It will also bring ownership of initiatives and empower communities to be able to assist in solving their own problems. It is envisaged that the proposed intervention will contribute towards building resilience of communities in the event of some shocks threatening nutrition security.

It is with this background that the UN Agencies (UNICEF, WFP, FAO, WHO) propose to support the Government of Zimbabwe to implement a multi sectoral community based model for reducing food and nutrition security challenges. Given that stunting is a result of multiple causes, the model will therefore call for efforts of multi-stakeholders including Health, HIV, WASH, Agriculture, Education, Women Affairs and social protection. The existing food and nutrition security coordination mechanisms at provincial, district, ward and village levels will be utilized to implement this model. It is envisaged that the proposed model will contribute towards building the resilience of communities in the event of some shocks threatening food and nutrition security. It will also promote ownership of the initiatives and empower communities to be able to assist in solving their own problems.

5. Objectives

Broad Objective

To reduce food and nutrition security challenges in 4 selected vulnerable districts of Zimbabwe through a multi-sectoral community based model approach and systems strengthening.

Specific Objectives

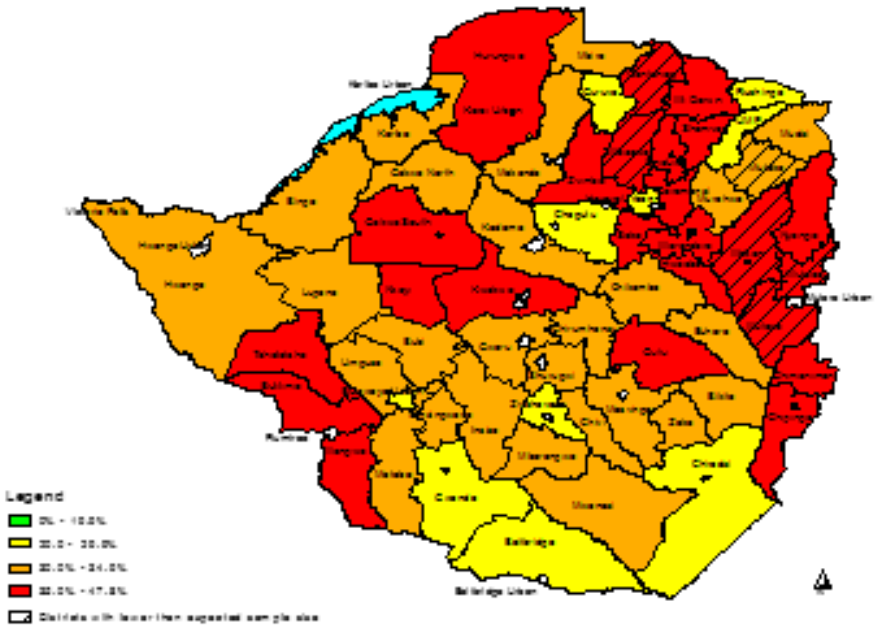
1. To build the capacity of multi sectoral Food and Nutrition Security Committees at all levels on planning, coordination, implementation of the community based model focussing on high impact nutrition specific and nutrition sensitive interventions along the continuum of care.
2. To assess the determinants of stunting / the drivers of stunting through primary and secondary data analysis.
3. To develop and implement micro-plans at community level based on key critical evidence based nutrition specific and nutrition sensitive interventions / service package to reduce stunting , specifically
    a. To reduce by at least 2% annually the proportion of children under five who are stunted in each district
    b. To protect, promote and support exclusive breastfeeding of infants for six months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age or beyond.
    c. To improve the nutrition of mothers and children, including adolescents, through household food security, access to basic services and adequate caring practices.

4. To set up a community based model to build the resilience of communities to respond to shocks and mitigate risks related to food and nutrition insecurity.
5. To develop and implement a comprehensive multi sectoral monitoring and evaluation system to track effectiveness of food and nutrition security interventions.
6. To promote learning and knowledge exchange towards scaling up to 4 additional districts by 2020 and nationwide in the longer term.

6. Targeted Districts

The multi-sectoral community based approach to reducing food and nutrition security challenges will be initially implemented in four districts (Chipinge, Mutasa, Chiredzi, Mwenezi) that have been prioritized based on the high levels of chronic malnutrition, food insecurity and population density of children under the age of five and poverty rates over the past 10 years. The average stunting rate in these four districts is 33% with the highest prevalence being in Chipinge District at 43.8%.

Figure 1.1a Prevalence of stunting in children 6-59 months of age, by district (WHO)



The total under 5 population in the four districts is about 160,000 which is about 8% of the total under 5 population in the country. A specific focus will be on children under two years of age, adolescent girls and women of child bearing age. Since HIV is a big area of concern integration, will be done at all possible point of interventions. Similarly, there will be integration of the other WASH, health, social protection, poverty alleviation and agricultural interventions as well.

See Annex 1 for the key nutrition indicators and Annex 2 for the demographic profile for the four targeted districts.

7. Strategies for Multi-Sectoral Community Based Approach for Addressing Food and Nutrition Security Challenges

The Proposed Strategies for Food and Nutrition Security Challenges Reduction using a Multi-Sectoral Community Based Approach will include:

- **Addressing context specific drivers of stunting** – The root causes of stunting are many and vary from community to community. Through the capacitated coordination structures at community level and with the involvement of the communities themselves, the drivers of stunting and / under nutrition will be identified for each community and interventions devised to address them with full involvement of the community structures. Community level participatory planning exercises will facilitate the identification of underlying causes of stunting resulting in the formulation of context specific interventions that help build resilience within the communities so that they are able to meet their own food and nutrition needs.
- **Improved targeting** - interventions will be targeted at the nutritionally-at risk households (i.e. vulnerable pre-pregnant , pregnant and lactating women, children under 2 years of age, adolescent girls with interventions to improve maternal and child nutrition and food insecure households with both nutrition specific and nutrition sensitive programmes).
- **Integrated response to stunting will be done** through convergence of multi-sectoral services (health, HIV, agriculture, WASH, social protection, Education, Women and gender) at the household level for greater synergy and complementarity. This will also include development and implementation of a comprehensive communication package on all the aspects for greater impact.
- **Developing community-based processes** aimed at empowering adolescent girls, pre-pregnant women and pregnant women.
- **Effective use of available resources** – Intensify implementation through existing structures and systems using a multi-sectoral approach towards greater efficiency of existing financial resources, strengthen planning and implementation.
- **Leveraging additional resources** for improved nutrition outcomes.
- **Capacity building of** existing multi-sectoral government structures as identified in the Food and Nutrition Security Policy.
- **Coordination and collaboration** within and across sectors.
- **Strengthened monitoring and feedback mechanism** from community to national levels and back in a participatory manner.

