Zimbabwe Livelihoods Assessment Committee (ZimLAC)

2025 Rural Nutrition Assessment




Report

Food & Nutrition Council
Every Zimbabwean Free from Hunger & Malnutrition

Foreword

Malnutrition is a major impediment to economic growth and development. Improving nutrition contributes to productivity, economic development and poverty reduction by improving physical work capacity, cognitive development, school performance and health outcomes. Existing global and regional evidence has shown that poor nutrition perpetuates the cycle of poverty by increasing mortality, increasing susceptibility to diseases, impairing cognitive development and educational achievement and reducing work capacity and productivity in adulthood. The Government of Zimbabwe recognises the indisputable importance of nutrition security as illustrated in its key Policies (Food and Nutrition Security Policy and National Development Strategy 1). In addition, the Constitution recognises the right to adequate food and nutrition, coupled with access to basic health care and social services in terms of Article 15(a, b and c), 19 (2)(b), 21 (2_(b) and Article 77(b).

The National Development Strategy 1 clearly defines the country's aspiration to transit into an "Upper Middle Income Society" and has nutrition embedded as one of the key outcomes. Recognising that the nutritional well-being of the citizens of Zimbabwe lays the foundation for concrete economic growth and development, the NDS1 prioritises public health measures that safeguard proper absorption and utilisation of essential nutrients to prevent nutrient imbalances affecting the nation. Improved nutrition is the platform for progress in health, education, employment, empowerment of women and the reduction of poverty and inequality, and can lay the foundation for peaceful, secure and stable societies. Nutrition is both a maker and a marker of development and without adequate and sustained investments in good nutrition, the ambition to 'End hunger, achieve food security and improved nutrition and promote sustainable agriculture' may not be realised.

Thus, Zimbabwe's existing policies express a shared vision and commitment for accelerated action by Government and its development partners to improve national and household level food security, improve the quality of diets, ensure food safety, improve nutrition for adolescents, child bearing age group and reduce the multi-factoral etiology of stunting. As such it is important to explore and track key nutrition indicators that reflect attainment of set national, regional and global targets periodically.

Foreword

Nutrition information, especially estimates of child growth failure, provides a baseline for measuring progress as well as precision for public health to target interventions to those populations with the greatest need, in order to reduce health disparities and accelerate progress. The 2025 Rural National Nutrition Survey (as defined in the FNSP Commitment 6) brings to the fore the value of precision public health planning by providing spatially resolved disaggregated data to guide effective targeting of interventions to those populations with the greatest need. Cognisant of the complexity and multi-dimensional nature of not only the impact of malnutrition but also its causes. This report characterises the problems and identifies its key associated drivers, thereby facilitating evidence based decision making.

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 rural 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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Acknowledgements

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

- Office of the President and Cabinet
- Food and Nutrition Council
- Ministry of Finance, Economic Development and Investment Promotion
- Ministry of Lands, Agriculture, Fisheries, Water and Rural Development
- Ministry of Public Service, Labour and Social Welfare
- Ministry of Health and Child Care
- Ministry of Local Government and Public Works
- Ministry of Women Affairs, Community, Small and Medium Enterprise Development
- Rural District Councils (RDCs)
- United Nations Children's Fund (UNICEF)
- United Nations World Food Programme (WFP)
- United Nations Development Programme
- United Nations Food and Agriculture Organisation (FAO)
- ZIMSTAT
- START NETWORK
- Community Technology Development Organization
- World Vision
- Red Cross
- Bindura University of Science Education
- Marondera University of Agricultural Sciences and Technology
- Harare Institute of Technology
- Plan International
- SOS Children's Village
- Simukaupenye Youth Academy
- UTARIRI integrated Biodiversity, Climate Change and Livelihoods Programme
- CESVI
- Friends for Matibi
- CARITAS
- International Medical Corps
- Lower Guruve Development Association
- LID Agency
- Welthungerhilfe
- AMALIMA Loko
- National AIDS Council
- Insiza Godlwayo AIDS Council
- Aqua Culture Zimbabwe
- Score Against Poverty
- DAAP
- CARE International
- Nutrition Action Zimbabwe
- Bethany Project
- Médecins Sans Frontières
- Organisation of Rural Associations for Progress
- Zimbabwe Project Trust
- Environmental Management Agency
- SNV Netherlands Development Organisation
- CARE/Takunda
- Mercy Corps
- Hope for Kids
- Mavambo Trust
- Tsuro Trust
- Mwenezi Development Trust Centre

Acronyms

BMI	Body Mass Index
EA	Enumeration Area
EFF	Egg and or Flesh Meat Consumption
FNSP	Food and Nutrition Security Policy
GAM	Global Acute Malnutrition
IYCF	Infant and Young Child Feeding
MAD	Minimum Acceptable Diet
MDD	Minimum Dietary Diversity
MDD-W	Minimum Dietary Diversity Women
MFNSS	Multisectoral Food and Nutrition Security Strategy (2023-2025)
MMF	Minimum Meal Frequency
NDS1	National Development Strategy 1
SAM	Severe Acute Malnutrition
SD	Standard Deviation
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
ZimLAC	Zimbabwe Livelihoods Assessment Committee
ZVF	Zero Vegetable or Fruit Consumption

Background

- In 2012 the World Health Assembly Resolution 65.6 endorsed a Comprehensive implementation plan on maternal, infant and young child nutrition which specified a set of six global nutrition targets that by 2025 aim to ensure that there is no increase in childhood overweight; increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%; reduce and maintain childhood wasting to less than 5%.
- The Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods identified malnutrition in every form as presenting a significant threat to human health throughout the lifecycle. The Malabo Declaration also aims to improve nutritional status and in particular, the elimination of child under-nutrition in Africa with a view to bringing down stunting to 10% and underweight to 5% by 2025.
- To achieve the goal of '**becoming an empowered and prosperous Upper Middle-income Society by 2030**', the Government of Zimbabwe created the Multi-Sectoral Food and Nutrition Security Strategy for Zimbabwe 2021-2025 (MFNSS 2021-2025) in alignment with the National Development Strategy (NDS) 1 (2021-2025). NDS1 serves as the first 5-year Medium Term Plan to realize the country's Vision 2030 while addressing global Sustainable Development Goals (SDGs) and Africa Agenda 2063. These policies reflect a collective commitment to enhance diet quality, ensure food safety, and improve nutrition for all age groups through a life cycle approach.
- At the beginning of the NDS1, the country was facing a triple burden of malnutrition characterised by under nutrition, over nutrition and micronutrient deficiency. This was attributed mainly to gaps in the country's food system. The majority of rural households consumed mostly cereals; condiments, vegetables, oils and sugar, which leads to poor dietary diversity and insufficient consumption of essential nutrients. The NDS1 outcomes for Nutrition Security target **to reduce the prevalence of under-five stunting from 23.5% to 17% by 2025; reduce the prevalence of iron deficiency anaemia in women of child bearing from 27% to 13% by 2025.**
- Combating all forms of malnutrition remains the country's top priority. Thus, nutrition data is key as Zimbabwe continues fostering collaboration and coordination among various stakeholders towards improved nutrition outcomes.

Purpose

The main purpose of the survey was to assess the nutrition status among the rural population in Zimbabwe to facilitate evidence based decision making and programming for better nutrition outcomes.

Objectives

1. To assess the nutrition status of the rural population.
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 for 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.

Assessment Methodology

Methodology – Assessment Design

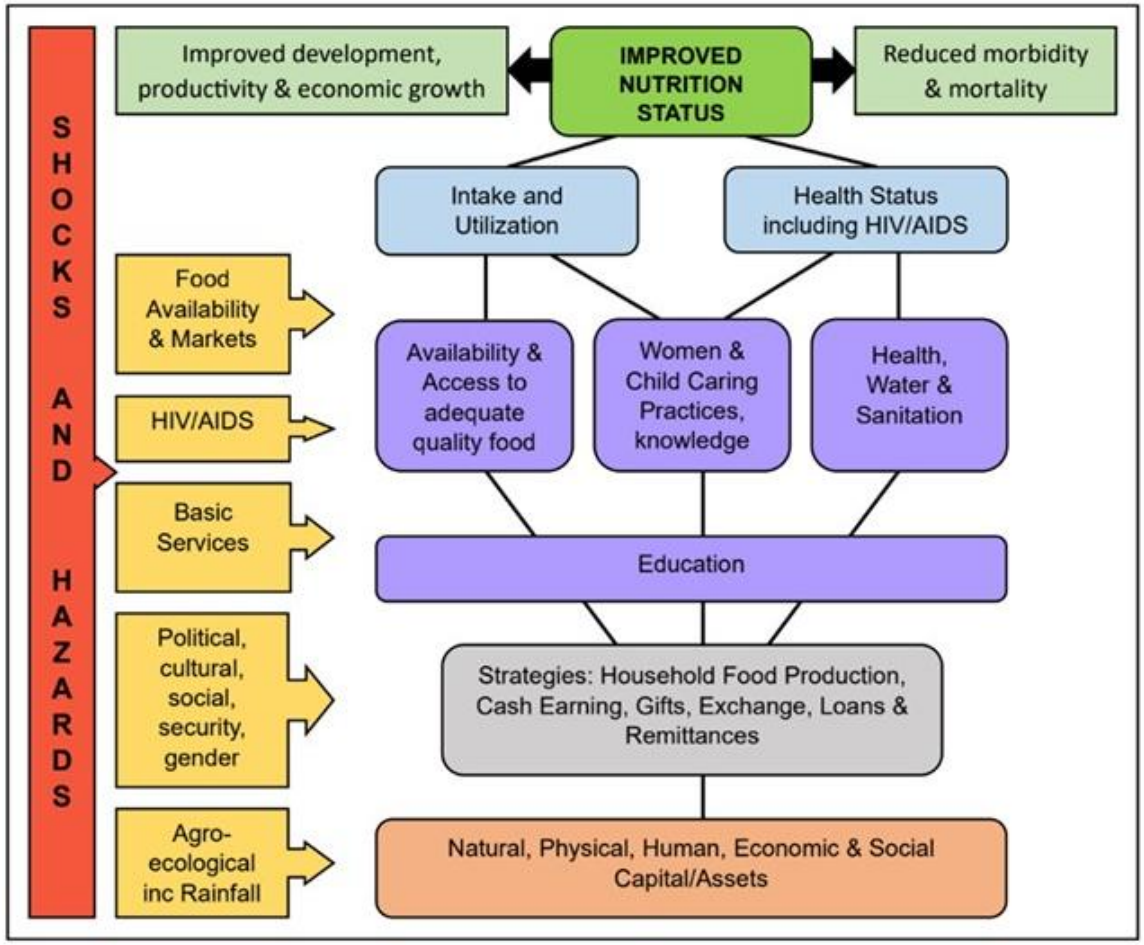


Figure 1: Food and Nutrition Conceptual Framework

- In recognition of the complex and multi-dimensional nature of not only the impacts of nutrition status but also its causes, the design of the Nutrition Survey 2025, was guided by the nutrition conceptual framework as pronounced in the Food and Nutrition Security Policy and the Multisectoral Food and Nutrition Security Strategy (2023-2025).

- The frameworks also place nutrition as an outcome of multi sectoral efforts at various levels and its role in driving economic development.
- In addition, the framework recognises that malnutrition can be attributed to environmental-centric dysfunction (that is chronic exposure to pathogenic bacteria, viruses and parasites due to poor hygiene, contaminated water and open defecation causing epithelial atrophy, malabsorption and inflammation).

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 supervisory team was made up of members from Government, United Nations, Technical Organisations, Non-Governmental Organisations and Academia.
- 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 Coordinator's 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.

Data Collection, Preparation and Analysis

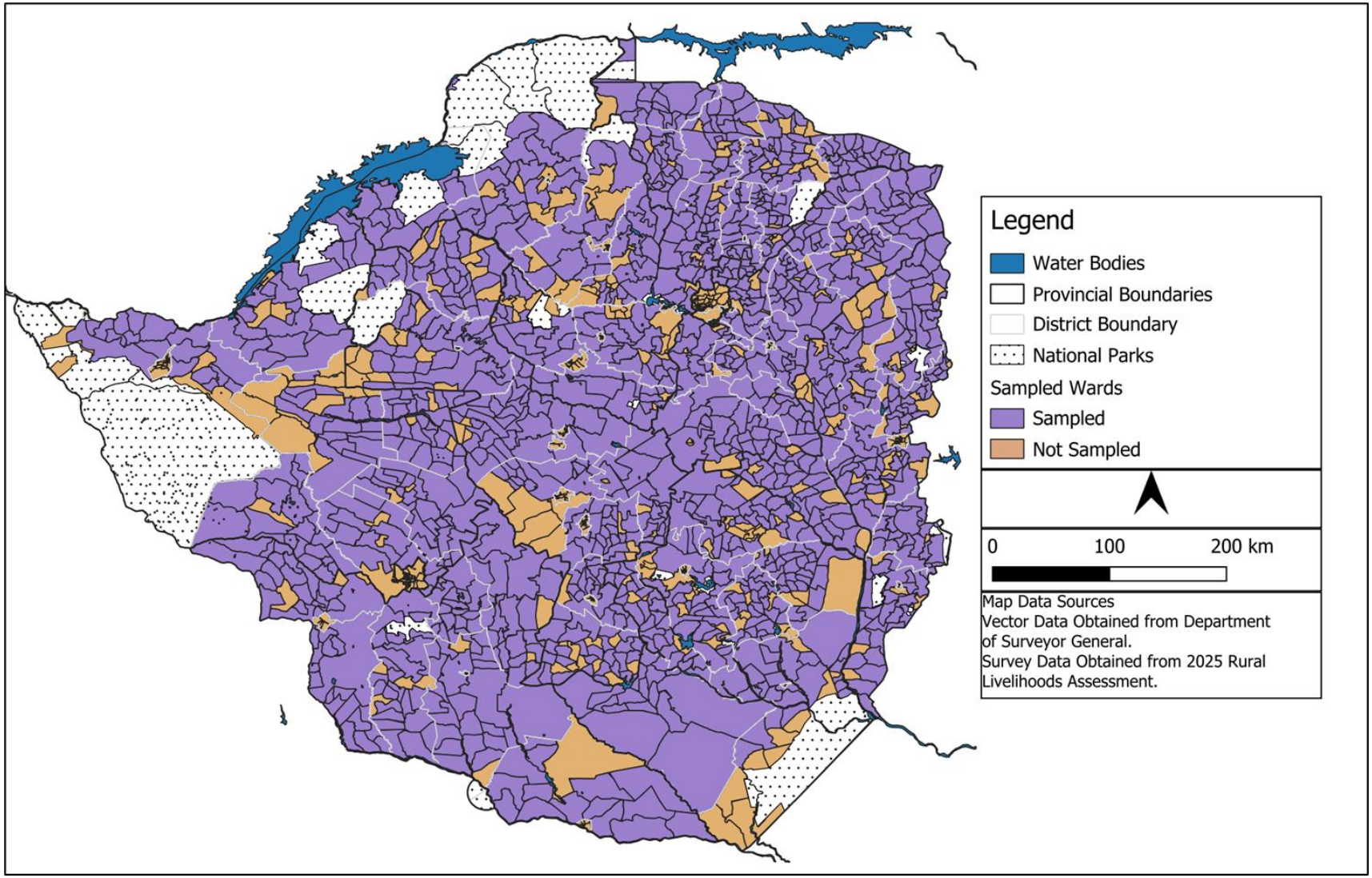
- Each district enumeration team had four enumerators, comprising of 3 enumerators and 1 anthropometrist who had the responsibility of measuring children aged 6-59 months, school-aged children, adolescents and adults in the selected household. Enumerators underwent a 2 days data collection and instrument 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.
- Enumerator training was held from 19 to 20 May 2025. Primary data collection took place from 21 May to 9 June 2025. Various secondary data sources and field observations were used to contextualise the analysis and reporting.
- 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.

Sampling and Sample Size for Nutrition Outcomes

- All members in the households were considered for anthropometric measurements, while adults were considered for non-communicable disease risk factors and individual diets targeted at women and children under 5 years.
- At least 450 households were sampled per district and a total of 27628 households were interviewed.
- Anthropometric measurements were taken from 24506 Children aged 6-59 months, 3573 Children aged 5-9 years, 4807 Adolescents 10-19 years, and 19678 Adults aged 20 years and above.

Province	Total
Manicaland	3168
Mash Central	3642
Mash East	4171
Mash West	3142
Mat North	3176
Mat South	3315
Midlands	3627
Masvingo	3387
National	**27628**

Sampled Wards



RESULTS

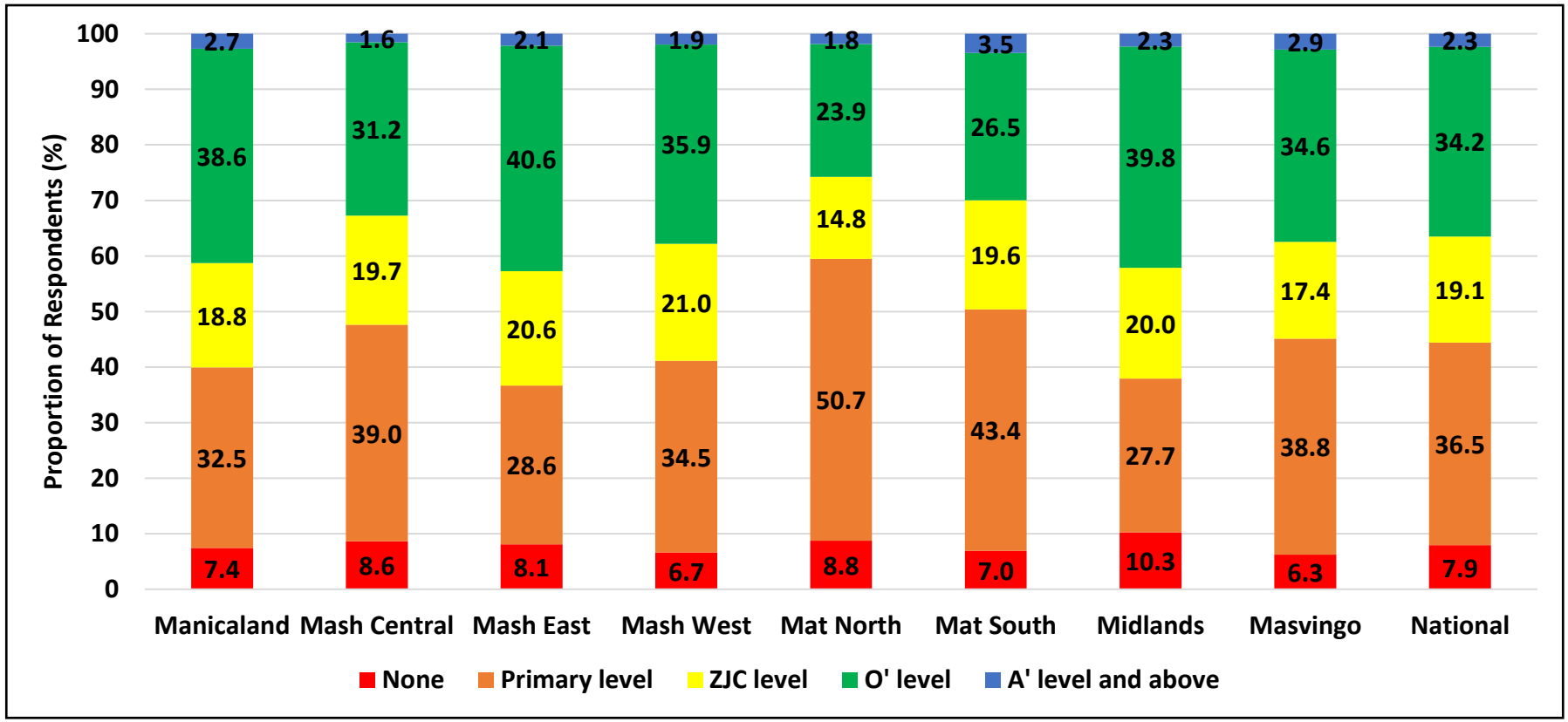
Household Demographics

Characteristics of Respondents

Province	Average Age of Respondents (years)	Sex of Respondents	
		Male (%)	Female (%)
Manicaland	41	26.0	74.0
Mash Central	36	21.1	78.9
Mash East	39	22.6	77.4
Mash West	38	30.5	69.5
Mat North	43	24.0	76.0
Mat South	48	32.5	67.5
Midlands	41	26.3	73.7
Masvingo	45	27.2	72.8
National	**41**	**26.1**	**73.9**

- The average age of the respondents was 41 years.
- About 73.9% of the respondents were female.

Education Level of Respondent



- The majority of the respondents had received some form of education (92.1%). This provides a good basis for engagement on the subject matter of nutrition.

Sample Characterisation by Age

				Diet and Anthropometry					Other Relevant Age Categories			
	Males	Female	Total	Under 5 years		0-23 months	6-23 months	Females 15 to 49 years	5 to 9 years	10 to 19 years	18 to 59 years	60 years and above
Province	N	N	N	N	%	N	N	N	N	N	N	N
Manicaland	3158	4376	7534	3299	43.8	1168	1020	1615	510	777	2512	590
Mash Central	3302	4954	8256	3865	46.8	1400	1221	2044	532	749	2844	430
Mash East	3628	5188	8816	4255	48.3	1513	1297	1896	486	696	2856	692
Mash West	3417	4525	7942	3630	45.7	1285	1061	1824	529	755	2804	378
Mat North	2668	4141	6809	2773	40.7	991	794	1530	496	760	2218	707
Mat South	2356	3438	5794	2559	44.2	836	722	1111	200	448	1896	831
Midlands	3594	5162	8756	3935	44.9	1230	1145	1870	566	871	2858	706
Masvingo	3275	4384	7659	3040	39.7	996	852	1506	573	978	2427	825
National	25398	36168	61566	27356	44.4	9419	8112	13396	3892	6034	20415	5159

- The characterization of the sample by age represents an adequate sample to report on diet quality, infant and young child feeding practices and nutrition status for the 6-23 months, 0-23 months, under –five and females (15-49 years).
- The other relevant age categories were targeted for nutrition status only.

Religion of Household Head

Province	Religion									
	Roman Catholic (%)	Protestant (%)	Pentecostal (%)	Apostolic Sect (%)	Zion (%)	Other Christian (%)	Islam (%)	Traditional (%)	Other religion (%)	No religion (%)
Manicaland	5.7	12.2	12.8	**44.4**	8.7	3.1	0.3	1.8	1.0	9.9
Mash Central	4.2	2.9	8.3	**54.1**	1.6	1.8	0.9	2.3	0.7	22.8
Mash East	7.8	8.4	11.4	**47.0**	1.4	4.4	0.4	2.9	1.7	14.3
Mash West	6.1	5.8	14.8	37.0	5.7	3.6	0.6	4.4	1.2	20.7
Mat North	5.4	9.7	14.7	20.6	22.3	5.4	0.1	2.3	1.7	17.5
Mat South	6.1	5.0	11.6	21.2	22.7	12.6	0.1	2.3	2.1	15.5
Midlands	9.4	9.1	9.2	34.9	8.2	13.4	0.2	0.9	1.1	13.7
Masvingo	10.8	8.2	10.2	33.6	19.9	6.2	0.1	1.6	1.3	7.9
National	7.0	7.6	11.5	37.3	10.8	6.3	0.4	2.3	1.3	15.4

- Religion of household head can influence intra-household diet choices including some taboos.
- Nationally, the majority of household heads were from the Apostolic Sect (37.3%) while 15.4% of the household heads had no religion.
- Mashonaland Central (54.1%), Mashonaland East (47.0%) and Manicaland (44.4%) had the highest proportion of household heads belonging to the Apostolic sect.

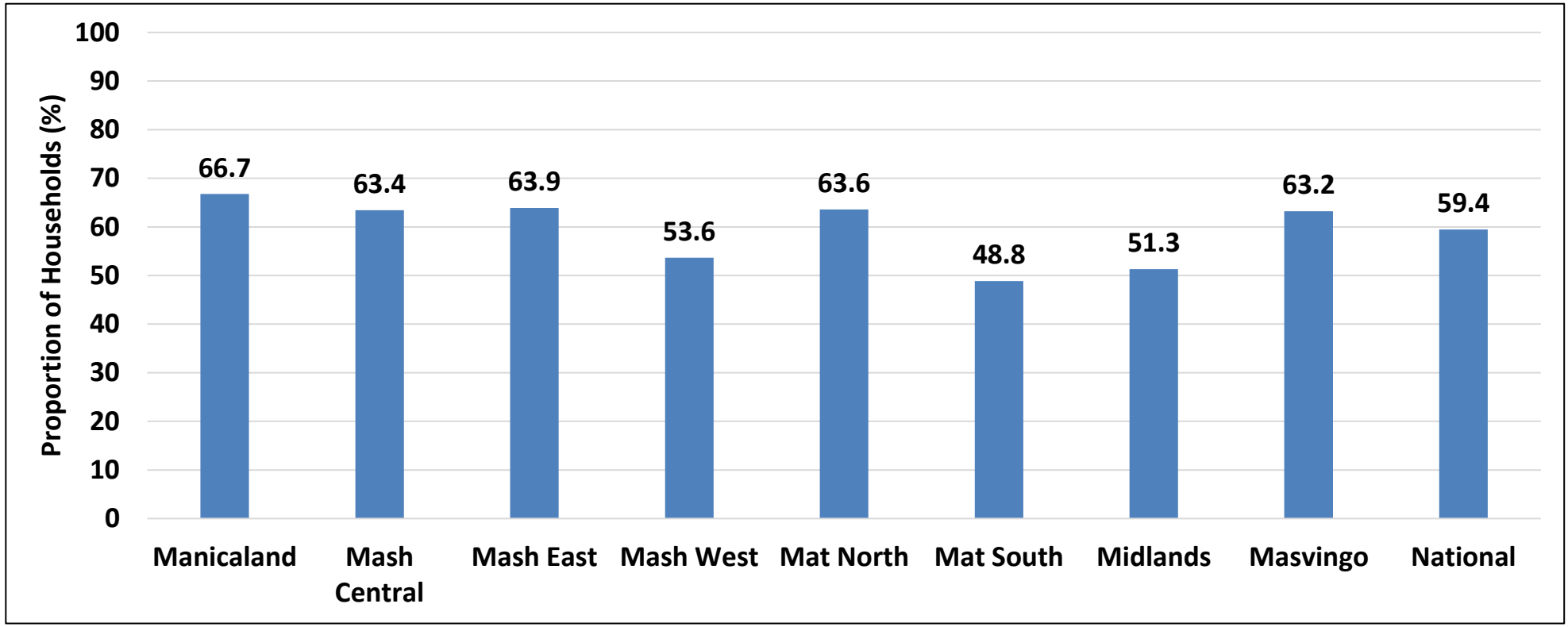
Chronic Conditions

Age category	HIV/ AIDS (%)	Hypertension (%)	Diabetes (%)	Asthma (%)	Arthritis, chronic body pain (%)	Heart disease (%)	Ulcers/ chronic stomach pain (%)	Other (%)	Mental illness (%)	Epilepsy/ seizures/fits (%)	Stroke (%)	Tuberculosis (%)	Cancer (%)	Kidney diseases (%)
5-10 Years	0.1	0.0	0.0	0.2	0.0	0.0	0.1	0.1	0.0	0.1	0.0	0.0	0.0	0.0
10-19 Years	0.5	0.0	0.0	0.4	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
18-59 Years	4.1	1.8	1.1	0.7	0.2	0.3	0.3	0.2	0.2	0.1	0.1	0.1	0.1	0.1
60 Years and above	4.6	**13.9**	**7.6**	1.6	2.2	1.1	0.7	0.8	0.4	0.1	0.7	0.3	0.4	0.2
National	2.9	2.6	1.5	0.7	0.4	0.3	0.3	0.2	0.2	0.1	0.1	0.1	0.1	0.1

- The main chronic conditions reported were HIV/AIDS (2.9%) and hypertension (2.6%).

Nutrition Information

Households that Received Any Information on Health and Nutrition



- Access to nutrition and health information empowers communities in making health and nutrition behavior changes.
- Nationally, 59.4% of the households reported to have received any information about health and nutrition.

Actions Done After Receiving Health and Nutrition Information (59.4%)

Province	Changed the foods eaten (%)	Healthy eating (%)	Changed eating portions (%)	Undertaking physical activities (%)	Changed agricultural practices (%)
Manicaland	23.0	35.6	8.5	5.0	10.3
Mash Central	28.2	30.6	9.1	6.9	10.2
Mash East	28.8	32.3	14.3	10.5	11.6
Mash West	23.8	19.8	6.7	3.6	4.2
Mat North	24.7	27.4	7.0	5.2	8.6
Mat South	17.1	19.2	6.6	4.7	9.1
Midlands	16.9	19.5	6.3	4.2	6.7
Masvingo	31.8	28.6	7.7	6.4	7.0
National	**24.4**	**26.8**	**8.5**	**6.0**	**8.6**

- After receiving the health and nutrition information, most households reported that they had resorted to healthy eating (26.8%) and changing the food they usually eat (24.4%).

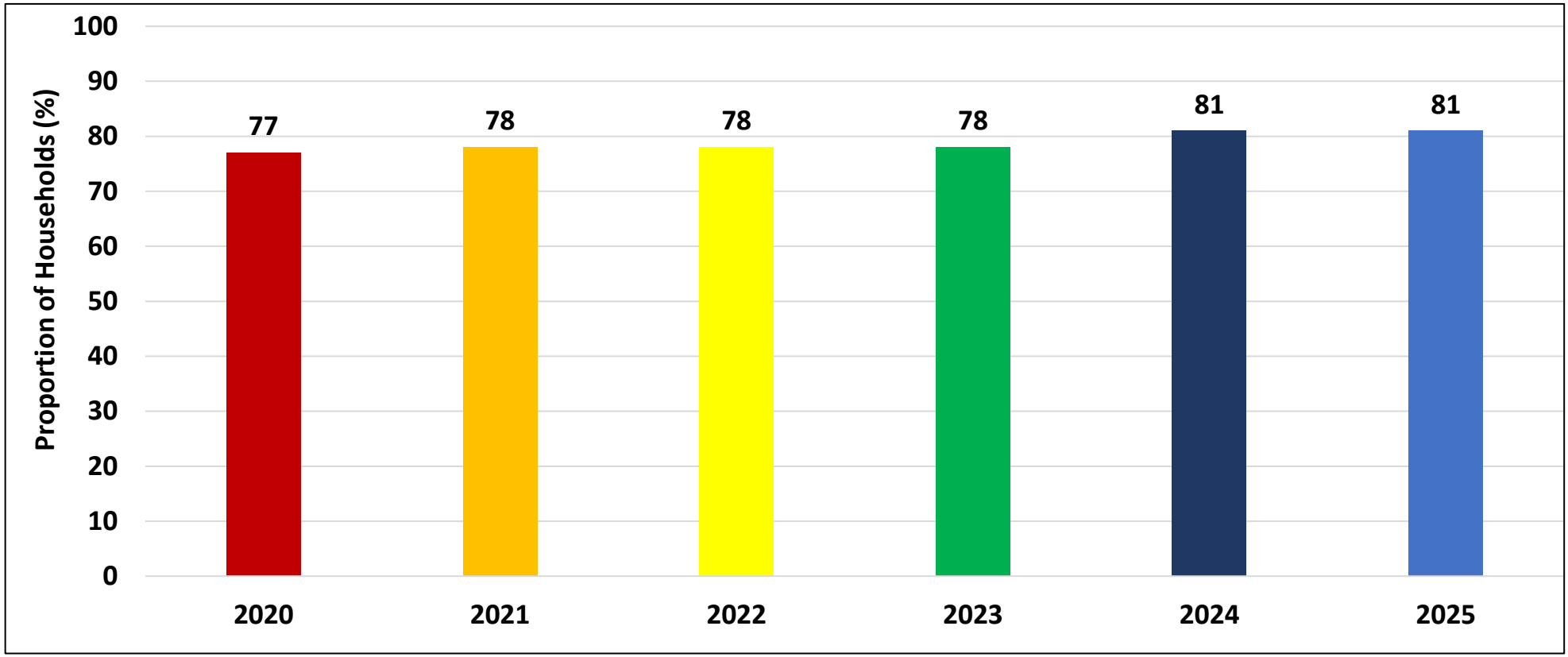
Water, Sanitation and Hygiene

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.

Access to Improved Water Source



- Access to improved water sources increased from 77% in 2020 to 81% in 2025.
- This is a reflection of the country's progress towards achieving SDG 6 which is fundamental for human health, economic development and environmental sustainability.
- Government is commended for spearheading the Presidential Borehole Programme.

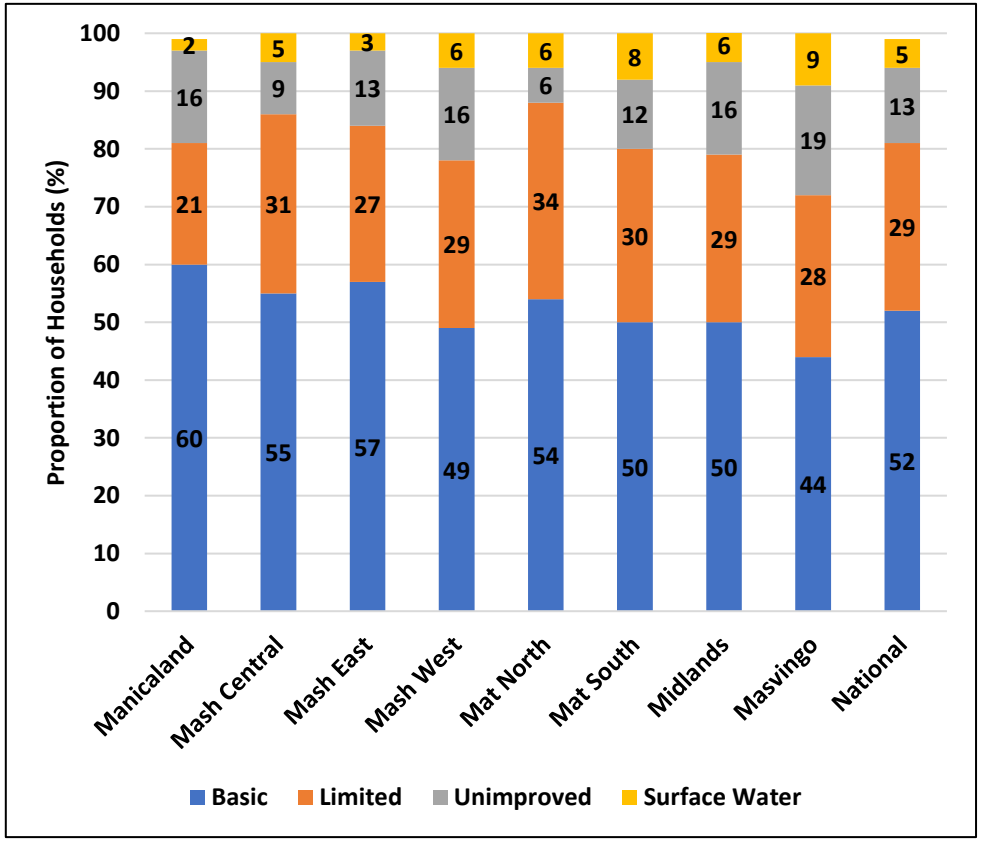
Main Source of Drinking Water

Province	Piped into dwelling (%)	Piped into yard/plot (%)	Piped into public tap/ standpipe (%)	Piped into neighbour's yard (%)	Borehole/ Tube well (%)	Protected well (%)	Unprotected well (%)	Protected spring (%)	Unprotected spring (%)	Surface water (%)	Sand abstraction (%)	Other (%)
Manicaland	1.9	11.6	8.7	1.5	34.4	24.2	9.9	1.7	3.1	2.7	0.2	0.0
Mash Central	0.7	0.9	11.8	0.3	44.9	22.1	11.8	0.2	1.0	5.0	1.1	0.0
Mash East	1.3	2.2	10.0	0.8	27.0	43.1	12.4	0.8	1.2	1.0	0.0	0.0
Mash West	2.2	3.5	12.8	1.1	42.3	17.4	12.4	0.4	0.5	6.5	0.7	0.0
Mat North	2.3	3.6	19.3	3.8	50.6	8.1	3.6	0.1	1.1	6.5	1.0	0.0
Mat South	3.5	3.2	10.4	3.2	50.7	7.0	6.9	0.3	0.6	13.7	0.2	0.4
Midlands	1.7	2.5	6.6	3.6	37.7	24.3	14.9	0.3	0.8	3.7	3.4	0.2
Masvingo	2.2	3.2	9.0	3.0	39.9	17.1	15.1	0.7	1.0	7.5	0.9	0.2
National	**1.9**	**3.7**	**11.0**	**2.1**	**40.4**	**21.4**	**11.0**	**0.6**	**1.2**	**5.6**	**1.0**	**0.1**

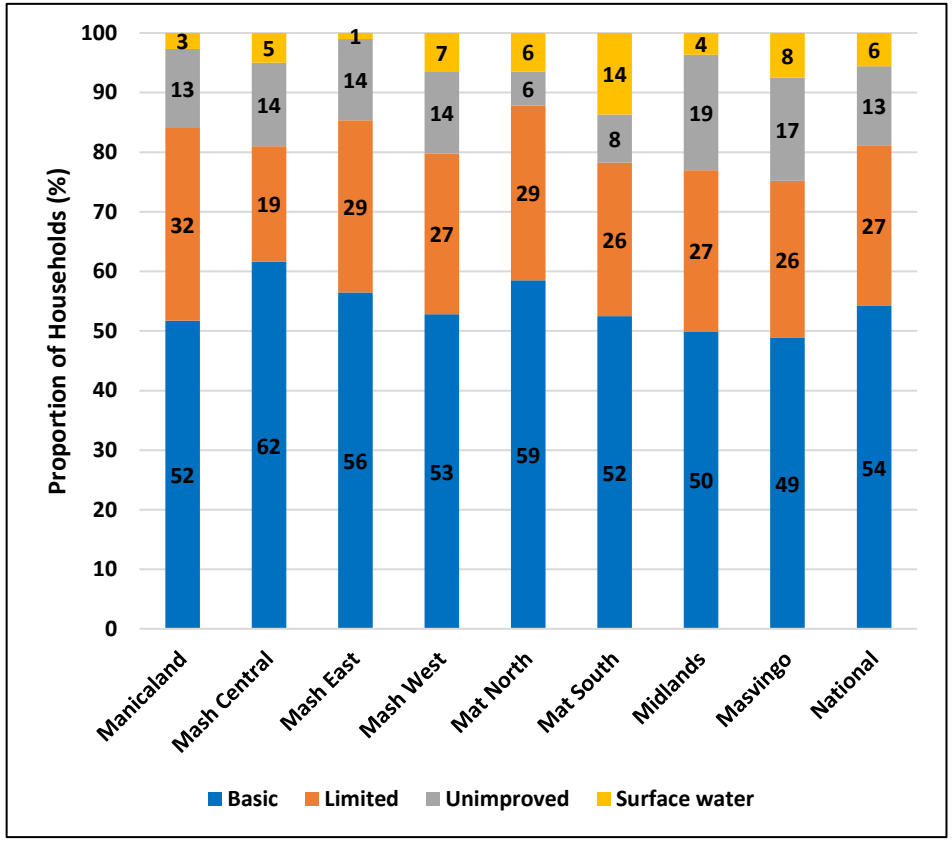
- The majority of households were drinking water from boreholes or tube wells (40.4%).
- About 5.6% of the households were drinking surface water.