8. Approach for Household Targeting for Community Based Model for Addressing Food and Nutrition Security Challenges

- Household targeting for the Multi-sectoral Community Based Model for Addressing Food and nutrition security challenges should utilize the existing local leadership, ward development coordinators and village health workers.
- Currently the village head in every ward has a village register of all households and their members that are under his governance and this will allow for mapping of households within wards and villages.
- Ward development coordinators currently have registers of household demographics for each household in the selected districts that will enable ease of mapping of households with nutritionally vulnerable community members.
- The Village Health Worker for every village also has a register of households that have children under five years of age, pregnant and lactating women. This existing health system register should be utilized to further identify households with potential nutritionally vulnerable community members.

Targeting of Vulnerable Community Groups to be Reached

Within households with nutritionally vulnerable community groups, selection should be done using the following criteria:

a. All pregnant women with a < 19 cm mid upper arm circumference (MUAC) / HIV positive / HIV exposed or those who become pregnant and have a <19 MUAC/ HIV positive / HIV exposed
b. All Teenagers with pregnancies
c. All Children under two years of age who were born with a low birth weight
d. All Children under two years of age who are underweight / stunted and growth faltering

Once households have been targeted using the above mentioned criteria then household questionnaires will be administered to further determine the drivers of stunting and vulnerability within that household by members of the WFNSC.

Community Based Group

Village structure **Guided supervised and monitored by**
Ward councillor and Chief

Community health nurse, Environmental Health Technician, Ward Development coordinator, head master, nutrition assistant , Agriculture extension worker , Chair child protection committee, health centre committee , youth officers, traditional leadership, religious leaders, traditional healers, case care workers

Village worker
Community health club members
Community Nutrition Garden members
Village development and FNS committee

Religious leaders
Village Head man
Water committee

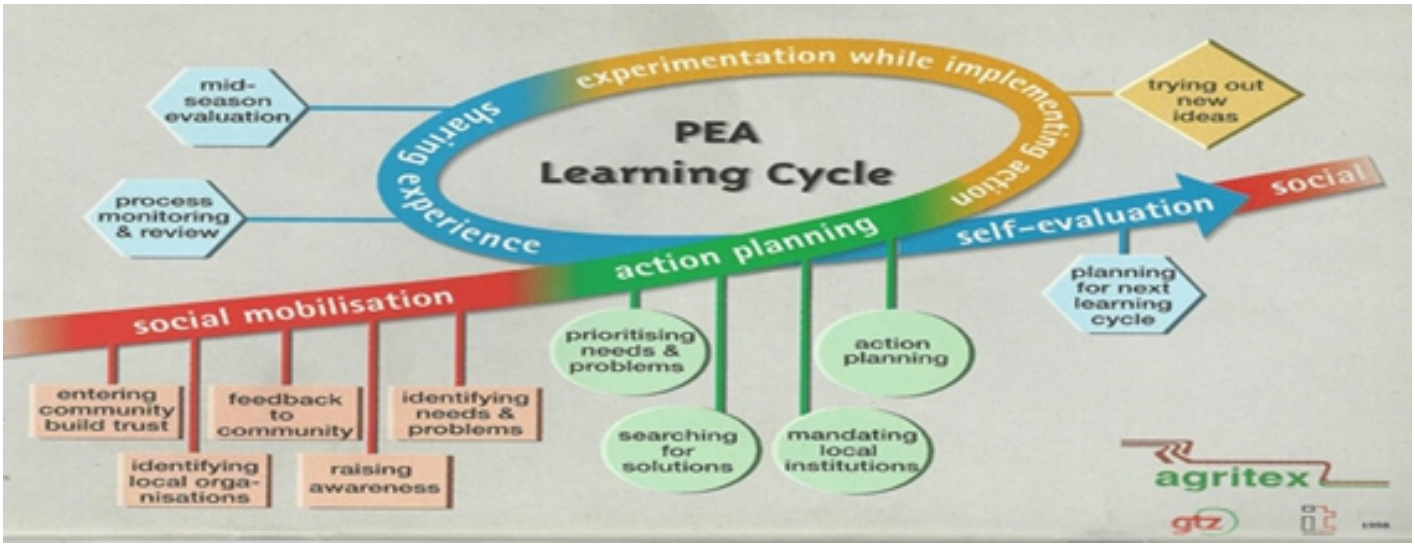
Lead mothers
Lead fathers
adolescent Peer champions

social clubs
income generating groups
any other existing village group

Ward/Community social mobilisation and action planning process will include:

- Orientation and sensitization of the community and raising awareness ,
- Identifying local leadership and institutions for community processes ,
- Constituting the Ward/Community Food and Nutrition Security Committee ,
- Assessment of poverty level and Wealth ranking,
- Identifying needs and problems / drivers of stunting ,
- Prioritizing nutrition specific and nutrition sensitive problems and needs ,
- Searching for solutions from local/indigenous and local wisdom, knowledge, experiences and best practices and
- Action planning

Community Participatory Extension Approach Process



9. Steps For Implementation Of The Multi-Sectoral Community Based Approach To Addressing Food And Nutrition Security Challenges

Planning Phase

Step 1: National Level Joint Action Plan Committee Established (Ministries of Local government, Health, Agriculture, Social services, Education, Women and Gender, Trade and industry Finance and Economic Planning)

Step 2 Sensitization & Coordination Workshops at National, Provincial & District levels (NFNSC, PFNSC & DFNSC)

Step 3: Training of WFNSCs on micro planning, coordination, and analysis of drivers of stunting at ward level

Step 4: Selection & mapping of nutritionally-vulnerable households by the Ward Food & Nutrition security committees and village

Step 5: Assessment of drivers of stunting through FGDs, household interviews & secondary data analysis by WFNSCs and community members

Step 6: Formulation of Micro plans at village and ward level by WFNSC and village heads

Step 7: Implementation of micro plans & interventions by community and service providers (Health, Agriculture, WASH, Social Protection, and Gender)

Step: 8
Ongoing coordination & monitoring within and across line ministries as household needs are identified

Step 9: PA coordinates quarterly review and monthly review at District, Ward and Village Levels to review progress and address issues and bottle-necks in implementation

Step 10: Feedback to the Local Government, Food & Nutrition Council

Implementation Accountability Channels

N.B: Steps1-3

These involve setting up committees in Districts where they are not in existence while strengthening the already existing ones. These committees are multisectoral in nature incorporating different Government Ministries and departments as well as UN agencies, civil society and community members. The committees at Provincial and District level are chaired by Ministry of Agriculture, Mechanisation and Irrigation Development, and Ministry of Labour Social Welfare is Vice-Chair, with Ministry of Health and Child Care being Secretariat. The FNSCs will lead the co-ordination of food and nutrition security activities at sub-national level through providing a platform for interaction amongst relevant Government Ministry representatives, partners and the civil society. The Ward and Village FNSCs have traditional leadership (Chiefs and Village Heads) and Councillor under Local Government. Membership of the Ward and Village level FNSCs will be Government officers including Agritex Extension officers, Community Nurses, Environmental Health Technicians, Village Health Workers, Ward development coordinators and other ministry representatives with ward level workers. The trainings will also focus on the UNICEF conceptual framework on the causes of malnutrition as a way of capacitating communities in identifying challenges within their areas. This is further explained under the proposed strategies section. These sub national committees will participate in collection, analysis and use of information and ensure that there is ownership and utilization of information at sub-national level.

10. Interventions / Service Package For Multi-Sectoral Community Based Approach To Addressing Food and Nutrition Security Challenges

Interventions will be determined by the root causes of food and nutrition security challenges, specific drivers identified in each community and existing gaps in the delivery of services at household and community level in the targeted districts. The Ward and District level FNSCs will receive training on how to strengthen the existing service delivery system for the proven high impact nutrition specific and nutrition sensitive actions. Below are the proposed set of nutrition specific and nutrition sensitive interventions, however the package of interventions and the specific targeting for each ward will be based on specific needs of the community which emerged through the baseline survey, FGDS, targeting approach and the intra household analysis of drivers of stunting.

Nutrition Specific Interventions

IYCF promotion: Given that optimal IYCF is a cornerstone of child survival, nutrition, health, growth and development as well as prevention of childhood obesity and later non-communicable conditions (diseases), the focus will be to increase exclusive breastfeeding rates and appropriate and adequate complementary feeding of children in targeted districts. This will be done through a combination of both one-on-one peer-to-peer counseling and group counselling. Community based counselors will be trained in community IYCF using UNICEF generic IYCF training package to facilitate IYCF support groups, conduct action oriented sessions on IYCF and provide individual IYCF counselling. Integration with HIV services at community level will include identification of HIV exposed babies and counselling the mothers on exclusive breastfeeding and referral to a health facility of those who opt for exclusive replacement feeding. Furthermore, HIV positive lactating mothers will be counselled on prevention of mother to child transmission of HIV during the lactation period. Implementation of communication campaigns tailored to the local context to promote optimal IYCF will also be conducted.

Micro-nutrient supplementation for pregnant women and children 6-59 months: Addressing micronutrient deficiencies contributes to the social, economic and intellectual development of individuals and communities. Women of child bearing age, children under the age of five years and adolescent girls are most affected and will be targeted. Women and adolescent girls will be supplemented with iron and folate during pregnancy and for 6 months after delivery. Children aged 6 to 59 months will be given vitamin A supplements twice a year from health facilities and EPI outreach points to reduce incidence and the risk of death from severe illness, prevent blindness and improve eye sight. Key messages on the benefits of iodised salt and consumption of fortified foods will be promoted through the FNSCs at district and ward levels. Household production and consumption of vitamin A and iron rich foods including foods of animal origin will be promoted to prevent micronutrient deficiencies.

Management of severe acute malnutrition: In order to achieve early identification of children with severe acute malnutrition in the community, trained community health workers will measure the mid-upper arm circumference of infants and children and examine them for bilateral pitting oedema. The community's awareness of severe acute malnutrition as a public health issue will be enhanced. Infants and children who are 6–59 months of age and have a mid-upper arm circumference <115 mm, or have any degree of bilateral oedema, will be immediately referred for full assessment at the nearest health facility for the management of severe acute malnutrition. Follow-up of infants and children with severe acute malnutrition periodically during and after discharge from treatment at the health facility is essential to ensure compliance, assess response to treatment and avoid relapse. Identified cases will also be linked /referred to other community services such as HIV testing, IYCF, vitamin A supplementation. All community activities related to the treatment of severe acute malnutrition will be reported to the nearest health facility.

Treatment of Moderate acute malnutrition: Moderate acute malnutrition has been found to be high in pregnant and lactating women, women and children who have HIV/TB. To protect these nutritionally vulnerable groups from deterioration in nutrition status, a supplementary feeding intervention will be implemented (only in Mutasa) to protect the health of moderately acute malnourished HIV/TB clients as they undergo ARV/DOT therapies as well as to malnourished pregnant and lactating women and children under the age of five.