Main Drinking Water Services

2024



2025

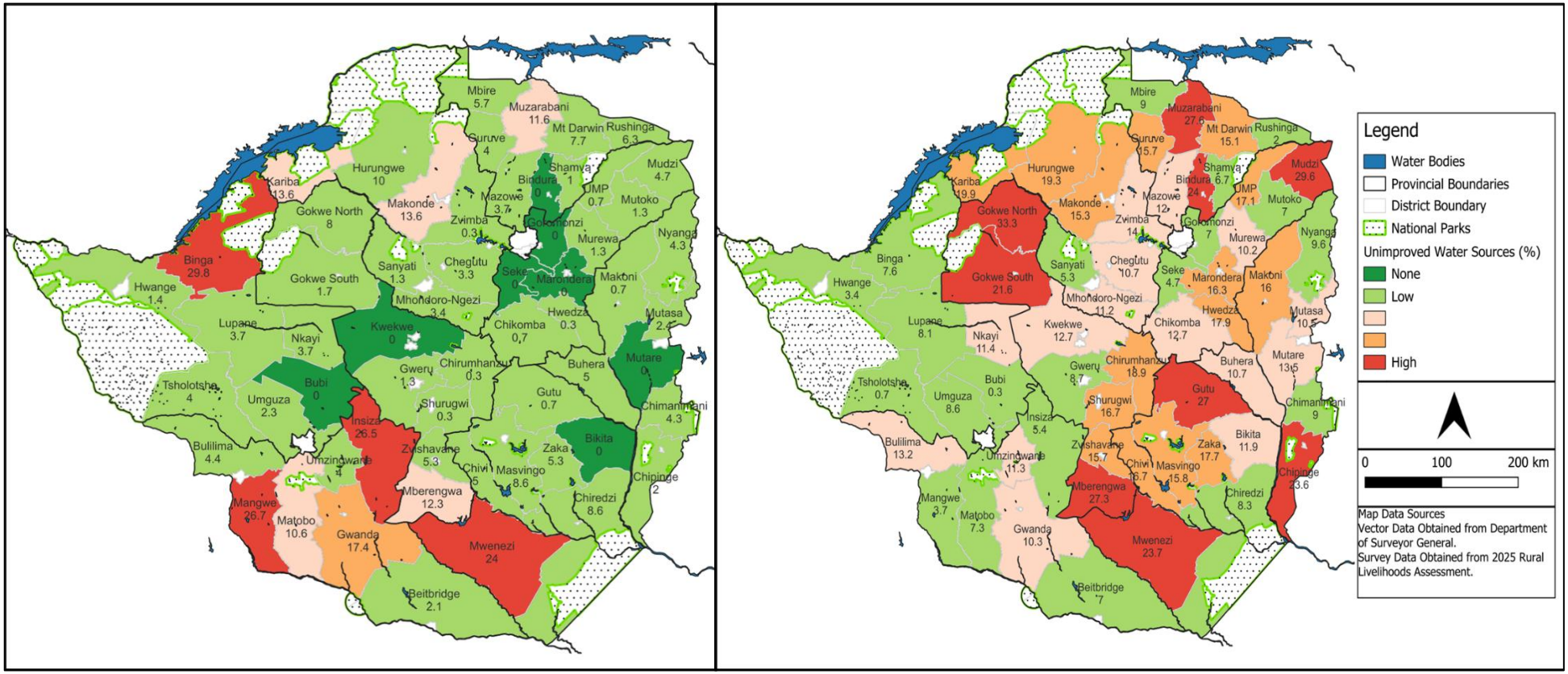


- There was an increase in the proportion of households accessing basic water services from 52% in 2024 to 54% in 2025.
- Attention should be given to the 27% of households which were drinking water from improved sources, but their collection time was exceeding 30 minutes for a round-trip, including queuing.

Water Services

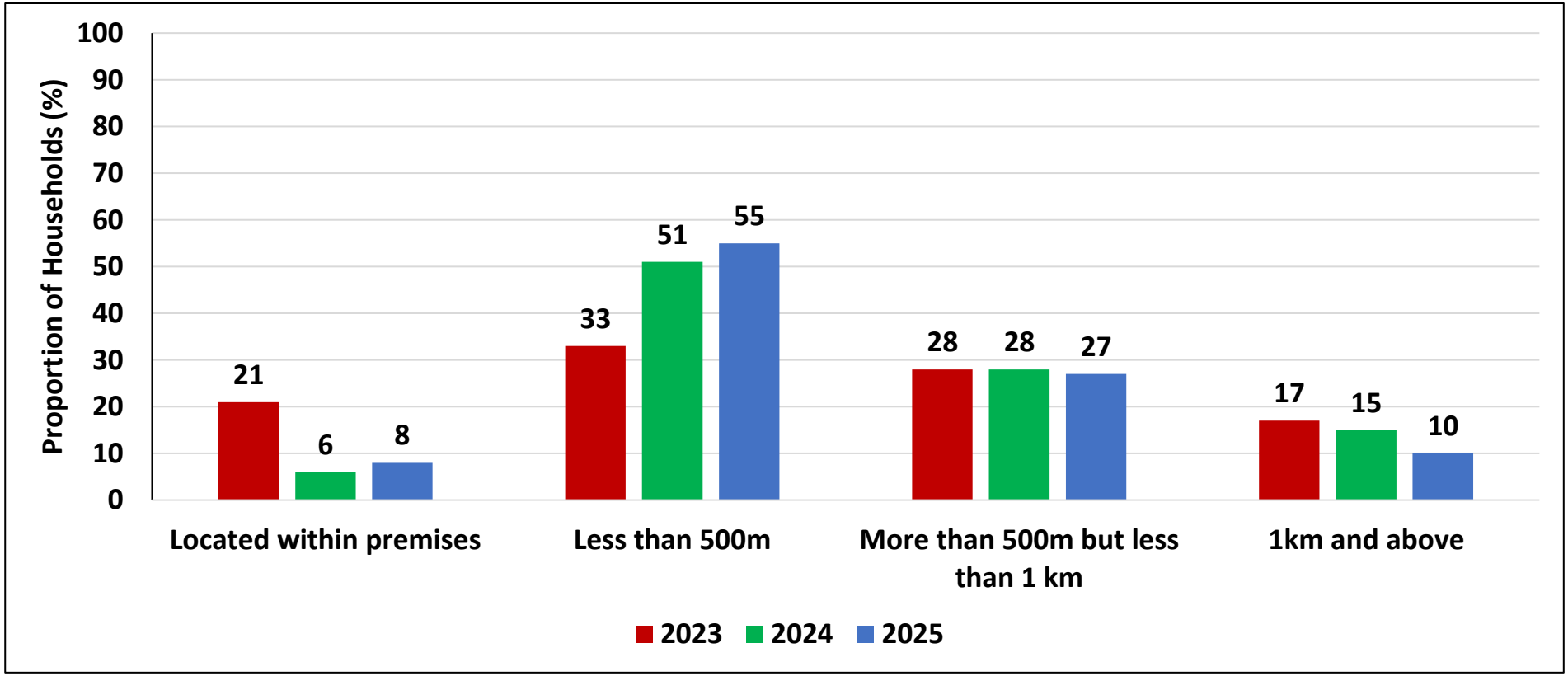
Households Drinking Surface Water

Households Using Unimproved Water



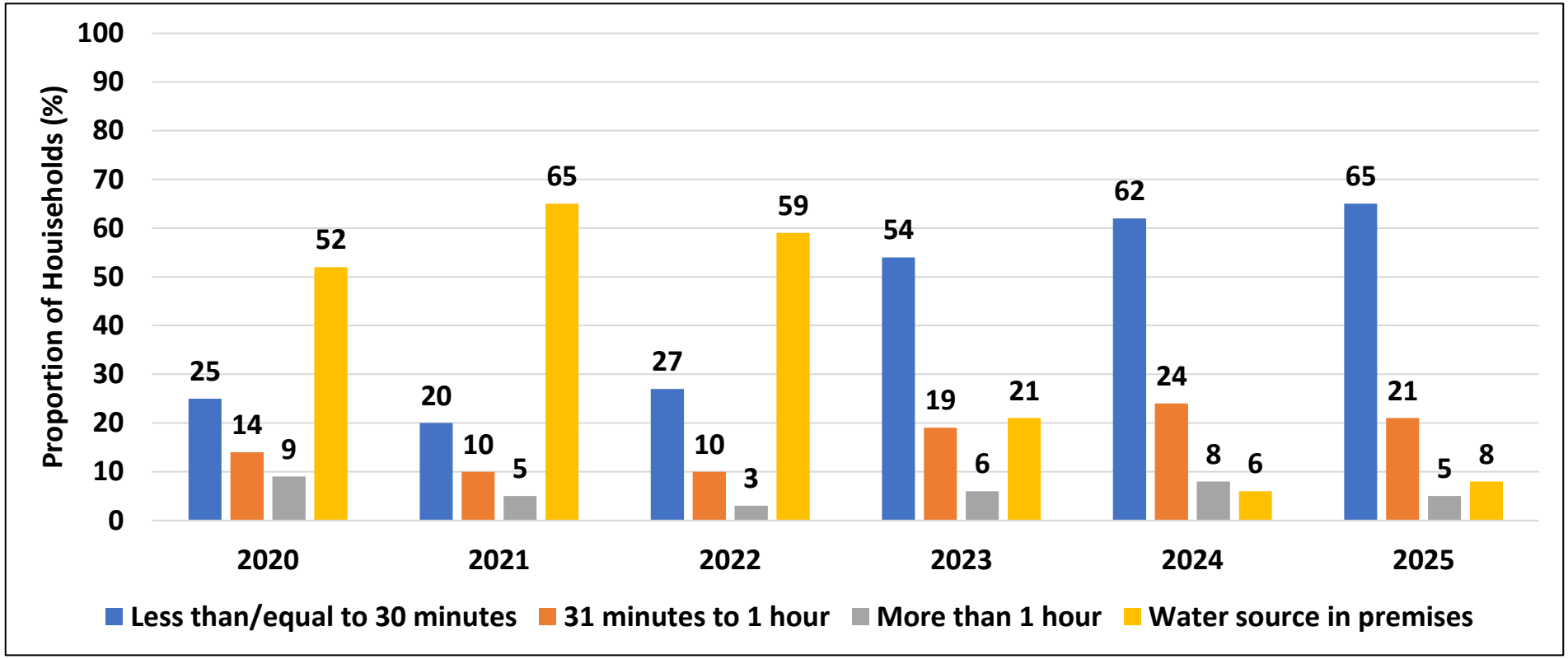
- Binga (29.8%) and Mangwe (26.7%) had the highest proportion of households which were drinking surface water.
- Gokwe North (33.3%) had the highest proportion of households using unimproved water services.

Distance Travelled to Main Water Source



- About 90% of the households accessed water within a kilometer.
- However, attention should be given to 10% of the households which were accessing water from a distance above one kilometer.

Time Taken to and from Main Drinking Water Source



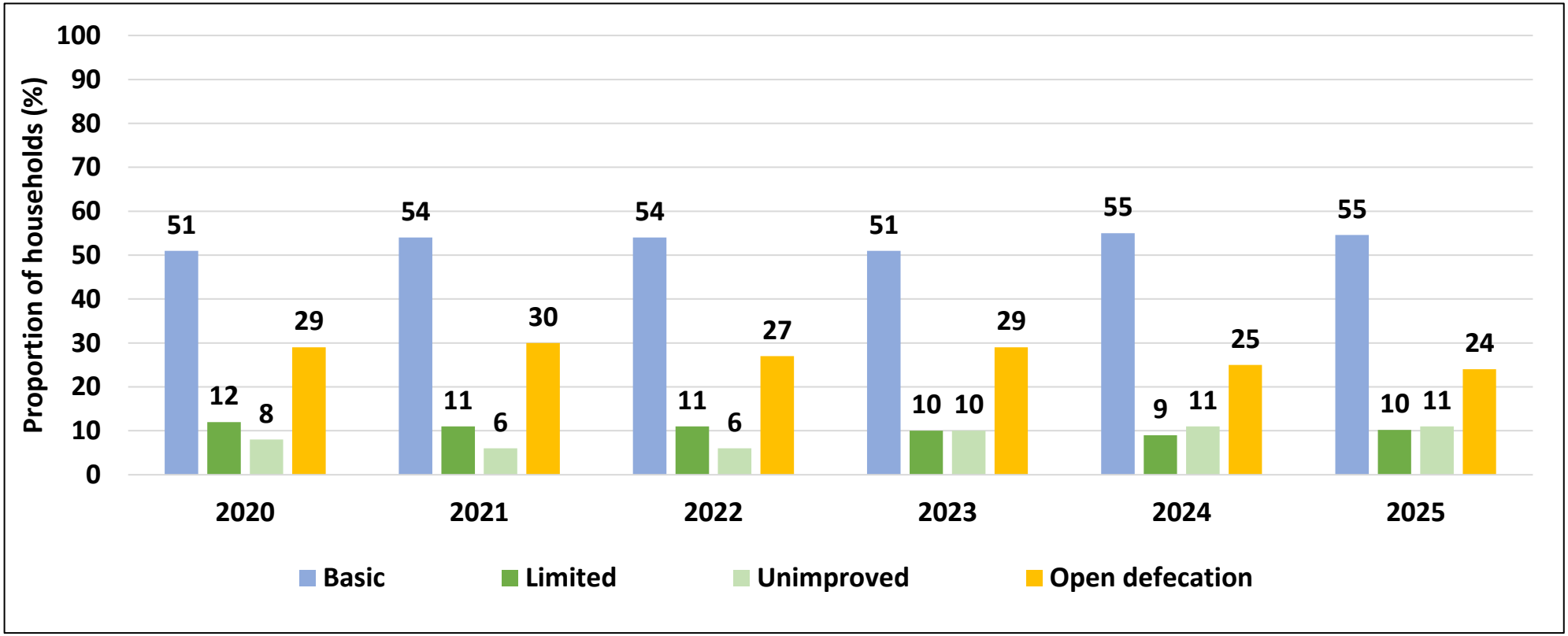
- The proportion of households spending thirty minutes or less for a round trip to collect water from their main drinking water source increased from 25% in 2020 to 65% in 2025.
- About 5% of the households spent more than one hour for a round trip to collect water from the main drinking water source

Sanitation

Ladder for Sanitation

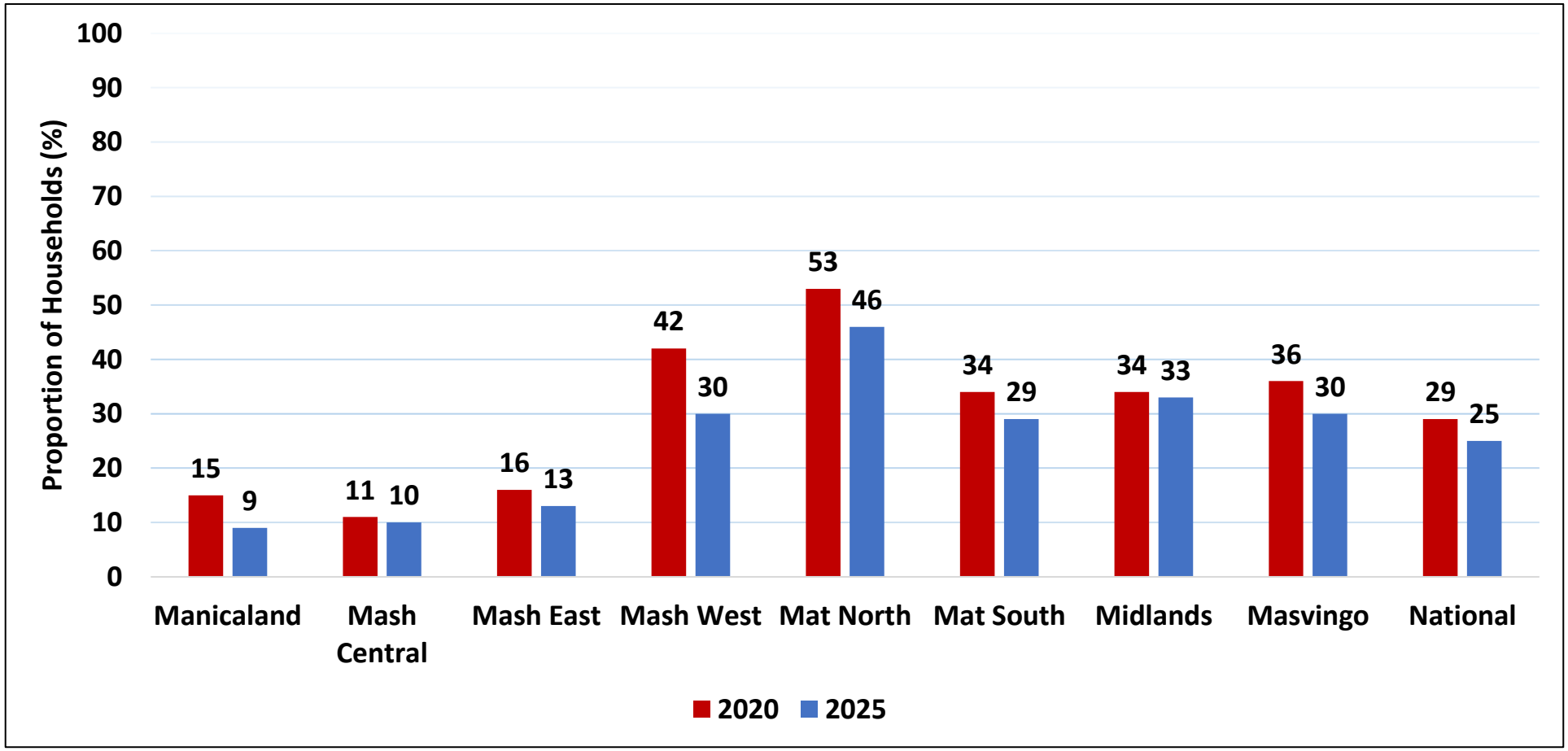
Service level	Definition
Safely Managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite.
Basic Sanitation Facilities	Use of improved facilities which are not shared with other households.
Limited 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.	

Household Sanitation Services



- There was a slight increase in the proportion of households with basic sanitation services from 51% in 2020 to 55% in 2025.
- There was a decline in the proportion of households practising open defecation from 29% in 2020 to 24% in 2025.

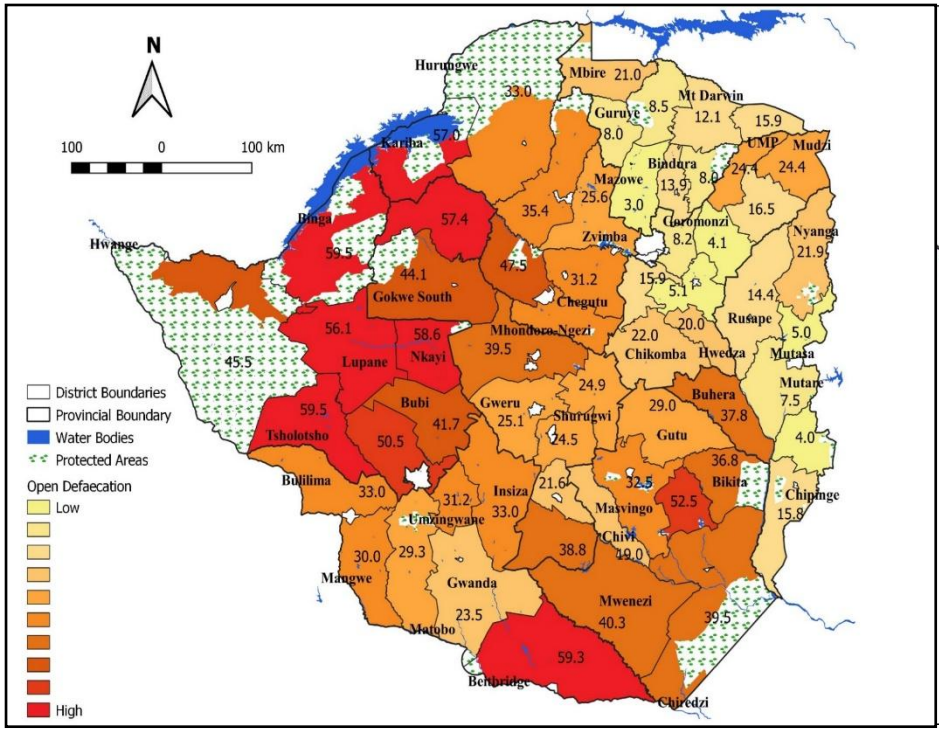
Open Defecation by Province



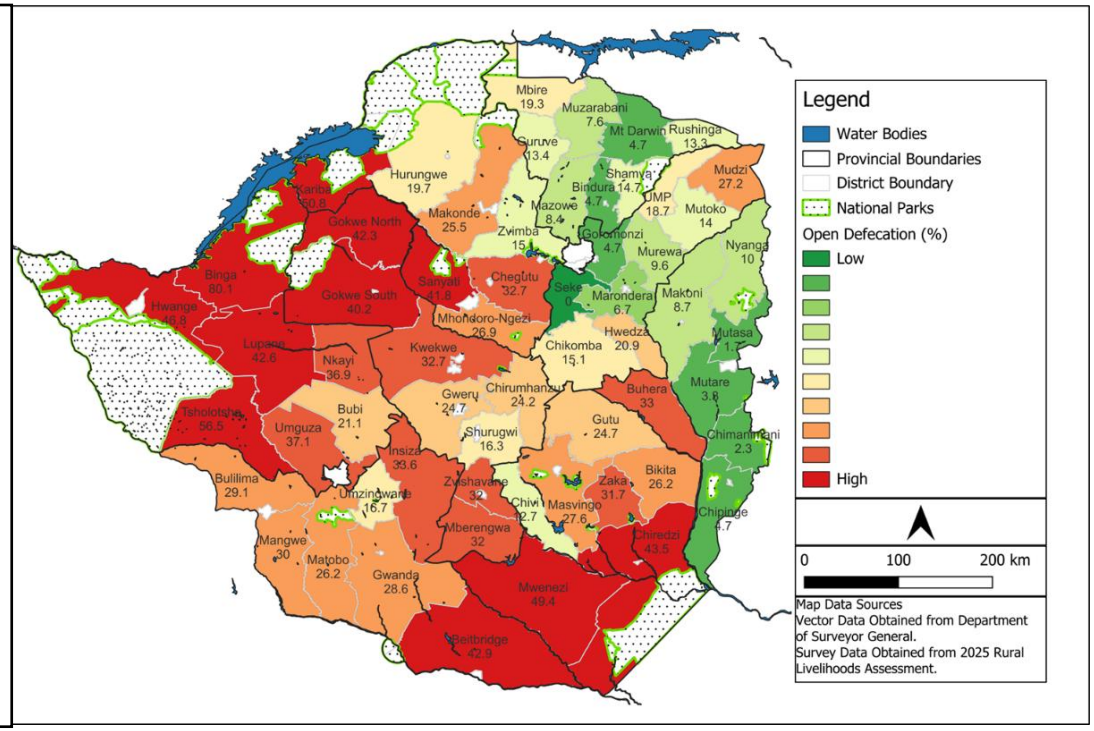
- Matabeleland North had the highest proportion of households which practised open defecation.

Open Defecation By District

2020



2025



- Binga (80.1%), Tsholotsho (56.5%), Kariba (50.8%) and Mwenezi (49.4%) had the highest proportion of households which practised open defaecation.

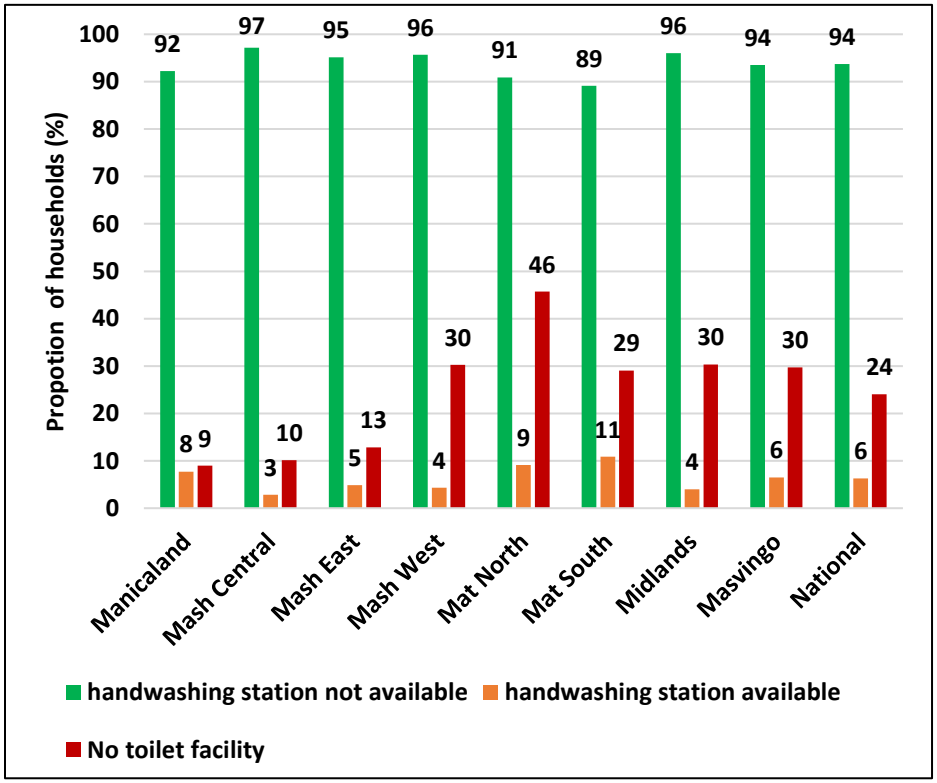
Ladder for Hygiene

Service level	Definition
Basic	Availability of a handwashing facility on premises with soap and water.
Limited	Availability of a handwashing facility on premises without soap and water.
No Facility	No hand washing facility on premises.

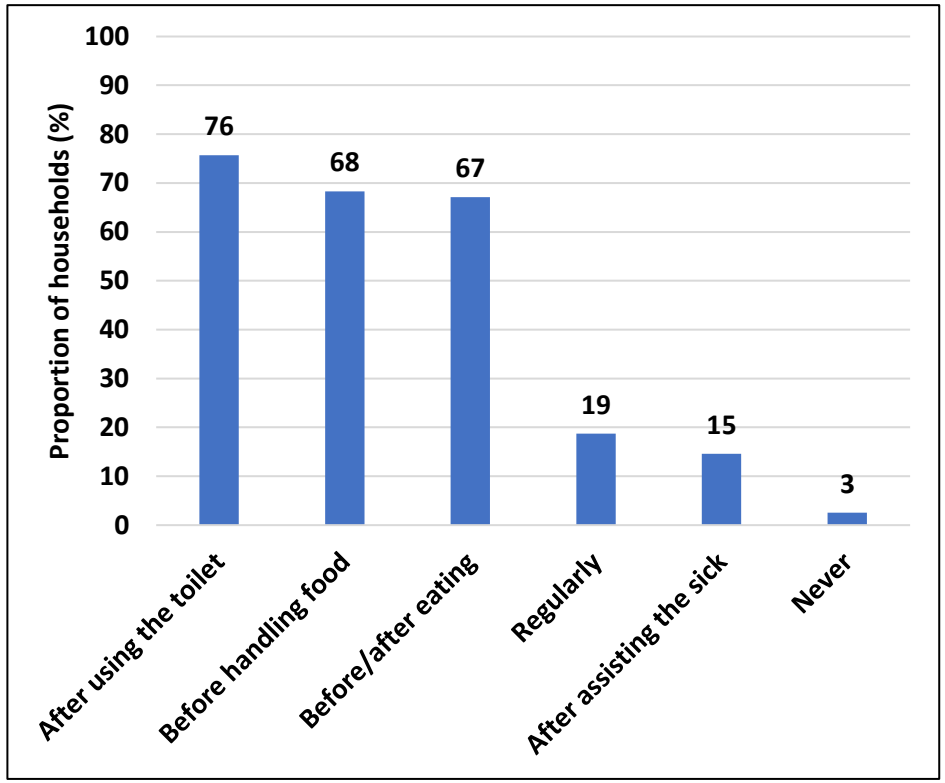
Note: handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy taps, and jugs or basins designated for hand washing. Soap includes bar soap, liquid soap, powdered detergents and soapy water but does not include sand, soil, ash and other handwashing agents.

Handwashing

Handwashing facilities



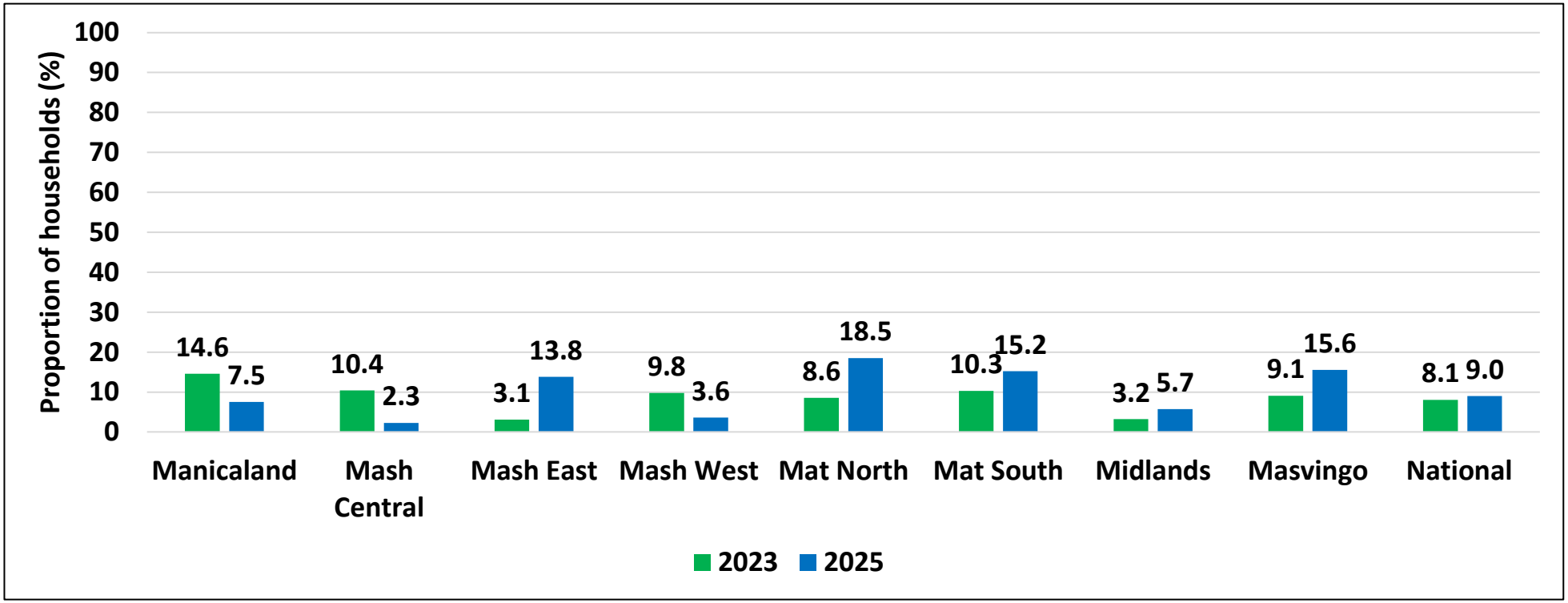
Handwashing at Critical Times



- The proportion of households without handwashing facilities was 94%.
- The majority of households reported that they washed their hands after using the toilet (76%) whilst 3% reported that they never washed their hands.

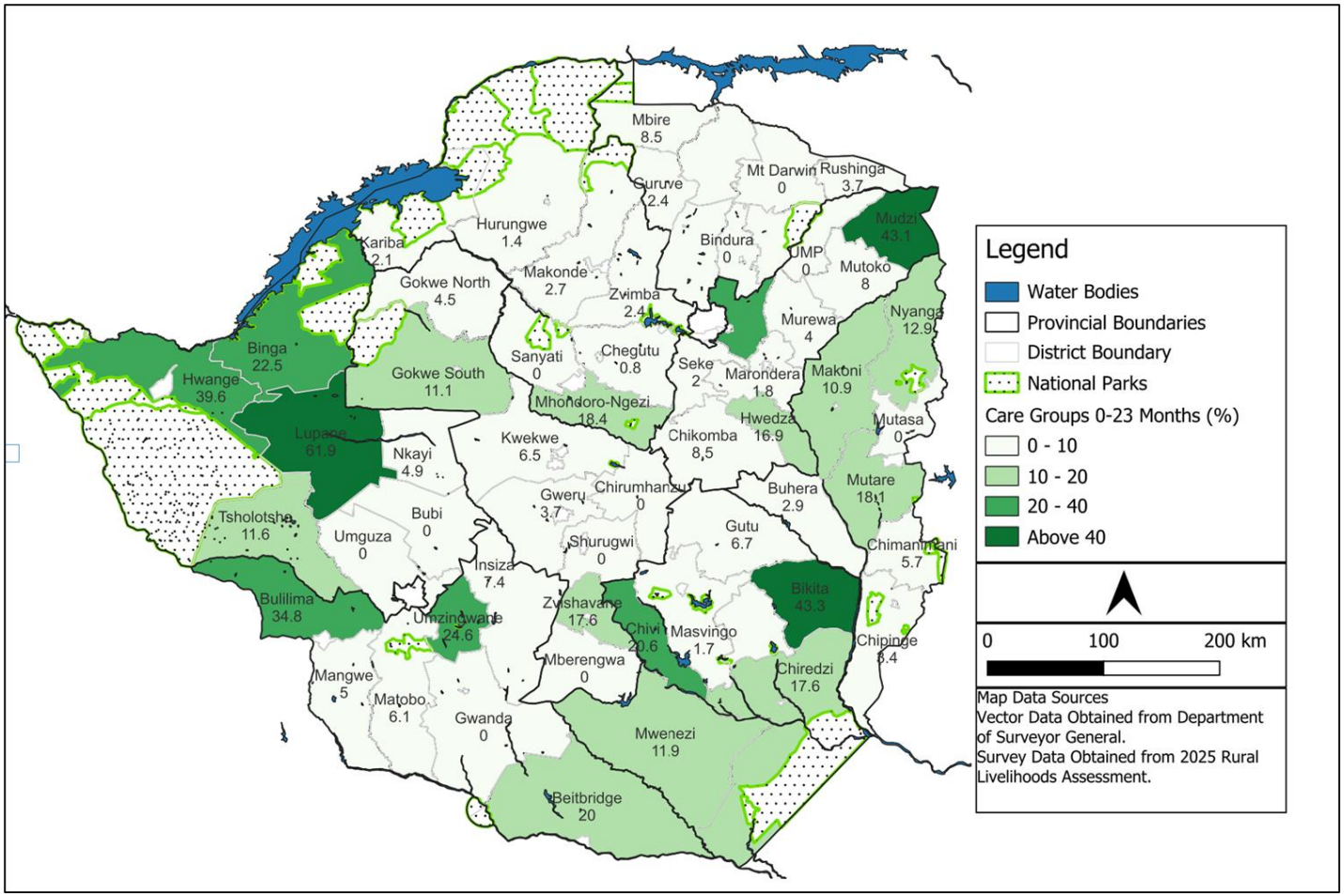
Care Groups

Care Group/IYCF Support Group Membership (0-23 Months Caregiver)



- The care-group approach is a community-based strategy for promoting health and nutrition behavior change.
- The proportion of households that had a caregiver who was a member of a care group or Infant and Young Child Support group was 9%.
- Matabeleland North (18.5%), Masvingo (15.6%) and Matabeleland South (15.2%) had the highest proportions.

Care Group/IYCF Support Group Membership by District



- Lupane (61.9%), Bikita (43.3%), Mudzi (43.1%), Hwange (39.6%) and Bulilima (34.8%) had the highest proportion of households which had a caregiver of a child aged 0 - 23 months who was a member of a care group or IYCF support group.

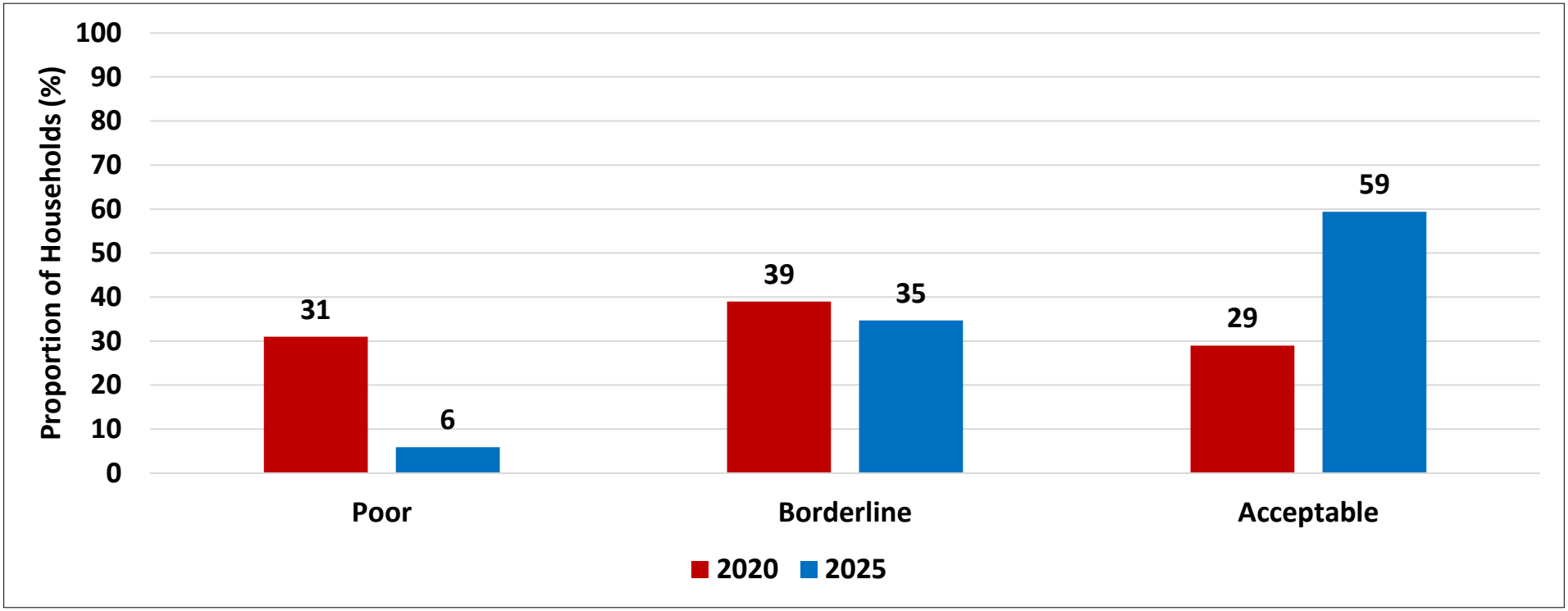
Household Consumption Patterns

Food Consumption Score (FCS)

Food Consumption Score

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

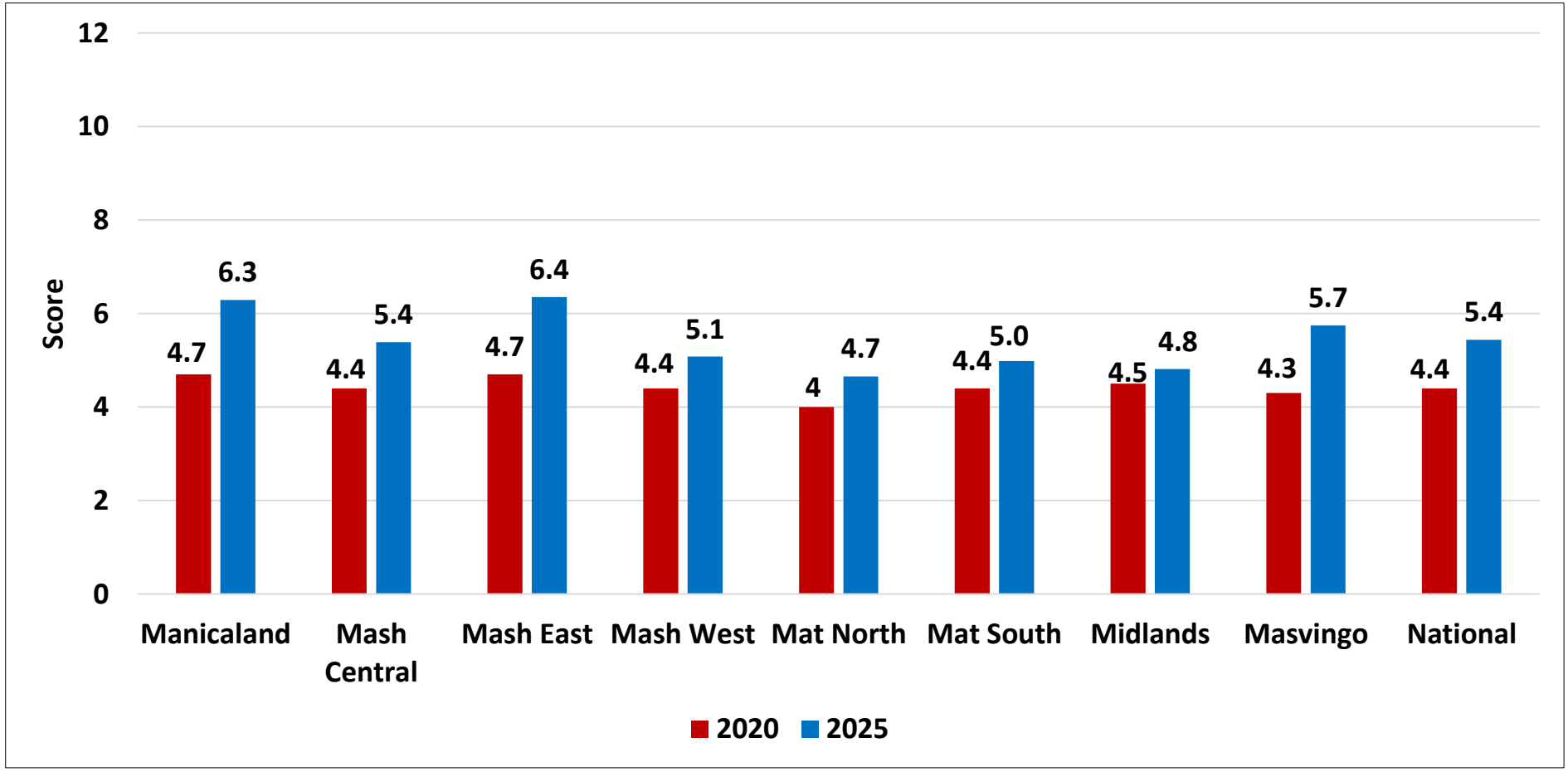
Food Consumption Patterns Trend



- There was an increase in the proportion of households with acceptable food consumption from 2020 (29%) to 2025 (59%).
- The proportion of households which consumed poor diets decreased from 31% in 2024 to 6% in 2025.
- This reflects an improvement in the quality of life for rural households as evidenced by the consumption of more diverse and nutritious food groups.

Household Dietary Diversity

Average Household Dietary Diversity Score



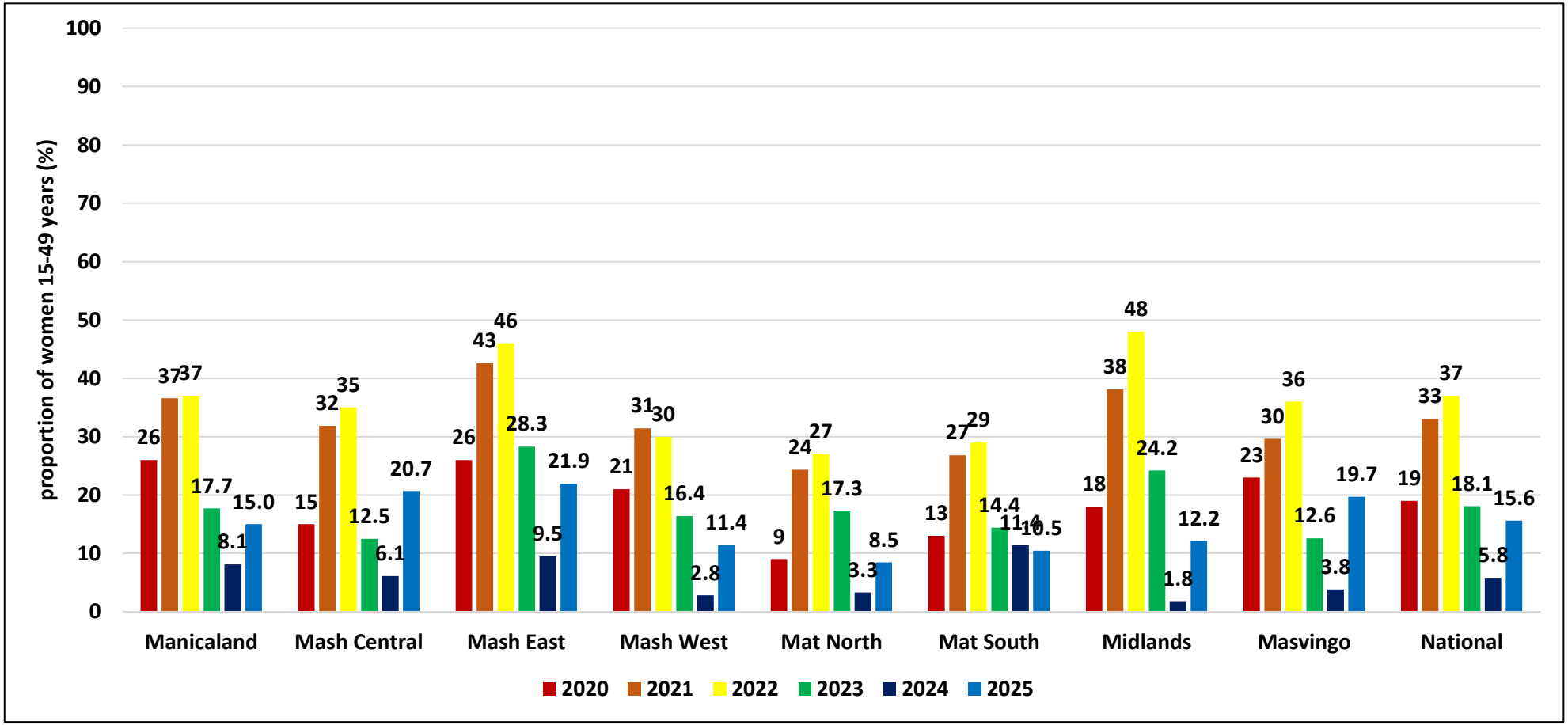
- There was an improvement in the dietary diversity score from 4.4 in 2020 to 5.4 in 2025.

Household Dietary Diversity by Food Groups (24 Hour Recall)

Province	Cereals (%)		Tubers (%)		Pulses (%)		Dairy products (%)		Meat (%)		Fish (%)		Eggs (%)		Vegetables (%)		Fruits (%)		Oil (%)		Sugar (%)		Condiments (%)	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Manicaland	96	98	15	64	14	59	10	67	27	55	9	35	11	59	90	96	36	74	84	98	57	85	88	98
Mash Central	96	98	11	50	11	48	9	53	30	48	11	30	12	42	88	92	23	65	69	95	44	83	82	94
Mash East	99	98	13	64	13	54	16	69	29	59	8	33	11	52	95	97	35	71	89	98	69	92	95	97
Mash West	96	89	6	47	6	43	10	50	24	55	12	36	8	39	88	86	14	70	79	92	48	77	90	90
Mat North	93	96	4	47	10	45	9	66	21	51	5	29	4	47	84	87	13	59	67	92	57	85	84	96
Mat South	94	93	8	52	13	46	15	67	34	61	7	40	7	47	78	89	20	58	68	96	73	90	87	94
Midlands	97	90	9	51	12	51	15	58	31	52	6	22	8	41	91	88	24	55	79	93	59	75	87	91
Masvingo	99	98	12	60	21	55	13	65	24	50	6	30	4	40	88	94	21	66	77	97	59	88	89	96
National	**97**	**95**	**10**	**56**	**12**	**51**	**12**	**62**	**28**	**54**	**8**	**32**	**8**	**47**	**88**	**91**	**24**	**66**	**77**	**95**	**59**	**85**	**88**	**95**

- Cereals (95%), oil (95%) and vegetables (91)% were the most consumed food groups.
- Meat consumption was highest in Matabeleland South (61%) and Mashonaland East (59%).

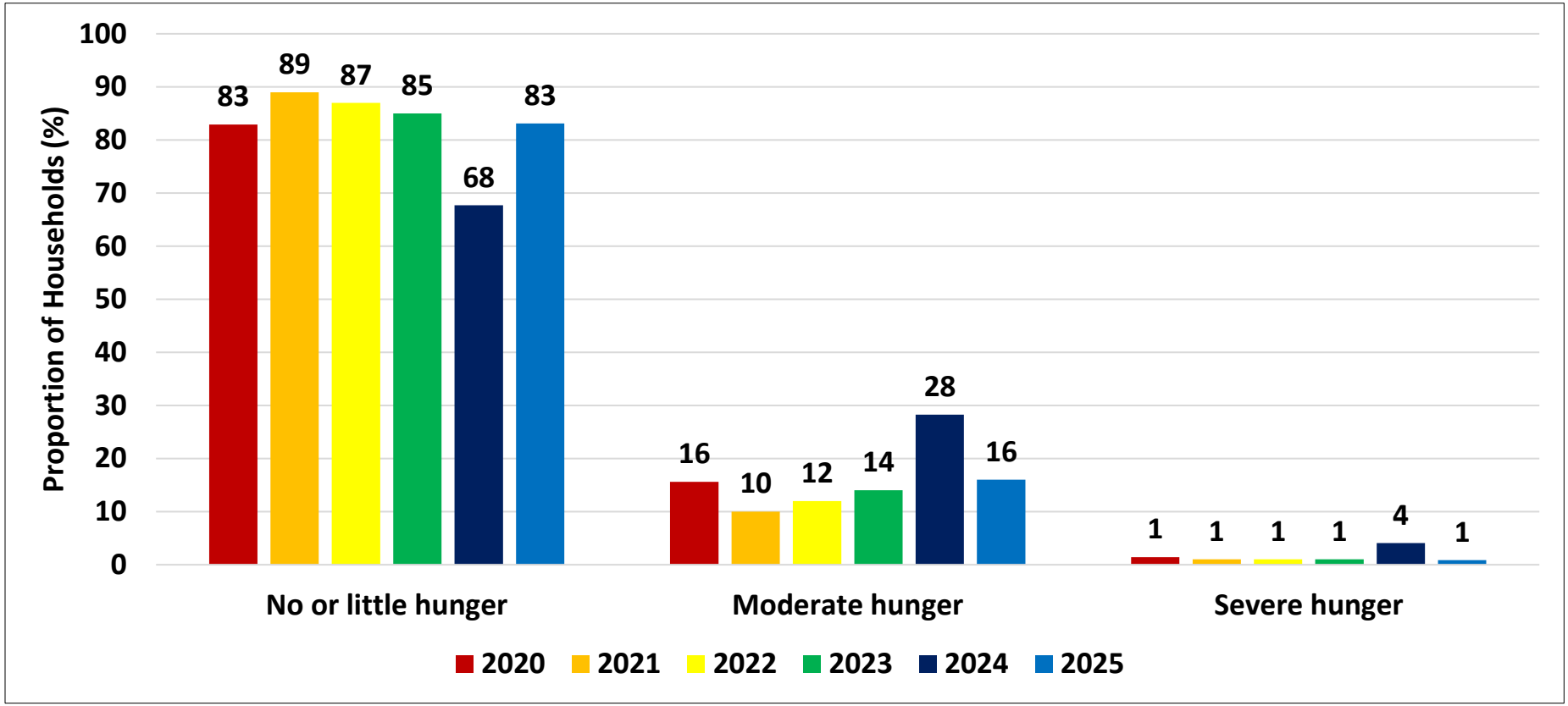
Minimum Dietary Diversity- Women



- Mashonaland East (21.9%) and Mashonaland Central (20.7%) had the highest proportion of women who consumed a minimum dietary diversity.

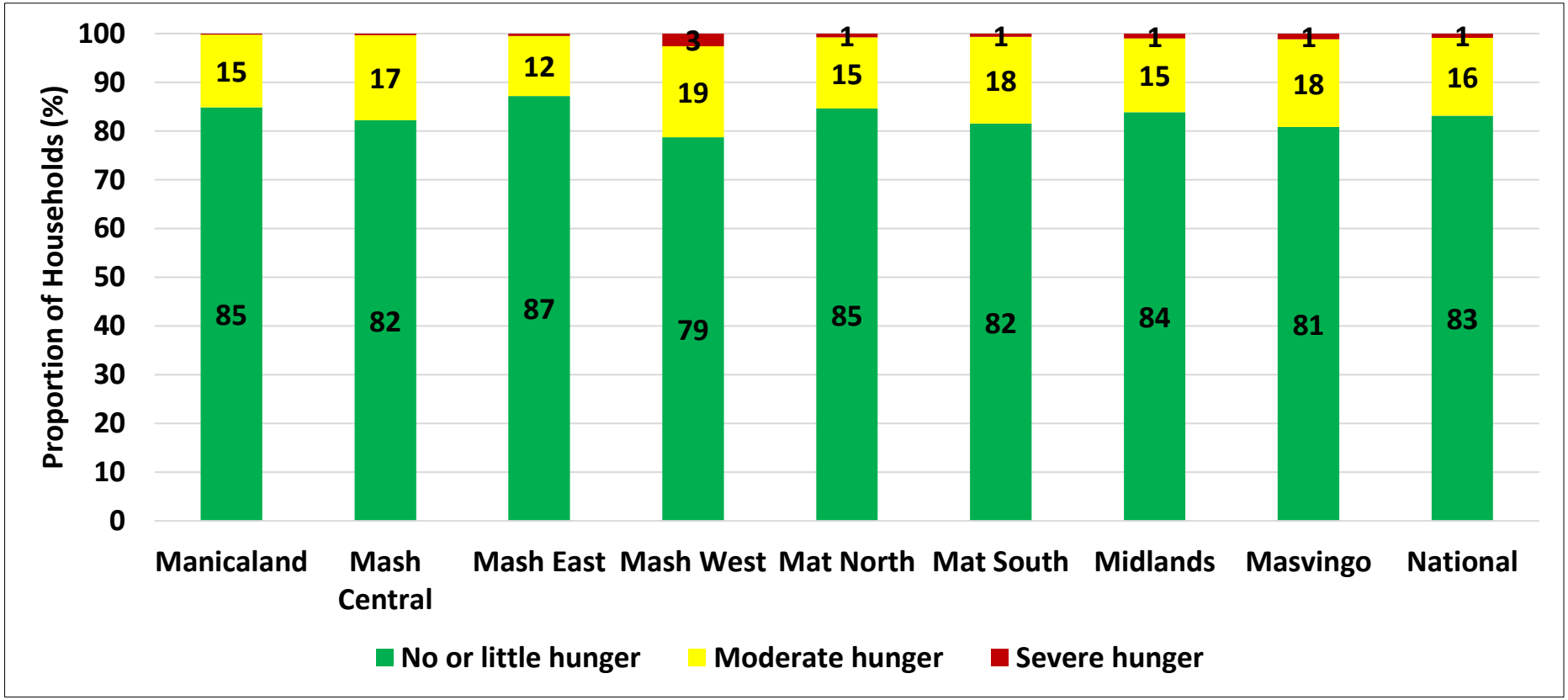
Household Coping

Household Hunger Scale



- There was an improvement in food access as evidenced by an increase in the proportion of households which experienced no or little hunger from 68% in 2024 to 83% in 2025.

Household Hunger Scale



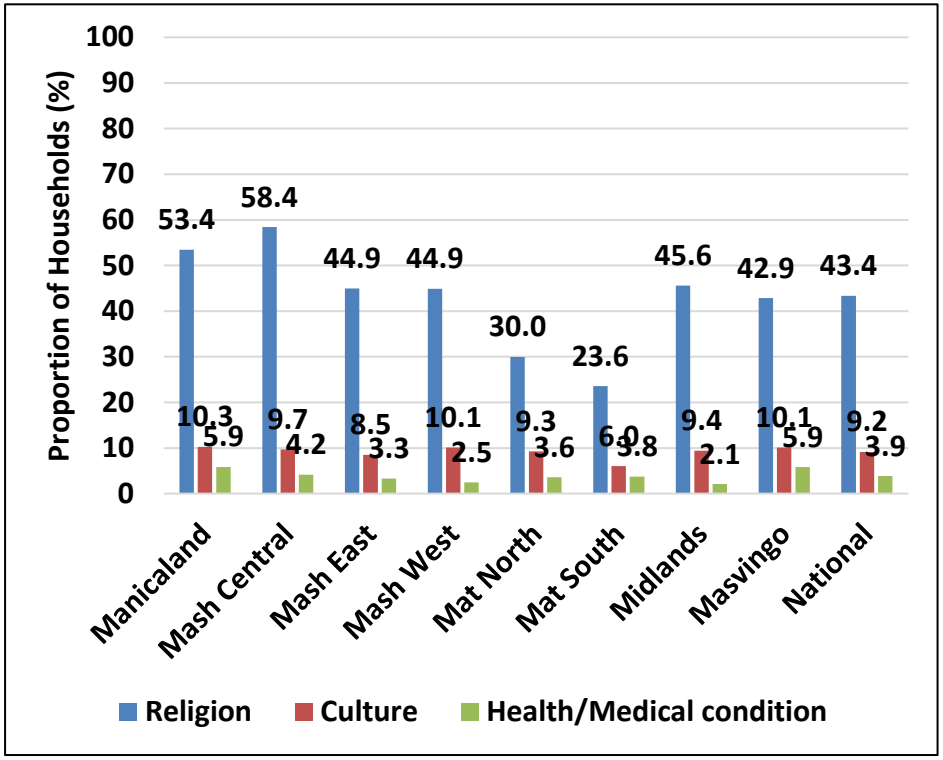
- Mashonaland East (87%) had the highest proportion of households with no or little hunger whilst Mashonaland West (19%) had the highest proportion of households with moderate hunger.

Taboos

Household Food Taboos

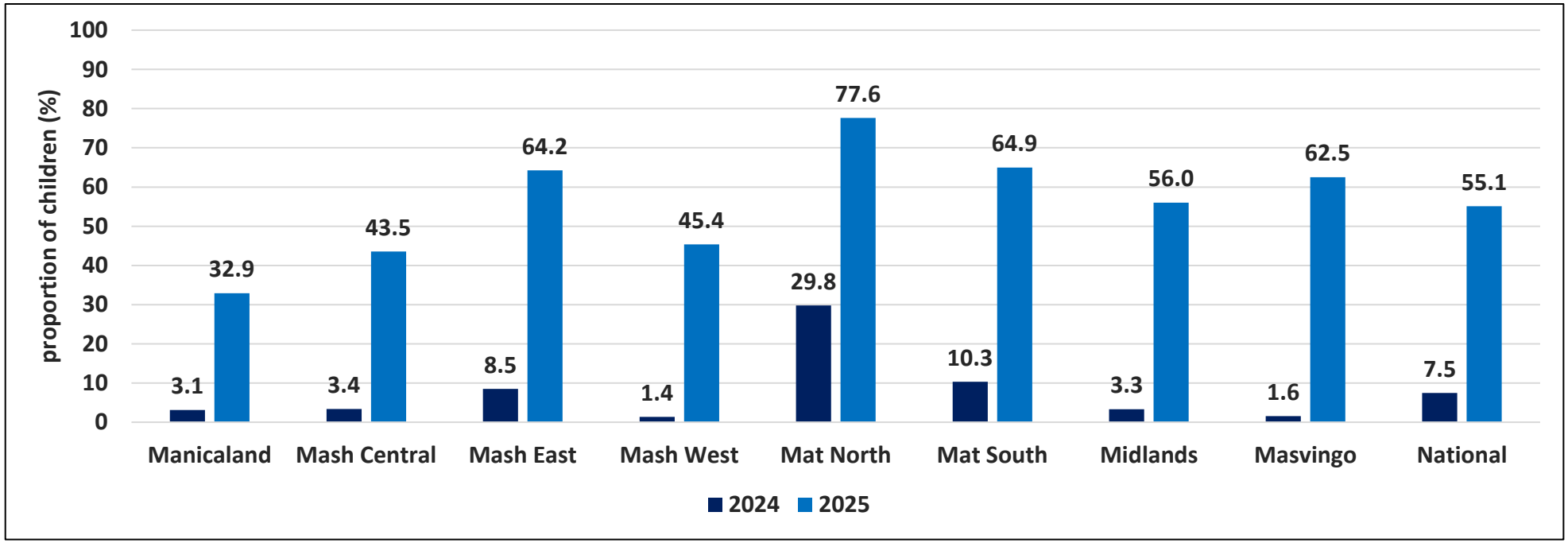
Province	Certain meat and meat products not consumed (%)	Certain fruits not consumed (%)	Traditional cereals not consumed (%)	Certain insects not consumed (%)	No taboos or restrictions (%)
Manicaland	58.8	1.6	1.0	3.8	39.9
Mash Central	60.2	7.2	3.6	15.0	33.8
Mash East	49.6	3.2	3.0	4.8	52.5
Mash West	52.6	2.2	1.1	4.5	45.0
Mat North	35.5	0.9	0.7	5.1	60.5
Mat South	30.3	4.1	3.8	4.1	62.4
Midlands	46.4	3.0	2.1	3.4	49.2
Masvingo	49.1	2.0	1.2	5.3	49.0
National	**48.1**	**3.1**	**2.1**	**5.8**	**48.9**

Reasons for Taboos



- Nationally, 48.1% of the households had taboos on the consumption of particular meat and meat products which may have negative effects on individual dietary diversity options ultimately affecting the quality of diets.
- Religion (43.4%) was the most reported reason for dietary related taboos.

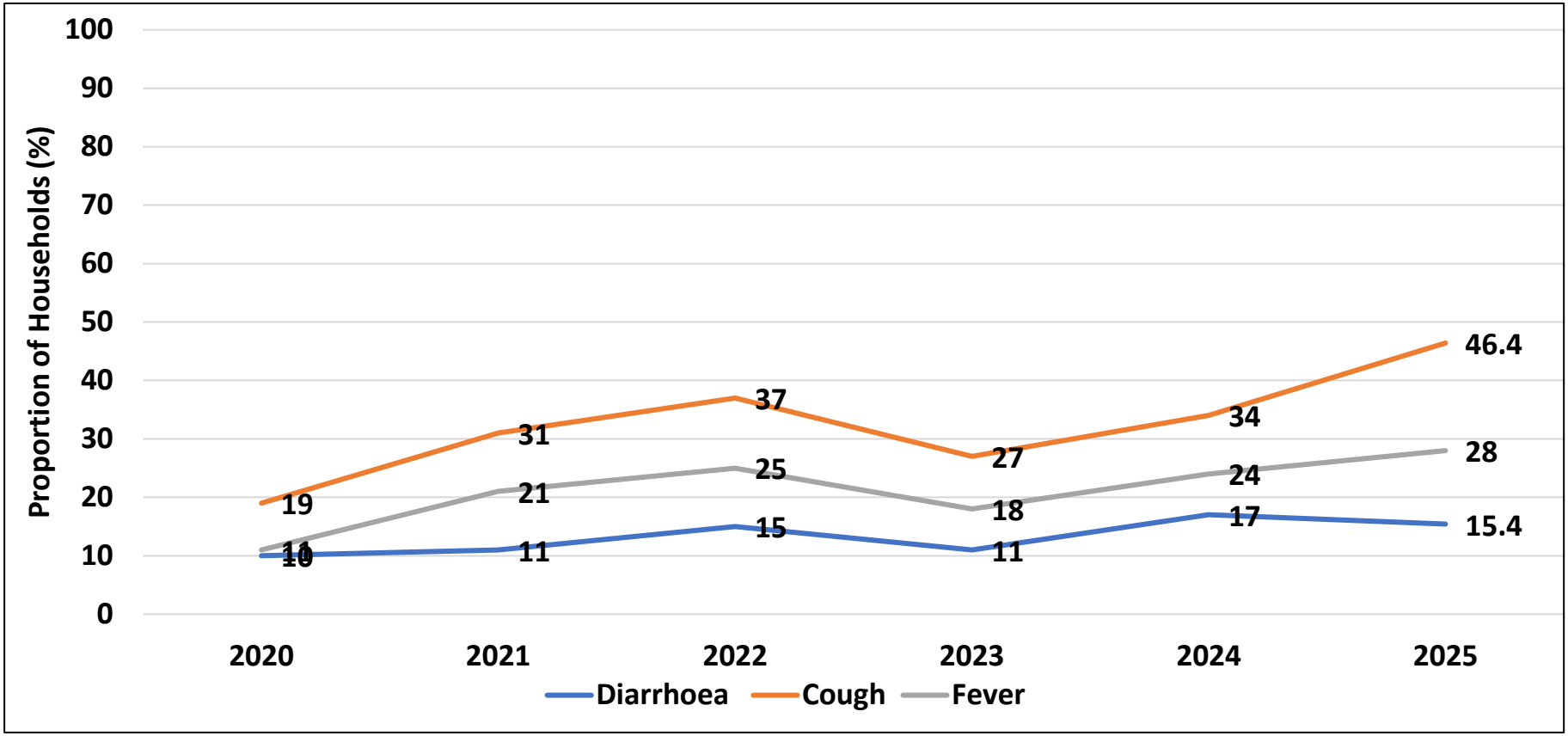
Proportion of Children Receiving Hot Meals at School



- A child or young person who is hungry does not learn well. A healthy diet in sufficient quantity is essential for learning and development.
- There was an improvement in the proportion of children who received a hot meal at school during the first term of the year from 7.5% in 2024 to 55.1% in 2025.
- Matabeleland North (77.6%) had the highest proportion of children that reported receiving hot meals at school.

Child Health

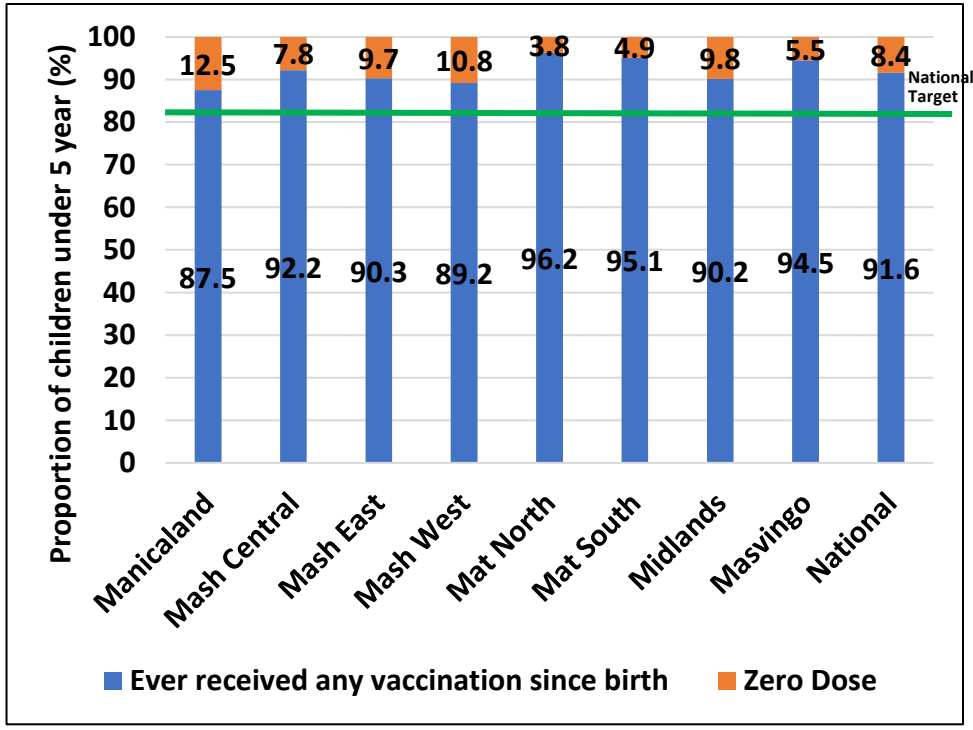
Child Illness (6-59 Months)



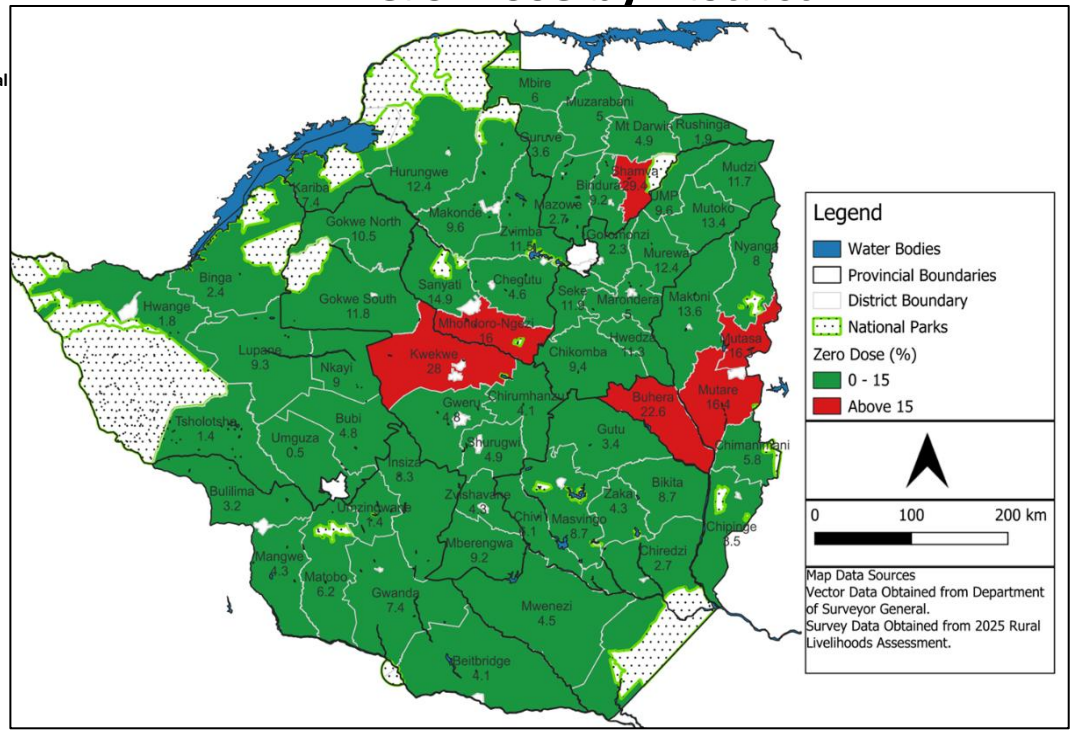
- Child illness is a negative contributor to child nutrition status.
- Cough was the most common illness over the years.

Vaccination Status of Children (0-59 Months)

Vaccination Since Birth



Zero-Dose by District



- Immunization allows children everywhere to live lives free of many forms of disability and illness. The Government is commended for successfully reaching the national target of 85% for children that had received vaccination since birth. However, attention should be given to districts with low vaccination whose zero dosage was above 15% (Shamva, Kwekwe, Buhera, Mutare, Mutasa and Mhondoro-Ngezi).

Vitamin A Supplementation

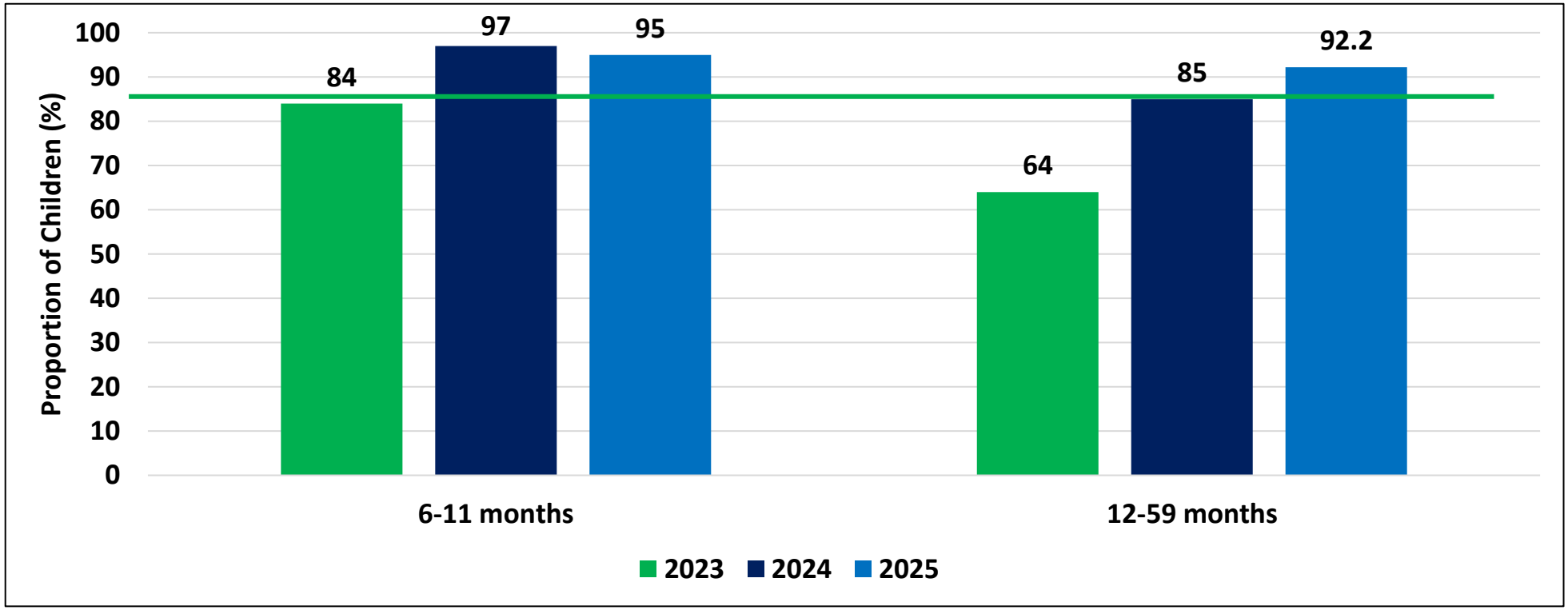
Vitamin A Supplementation for Children 6-59 Months

- The World Health Organization recommends Vitamin A Supplementation (VAS) once every six months for children in the age group of 6 59 months.
- Vitamin A supplementation has been proven to lower the risks of mortality, incidence of diarrhoea and measles in children, particularly those aged 6 months to 5 years.

The Zimbabwe VAS schedule

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 6 months from age 6 months, until child reaches 5 years

Vitamin A Supplementation (6-59 Months)



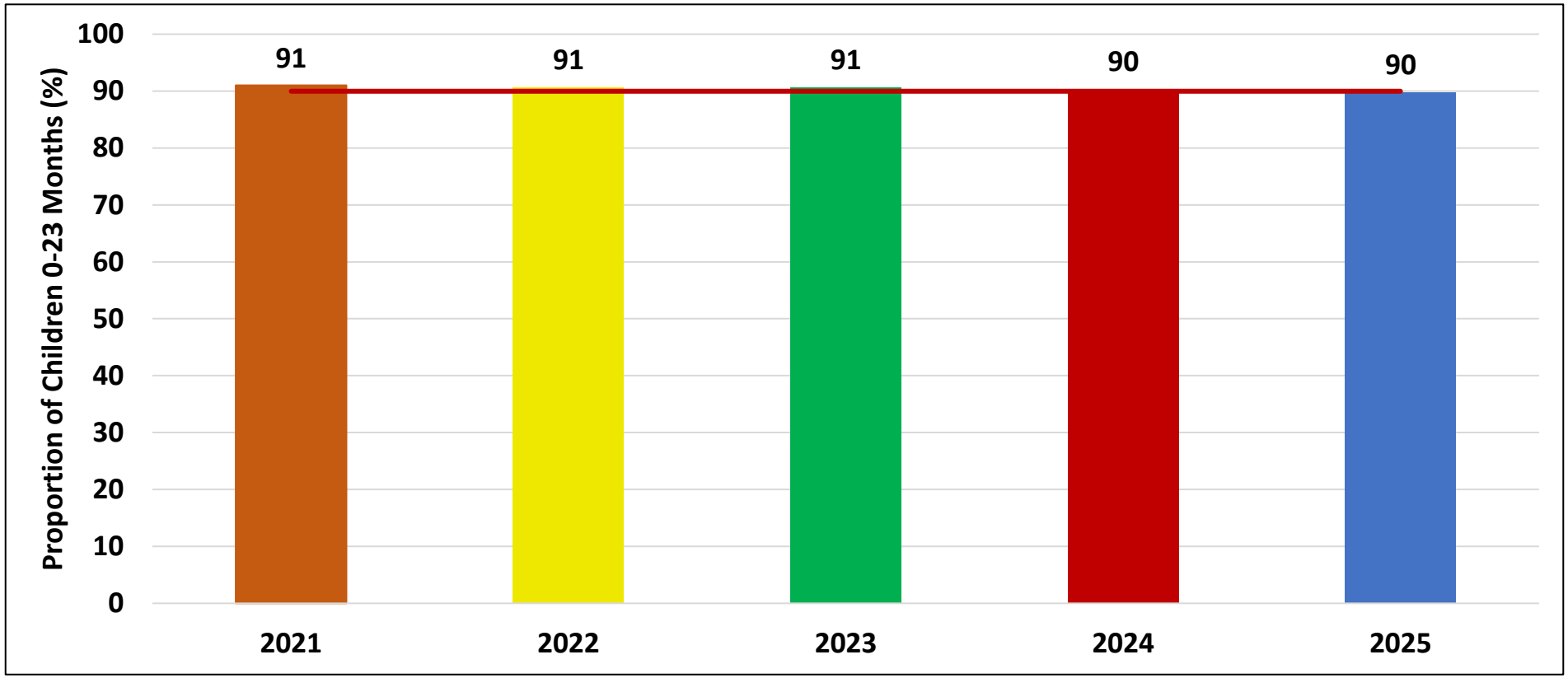
- Vitamin A is essential for the functioning of the immune system and the healthy growth and development of children. Provision of vitamin A supplements every six months is a quick and effective way to improve vitamin A status and reduce child morbidity and mortality in the long term.
- The Government is complimented for attaining its aspiration as outlined in the NDS1 to reach a target of 90% for vitamin A supplementation for children 6-59 months.

Infant and Young Child Feeding

Infant and Young Child Feeding

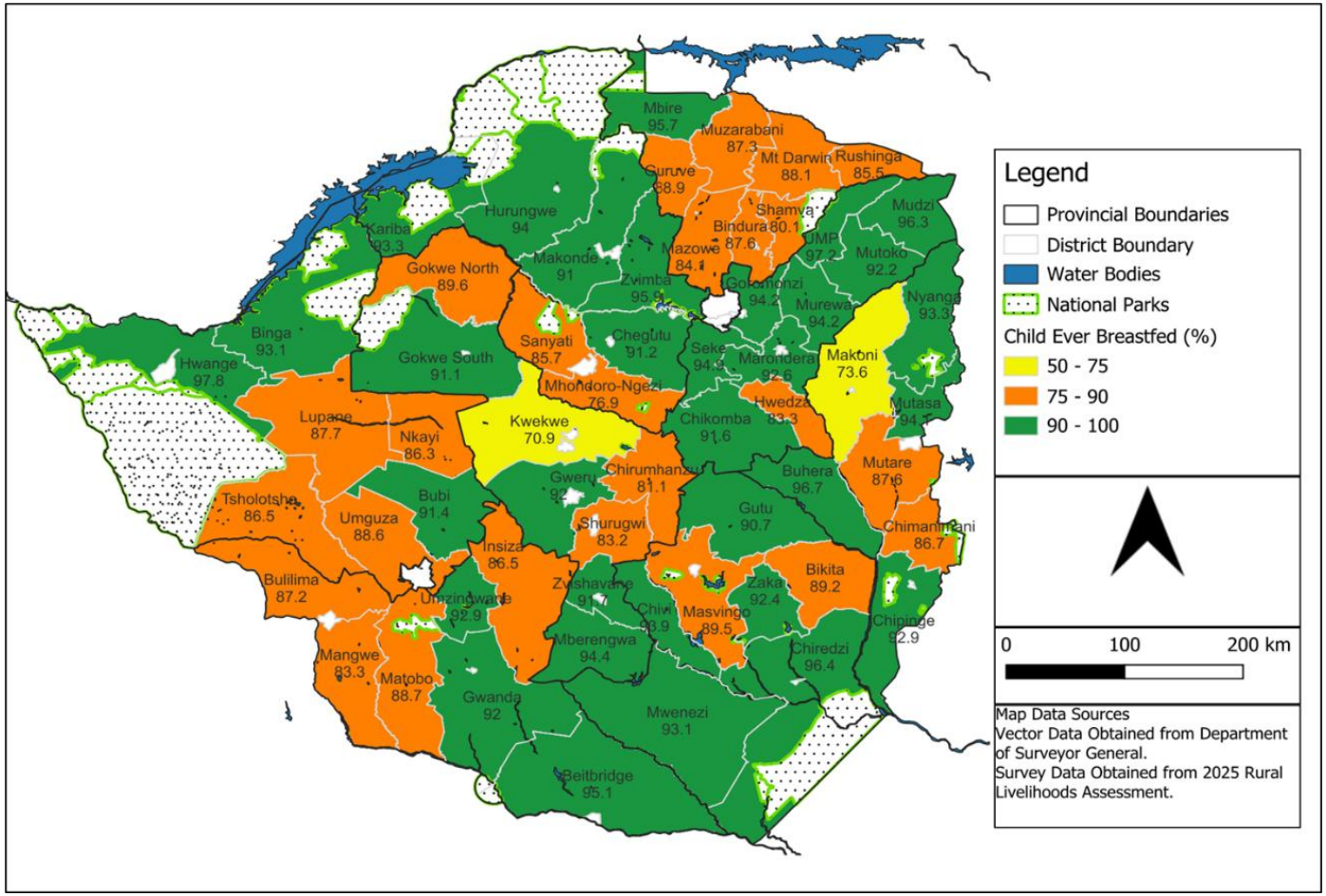
- Infant and young child feeding (IYCF) practices directly affect the health, development and nutritional status of children less than two years of age and ultimately, impact child survival. Improving IYCF practices in children 0 –23 months of age is therefore critical to improved nutrition, health and development.
- To enable mothers to establish and sustain **exclusive breastfeeding for 6 months**, WHO and UNICEF recommend:
    - initiation of breastfeeding within the first hour of life;
    - exclusive breastfeeding (i.e. only breast milk with no additional food or drink, not even water);
    - breastfeeding on demand, as often the child wants, day and night; and
    - no use of bottles, teats or pacifiers.
- The **recommendations** for feeding infants and young children (6-23 months) include:
    - continued breastfeeding;
    - introduction of solid, semisolid or soft foods at 6 months;
    - appropriate food diversity (at least five food groups per day);
    - appropriate frequency of meals: two to three times a day between 6 and 8 months, increasing to three to four times a day between 9 and 23 months, with nutritious snacks offered once or twice a day as desired;
    - safe preparation of foods; and
    - feeding infants in response to their cues.
- 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.