Nutrition Sensitive Interventions:

Health: The Lancet Series (6th June 2013) provides evidence to show that Antenatal Care, Skilled Birth Attendance, post-natal care, immunization appropriate management of common childhood illnesses have a positive effect in stunting reduction. Ensuring improved and equitable use of quality health services will therefore significantly complement the nutrition-specific interventions. Specifically, the health interventions will focus on increasing the age at first pregnancy, ensuring early start and achieving at least 4 focused antenatal care visits, skilled attendance at delivery, ensuring optimal and quality post-natal care for mothers and babies, full immunization coverage and appropriate management of childhood diarrhoea, pneumonia and malaria.

Agriculture: As far as agriculture is concerned, focus will be to ensure increased access to safe, diverse nutritious foods (both crops and livestock) all year round. This will be achieved through promoting diversified agriculture production – in field and in micro-gardens and integrating small livestock production. Small livestock have been shown to contribute towards household consumption better than large stock. Access to food in almost all districts in Zimbabwe is affected by seasonality, with plenty of food during the rainy season and very little food during the dry season. To even this out, small scale food processing and preservation will be promoted to reduce loses during periods of plenty and safely preserve food for use during lean seasons. With increased diversified production, and increased nutrition awareness local agriculture markets will increase access to nutritious foods for household consumption. Women, the primary care-givers of children and families also contribute more than 70% of agriculture labour force in farming communities in Zimbabwe. Women's participation in agriculture can increase women's level of income that can be used to improve household nutrition. However, without due diligence, women's participation in agriculture can compromise child care resulting in children becoming malnourished. This could explain the reason why the food secure districts on Zimbabwe have high levels of malnutrition.

WASH: Studies have shown that water, sanitation and hygiene interventions have a positive effect on health and nutrition outcomes through reduction in diarrheal morbidity as well as a reduction in the prevalence of stunting in children in some countries. The key WASH interventions that will be incorporated into the multi-sectoral community based approach for addressing stunting will include, ensuring communities and households have access to safe water, provision of basic sanitation, promotion of hand washing with soap or ash, through hygiene behaviour change communication. The demand-led sanitation and hygiene approach will be supported in selected districts to help communities to realize the need to stop practicing open defecation. To sustain good hygiene behaviours, communities will be encouraged to establish community health clubs and school health clubs which will be used as a platform for implementing participatory health and hygiene activities.

Social Protection: Recent evidence shows the impact of social protection on nutrition outcomes in Sub-Saharan Africa. Impacts are seen on specific anthropometric indicators, as well as on household consumption and food expenditure, dietary diversity, access to basic social services, as well as addressing decision making power and intra-household dynamics. The multi-sectoral community based approach will incorporate social protection through developing the social protection system which will include, safety nets (lean season assistance) and unconditional cash transfers to help to protect the most vulnerable women and children, households and communities from food insecurity and entering or falling deeper into poverty. For non-labor constrained households, food assistance and cash for assets interventions will be incorporated that will create and/or rehabilitate critical and sustainable agriculture and livestock-related productive assets in the prioritized districts as a productive safety net for chronically food insecure people. The productive asset creation intervention will ensure at least 50 percent participation of women in the design, implementation and maintenance of community assets as well as in activity management. For labor constrained households, cash transfers to households that are food poor will be implemented to help increase incomes and household consumption as well as expenditures on both food and non-food items. Expected outcomes include resilience of communities to recurrent shocks and enhanced food and nutrition security, measured through community asset scores and food security outcome indicators. In addition, it is anticipated that cash transfers in the Zimbabwean context will have impact across a range of outcomes including in health, education, nutrition, poverty and food security, sustainable livelihoods and child protection.

Education: Attainment of secondary level education by women, has been shown to have positive effects on nutrition outcomes in Zimbabwe. In light of this evidence, the multi-sectoral community based model for addressing stunting will focus on supporting completion of secondary level education by adolescent girls, as well as provision of comprehensive school health services (HIV/AIDS, sexuality, life skills, nutrition education and micronutrient related interventions). Where needed, out of school adolescent girls will be targeted with life skills education and training particularly skills on food and nutrition. Collaborations will be pursued with Technical and Vocational Colleges and Ministries of Primary and Secondary Education; State for Liaising on Psychomotor Activities and Higher & Tertiary Education, to expand their Integrated Skills Outreach Programme. In this multi-sectoral community based program for addressing food and nutrition security challenges, the integrated skills outreach program could be implemented with a special focus on income generation for out of school adolescent girls, through value addition of locally available foods, to enhance food security-in line with ZIMASSET outcomes. Also through the education platform, where a need is identified, school gardening will be integrated into ECD and primary level education under the auspices of the School Development Committee as part of the school income development. An integrated school gardening program that incorporates safe food production, preparation, preservation and storage, health and hygiene promotion will be implemented, through existing school structures and it is anticipated that school children will become messengers of change to their families and communities.

11. Monitoring and Evaluation Framework and Plan

The monitoring and evaluation function of the Multi-sector Community-Based Approach to the Reduction of Food and nutrition security challenges aims to achieve four purposes, namely:

- To provide near real time information that can be used to monitor and evaluate the intervention,
- Strengthen the use of information at village, ward, district, provincial and national level to support planning and corrective actions in keeping with mandates and responsibilities at different levels, thereby improving local decision making and strengthening the FNS committee structure,
- Creating social accountability through direct feedback from village level, and
- Facilitate learning on data collection and utilisation to improve programme results.

The Monitoring and Evaluation (M&E) function is focused on ensuring that appropriate data is collected and that each level of the implementation structures has access to quality data in a form that enables it to monitor and track its own actions and their effects on selected indicators.

Data Needs

Five types of data will be required for the M&E function to achieve its purpose. These are:

1. Nutrition and Stunting status (Changeable Practices and Household Assets)
2. Nutrition-sensitive factors (Changeable Practices and Household Assets)
3. Functionality and capacities of service infrastructures
4. Functionality of the Food and Nutrition Security Committees and support among different committee levels), and
5. Citizens' satisfaction with services (Feedback on services and response).

Specific indicators to meet each type of data need at each level have been identified and integrated in data collection tools.

Obtaining the data

Tools

Tools will be developed for the collection of data at different levels starting with the village level.

Village level tool: The village level tool will facilitate the tracking of some basic indicators about the village (status of children, changeable practices and household assets, services availability and functionality of structures). Household data collection will be guided by the presence within the household of pregnant women and children under 2 years of age.

Ward level tool: The ward level tool will consist of ward level data that is either only available at this higher level or is best presented at this level – examples include information on health facilities, schools, and other services provided at ward level. This ward level data will be collected either from first hand findings of the committee members or retrieved from external sectoral information flows. In addition will be data on the functioning of the ward level Food and Nutrition Security Committee.

It must be noted that it is the ward level that will be tasked with entering the village data in a digitized form. This data will later be visualized with capabilities for drill down to village level.

District and Provincial level tools: As with the ward level, tools at each of these levels will consist of information collected directly by the committee members as well as some information retrieved from external data flows.

Data collection

The development team has created data collection tools in consultation with the multi-sector stakeholders. Responsibilities for data collection at different levels, frequencies and timing of data collection will be exposed in a summarized way in documents to be finalized. A process map has been developed to illustrate the agreed flows of different types of data. In some cases collecting data may involve primary data collection while in others it would be extracted from existing data systems. Following the preliminary design of the data collection and management process, the practicability of the process will be tested at village, ward, district, province and national levels.

Quality control

A data quality control system will be established in consultation with stakeholders. A key responsibility of this function will be to ensure that data used within the intervention is sound and consistent with data from other sources. The committees will be responsible for ensuring quality control of the data. Electronic forms will also be pre-programmed to limit errors and regulate the information that can be entered as a way of ensuring quality data.

Data Management System

An electronic system was developed for the management of data. A System developer was contracted and designed forms for data collection on the easily adaptable Open Data Kit platform and Rapid-Pro platform for SMS. The system has features allowing for appropriate dashboards at village, ward, district, province and national level (although the village level will not be expected to make use of the system but paper reports). The system has multiple views including by indicator category.

Data entry into the system occurs at ward level (on the basis of the ward level tool as well as the received paper-based village level data tool). Tablets are used to enter the village and ward level data on a monthly basis. As the data is uploaded, summary tables are produced based on pre-programmed algorithms in the form of dashboards.

The district level committees have computers and printers allowing them to provide support to lower levels as appropriate after reception and analysis of the feedback from server. The national level has a server hosting all the data for the system.

Data Viewing and Alerts

Each level has access to its own data as well as aggregated data from lower levels through a consolidated view with drill-down capabilities. Dashboards were developed at each level enabling each of the levels to view their data and discern trends (colour coding based on agreed thresholds will be used to ensure data requiring attention stands out).

Alerts have been pre-programmed into the data system such that when agreed thresholds are reached, system-generated SMS messages are sent to the appropriate individuals (for example a ward that has not submitted its data or where further investigation is required owing to deterioration).

Data Utilisation

The Food and Nutrition Security Committees at different levels have scheduled meetings (monthly at village, ward and district levels). Each committee at the different levels has responsibilities for chairing and secretariat roles outlined in its terms of reference. The terms of reference will need to be revisited to reflect responsibility for leading the discussion on data. The standard agenda for each level has been modified to include a component on data trends and necessary responsive actions. Compliance with the use of data will be tracked through a requirement in the reporting formats that will include a section on data, trends and proposed responses to data trends.

Building in a social accountability

Service delivery is improved by the availability and visibility of feedback on services. The M&E function supports the Multi-Sector Community-Based Approach to the Reduction of Food and nutrition security challenges to build in a social accountability component. The social accountability component consists of two parts (village reporting via SMS; and use of the RapidPro platform to poll and receive feedback from VFNS committee members). This component enables service providers to receive feedback and strengthen their case for support from higher levels. Village feedback will be generated during monthly meetings and may include a number of polls as required by the ward, district, province or national level.
To support the village level reporting, information is sent through basic cellphones to villages. This mode is used both for polling purposes and receiving alerts.

Data Access and Privacy Issues

The design of the data system is such that access to different types of data is based on authority levels awarded by the system administrator. Identifiers for individuals are stored separately with only codes used in the data files.