Children Ever Breastfed



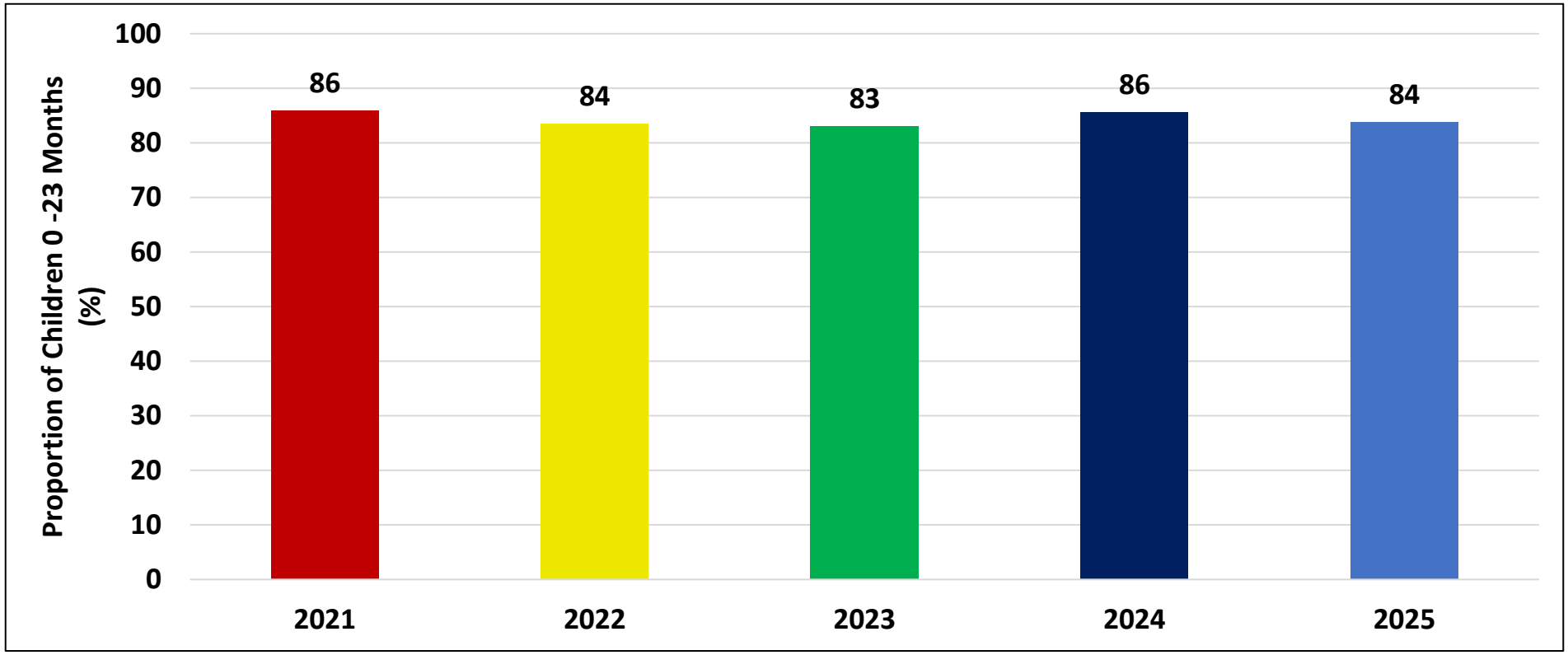
- Breastfeeding is one of the low cost high impact live-saving interventions. At birth, it provides 100% of the required daily nutrient intake.
- From 2021, the country has maintained at most 90% of the children 0-23 months having been ever breastfed, indicating the universal coverage to breastfeeding.

Children Ever Breastfed by District



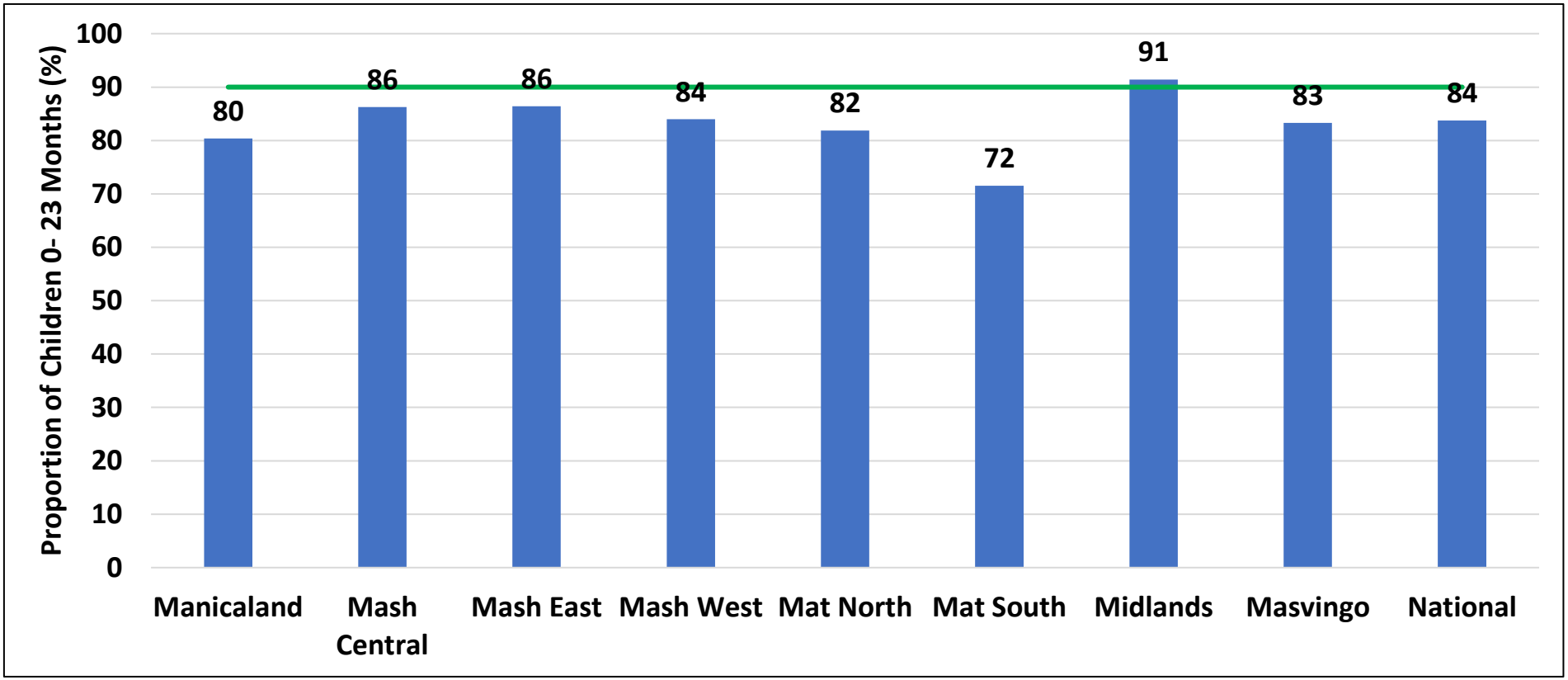
- Hwange had the highest proportion of children that were ever breastfed (97.8%).

Early Initiation of Breastfeeding Trend



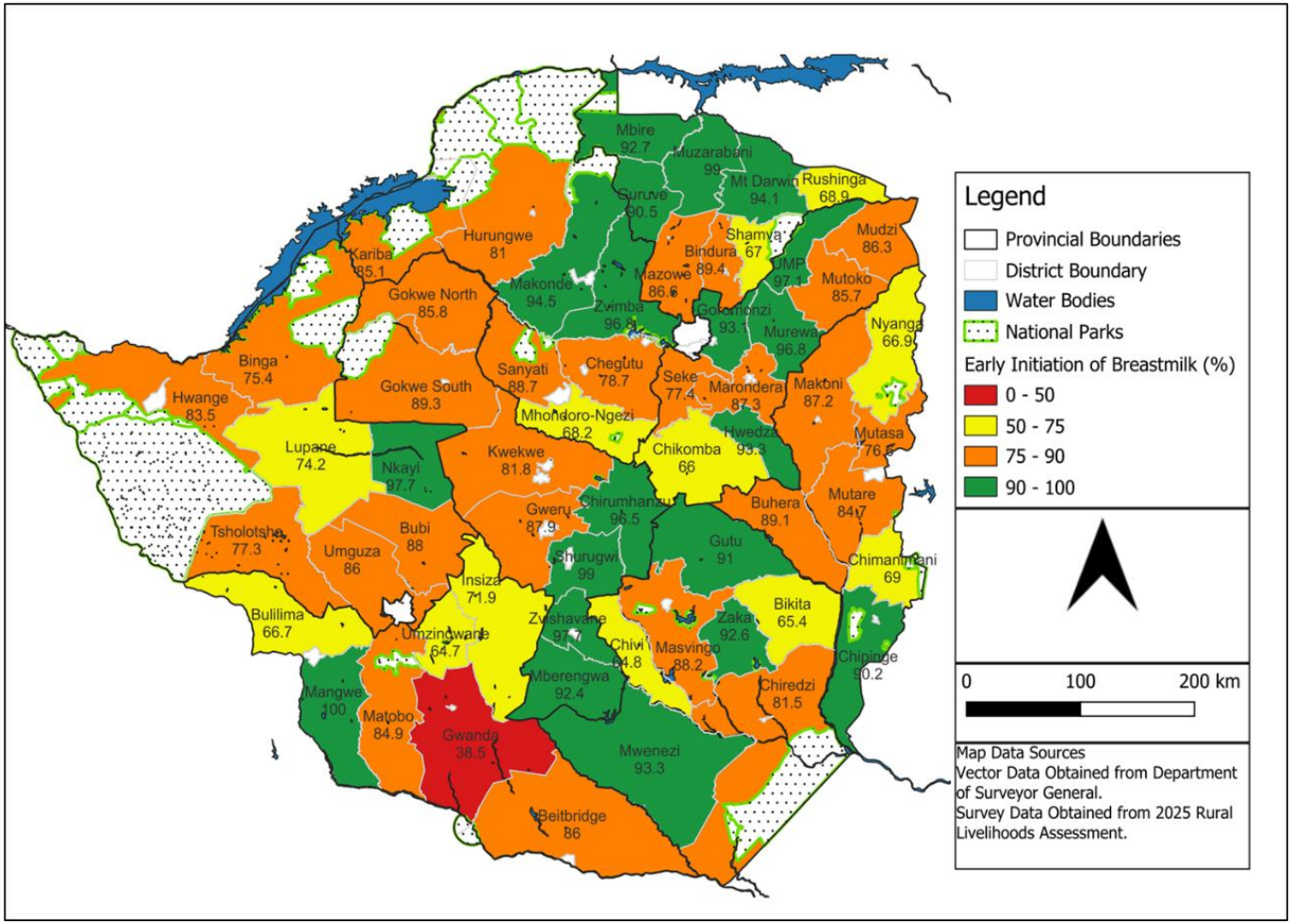
- The Government is applauded for taking accelerated action aimed at maintaining early initiation rates relatively above 80% over the past 5 years reflected by investments in baby and community baby-friendly initiatives.

Early Initiation of Breastfeeding



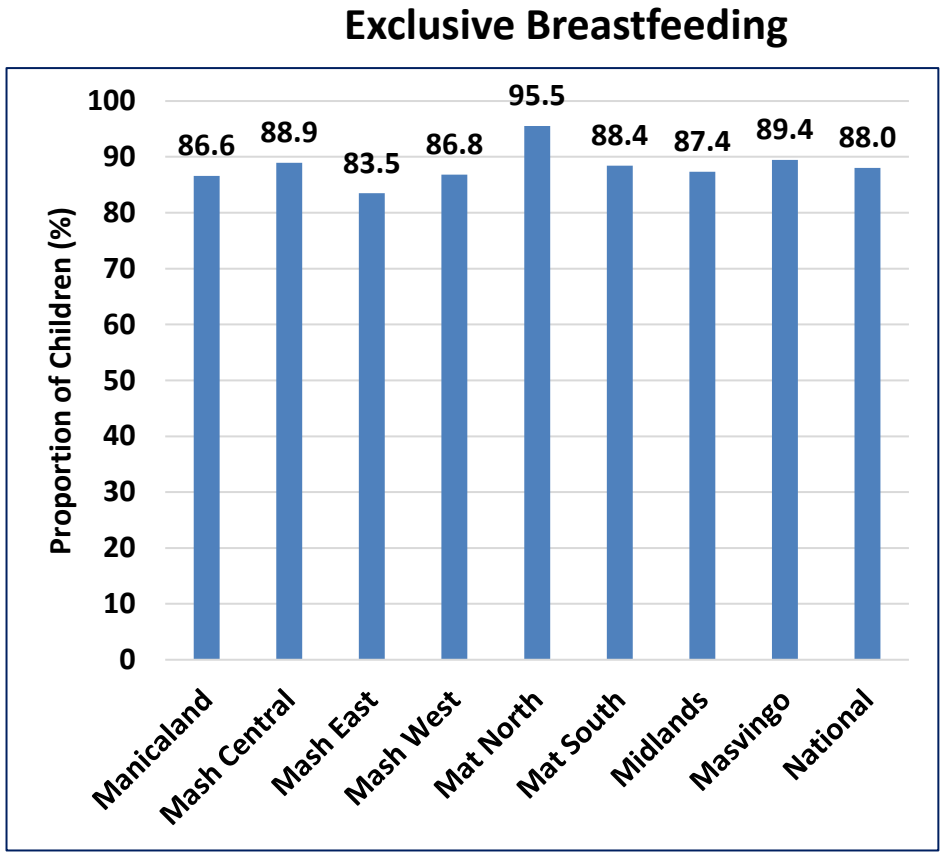
- Matabeleland South (72%) had the lowest early initiation of breastfeeding rate while Midlands (91%) had the highest.

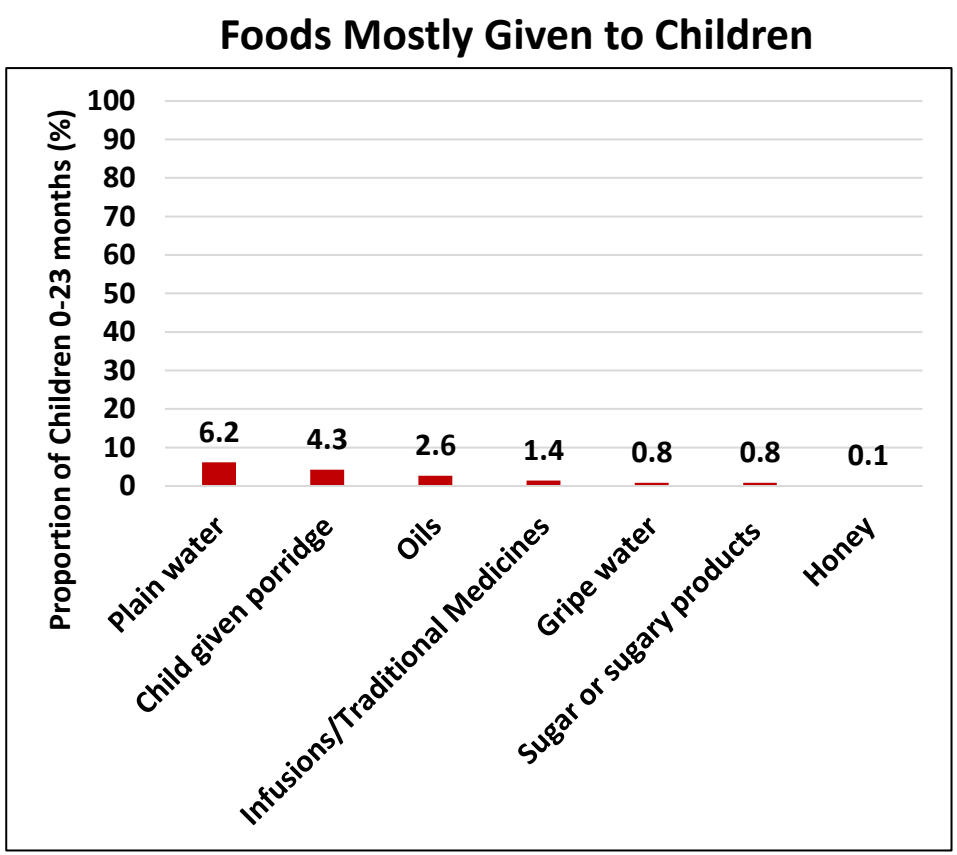
Early Initiation of Breastfeeding by District



- Gwanda (38.5%) had the lowest early initiation of breastfeeding rate.

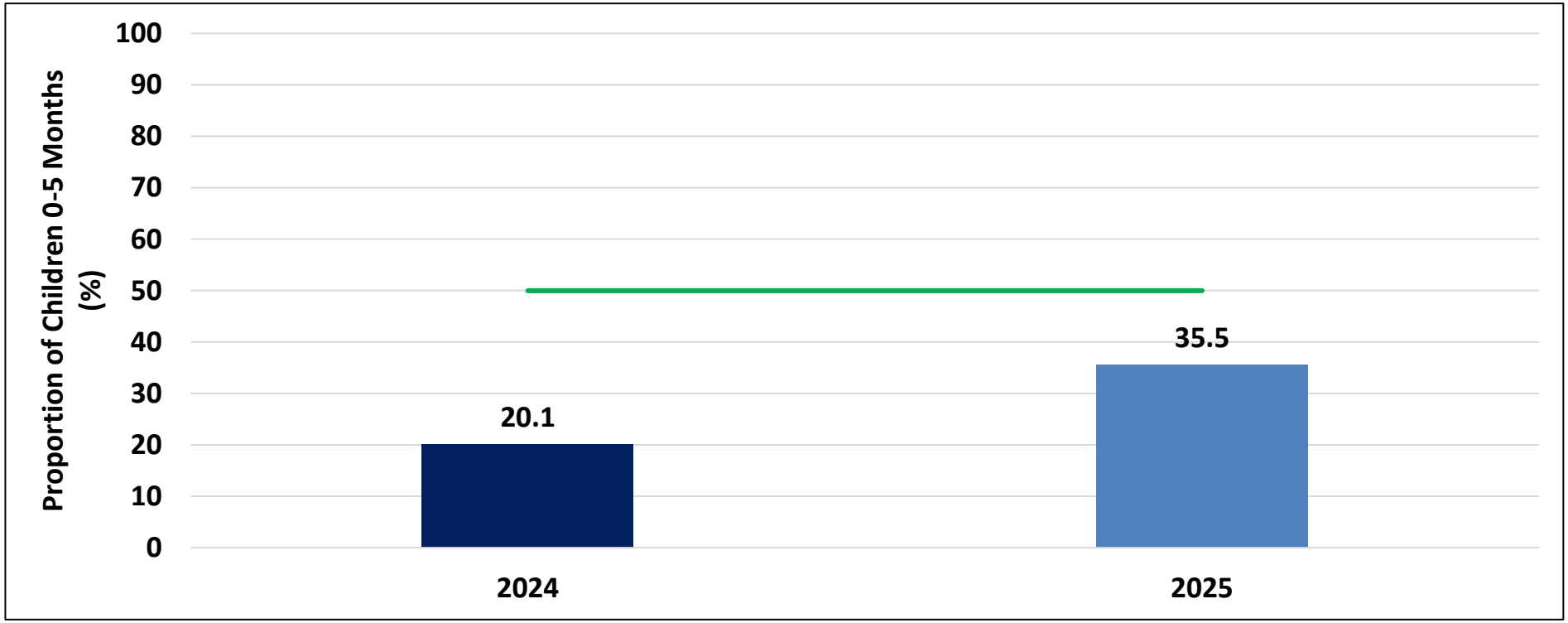
Exclusive Breastfeeding (First Two Days)





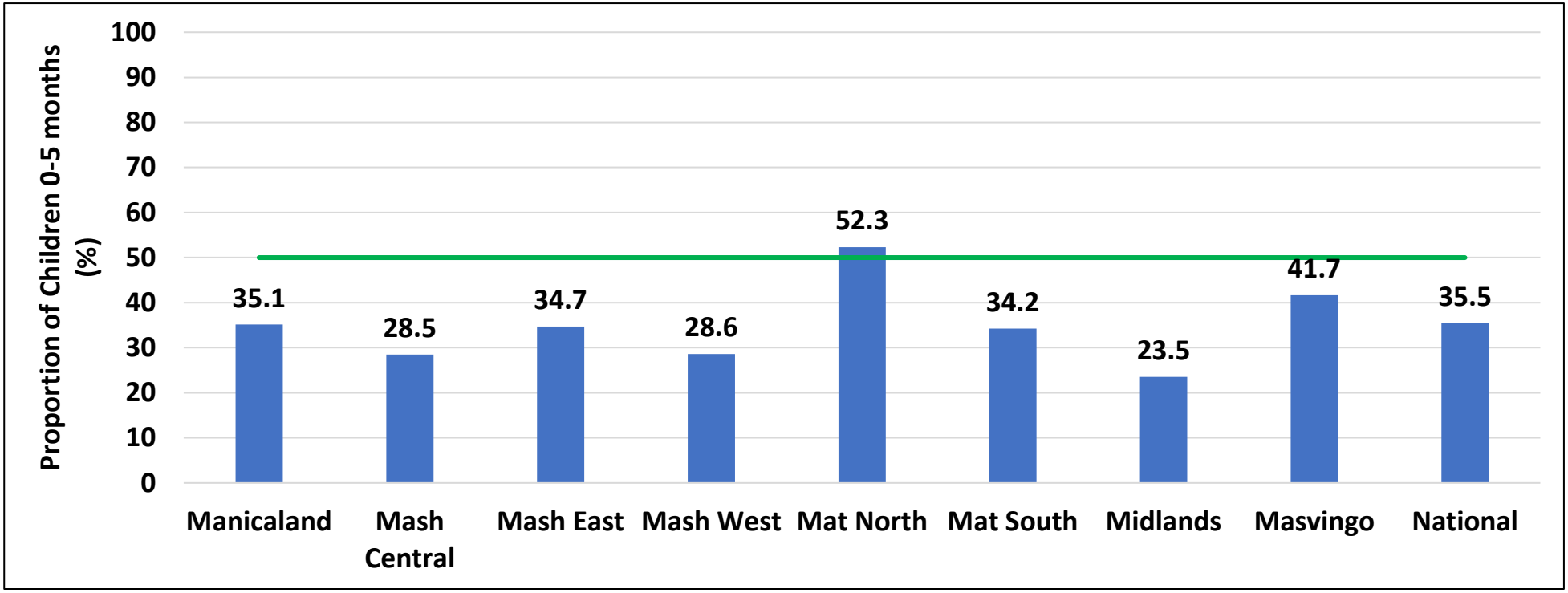
- Prelacteal feeds undermine the success of exclusive breastfeeding for the first six months.
- The exclusive breastfeeding during first two days was 88.0% and was highest in Matabeleland North (95.5%).
- Plain water (6.2%), porridge (4.3%) and oils (2.6%) were the common foods given to children during the first 2 days after birth.

Exclusive Breastfeeding (0 – 5 Months)



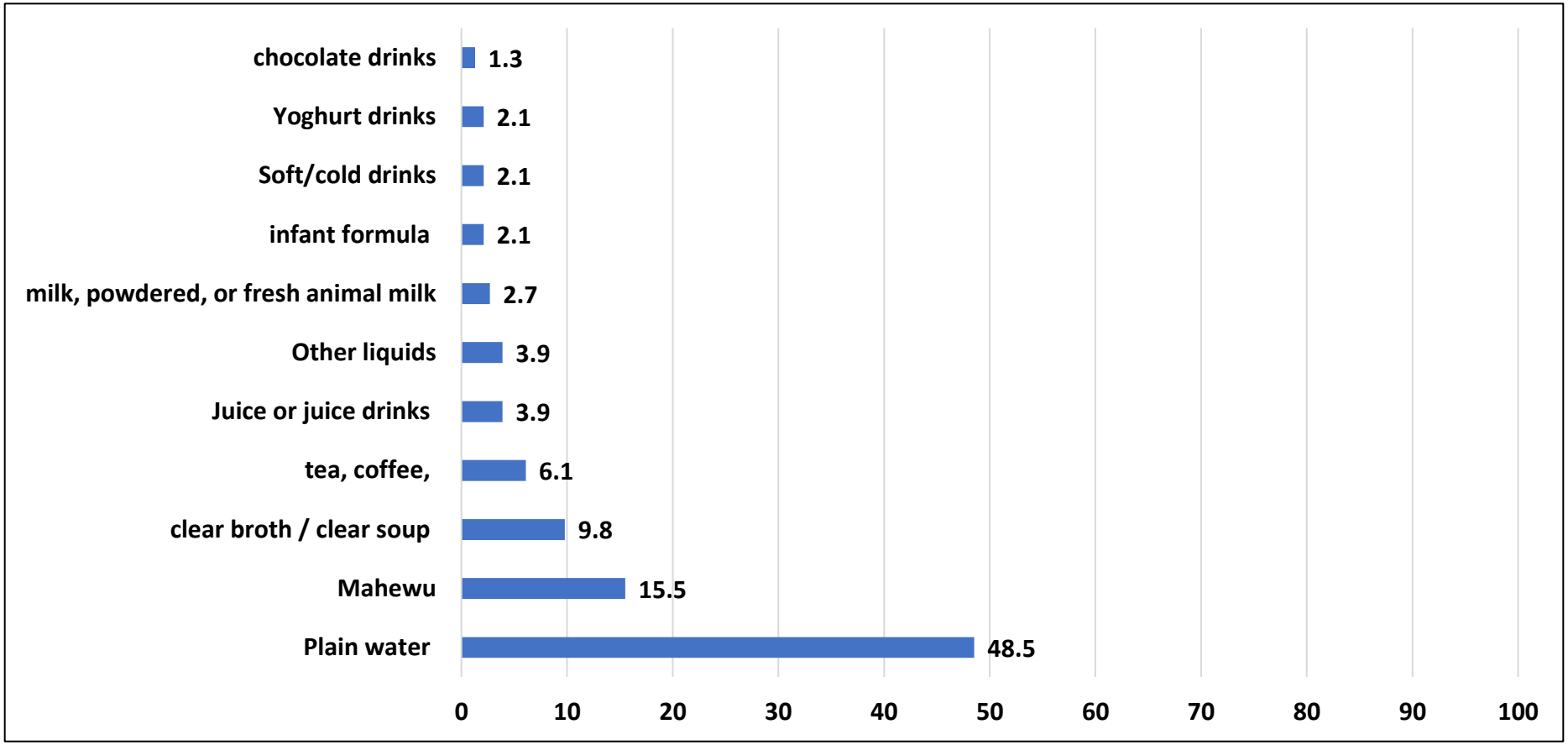
- Recognition is given to the investments in supporting, promoting and protecting gains around exclusive breastfeeding as reflected by the 74.5% increase in exclusive breastfeeding from 20.1% in 2024 to 35.5% in 2025.

Exclusive Breastfeeding (0-5 Months) by Province



- The highest exclusive breastfeeding rate was noted in Matabeleland North (52.3%) and was above the 50% 2025 Global target.
- The variation between the first two days and first 6 months reflects the need for offering continued support for optimal breastfeeding practices.

Liquids Consumed by Infants



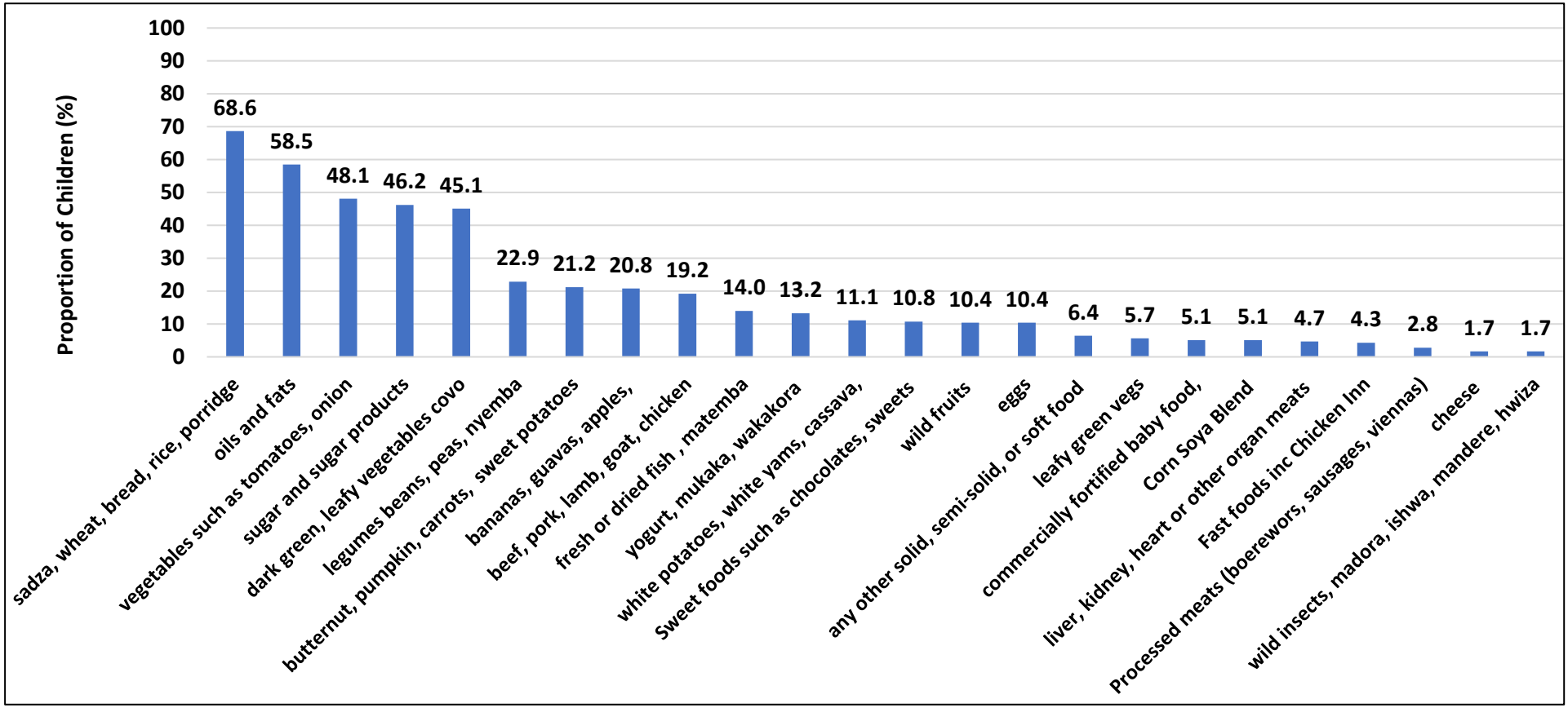
- Plain water (48.5%) and mahewu (15.5%) were the main liquids given to infants 0-5 months.

Liquids Given to Children in Addition to Breastfeeding

Province	Plain water (%)	Mahewu (%)	Clear broth / clear soup (%)	Tea, coffee, or herbal drinks (%)	Juice or juice drinks (%)	Milk (tinned, powdered, fresh animal milk) (%)	Infant formula (%)	Yoghurt drinks (%)	Soft/cold drinks (%)	Chocolate drinks (%)
Manicaland	45.0	13.2	6.2	2.3	0.8	2.3	3.9	0.0	0.0	0.0
Mash Central	56.4	16.1	9.0	9.0	3.8	3.8	1.9	3.2	1.3	1.3
Mash East	51.9	15.1	16.2	6.0	7.6	2.2	1.1	2.7	2.2	2.2
Mash West	56.0	13.6	8.7	4.3	3.3	1.6	3.3	0.0	2.2	0.0
Mat North	34.5	11.7	10.5	6.4	2.9	1.8	1.8	1.8	1.8	0.0
Mat South	44.4	12.2	10.0	1.1	2.2	3.3	3.3	5.6	2.2	0.0
Midlands	53.7	26.9	10.6	11.9	3.0	4.5	3.0	1.5	1.5	3.0
Masvingo	45.9	21.8	5.3	9.0	6.0	3.8	0.8	3.0	5.3	5.3
National	48.5	15.5	9.8	6.1	3.9	2.7	2.2	2.1	2.1	1.3

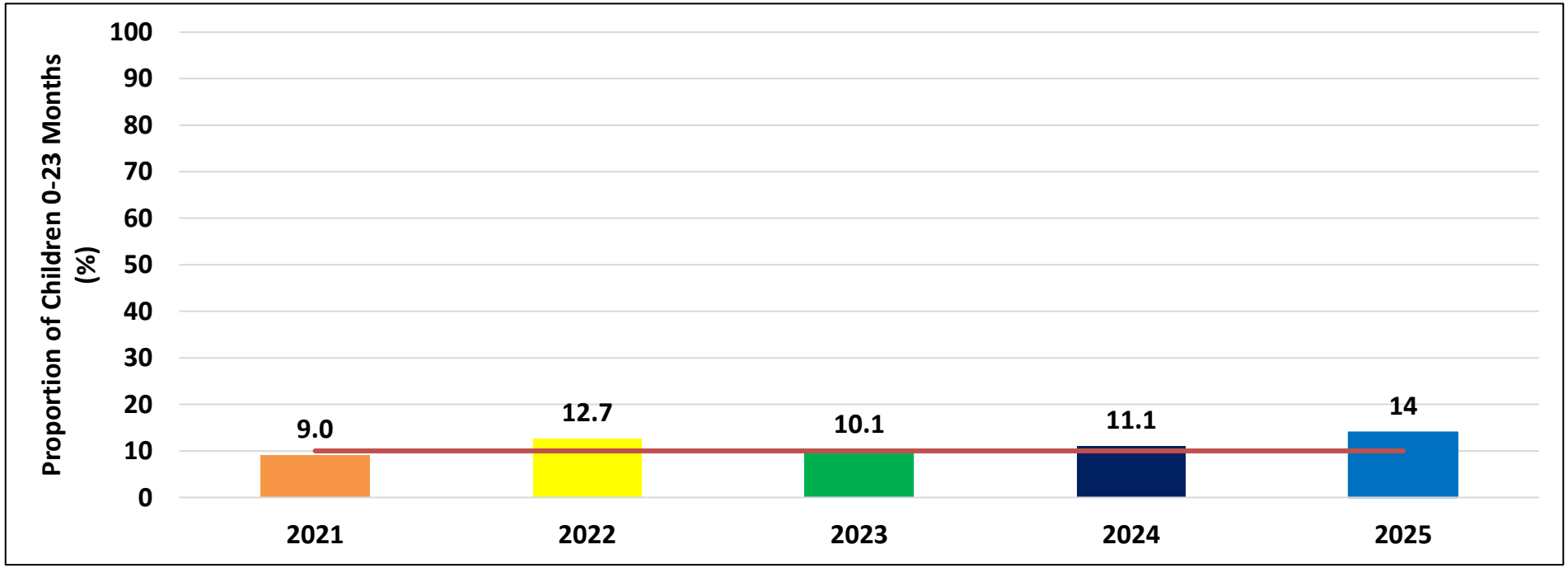
- Mashonaland Central (56.4%) and Mashonaland West (56%) had the highest proportion of children less than 6 months who were given plain water during the 24 hours preceding the survey.

Foods Consumed by Infants



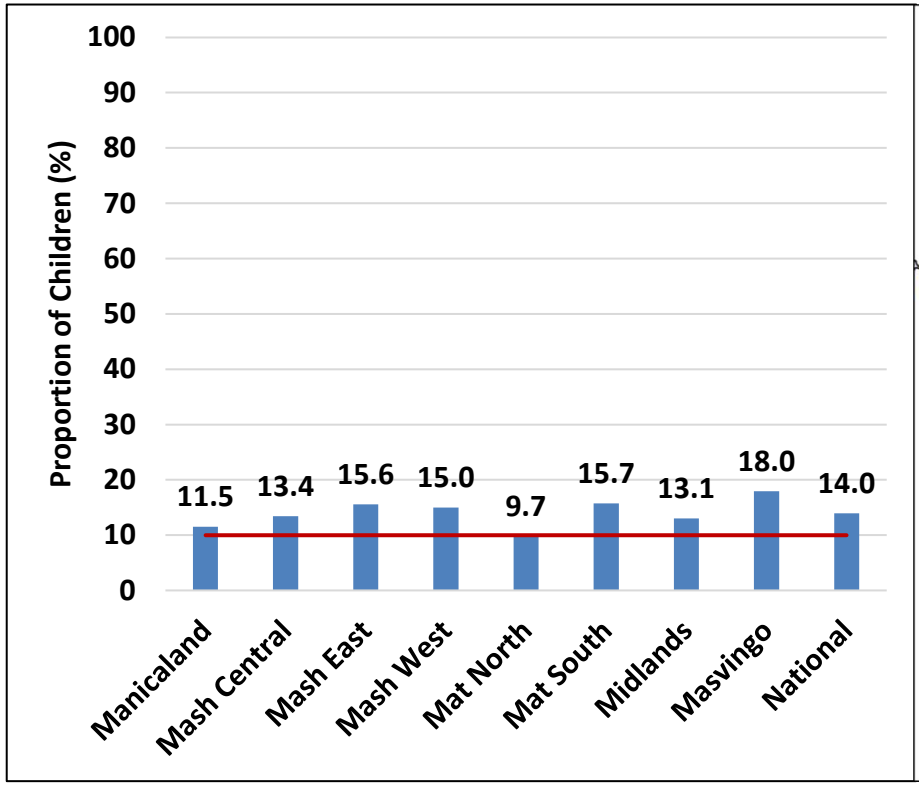
- The most common foods that were consumed by infants 0-5 months included foods made from cereals (68.6%), oils and fats (58.5%) and vegetables (tomatoes, onions) (48.1%).

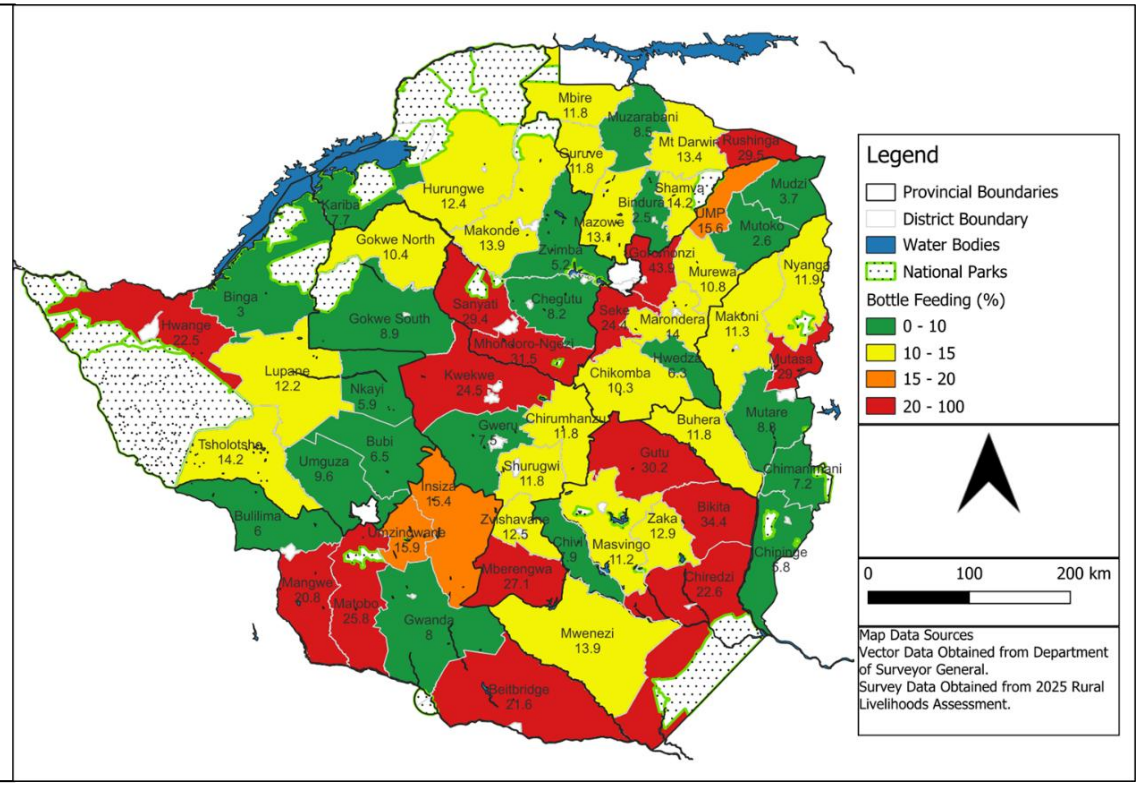
Bottle Feeding Trend



- Feeding an infant from a bottle with an artificial teat may make it more difficult for the baby to learn to attach well at the breast and has been associated with earlier cessation of breastfeeding. Moreso, in unhygienic conditions and poor preparation of infant formula, it puts the infant at a great risk of illness, resulting in increased risk of mortality.
- The WHO recommends that bottle feeding should be below 10%.
- National data indicates a concerning upward trend in bottle feeding, rising by over 50%, from 9% in 2021 to 14% in 2025.

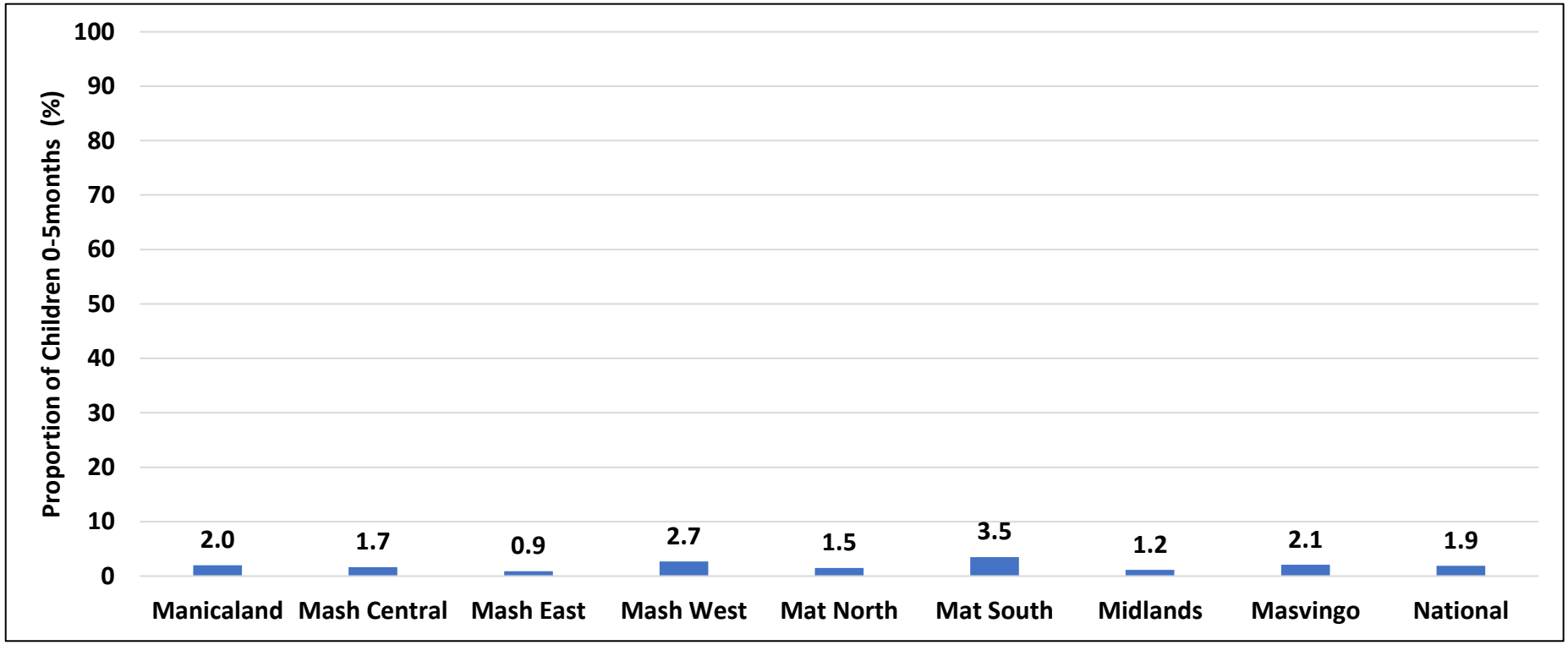
Bottle Feeding





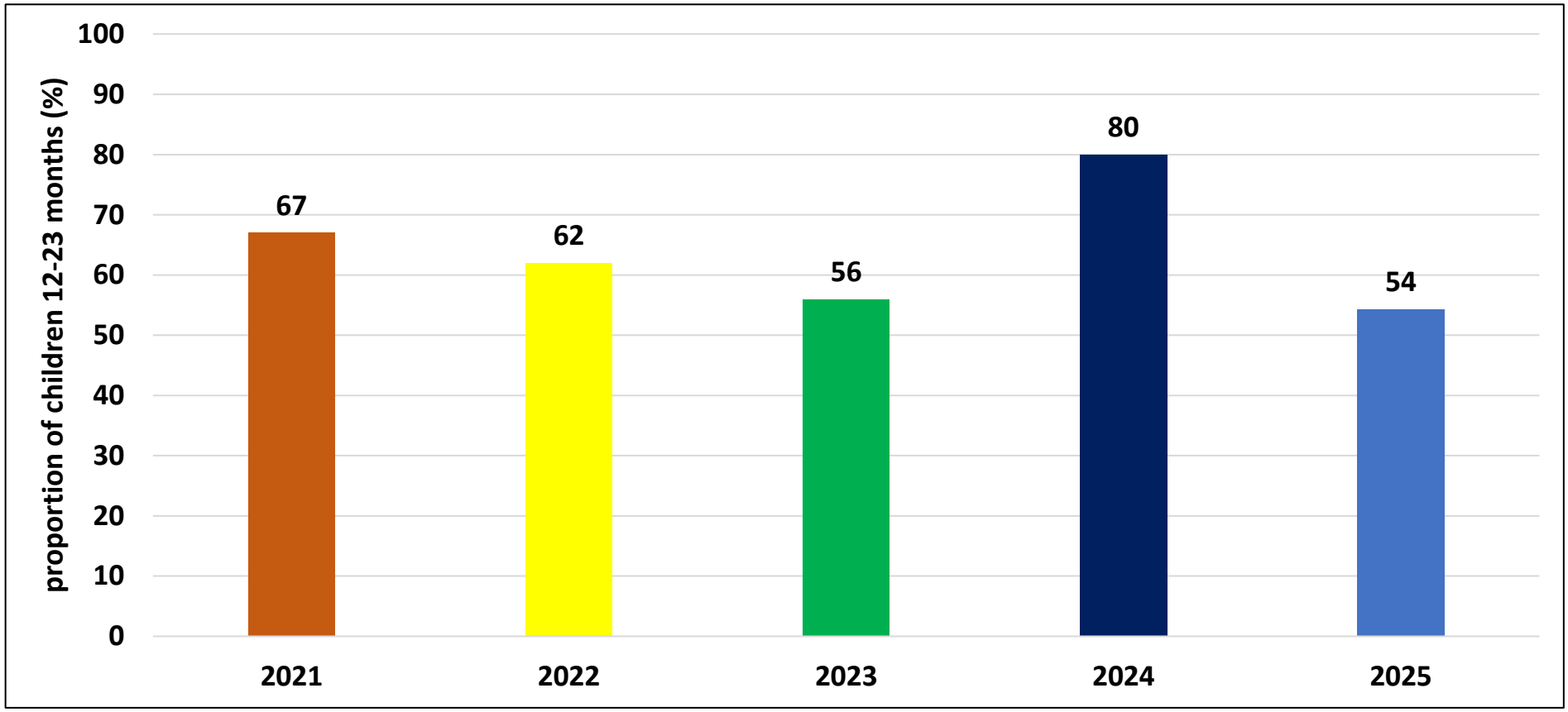
- All provinces except Matabeleland North had bottle feeding rates above the 10% threshold and this poses risk of poor breastfeeding practices, diarrhoeal diseases and mortality to children.
- Further variation exists at district level as shown in the map where low bottle feeding rates were in Mutoko (2.6%) and Binga (3%) while high bottle feeding rates were in Goromonzi (43.9%) and Bikita (34.4%).

Mixed Milk Feeding (0-5 Months)



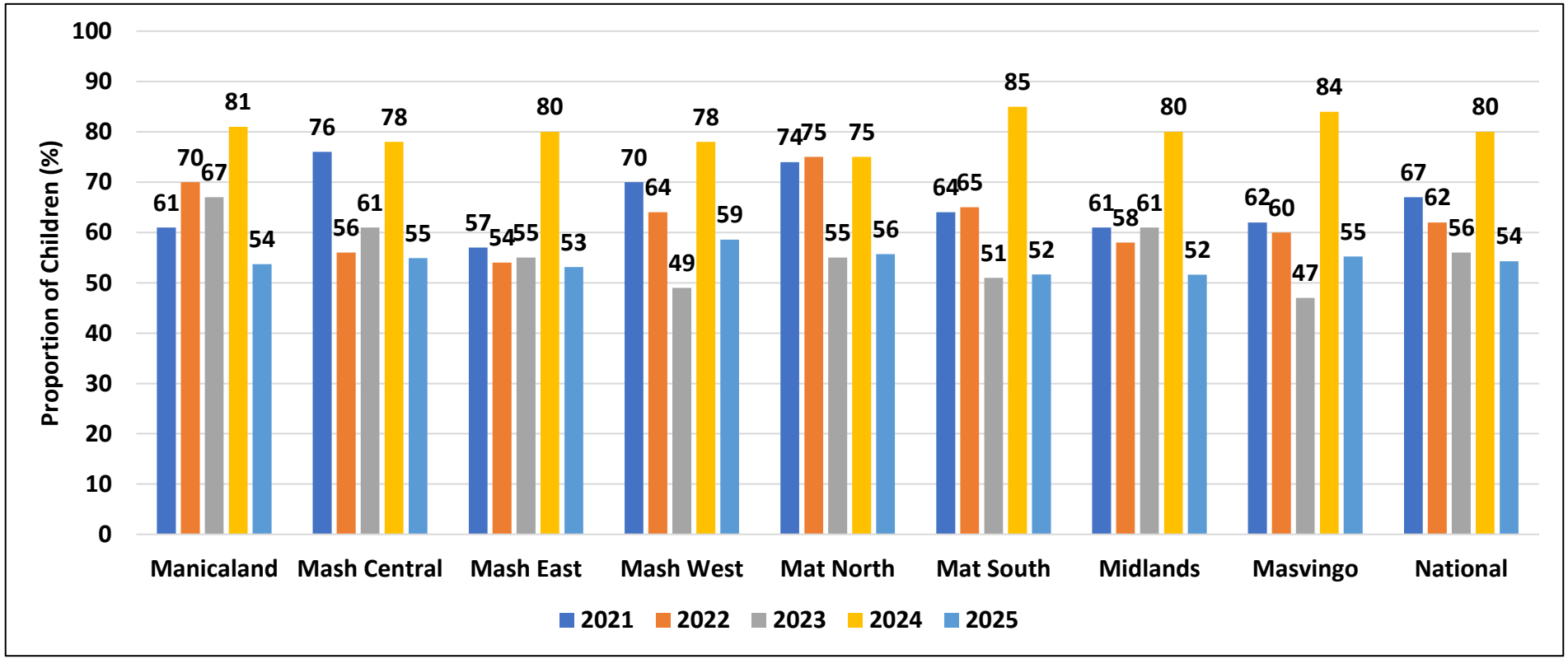
- The proportion of infants 0–5 months of age who were fed formula and/or animal milk in addition to breast milk during the previous day was 1.9%.
- Mixed milk feeding with breast milk is associated with increased risks of early cessation of breastfeeding, reduced breast milk production and altered gut microflora.
- The risk of diarrhoea among mixed-fed infants in poor sanitation areas tends to be higher than the risk among infants fed only breast milk.

Continued Breastfeeding Beyond 1 year



- Nationally, the proportion of children who continued to be breastfed beyond one year was 54%. This was a decrease from 67% in 2021.
- The spike in 2024 could be attributed to the poor seasonal performance hence leaving few options besides breastfeeding.

Continued Breastfeeding by Province

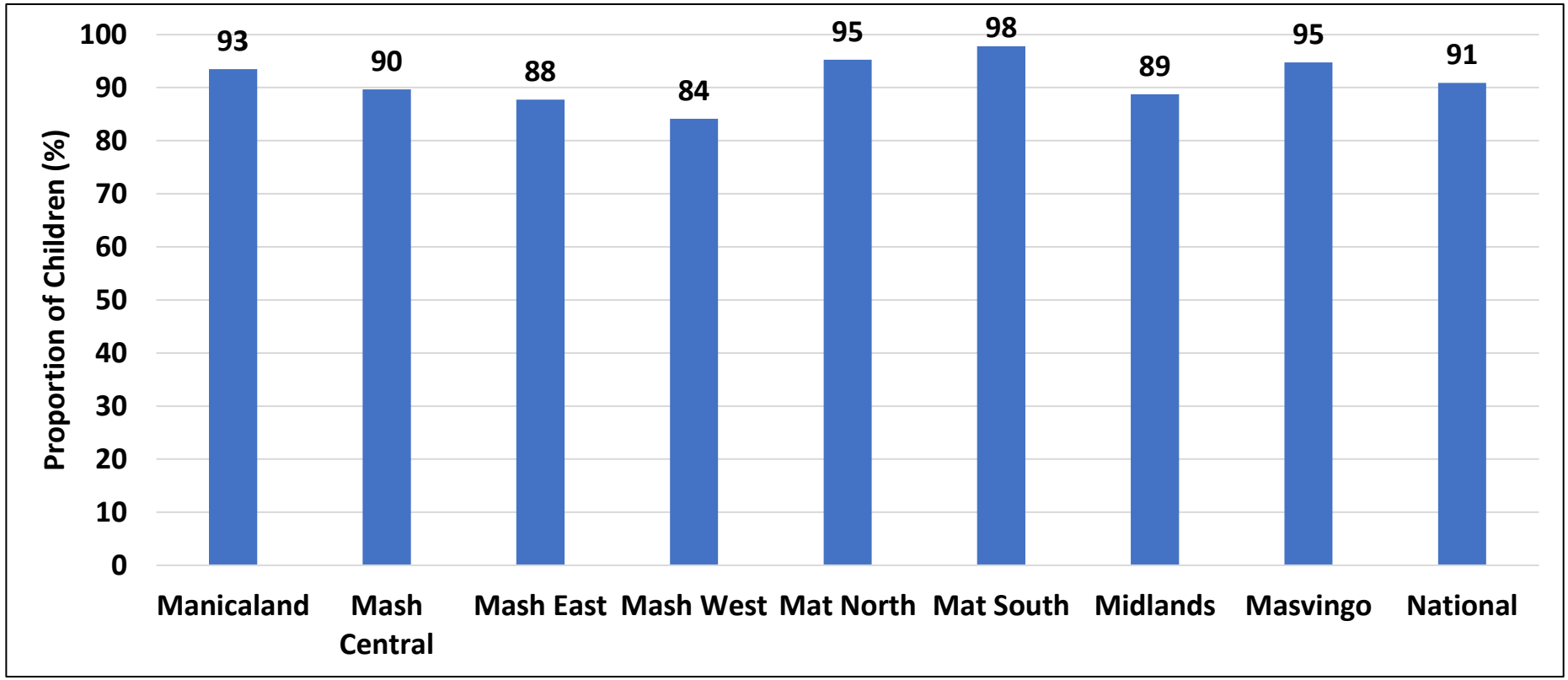


- Breast milk is a significant source of energy and nutrients in children. It provides one third of energy and nutrient needs for children aged between 12 and 24 months of age.
- Nationally, the proportion of children who continued to be breastfed beyond one year was 54%.
- Mashonaland West (59%) had the highest proportion of children who continued breastfeeding at one year. Meaning they have more children still benefitting from about a third of the nutrients from breastmilk.

Child Complementary Feeding

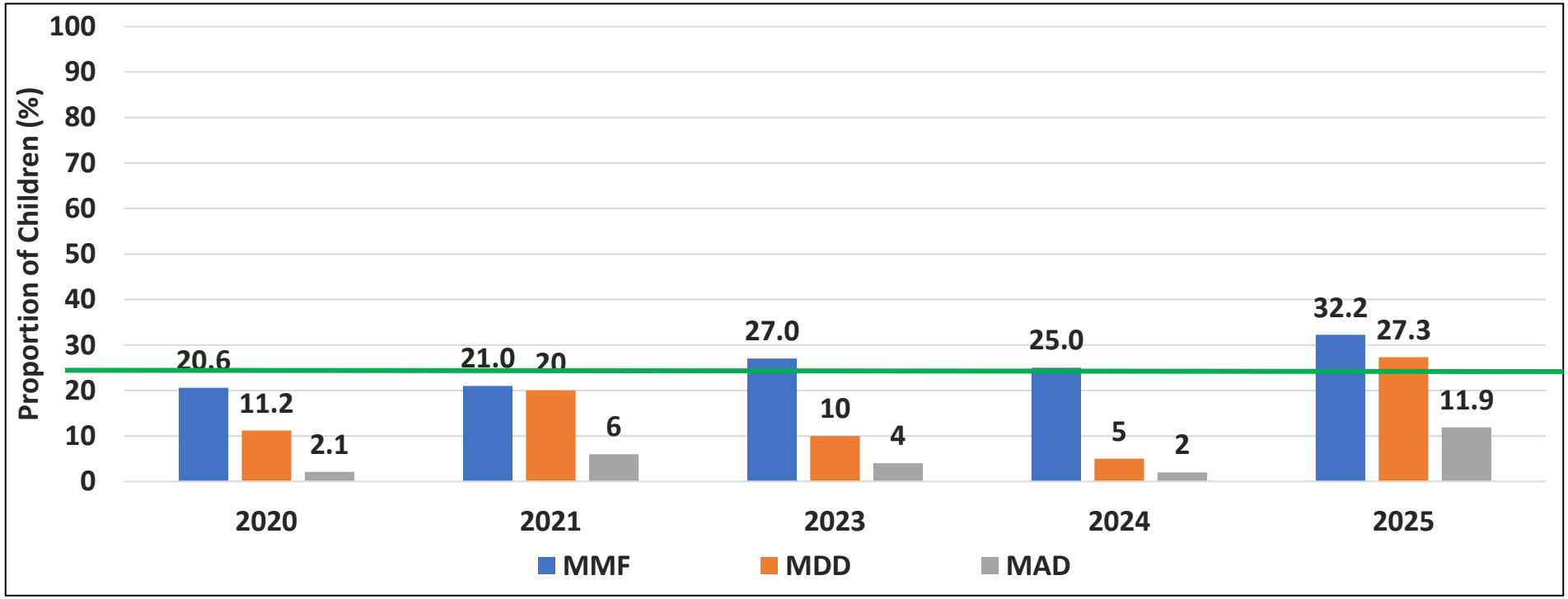
- **Minimum Dietary Diversity (MDD)** is a proxy indicator for adequate micronutrient density. Both breastfed and non-breastfed infants are expected to consume at least five of the seven food groups that are recommended by the World Health Organisation.
- **Minimum Meal Frequency (MMF)** is a proxy for 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.

Introduction of Solid Foods to Infants



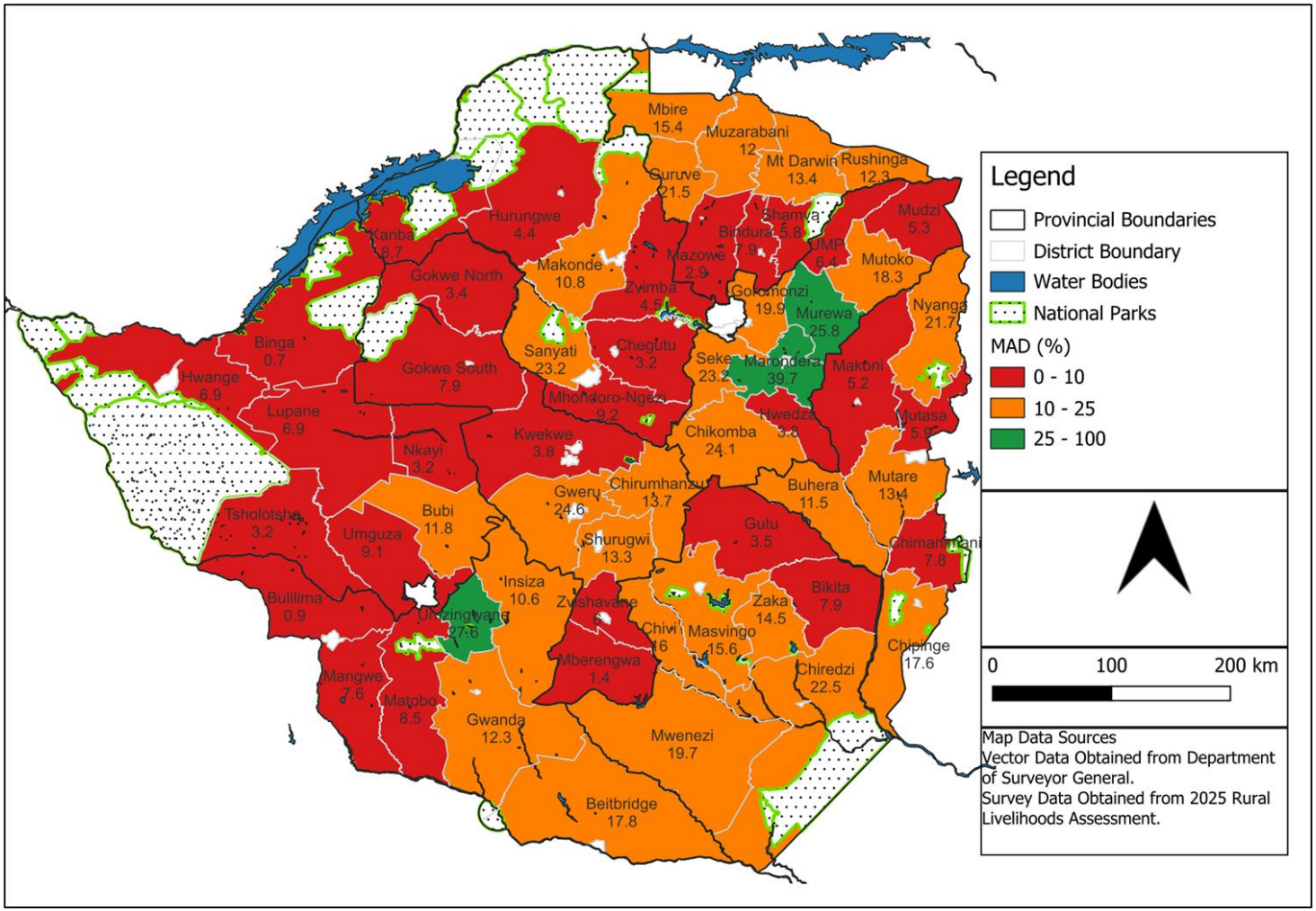
- Ninety-One percent of children 6-8 months of age were timely introduced to solids or soft foods.
- The proportion of children 6-8 months who were introduced to solid or soft foods was high across all provinces, an indication that complementary feeding was being introduced timely at the appropriate age.

Children 6-23 Months Diet Quality



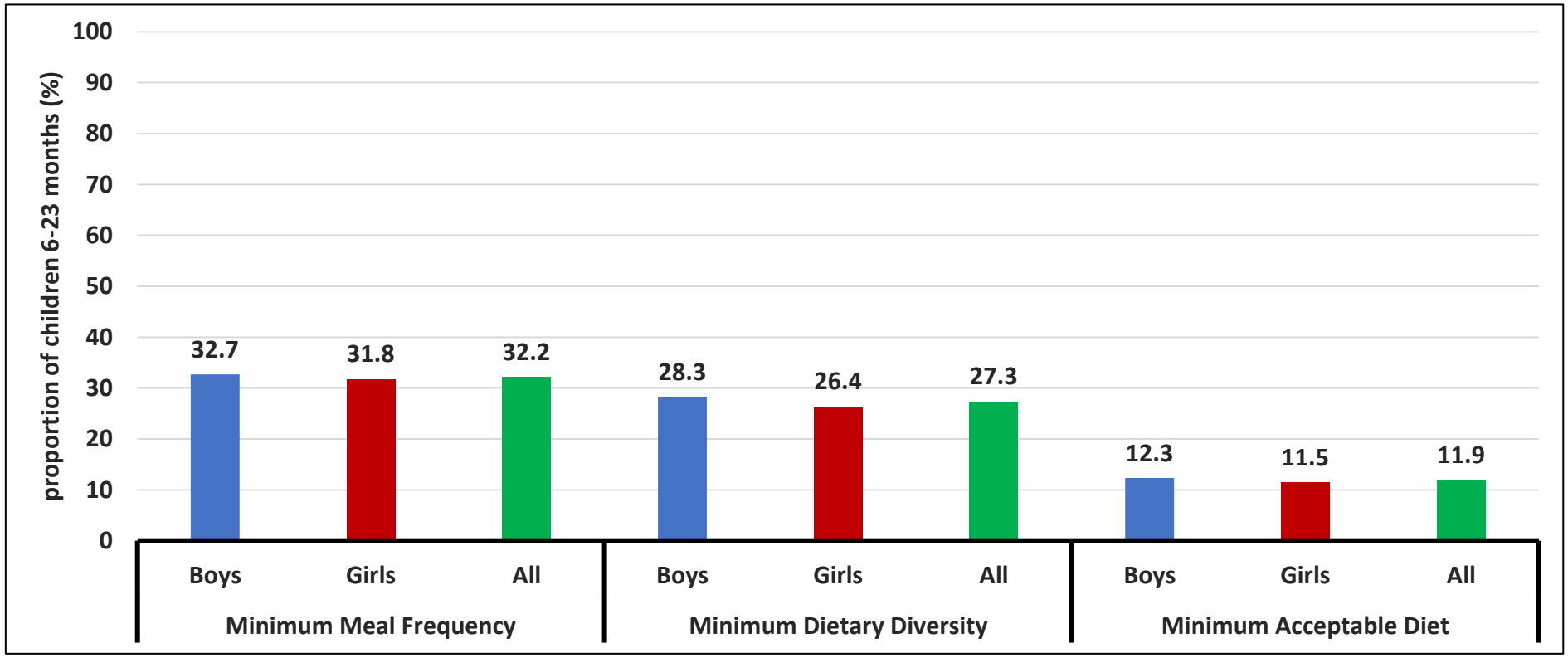
- Children aged 6–23 months should be fed meals at an appropriate frequency and in a sufficient variety to ensure that energy and nutrient needs are met.
- The proportion of children fed a Minimum Acceptable Diet improved from 2.1% in 2020 to 11.9% in 2025. However, this falls short of the Multisectoral Food and Nutrition Security Strategy target of 25%.
- The improvement in MAD from 2.1% to 11.9% could be related to increased consumption of egg /flesh and vegetables groups amongst children 6-59 months.

Minimum Acceptable Diet (MAD)
Children 6-23 months



- Marondera (39.7%), Umzingwane (27.6%) and Murewa (25.8%) had MAD which was above the national target.

Children 6-23 Months Diet Quality by Sex



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

Notes

❑ UNHEALTHY FOOD CONSUMPTION 6–23 MONTHS (UFC)

- In many low- and middle-income countries, dietary patterns are shifting toward higher intakes of added sugars, unhealthy fats, salt, and refined carbohydrates. Various guidance documents emphasize the importance of avoiding or limiting these types of foods when feeding infants and young children (IYC).
- Recent national guidelines advise against the consumption of foods such as candies, chocolate, chips, French fries, cakes, and cookies. Eating such foods can displace more nutritious options and restrict the intake of essential vitamins and minerals.
- Studies have linked unhealthy snack food and beverage consumption to a higher risk of nutrient inadequacy and lower length-for-age among one-year-olds. Food preferences established early in life often persist into later childhood and adolescence. If these practices continue into adulthood, they can increase the risk of becoming overweight or obese, as well as 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.

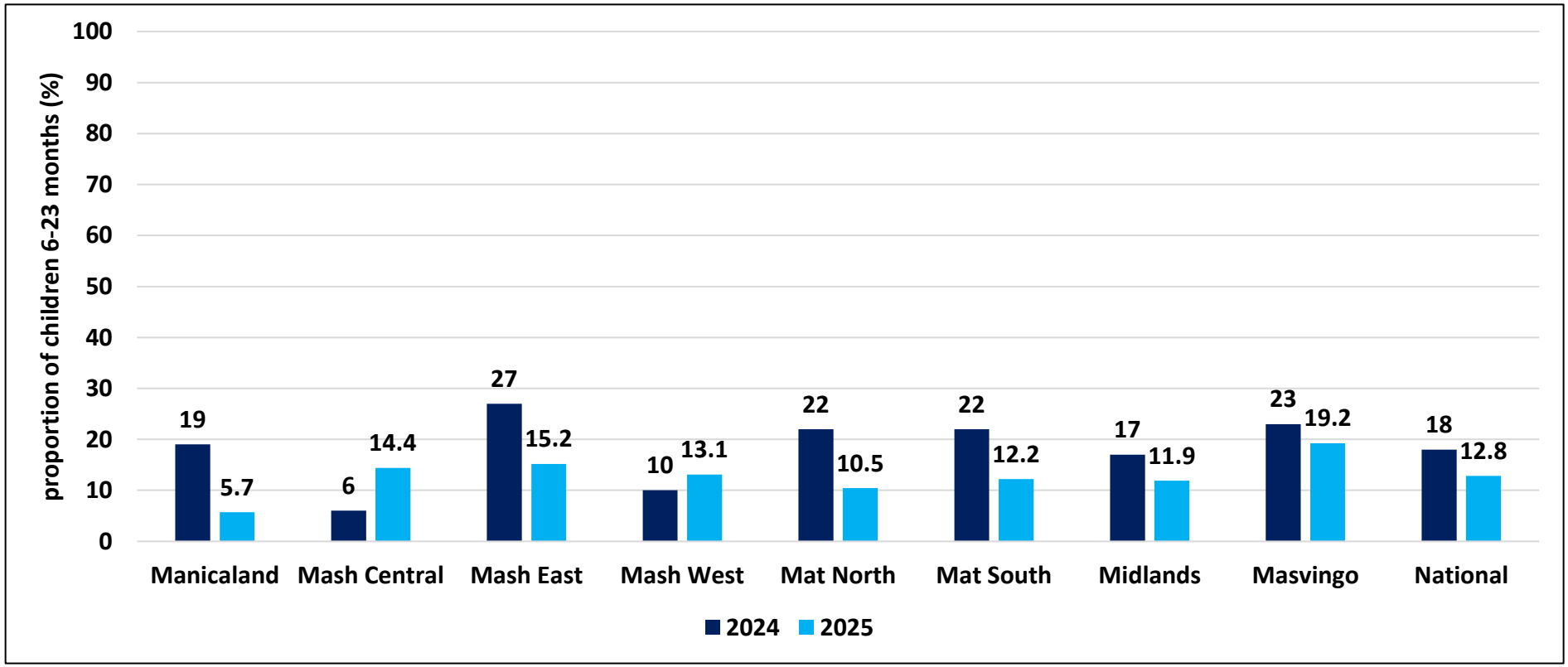
> **"sentinel unhealthy foods" are foods or categories of foods (e.g. "sweets" or "candies") that are likely to be consumed by IYC and are high in sugar, salt and/or unhealthy fats.*

❑ SWEET BEVERAGE CONSUMPTION 6–23 MONTHS (SwB)

- 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.

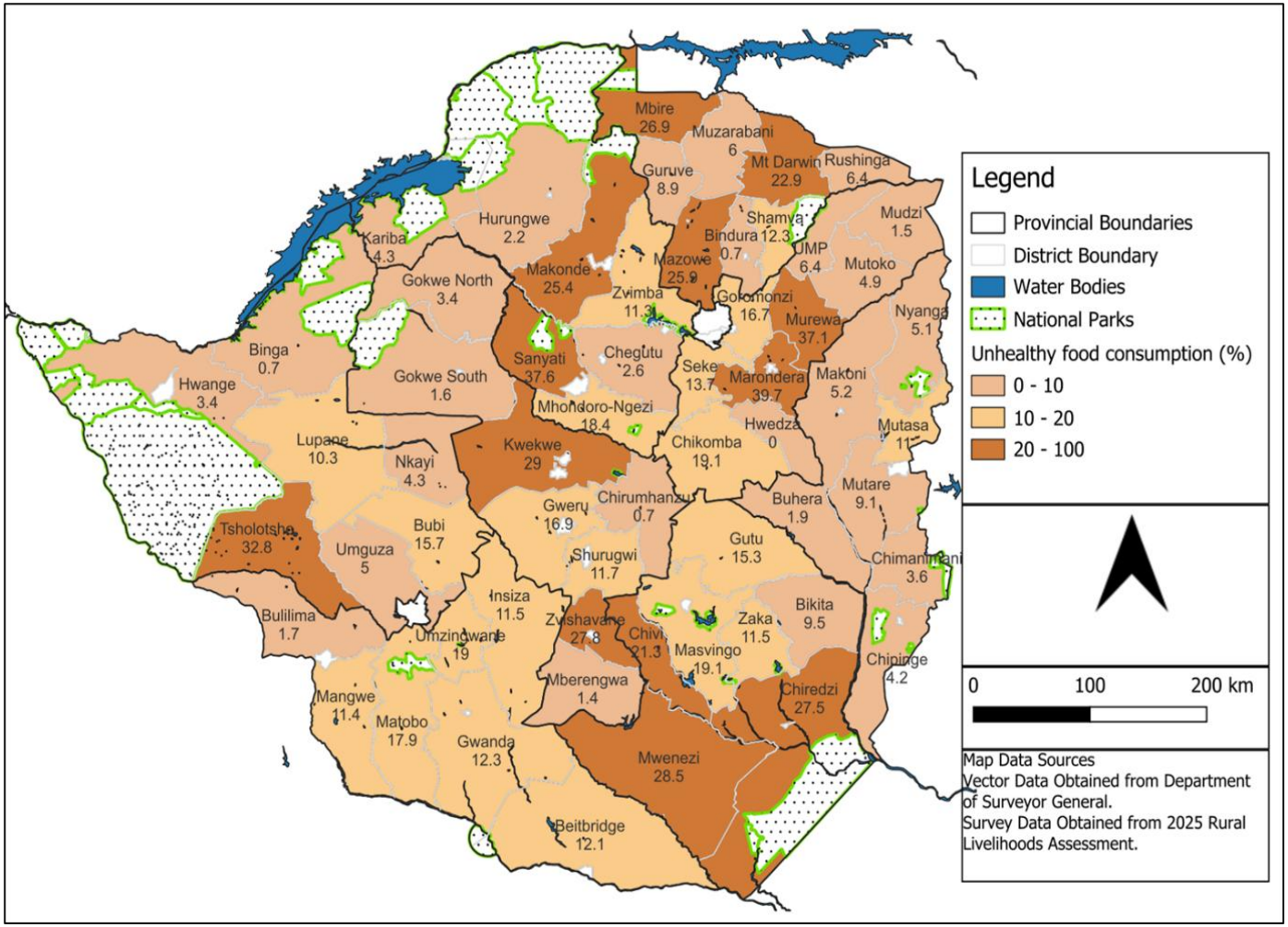
Indicator definition: percentage of children 6–23 months of age who consumed a sweet beverage during the previous day.

Unhealthy Food Consumption



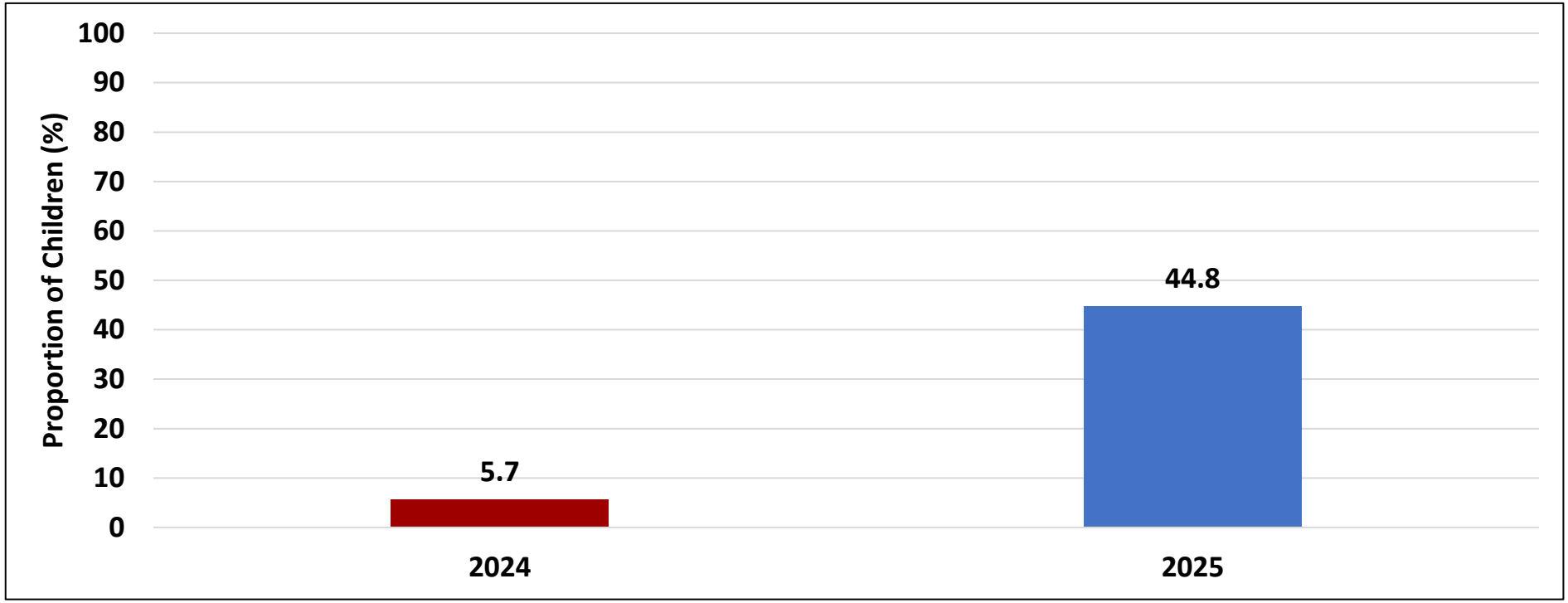
- National prevalence of unhealthy food consumption for children 6-23 months was 12.8%, an improvement from 18% in 2024.