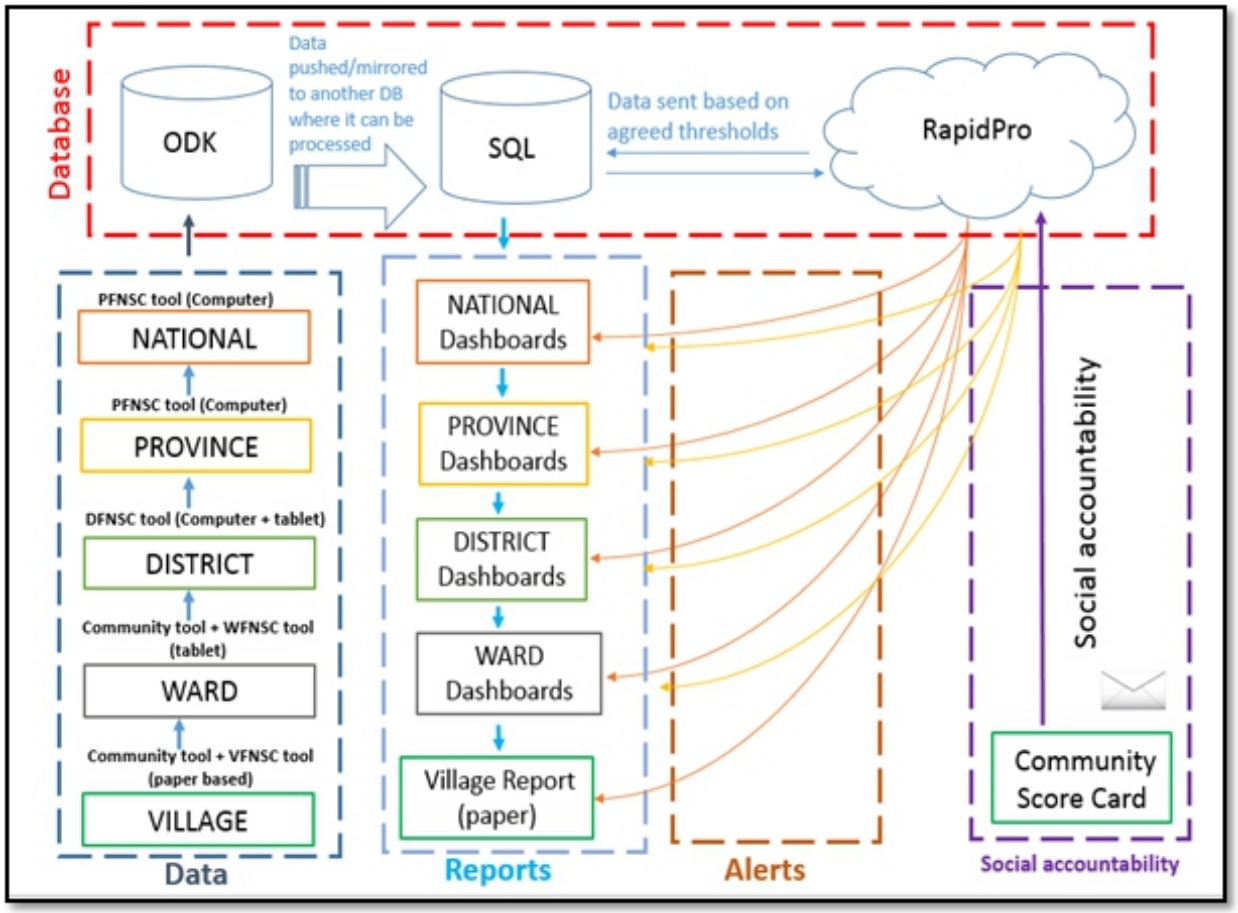
Learning Phase Operationalization

During the learning phase, the project was approved to operate in the 4 districts (Chipinge, Chiredzi, Mutasa, and Mwenezi). In each of the districts, five wards were selected and in each ward 3 villages were selected for inclusion. The necessary support will be provided to the 60 villages, 20 wards and 4 districts to gather and utilise appropriate data. Exclusion from this learning group will not mean exclusion from gathering relevant M&E data but rather that the excluded villages and wards will not in the early phase form part of the learning cohort. They will however have some basic M&E responsibilities as deemed fit by the multi-sector stakeholders.

Following the operationalization in a small number of villages and wards and the generation of lessons, the first level of scale-up will be to increase the number of included wards and villages (ideally to 100% within the four districts). This first level of scale-up will be used to learn more about the costs and strategies for cost management in scaling up the approach adopted by the project.

The second level of scale-up which would entail the expansion in the number of districts will fall outside of the initial lifespan of the multi-sector intervention. The investment in M&E will generate a model with potential scale-up and outline the strategy, costs and process of scaling-up.

Complete Overview of FNC M&E System



Programme Monitoring and Evaluation

The programme monitoring and evaluation component will focus on evidence for the delivery, effectiveness and impact of the multi-sector community-based response to stunting. Thus, a baseline will be developed gathering data on indicators consistent with the theory of change for the programme. Mid-term and end-term evaluations will be undertaken to assess the performance of the programme.

In between evaluations, the monitoring system developed under the Institutional Strengthening component will be used to provide monitoring data. Learning on the system itself will provide a basis for scale-up – beginning with the expansion of the number of wards covered in the district, followed by an expansion in the number of districts in line with the scale-up plans of the programme. In its early stages the monitoring and evaluation system will not be adequate for provincial and national level monitoring but will serve as a model to be scaled (in terms of inclusion of indicators routinely collected at each level and in terms of district inclusion).