Unhealthy Food Consumption



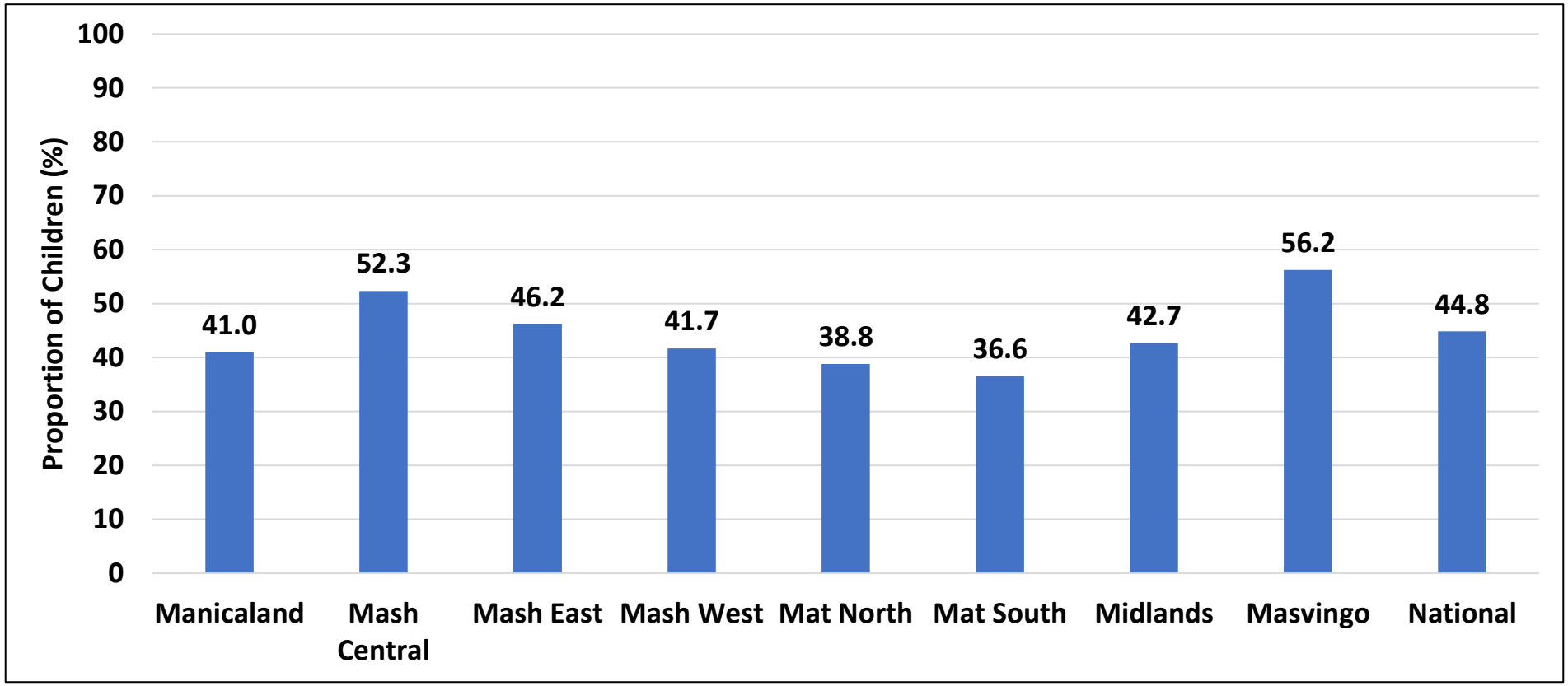
- Low unhealthy food consumption was in Binga (0.7%) and Mberengwa (1.4%).

Sweet Beverage Consumption Trend



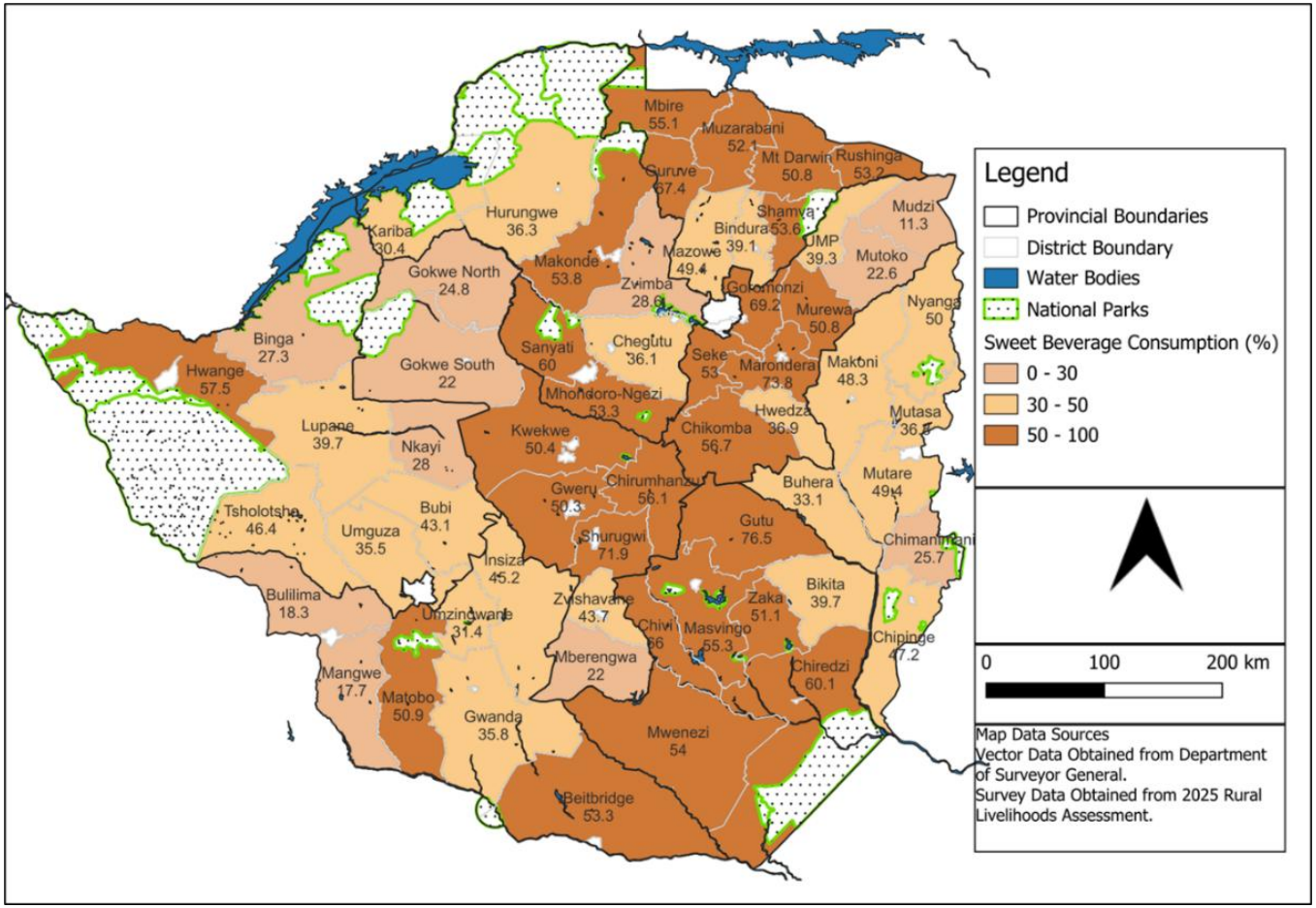
- The WHO infant and young child feeding principles advise against consumption of sweet beverages as it interferes with consumption of healthy foods.
- The consumption of sweet beverages increased from 5.7% in 2024 to 44.8% in 2025.

Sweet Beverage Consumption 6–23 Months



- Sweet beverage consumption among 6–23-month old children was high at 44.8% nationally.

Sweet Beverage Consumption
6-23 Months



- Gutu (76.5%) and Marondera (73.8%) had the highest consumption of sweet beverages by children 6 to 23 months, posing nutritional and health risks for children in those areas.

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.

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.

Notes

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

- The World Health Organization's guiding principles for feeding both breastfed and non-breastfed children recommend that "meat, poultry, fish, or eggs should be eaten daily, or as often as possible." Evidence shows that children who consume eggs and flesh foods have higher intakes of essential nutrients important for optimal growth, including energy, protein, vitamin B12, and zinc.

- Introducing meat as an early complementary food for breastfed infants is linked to improved protein and zinc intake; however, many countries report a low prevalence of egg and flesh food consumption.

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

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

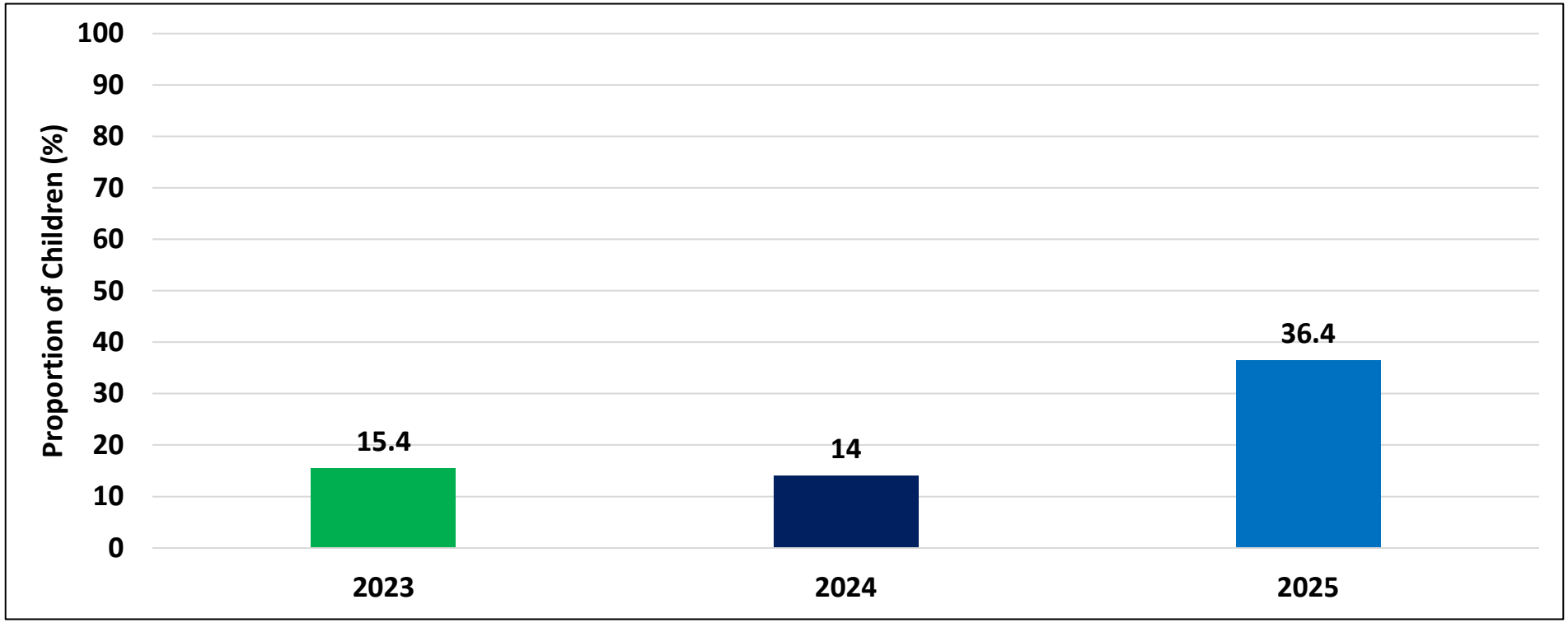
- Vegetable, fruit, egg and flesh meat consumption provides the much-needed nutrients required for optimum growth and development during this window of opportunity (first 1 000 days).

- 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.

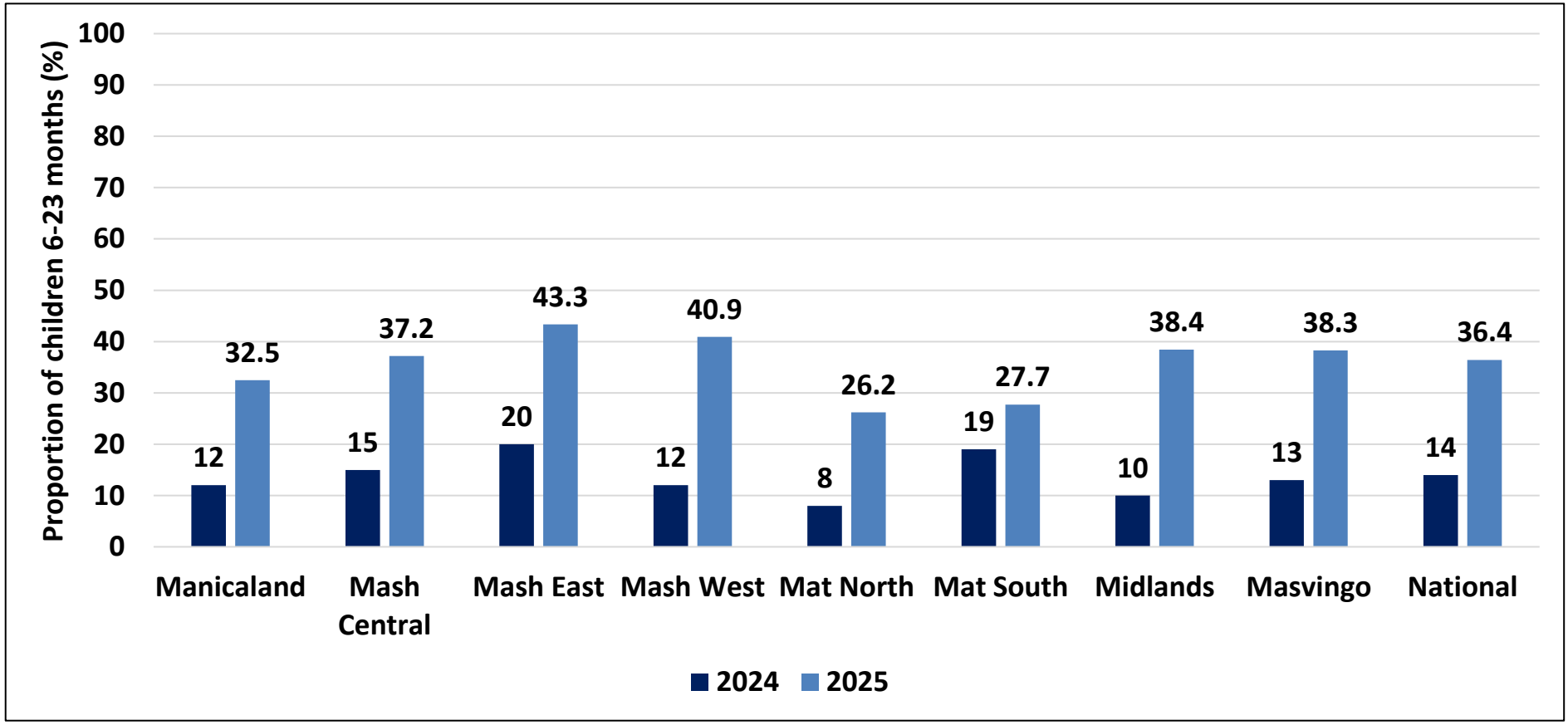
Indicator definition: percentage of children 6–23 months of age who did not consume any vegetables or fruits during the previous day.

Egg and/or Flesh Food Consumption Trend 6-23 Months



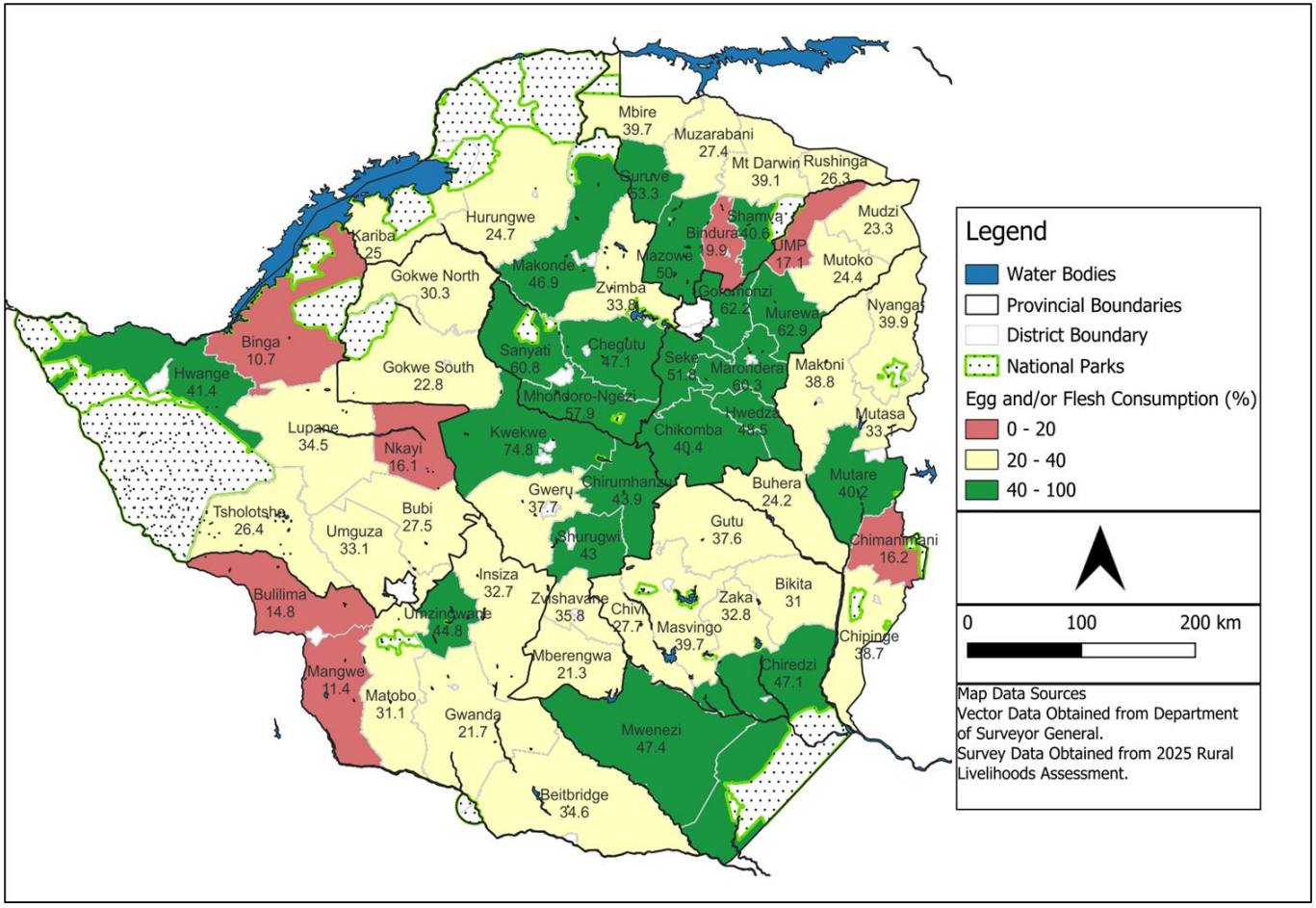
- There has been an improvement in the egg and/or flesh food consumption among children 6-23 months from 15.4% in 2023 to 36.4% in 2025, reflecting improved quality of diets for children.

Egg and/or Flesh Food Consumption 6-23 Months



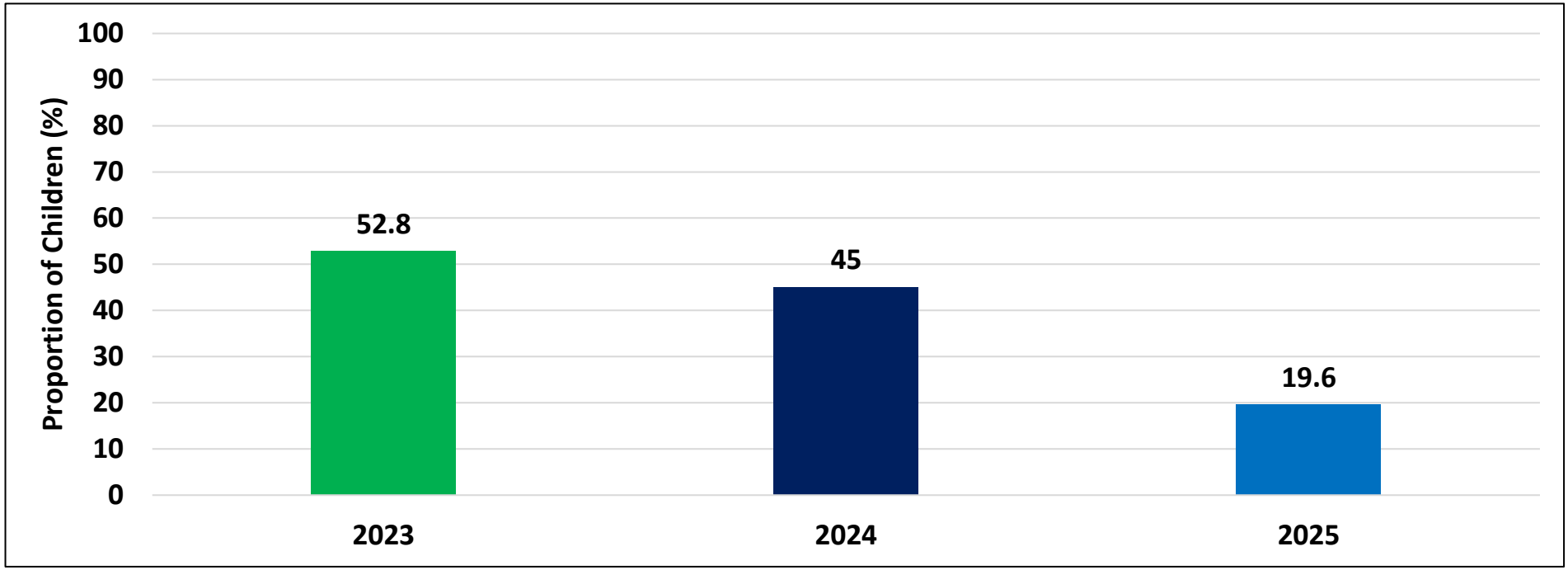
- Generally, there has been an improvement in the consumption of egg and/or flesh by children 6-23 months of age.

Egg and/or Flesh Food Consumption 6-23 Months



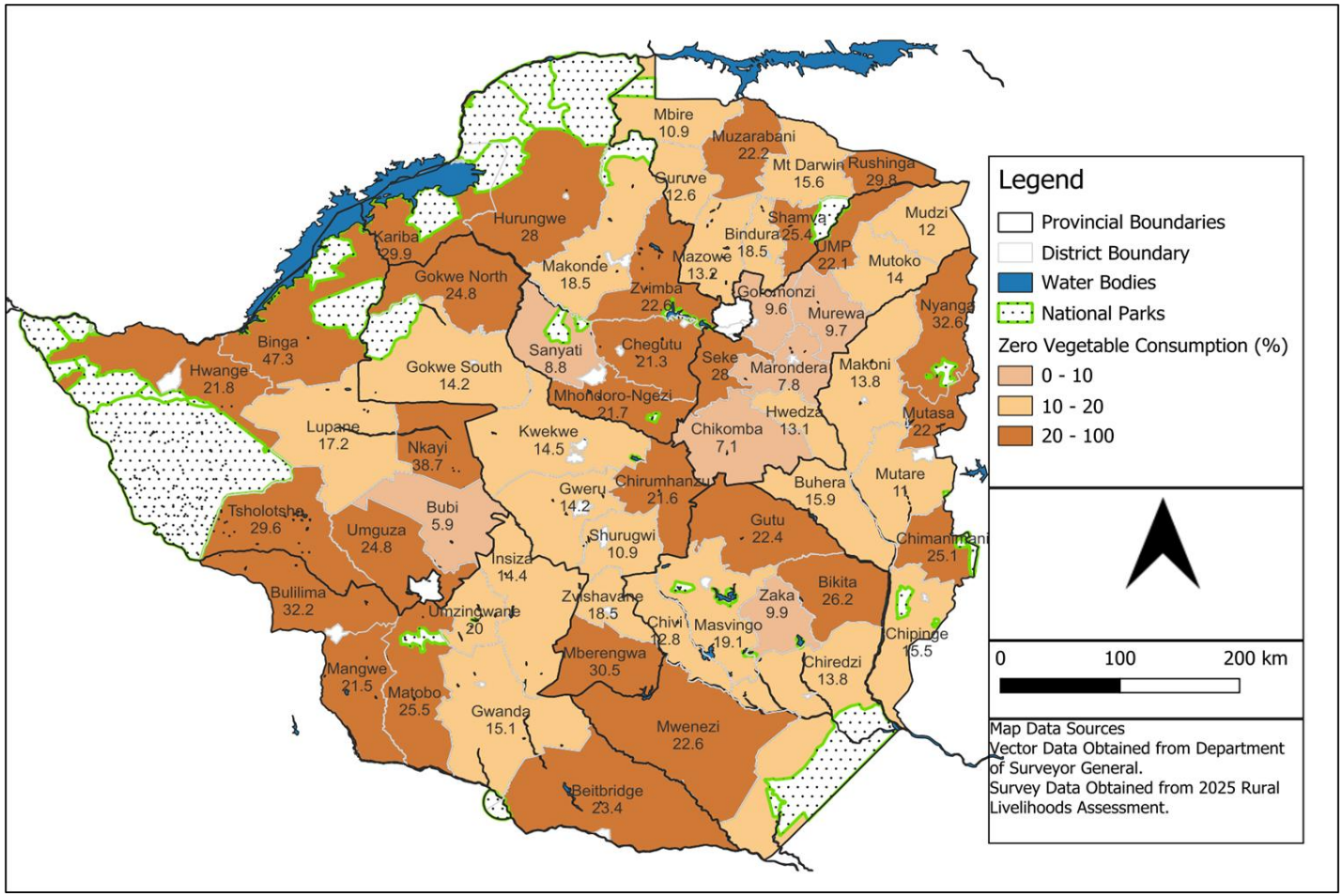
- Very low consumption eggs and/ flesh consumption was in Binga (10.7%) and Mangwe (11.4%). High consumption was in Kwekwe (74.8%) and Murewa (62.9%), indicating better access to protein-rich foods in these areas.

Non-Vegetable or Fruit Consumption 6-23 months



- Beyond the short-term effects of micronutrient deficiencies and diseases, insufficient fruit and vegetable intake raises the likelihood of developing non-communicable diseases.
- Non-vegetable/fruit consumption among children 6-23 months decreased from 52.8% to 19.6% between 2023-2025. This is applaudable as more children are being fed these vitamin, mineral and fibre rich foods.

Non- Vegetable or Fruit Consumption 6-23 months

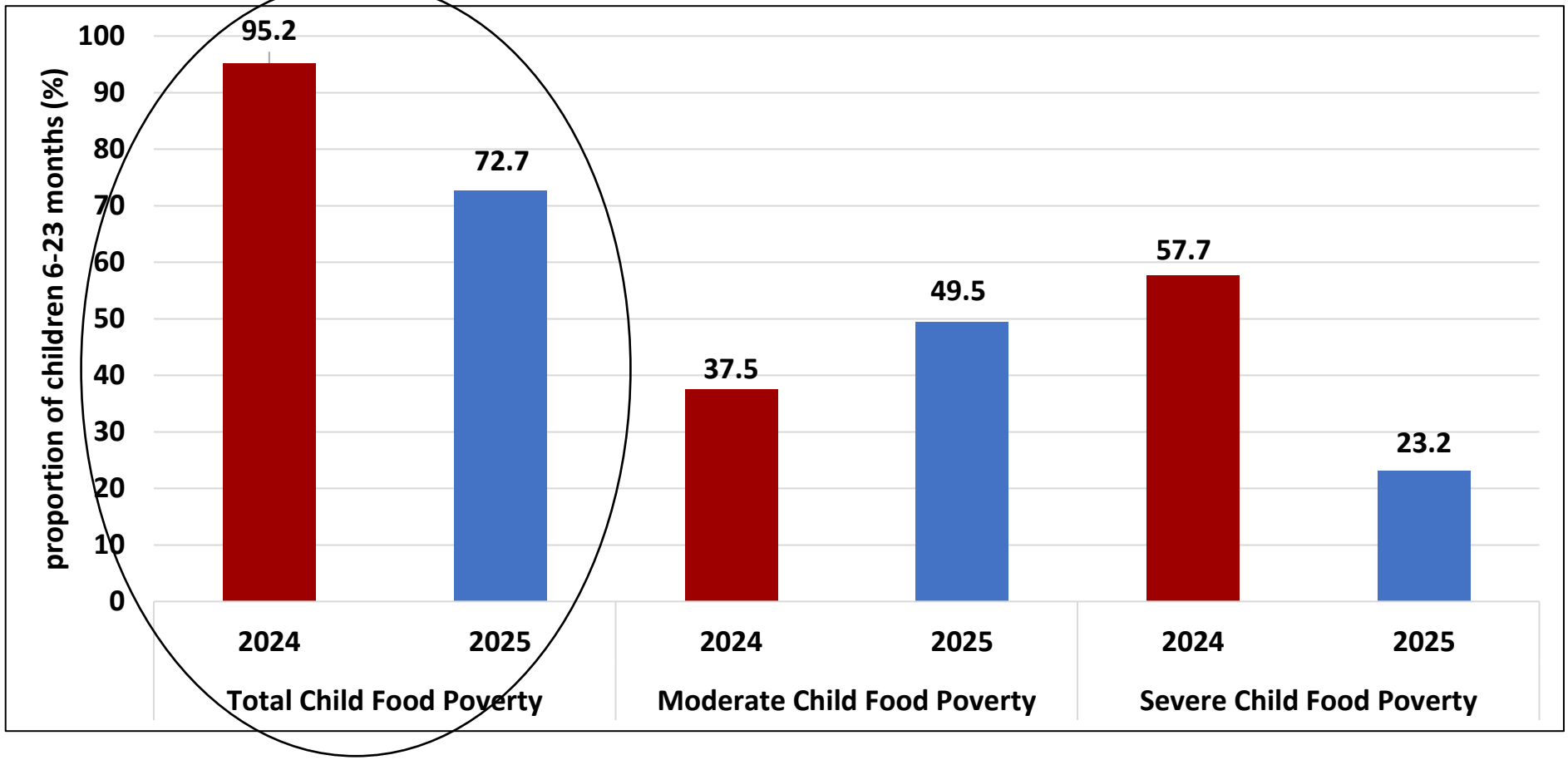


- Non-vegetable/fruits consumption was high in Binga (47.3%) and Nkayi (38.7%), which may indicate poor dietary diversity among children 6-23 months.

Child Food Poverty

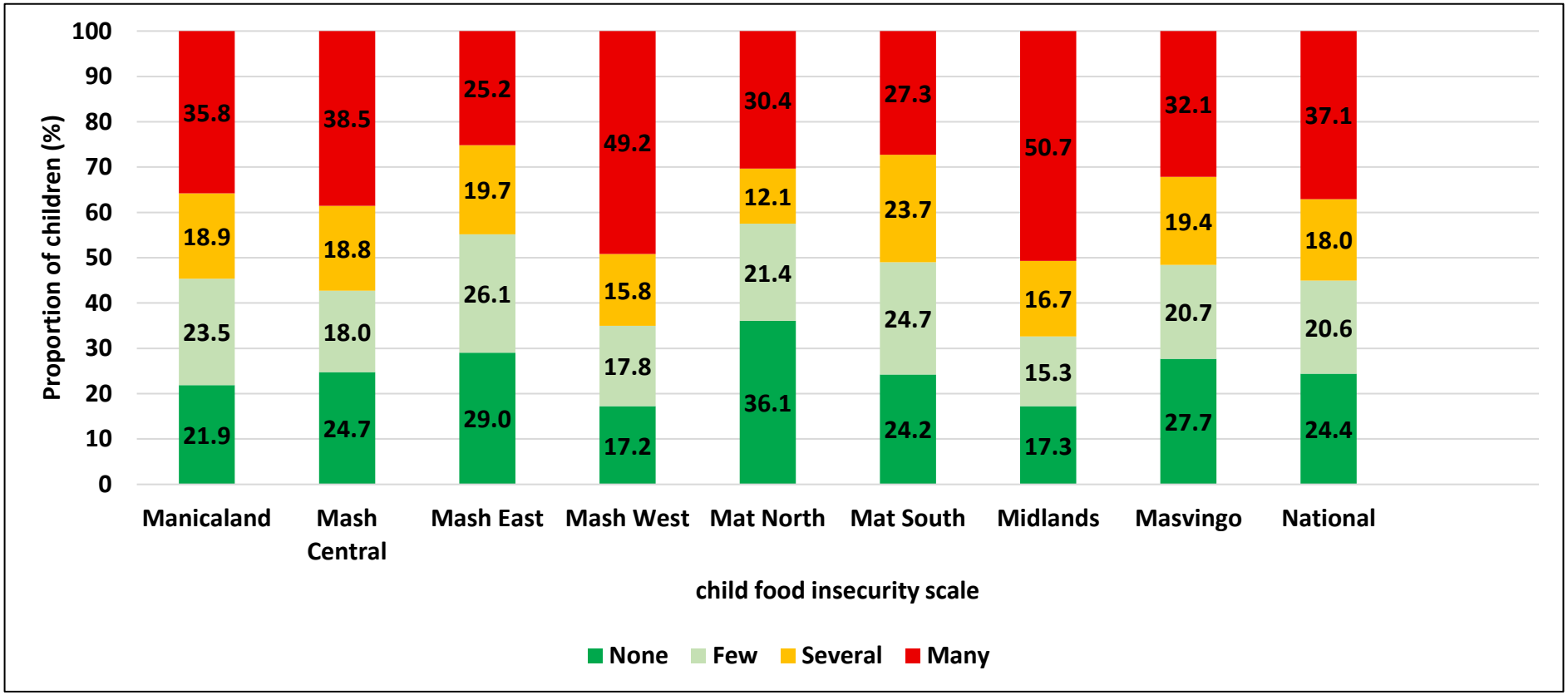
- **Children living in food poverty** is defined as the proportion of children under five years of age consuming foods and beverages from four or fewer of the eight defined food groups.
- **Severe child food poverty** refers to the proportion of children under 5 consuming foods and beverages from zero,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



- There has been an improvement in the proportion of children who did not meet a minimum dietary diversity from 95.2% in 2024 to 72.7% in 2025, 24 hours to prior to the survey.

Child Food Insecurity Experience Scale



- Children experience awareness of food insecurity, including physical (hunger, discomfort, tiredness), emotional (worry, sadness and cognitive) and awareness (knowing that food is running low) .
- Child food insecurity experience was present in 75.6% of the children and included experiences of cognitive, emotional and physical awareness of food insecurity.

Nutrition Status
Children 6-59 Months

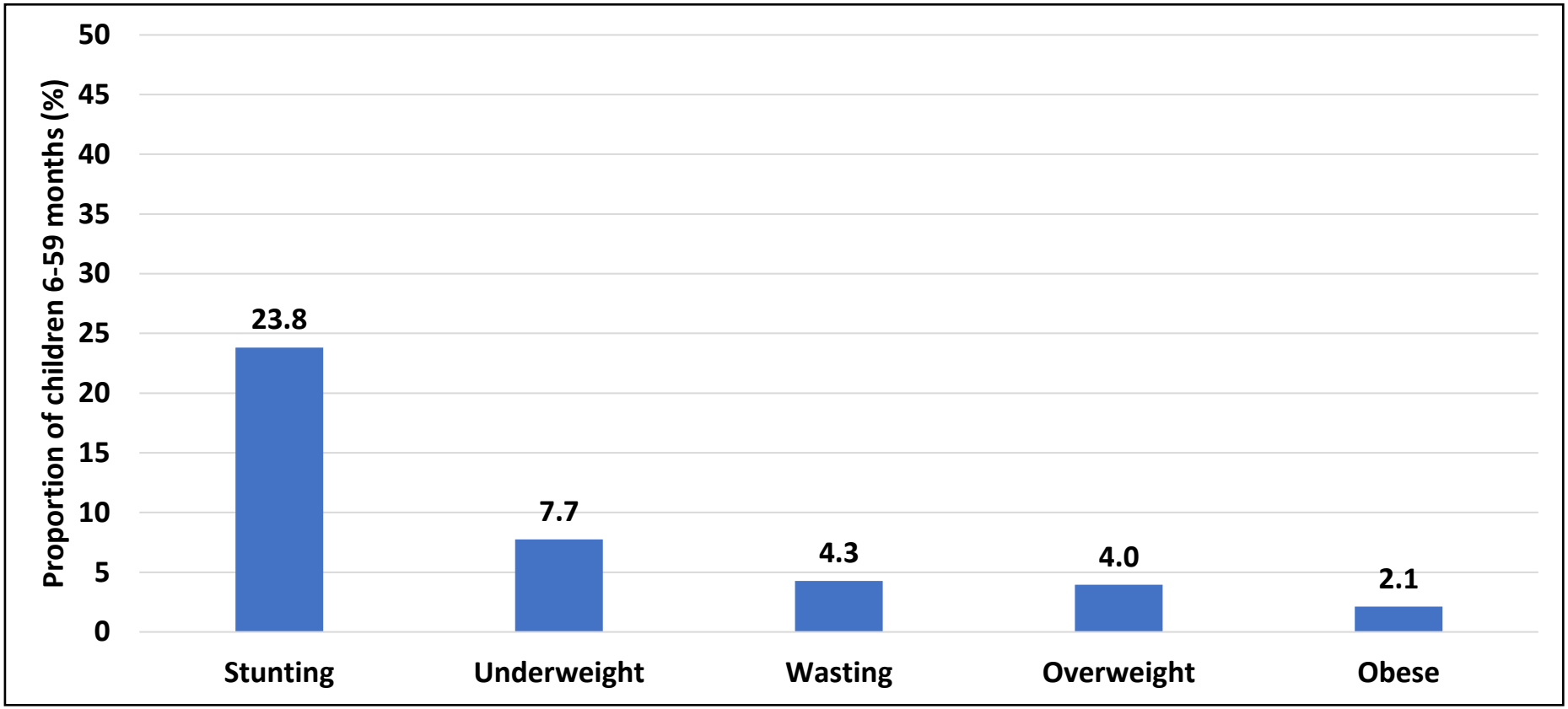
Child Nutrition Status

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 Cut-Offs and National Targets

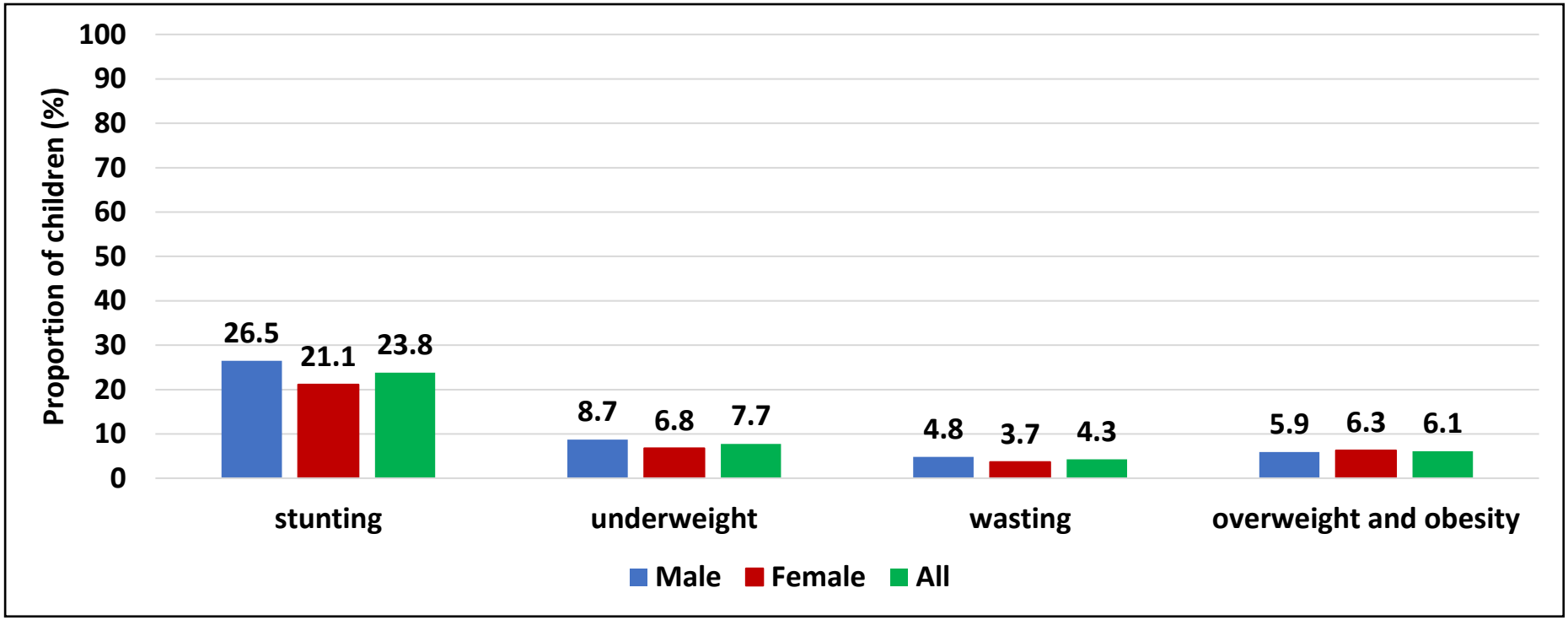
Indicator	Indicator definition (WHO standards, 2006)	National Target (%)	Prevalence cut-off values for public health significance
Stunting	Height/Length for age <–2 SD of the WHO Child Growth Standards median	**17.3%**	<2.5%: Very Low 2.5-<10%: Low 10-<20%: Medium 20-<30%: High ≥30%: Very High (DeOniset al., 2019
Global Acute Malnutrition	Weight for height <-2SD of the WHO Child Growth Standards median and/oedema	**5%**	<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		0% = acceptable >0%: Unacceptable
Underweight	Weight for age <-2SD of the WHO Child Growth Standards median and/oedema	**10%**	
Overweight	Weight for height >+2 SD –<+3SD of the WHO Child Growth Standards median	**<3%**	<2.5%: very low 2.5 to <5%: low 5 to <10%: medium 10 to <15%: high ≥15%: very high

Nutrition Status Indicators
Children 6-59 months



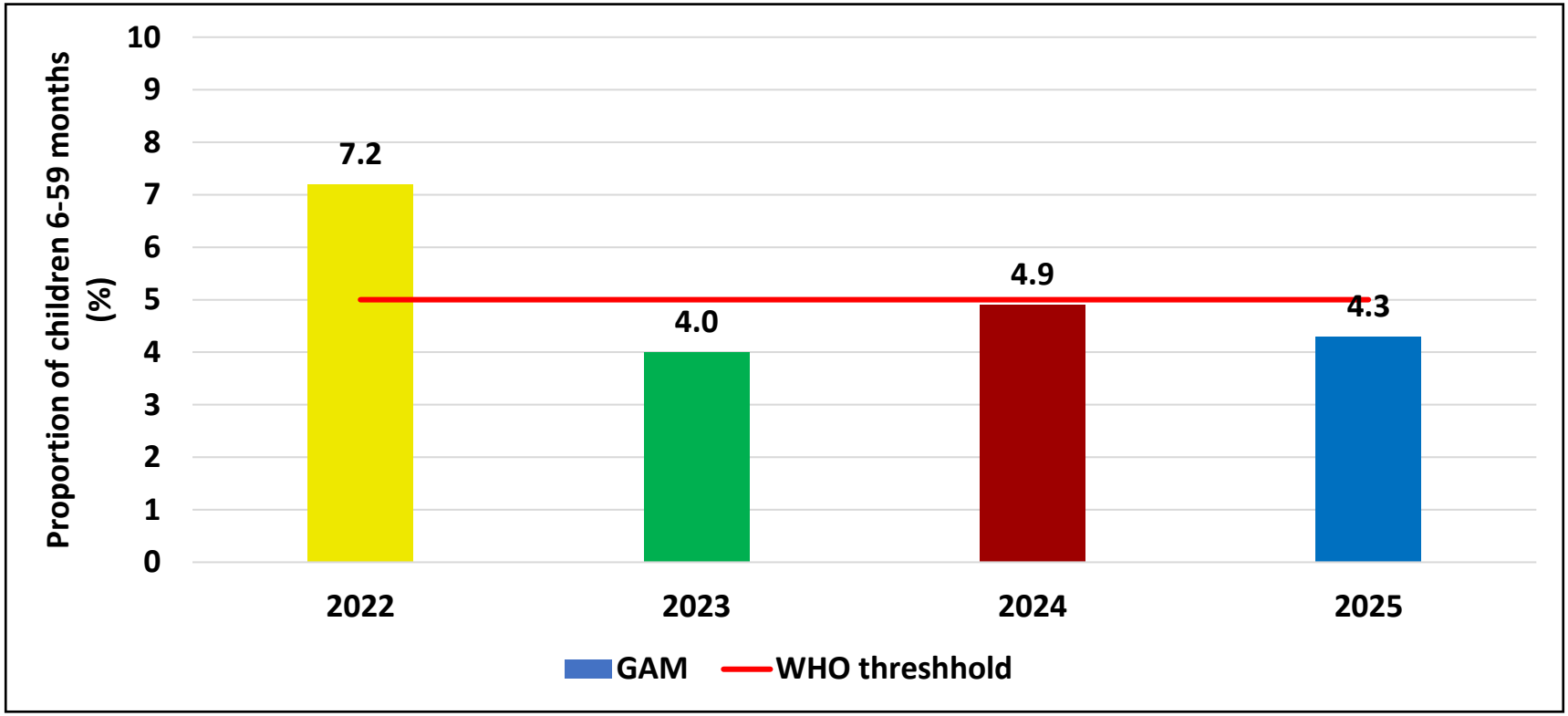
- Stunting prevalence remained high (23.8%) according to the World Health Organization classification (20-30%) high. It was also off the NDS1 target of 17.3%.
- Nationally, the prevalence of GAM (wasting) was 4.3% which was acceptable and was below the WHO threshold of 5%.

Nutrition Status Indicators
Children 6-59 months by Sex



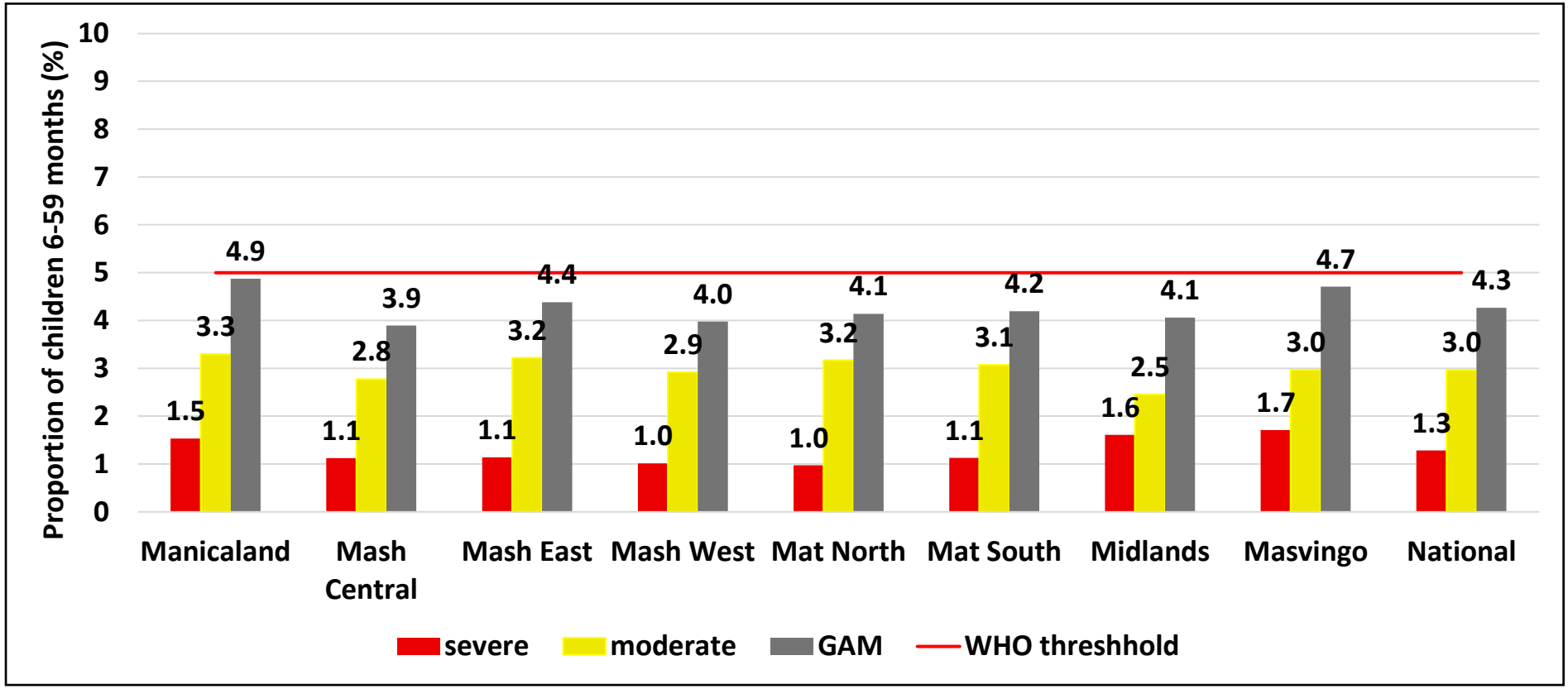
- The proportion of children 6-59 months of age who were stunted, underweight and wasted was higher among boys than girls.
- The proportion of children 6-59 months who were overweight and obese was higher among girls than boys.

Prevalence of Wasting
Children 6-59 Months (WHO classification)



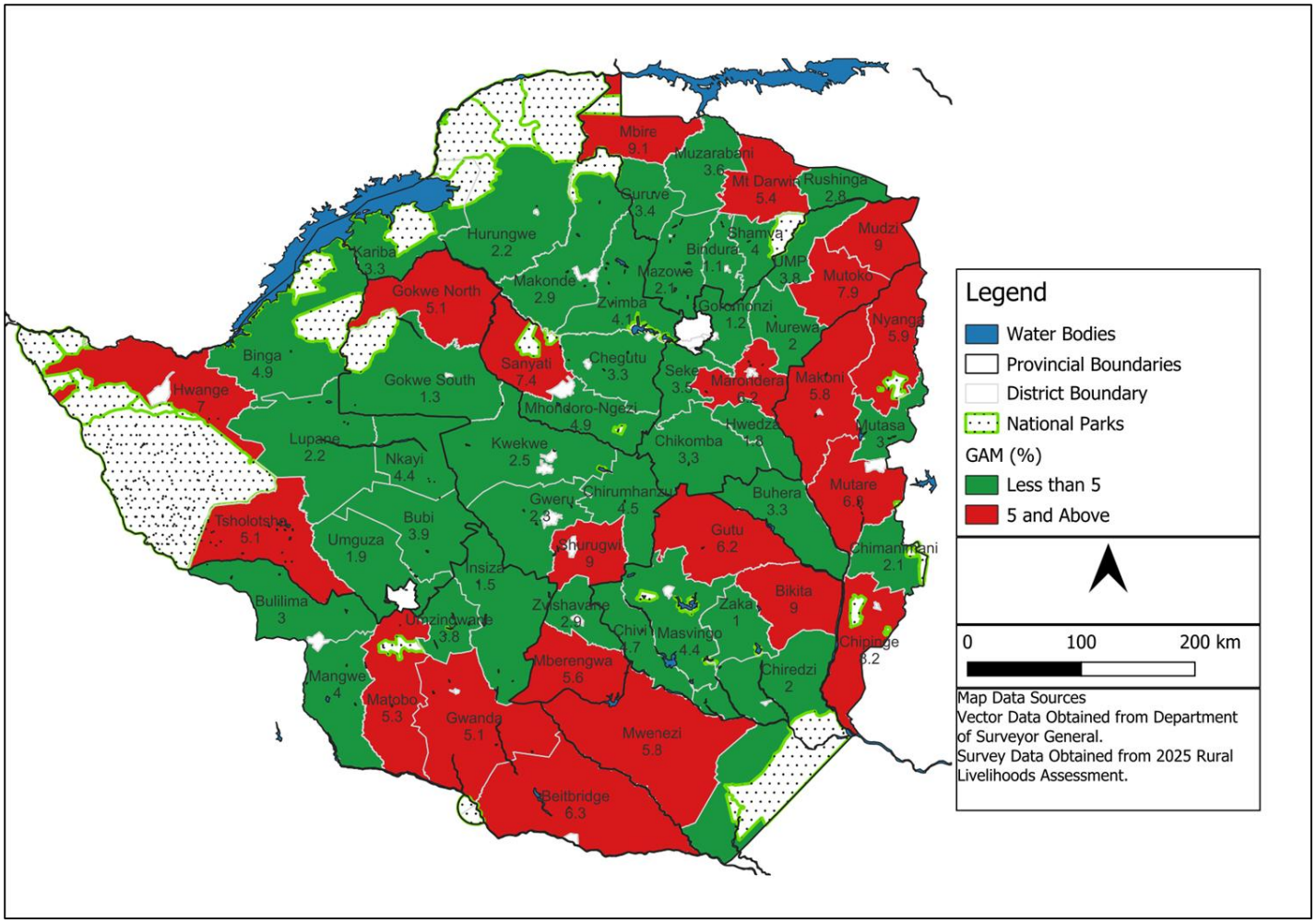
- From 2022, the GAM rates were below the WHO thresholds of less than 5% except for the year 2022 which was during the COVID-19 pandemic period.

Prevalence of Wasting
Children 6-59 Months (WHO classification)



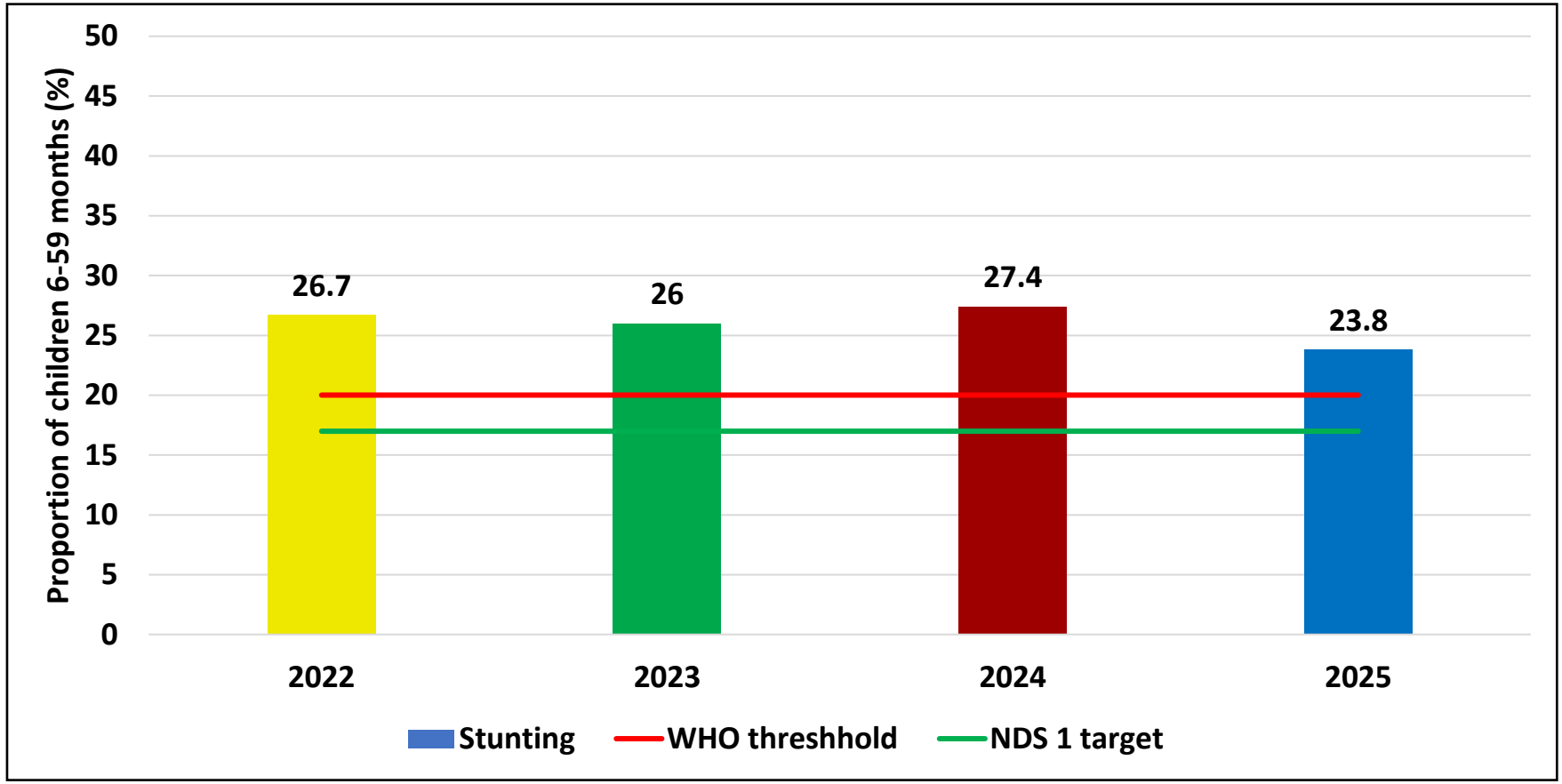
- The national prevalence for Global Acute Malnutrition (wasting) GAM was 4.3%, with Manicaland (4.9%) and Masvingo (4.7%) reporting the highest prevalence.

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



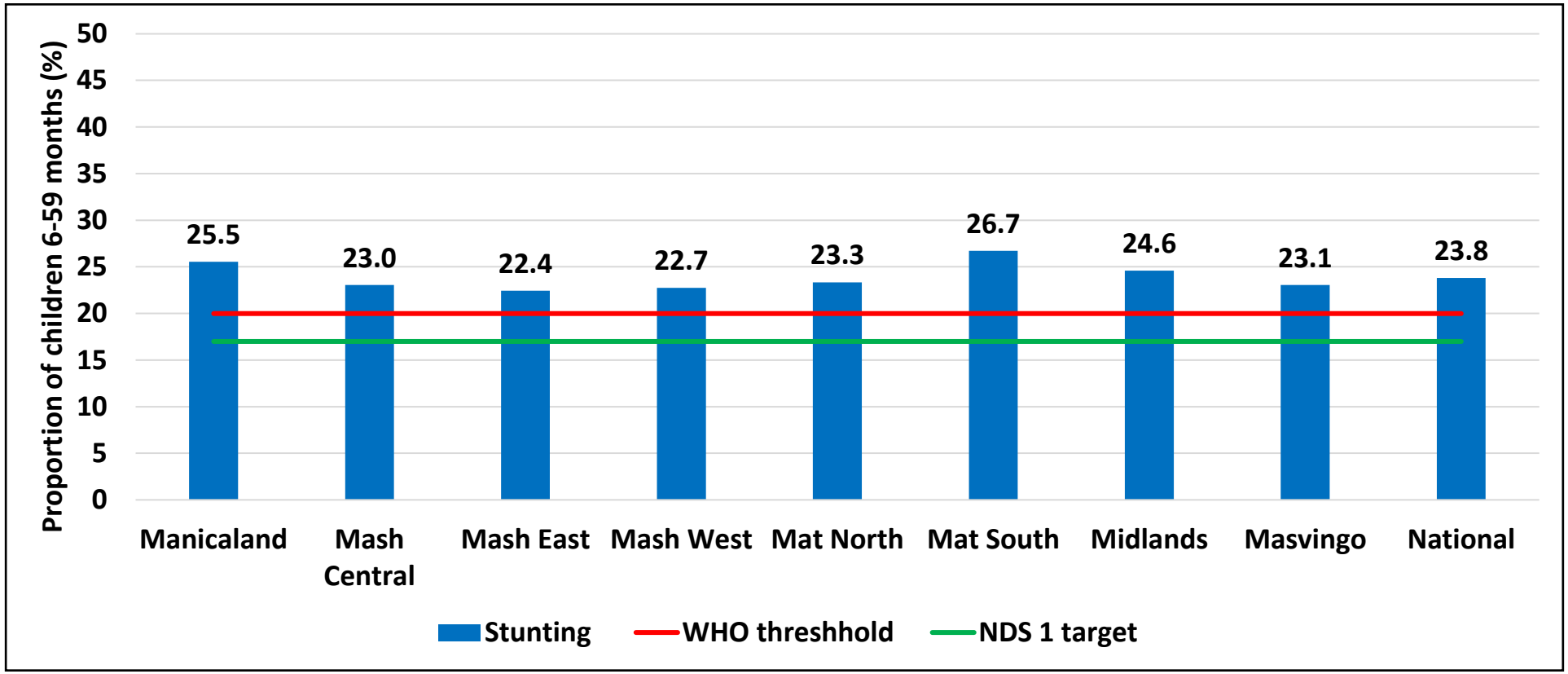
- Mbire (9%), Bikita (9%) and Mudzi (9%) recorded the highest proportions of GAM (wasting).

Prevalence of Stunting Children 6-59 Months



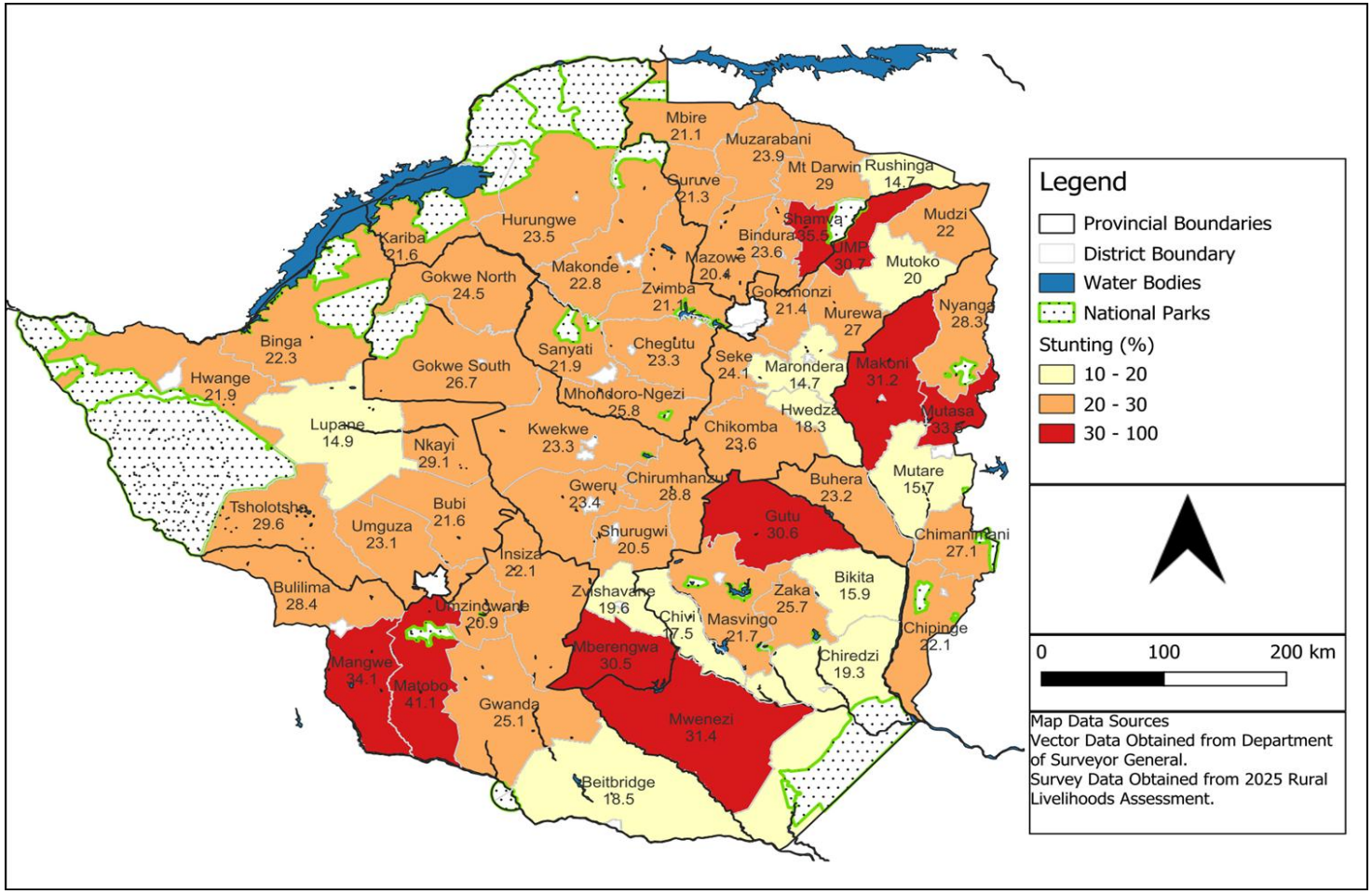
- From 2022, stunting prevalence has not yet met the NDS1 target (17.3%) nor the WHO threshold (at least 20%).

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



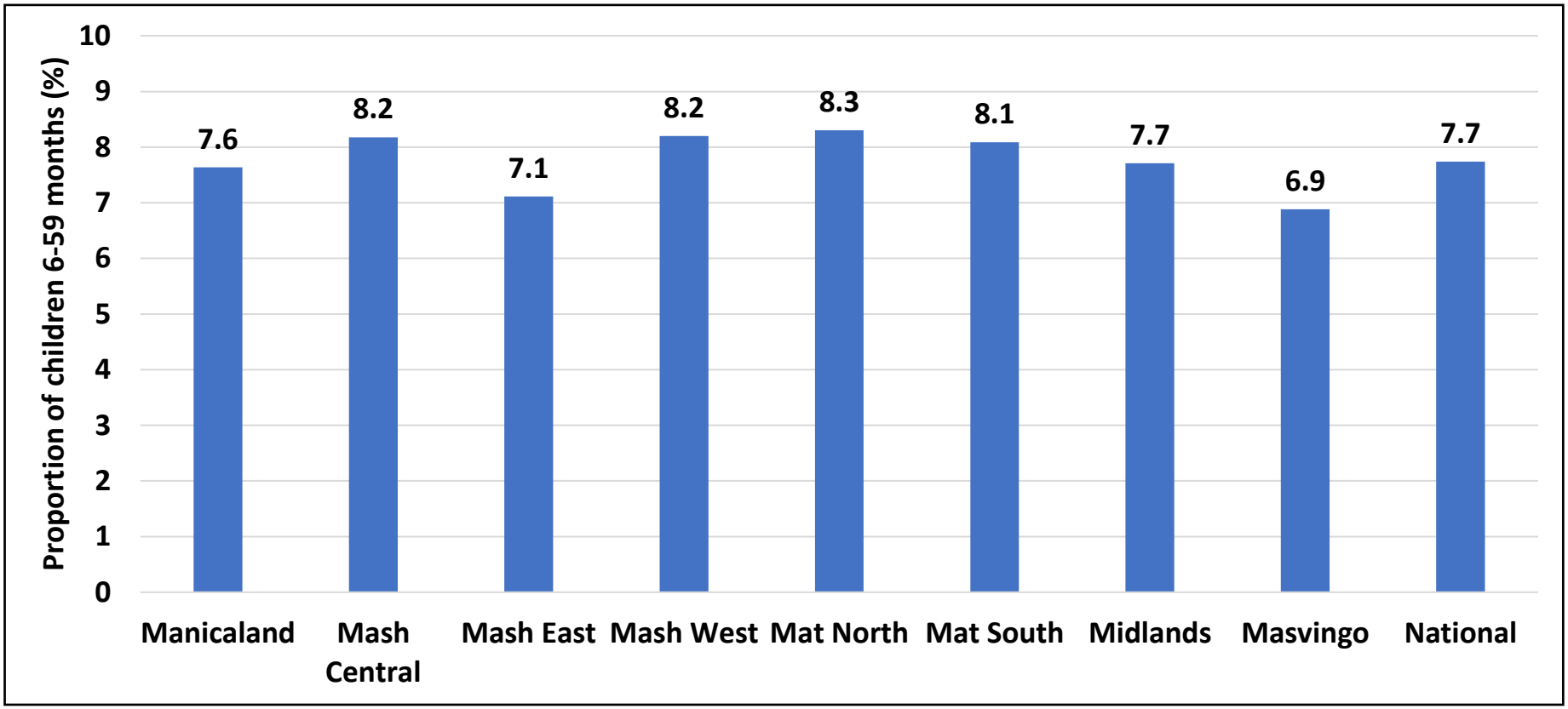
- All provinces recorded stunting levels above the WHO threshold of at least 20% classified as high (20-30%).
- Stunting levels were highest in Matabeleland South (26.7%) and Manicaland with (25.5%).

Prevalence of Stunting
Children 6-59 Months by District



- Stunting levels were highest in Matobo (41.1%), Shamva (35.5%) and Mangwe (34.1%).

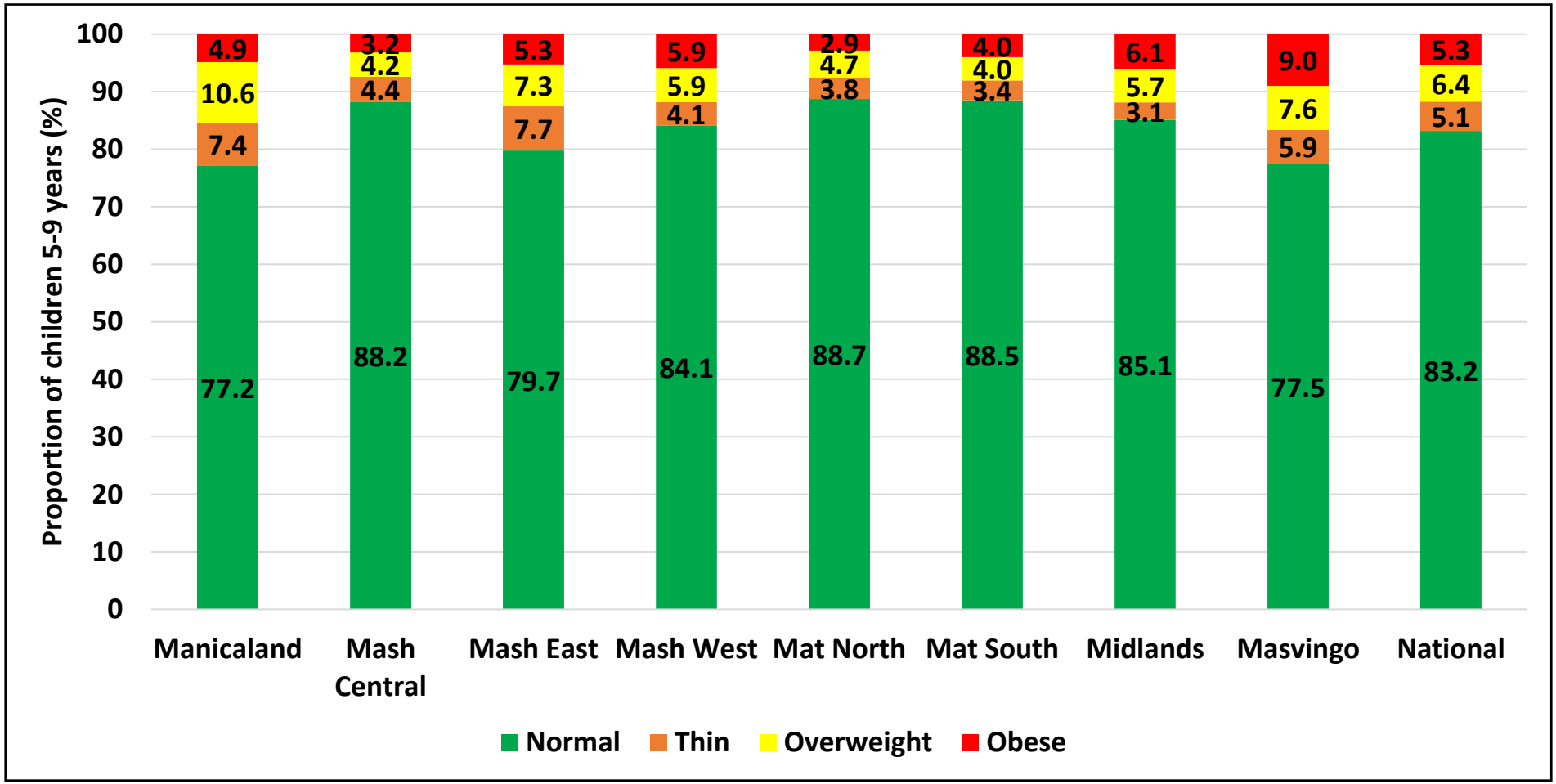
Prevalence of Underweight Children 6-59 months



- The national average for underweight was 7.7%, with more children presenting with underweight in Matabeleland North at 8.3%.

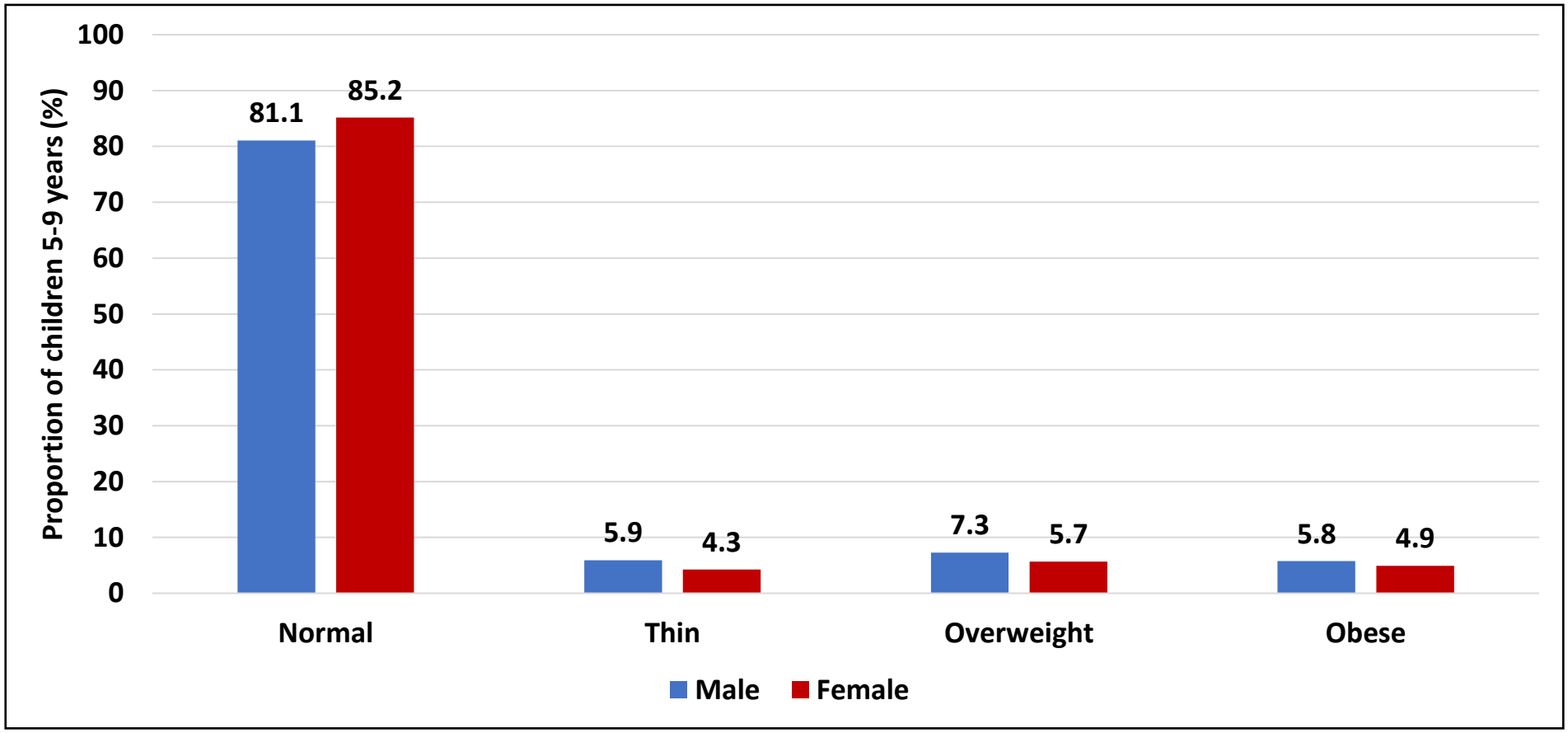
Nutrition Status
Children 5 to 9 Years

Nutrition Status of Children 5-9 Years (BMI-for-Age)



- Nationally, 5.3 % of the children aged 5 to 9 years were obese and 6.4 % were overweight whilst 83.2% were normal.

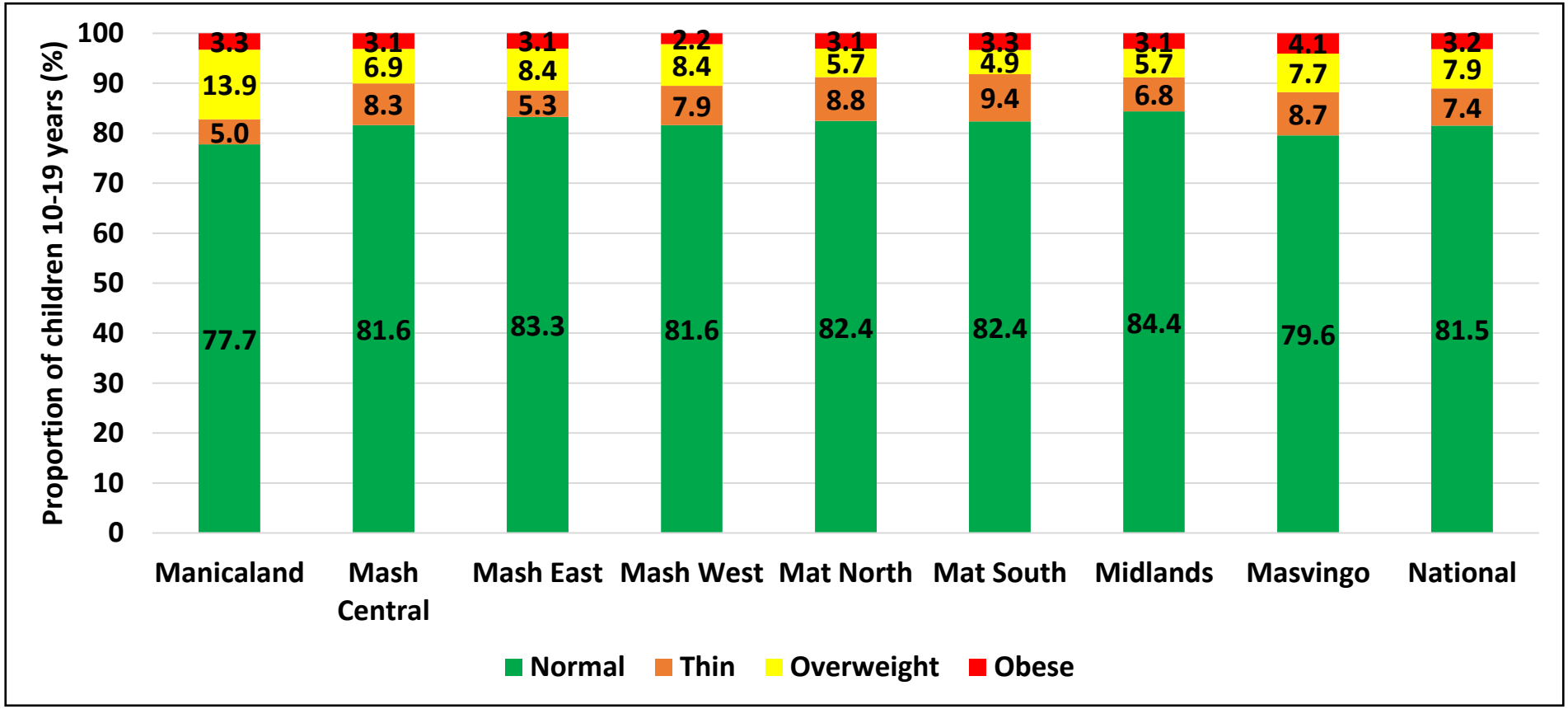
Nutrition Status of Children 5-9 Years (BMI-for-Age) by Sex



- Nationally, boys were more overweight and obese as compared to girls in the 5-9 years age group.