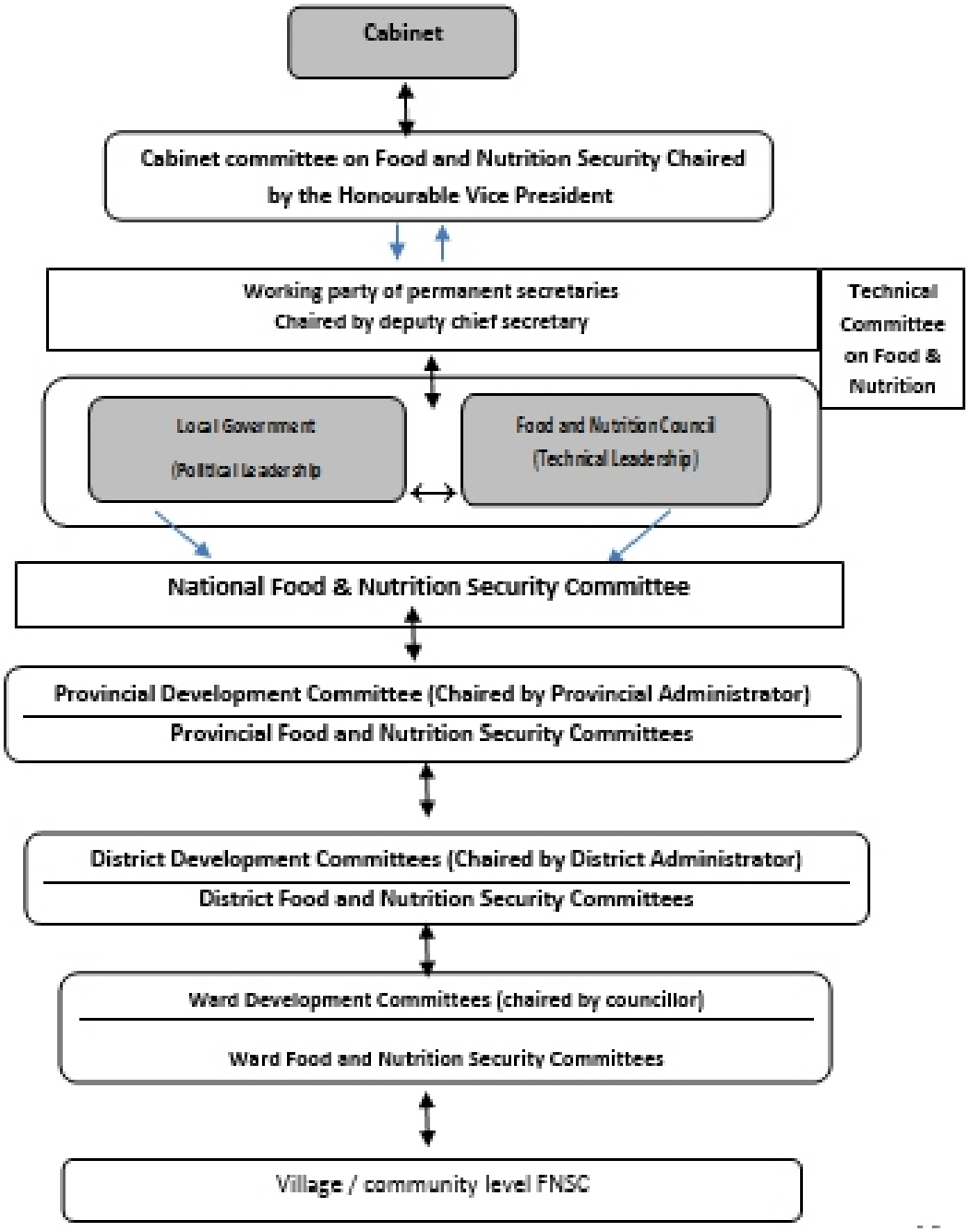
Promoting Learning

Learning will be promoted through support to knowledge sharing mechanisms fostering the flow of lessons between villages, wards, districts and between levels. A learning platform will be supported focusing on lessons on data utilisation and accountability systems as well as programming for the reduction of stunting.

12. Schematic Overview of Coordination & Accountability for Multi-sectoral Community Based Approach to Addressing Food and Nutrition Security Challenges

This community based multi-sectoral community based approach recognizes the role of Local Government at sub-national levels as convener and coordinator of the FNSCs and head of the district and provincial development committees. Figure 1 overleaf, outlines the proposed coordination and accountability framework for the model.

Figure 1: Coordination & Accountability Framework for Multi-sectoral Community Based Approach to Addressing Food and Nutrition Security Challenges



Annex 1: 2014 Baseline Profile of Key Nutrition Indicators in 8 Target Districts

Indicators	Chipinge	Chiredzi	Mwenezi	Mutasa
	2014	2014	2014	2014
Proportion of children 6-59 stunted	43.8%	27.4%	32.5%	29.9%
Proportion of children 6-59 wasted	3%	0.9%	3.5%	2.8%
Proportion of children 6-59 severely wasted	3%	0.9%	3.5%	1.8%
Exclusive Breastfeeding in children 0-5 months	43.7%	42.1%	53.1%	37.2%
Proportion Children 6-23 months meeting Minimum Acceptable diet	1%	5.8%	8.2%	3%

Source: 2014 SMART survey and 2014 LQAS Reports

Annex 2: Demographic Profile of 4 Selected Districts

	Chipinge	Mutasa	Mwenezi	Chiredzi	Total
Total Population	333686	168747	166263	30594	699290
Under 5 population	57061	25481	26602	4895	161467
Under 2 population	21055	12740	11638	2141	47574
Under1 population	12013	5588	5980	9725	33306
Expected deliveries	12546	8796	5704	3642	30688
Women of child bearing age	78417		9975	1835	90227
Expected pregnancies	15682	7036	7731		43372
Adolescent girls 15-19 yrs	13168	8522	8685	1384	31759
Total Number of wards	38	31	18	41	128
Urban Wards	8	0	0	8	16
Rural wards	30	31	18	33	112
Number of villages	337		760		2394
Number of health facilities	51	43	20	34	148
Number of District Nutritionists	1	1	1	1	4
No of Nutrition assistants	1	1	1	1	4

Annex 3: Multi-sectoral Community Based Food and Nutrition Security Challenges Reduction Results Framework

Outcomes	Key Progress Indicators, Baselines &Targets	Means of Verification	Outputs	Lead Agencies	Supporting Partners	Tentative Budget
Outcome 1: Infants, young children and mothers have improved and equitable use of nutritional services and improved nutrition and care practices, with a focus on food and nutrition security	Proportion of children breastfed within one hour of birth (timely initiation of breast feeding) Baseline (MICS 2014): 58.9% , Target (DHS/MICS 2017): 70%	HMIS report Annual reports LQAs	OUTPUT 1: Strengthened sub national capacity to implement and coordinate multi-sectoral scale up of services to protect, promote and support optimal infant and young child nutrition and related maternal nutrition.	UNICEF, WHO	Line Ministries: MoHCC, MAMID, MLSS, MoPSE, Local Government	
	Proportion of children 0-5 months exclusively breastfed Baseline MICS 2014): 41% Target (DHS/MICS 2017): 60%	HMIS report Annual reports LQAs				
	Proportion of children who are fed complementary foods in a timely manner (introduction of solid/ semisolid/ soft food) Baseline (MICS 2014): 87.3% Target (DHS/MICS 2017): 92%	HMIS report Annual reports LQAs				
	Proportion of Children fed on minimum acceptable diet. Baseline (NNS 2010): 11% Target (NNS MICS 2017): 50%	HMIS report Annual reports LQAs	OUTPUT 2: Children, caregivers and communities applying optimal nutrition and care practices; and seeking preventive, promotive and curative nutrition services in selected districts			
	Proportion of children received vitamin A supplements twice yearly (full vitamin A supplementation coverage. Baseline (NHMIS 2013) : 43 % Target(NHMIS 2013) : 80% Proportion of population consuming adequately iodized salt at household level.	HMIS report MOHCC reports				
	No. of districts with multi-sectoral, costed, & sustainable provincial plan (that includes clear targets on reducing food and nutrition security Baseline 0 %, Target 30 %	FNC reports	OUTPUT 3: Multi-sectoral Food & Nutrition Information systems with quality, sex disaggregated data and analysis established			
	No. of districts submitting bi-annual food and nutrition reports with identified indicators Baseline 0 %, Target 30 %					

Outcomes	Key Progress Indicators, Baselines &Targets	Means of Verification	Outputs	Lead Agencies	Supporting Partners	Tentative Budget
Outcome 2: Households with improved all year round household consumption of a diversified diet	Proportion of households with an acceptable Household Dietary Diversity Score (HDDS). Baseline: TBD , Target: 80%	ZIMVAC report, FNC reports	OUTPUT 1: Agriculture inputs, food and cash assistance provided to targeted vulnerable households OUTPUT 2: Increased access to safe and diversified food and livelihoods for communities, in particular women and children. OUTPUT 3: Communities build resilience to natural and man-made shocks and stresses for sustained food and nutrition security	FAO, WFP, UNDP	Line Ministries: MoHCC, MAMID, MLSS, MoPSE, Local Government	
	% Reduction in vulnerability reduction perception index Baseline TBD, Target TBD					
	Number of functional civil protection committees. Baseline: TBD					
	Percentage of communities with an increased asset score Baseline: TBD , Target: 80%					
	Percentage of households with reduced coping strategy index Baseline: TBD , Target: 80%					

Outcomes	Key Progress Indicators, Baselines &Targets	Means of Verification	Outputs	Lead Agencies	Supporting Partners	Tentative Budget
Outcome 3: Infants, young children and mothers have improved and equitable use of health services and improved health care practices.	Proportion of pregnant women attending at least 4 focused ANC visits. Baseline: Target: 90%	HMIS reports Annual reports LQAs	OUTPUT 3.1: All Primary Health Care Facilities and District Hospitals have the capacity to provide quality ANC to pregnant women (basic equipment and supplies, trained health workers).OUTPUT 3.2: All health facilities provide regular immunisation services including outreaches.	UNICEF, UNFPA, WHO	Line Ministries: MoHCC, Local Government	
	Proportion of infants fully immunized with specific antigens for given age. Baseline: , Target: 90%			UNICEF, WHO	Line Ministries: MoHCC, Local Govt	
	Proportion of mother-baby pairs receiving 3 (2) PNC visits within one week (48 hours) of delivery. Baseline: Target: 80%		OUTPUT 3.3: All Primary Health Care Facilities and District Hospitals have the capacity to provide quality PNC to pregnant women including home visits (basic equipment and supplies, trained	UNICEF, WHO	Line Ministries: MoHCC, Local Government	
	Proportion of under-5s with diarrhoea treated with ORS and zinc. Baseline: Target:		OUTPUT 3.4: All Primary Health Care Facilities and District Hospitals have the capacity to provide IMNCI services to sick under-5s including support to Village Health Workers (basic equipment and supplies, trained health workers).	UNICEF, WHO	Line Ministries: MoHCC, Local Government	
Outcome 4: Improved and equitable use of proven HIV prevention and treatment interventions by children, pregnant women and adolescent boys and girls	Proportion of HIV infected infants and children who are on treatment Baseline: TBD .Target: TBD	HMIS reports	Output 4. 1 80% health facilities are able to provide comprehensive Paediatric ART services.	UNICEF	Line Ministries: MoHCC	
	Proportion of HIV exposed children on HIV prophylaxis Baseline: TBD .Target: TBD	HMIS reports		UNICEF	Line Ministries: MoHCC	
	Proportion of pregnant and breastfeeding mothers with a known HIV status on appropriate treatment. Baseline: TBD Target: TBD	HMIS reports	Output 4.2 All health facilities are fully functional to provide comprehensive PMTCT services	UNICEF	Line Ministries: MoHCC	

Outcomes	Key Progress Indicators, Baselines &Targets	Means of Verification	Outputs	Lead Agencies	Supporting Partners	Tentative Budget
Outcome 5: Infants, young children and mothers have improved and equitable use of safe drinking water, sanitation healthy environments and improved hygiene practices	Proportion of households with access to safe water sources Baseline: TBD ,Target: TBD	Baseline Survey	Output 5.1 Communities, schools, men, women and children affected by emergencies have access to improved and sustainable drinking water Output 5.2 Communities, have access to improved sanitation services Output 5.3 Communities have adequate knowledge and skills on critical hygiene practices	UNICEF	Line Ministries: MoHCC, Local Govt	
	Proportion of households accessing basic sanitation services Baseline: TBD ,Target: TBD	Baseline Survey		UNICEF	Line Ministries: MoHCC, Local Govt	
	Proportion of households accessing critical WASH related information Baseline: TBD ,Target: TBD	Baseline Survey		UNICEF	Line Ministries: MoHCC, Local Govt	

Mandate: Effective planning, and co-ordination by the members of the Food and Nutrition Security Committees						
Output	**Indicator**	**Baseline (20xx)**	**Target**			
Strengthened sub national capacity to implement and coordinate multi-sectoral scale up of services to protect, promote and support optimal infant and young child nutrition and related maternal nutrition.	Provincial		**Q1**	**Q2**	**Q3**	**Q4**
	Proportion of planned PFNSC meetings conducted					
	Proportion of PFNSC with completed provincial profiles					
	District					
	Proportion of planned DFNSC meetings conducted with minutes					
	Proportion of DFNSCs with completed profiles					
	Proportion of follow up actions implemented from meetings and quarterly reports submitted					
	Ward					
	Proportion of planned WFNSC meetings conducted					
	Proportion of core members consistently present at WFNSCs meetings					
	Proportion of WFNSCs with completed baseline assessment					
	Proportion of WFNSCs with completed community consultations					
	Proportion of WFNSCs with completed micro-plans					
	Proportion of work plan outputs achieved and quarterly reports submitted					
	Proportion of follow up actions implemented from meetings					
	Proportion of core members consistently present at WFNSCs meetings					
	Proportion of key set of indicators submitted in district quarterly reports					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