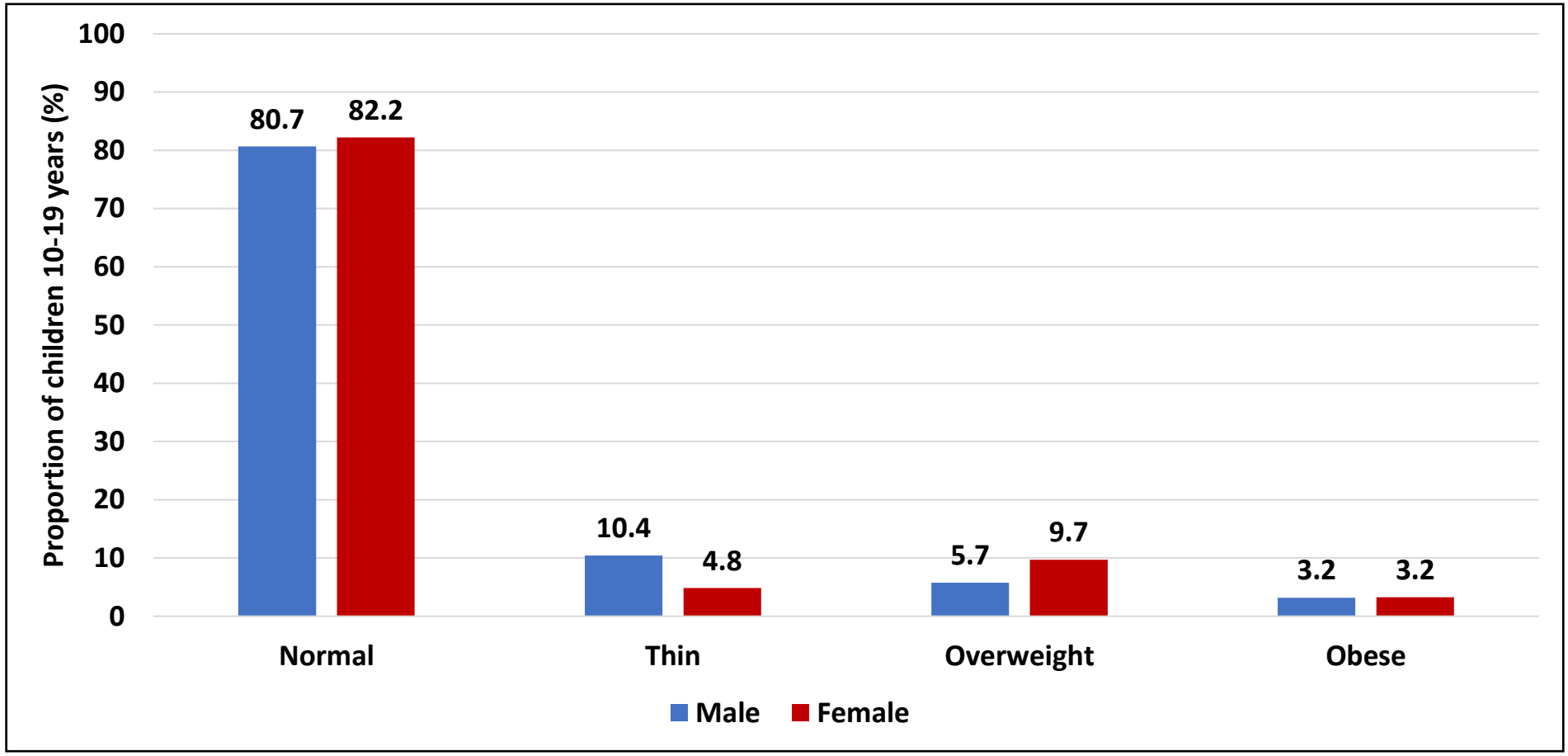
Nutrition Status
Adolescents 10 to 19 Years

Nutrition Status of Adolescents 10-19 Years (BM1-for-Age)



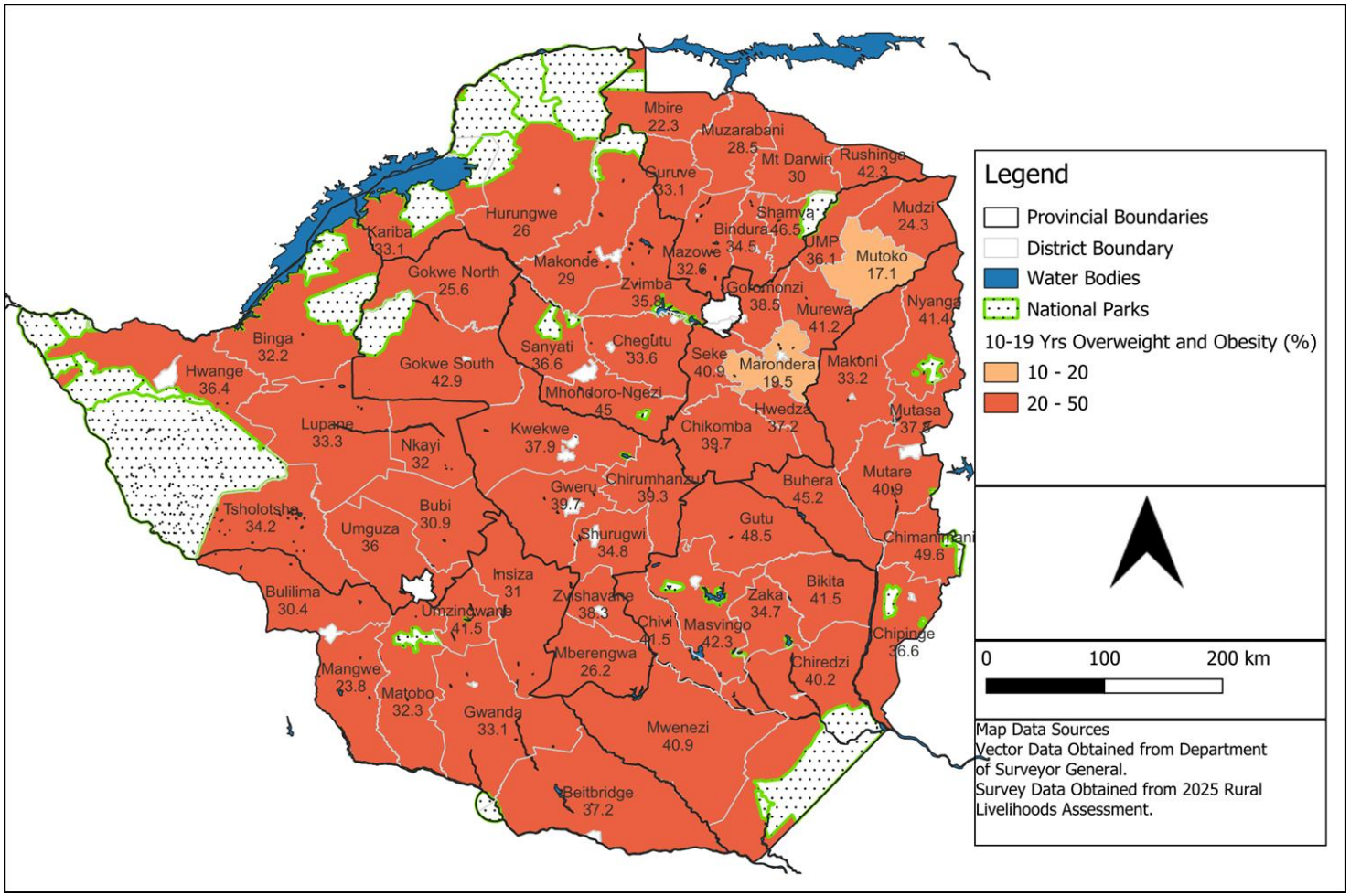
- At least 11.1% of the adolescents were overweight and obese.

Nutrition Status of Adolescents 10-19 Years



- Females were more overweight than males in the adolescents age group (10-19 years).

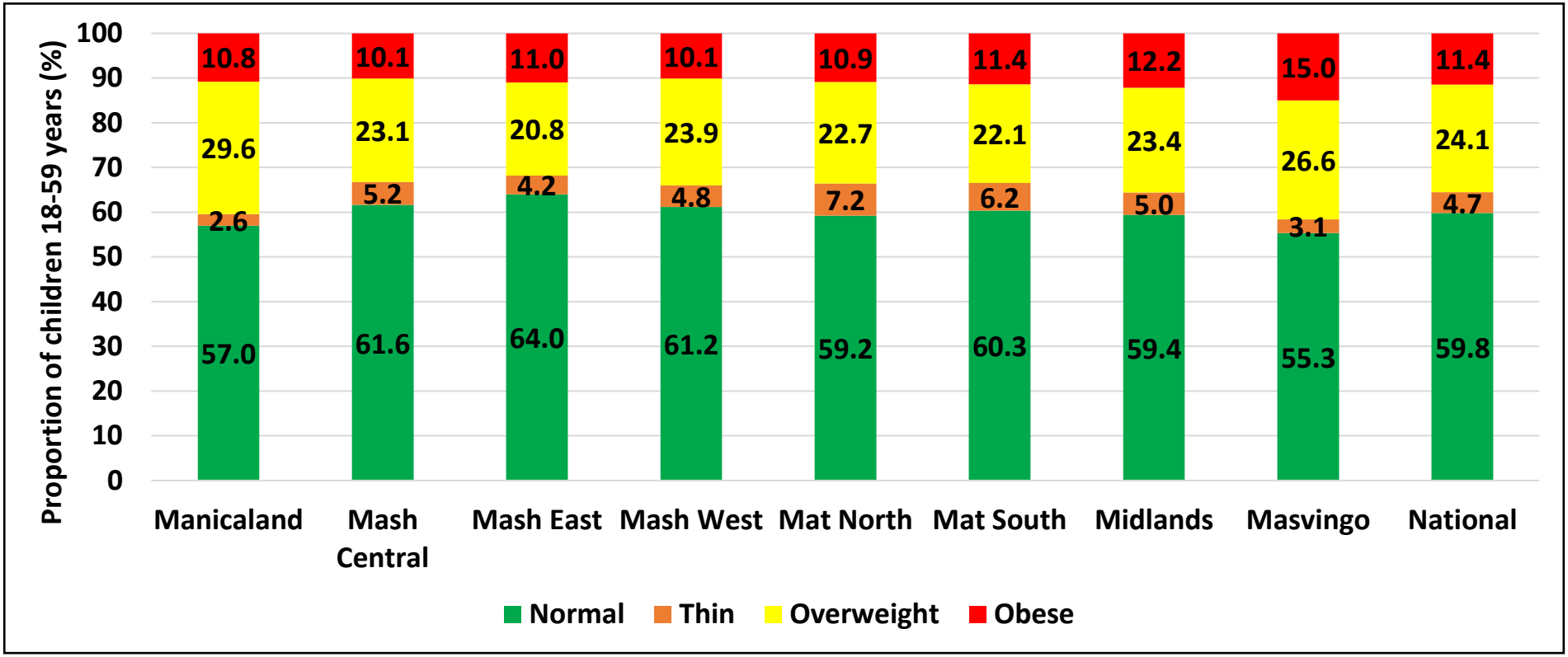
Nutrition Status of Adolescents 10-19 Years by District



- Most of the districts reported overweight and obesity levels in the range of 20-50%.

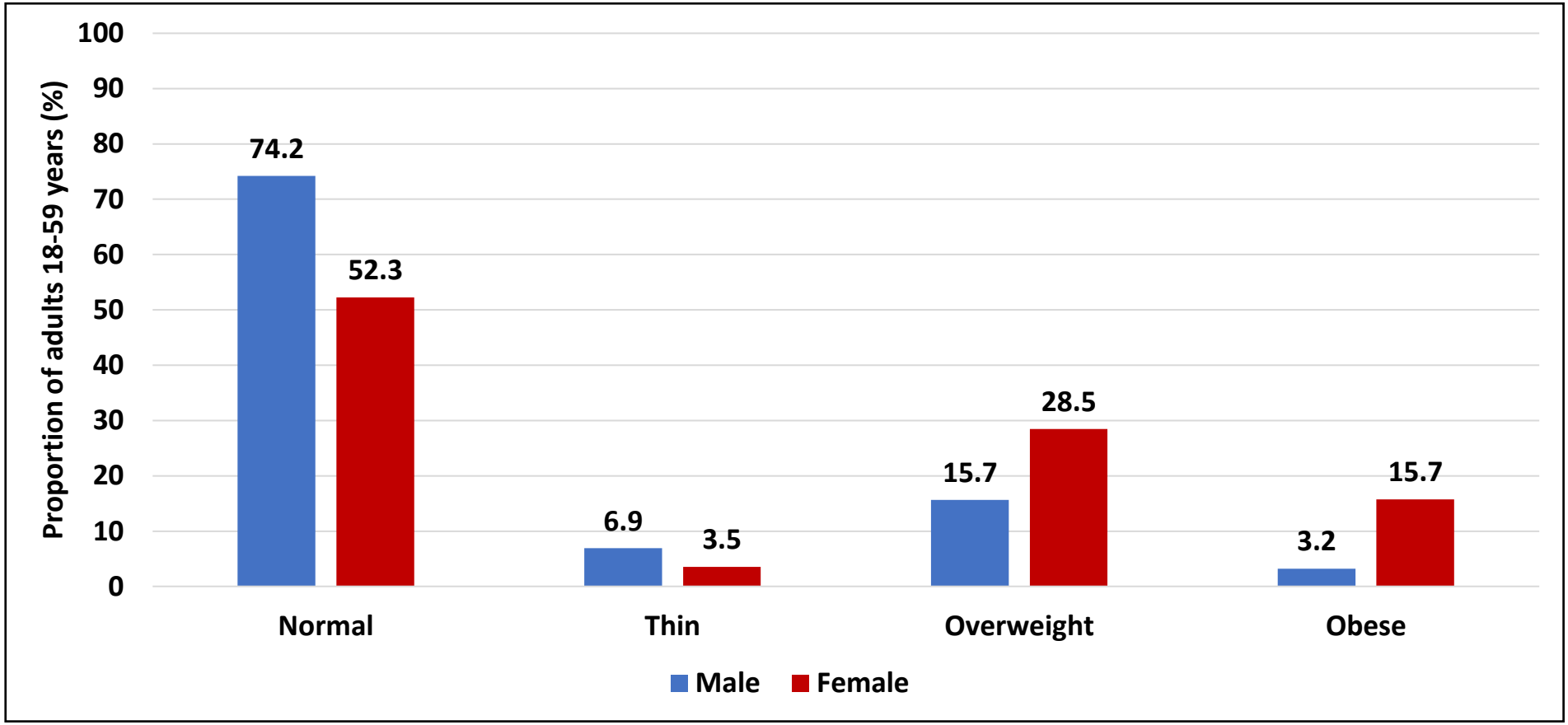
Adult Nutrition Status

Nutrition Status of Adults 18-59 Years (BMI) by Province



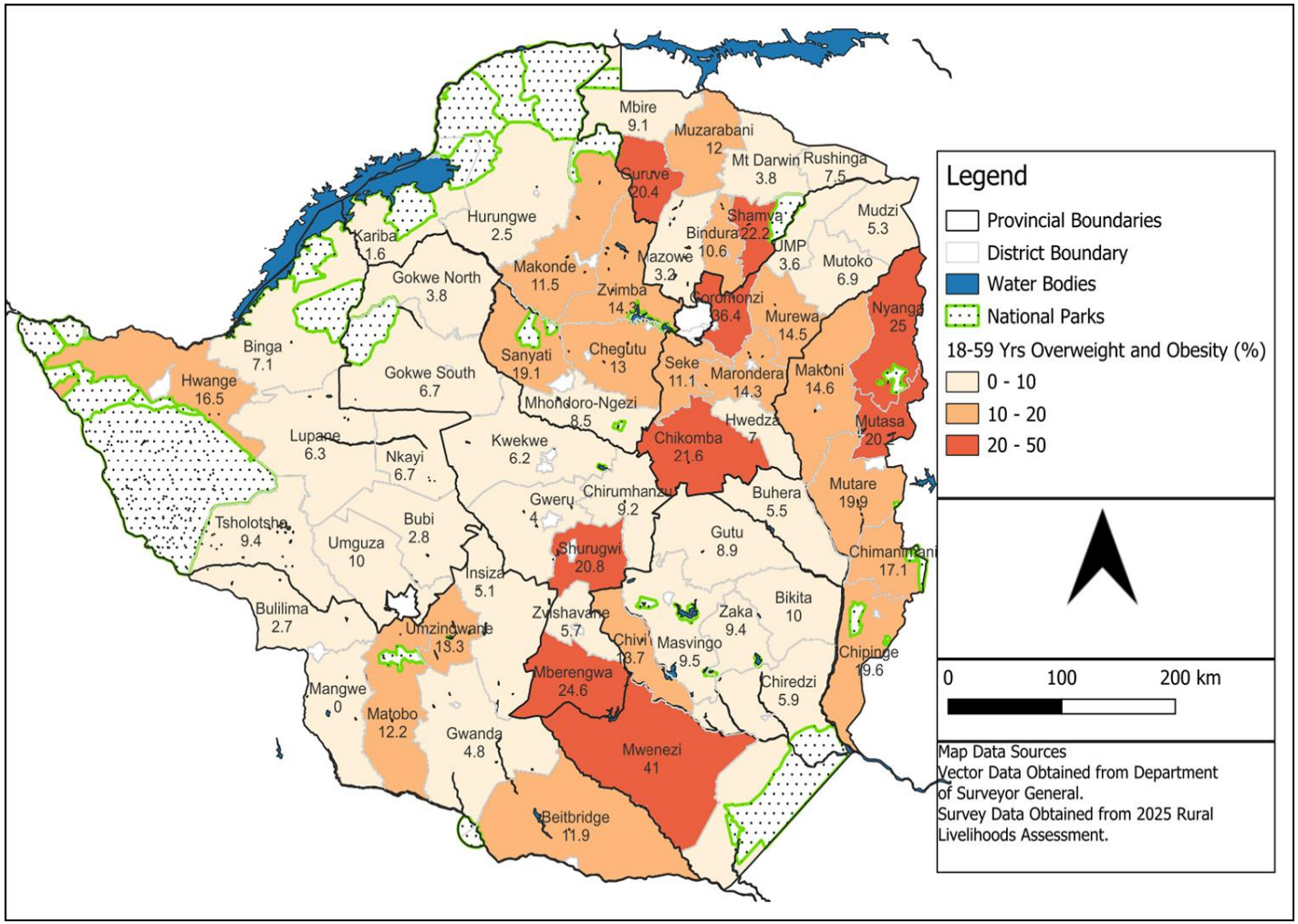
- Body mass index was used to classify adults aged 18 years and above. Having excess fat deposits in the body leads to serious health consequences such as cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis and some cancers (endometrial, breast and colon).
- Nationally, 35.5% of the adults aged 18-59 years were overweight and obese.

Nutrition Status for Adults 18-59 Years (BMI) by Sex



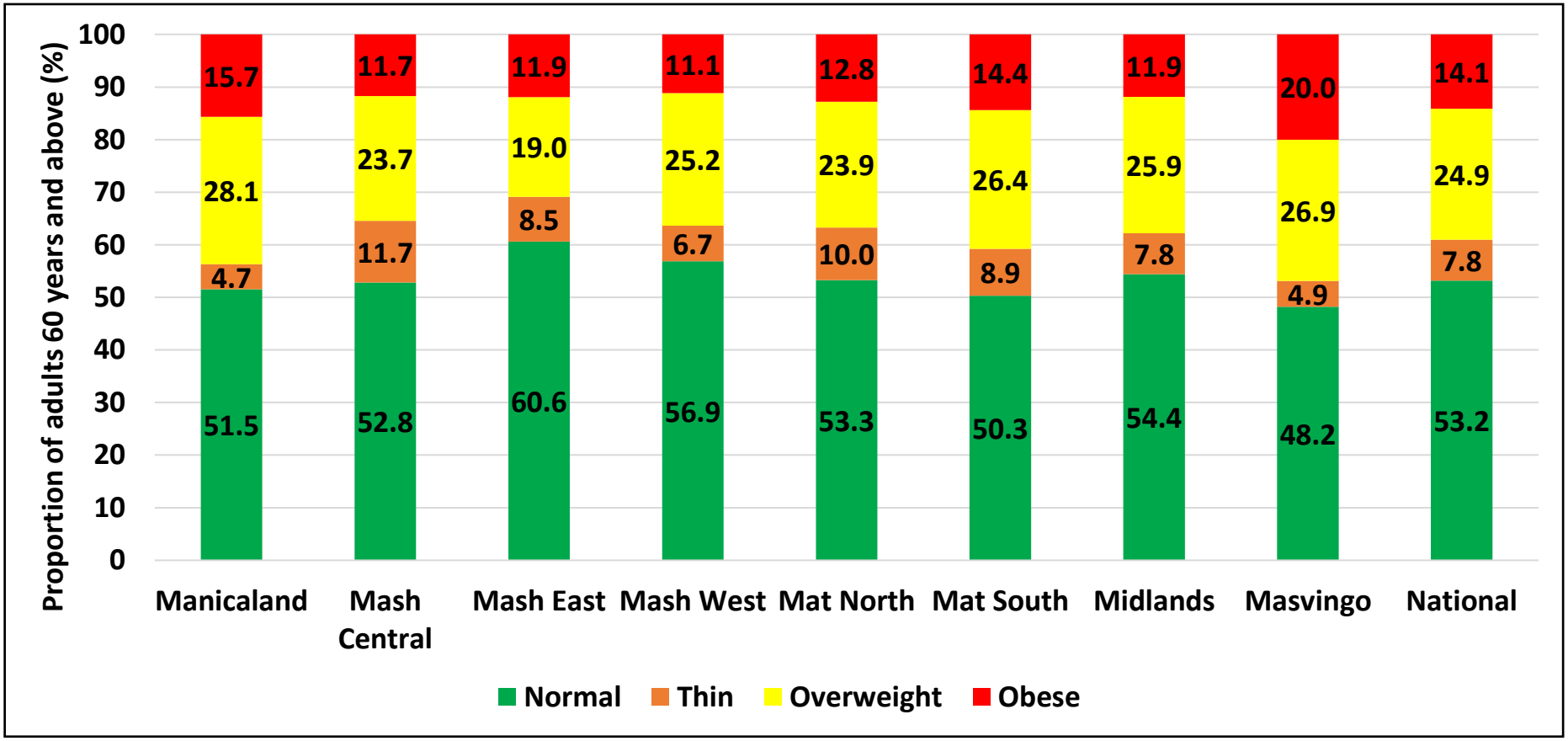
- More females were both overweight (28.5%) and obese (15.7%) as compared to males in the 18-59 years age group.

Nutrition Status for Adults 18-59 Years (BMI) by District



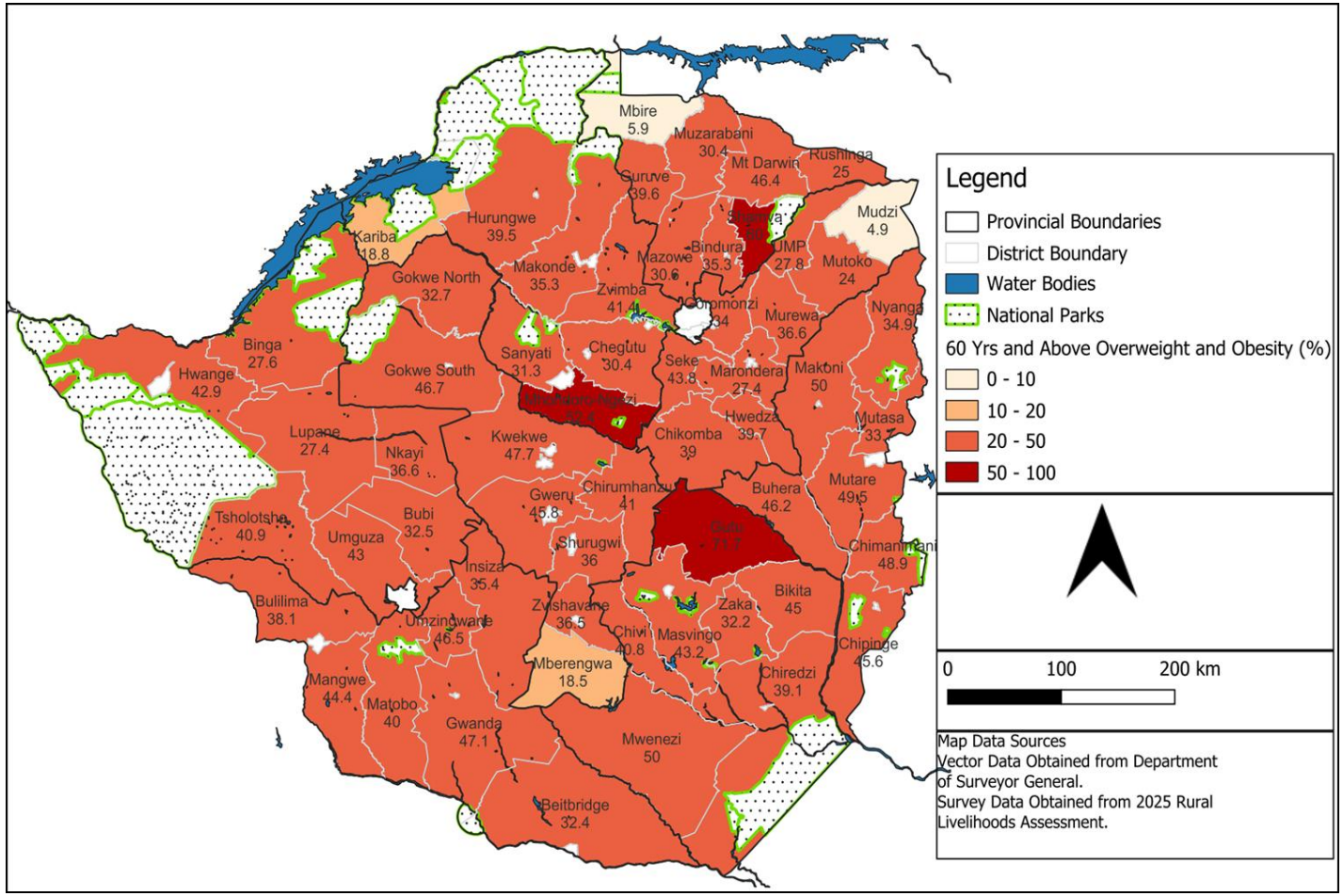
- Mwenezi (41%) and Goromonzi (36.4%) reported the highest levels of overweight and obesity.

Nutrition Status for Adults 60 Years and above (BMI) by Province



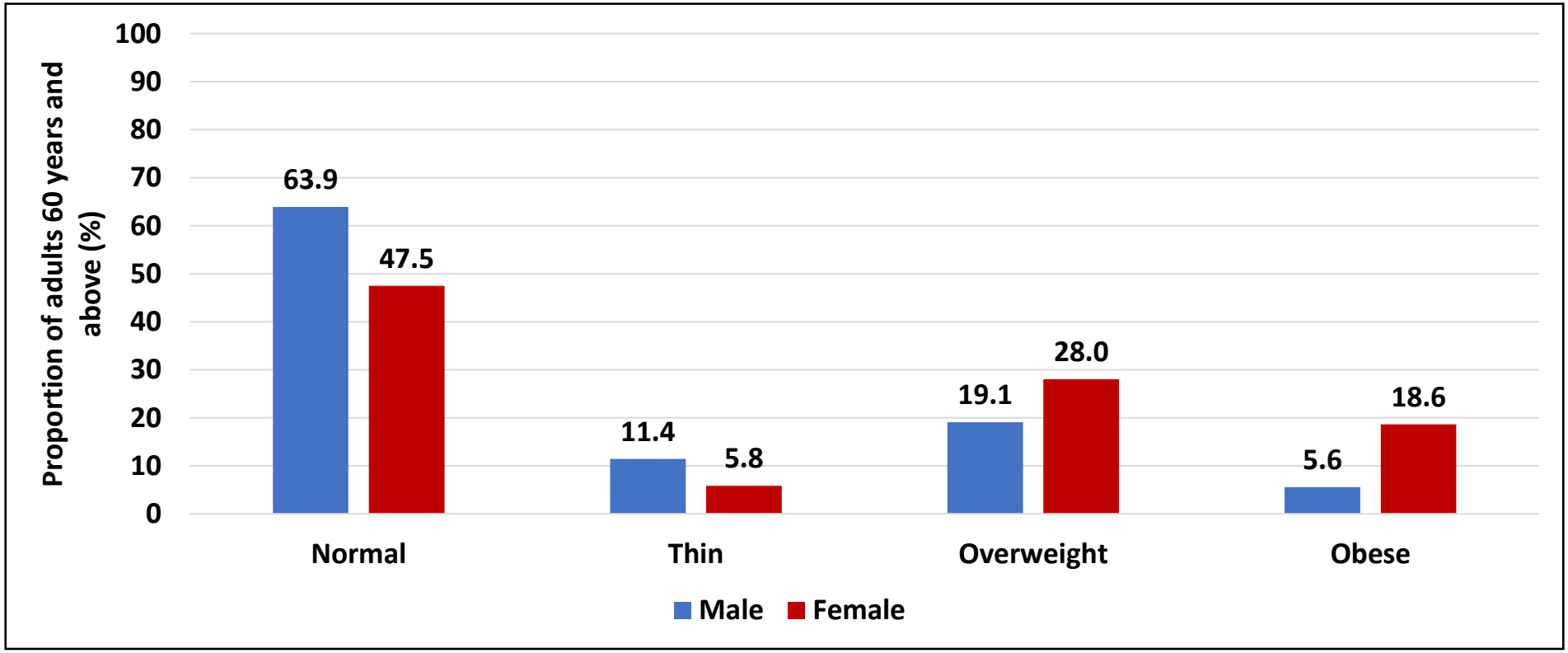
- Nationally, 39% of adults above 60 were overweight and obese, whilst 53.2% were normal.

Nutrition Status for Adults 60 Years and Above (BMI) by District



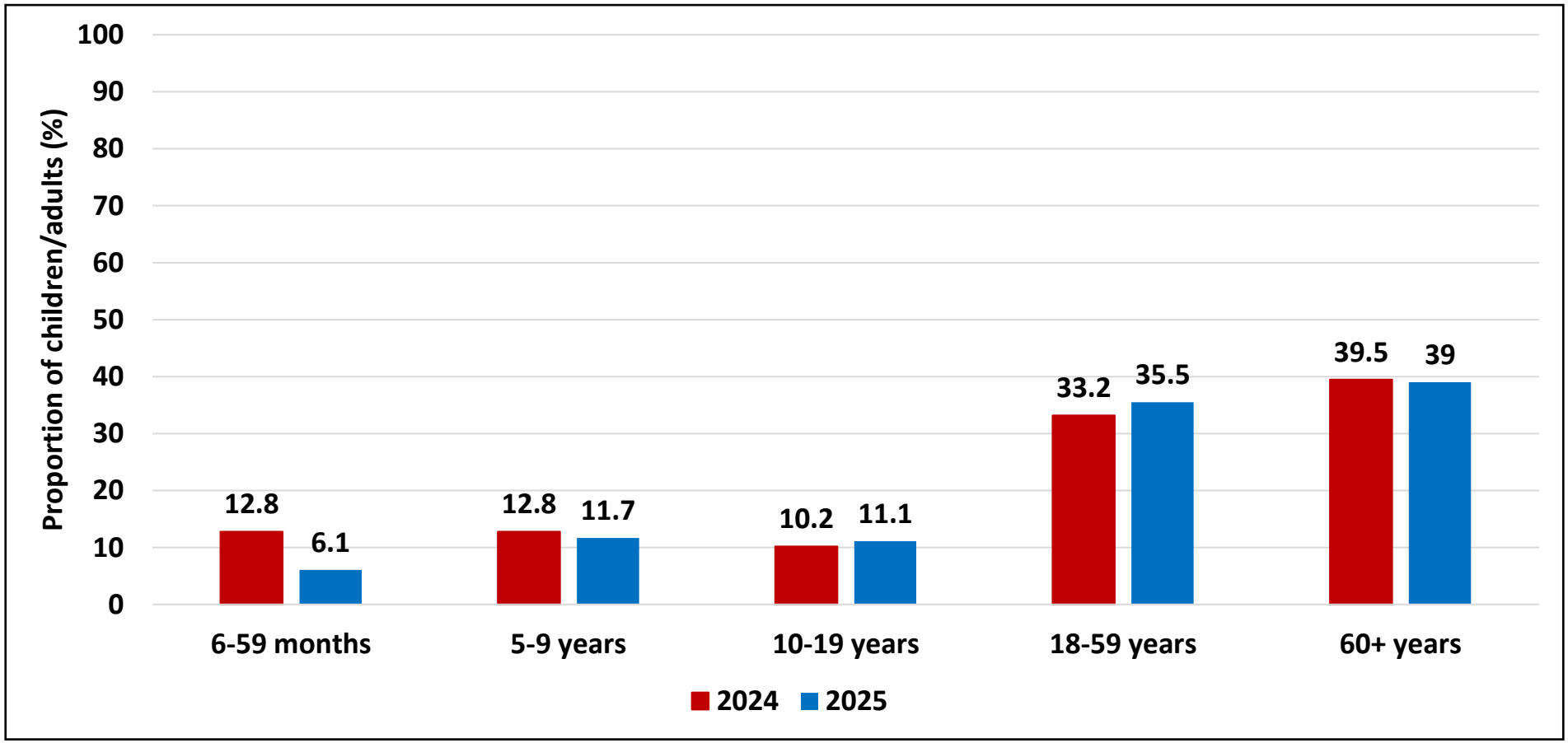
- Gutu (71.7%), Shamva (60%) and Mhondoro – Ngezi (52.4%) reported the highest levels of overweight and obesity in the 60+ years age group.

Nutrition Status for Adults 60 Years and Above (BMI) by Sex



- The proportion of adults 60 years and above who had normal nutrition status was 63.9% among males and 47.5% among females.
- However, 24.7% (males) and 46.6% (females) were overweight and obese.

Overweight and Obesity for All Age Groups by Year



- Overweight and obesity was increasing as the age was increasing with the 60+ age group reporting 39.5% in 2024 and 39% in 2025.

Correlations Results

Key Nutrition Outcomes with Food Security Indicators and Household Characteristics

Correlation of Nutrition Outcomes and Background Characteristics

	(1) Stunting	(2)	(3) Underweight	(4)	(5) Wasting	(6)	(7) Overweight & Obese	(8)
VARIABLES	coef	se	coef	se	coef	se	coef	se
Household head age	-0.001	(0.000)*	0.000	(0.000)	-0.000	(0.000)	0.000	(0.000)
Female headed households	0.051	(0.012)***	0.008	(0.007)	0.002	(0.005)	0.017	(0.007)**
Primary level	-0.010	(0.022)	-0.005	(0.014)	-0.018	(0.011)	0.004	(0.012)
ZJC level	-0.022	(0.024)	0.003	(0.015)	-0.007	(0.012)	0.002	(0.013)
O' level	-0.038	(0.022)*	-0.016	(0.014)	-0.023	(0.012)**	0.006	(0.013)
A' level	-0.082	(0.044)*	-0.024	(0.026)	-0.034	(0.019)*	0.007	(0.026)
Diploma/Certificate after primary	-0.075	(0.062)	-0.072	(0.023)***	-0.051	(0.021)**	0.014	(0.040)
Diploma/Certificate after secondary	-0.140	(0.045)***	-0.046	(0.028)*	-0.022	(0.027)	0.023	(0.040)
Graduate/Post-Graduate	0.011	(0.086)	-0.056	(0.034)*	0.026	(0.055)	-0.016	(0.049)
Protestant	0.012	(0.027)	-0.005	(0.015)	-0.010	(0.015)	-0.008	(0.018)
Pentecostal	0.020	(0.025)	0.008	(0.015)	-0.016	(0.013)	-0.009	(0.016)
Apostolic Sect	0.049	(0.022)**	0.024	(0.013)*	-0.016	(0.012)	-0.016	(0.014)
Zion	0.046	(0.027)*	0.012	(0.016)	-0.028	(0.013)**	-0.012	(0.017)
Other Christian	0.010	(0.028)	0.045	(0.019)**	-0.005	(0.016)	-0.010	(0.018)
Islam	0.063	(0.093)	0.114	(0.071)	-0.000	(0.044)	0.041	(0.061)
Traditional	0.089	(0.041)**	0.042	(0.026)	-0.036	(0.016)**	-0.006	(0.024)
Other religion	0.073	(0.054)	0.081	(0.041)**	-0.015	(0.025)	-0.028	(0.027)
No religion	0.026	(0.024)	0.011	(0.014)	-0.020	(0.013)	-0.022	(0.015)
Household size	0.032	(0.005)***	0.010	(0.003)***	0.001	(0.001)	0.002	(0.002)
Ln monthly income USD	-0.002	(0.003)	-0.002	(0.002)	0.000	(0.002)	-0.003	(0.002)
Household head disability	0.013	(0.022)	0.015	(0.014)	0.022	(0.012)*	-0.002	(0.013)
Household chronic condition	0.002	(0.017)	-0.018	(0.010)*	0.001	(0.008)	-0.000	(0.009)
Asset index	-0.004	(0.002)**	-0.003	(0.001)***	-0.000	(0.001)	-0.000	(0.001)
Mash Central	-0.039	(0.019)**	-0.011	(0.012)	-0.028	(0.009)***	-0.060	(0.012)**
Mash East	0.011	(0.020)	-0.005	(0.013)	-0.019	(0.009)**	-0.042	(0.013)**
Mash West	-0.015	(0.019)	0.001	(0.013)	-0.016	(0.010)	-0.062	(0.012)**
Mat North	0.004	(0.022)	-0.002	(0.014)	-0.019	(0.010)*	-0.080	(0.012)**
Mat South	0.081	(0.029)***	0.013	(0.018)	-0.011	(0.014)	-0.017	(0.017)
Midlands	0.008	(0.019)	-0.026	(0.012)**	-0.027	(0.009)***	-0.049	(0.012)**
Masvingo	0.006	(0.023)	-0.025	(0.014)*	-0.018	(0.011)	0.007	(0.016)
Constant	0.179	(0.044)***	0.077	(0.027)***	0.102	(0.022)***	0.121	(0.026)**
Observations	10,093		10,093		10,093		10,093	
R-squared	0.017		0.009		0.004		0.012	

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

- Female headed households were 5.1% more likely to have a stunted children compared to their counterparts hence this was significant at 1% level of significance.
- Increase in household head level of education was associated with reduced probability of undernutrition(stunting, underweight and wasting).
- Households with household heads affiliated to the apostolic, Zion and traditional religions were more likely to be malnourished compared to other religions after using catholic religion as base religion.
- Households with bigger household sizes were more likely to have a stunted and underweight child compared to their counterparts.

Correlation of nutrition outcomes and access to health or nutrition information

VARIABLES	Stunting		Underweight		Wasting		Overweight & Obesity	
	coef	se	coef	se	coef	se	coef	se
Household have access to services of a VHW	-0.024	(0.014)*	-0.001	(0.008)	0.003	(0.006)	-0.035	(0.009)***
Nutrition Services from a Village health worker	-0.017	(0.010)*	0.002	(0.006)	0.001	(0.005)	-0.007	(0.006)
Distance to the nearest health facility is < kms	-0.028	(0.010)***	0.002	(0.006)	-0.002	(0.005)	-0.004	(0.006)
Caregiver part of a care-group	0.015	0.012	0.004	(0.007)	0.013	(0.005)***	0.009	(0.006)
Constant	0.304	0.013***	0.098	(0.008)***	0.048	(0.005)***	0.106	(0.008)***
Observations	10094		10094		10094		10094	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Results showed that access to services of a village health worker, or nutrition services from a village health worker was associated with reduction in stunting hence this was significant at 10%.
- Access to a village health worker was associated with a 3.5% less likelihood of a child being overweight or obese at 1% level of significance.
- Households distance to health facility within a 5km radius was associated with a 2.8% reduction in stunting and this was significant at 1%.

Correlation of nutrition outcomes and access to health or nutrition information

VARIABLES	Stunting		Underweight		Wasting		Overweight & Obese	
	coef	se	coef	se	coef	se	coef	se
Food Consumption Score	-0.001	(0.000)***	-0.000	(0.000)	-0.000	(0.000)	0.000	(0.000)
Household Dietary Diversity Score	-0.005	(0.002)**	-0.000	(0.002)	-0.000	(0.001)	-0.001	(0.002)
Household Hunger Score	0.008	(0.005)*	0.006	(0.003)*	0.003	(0.002)	0.004	(0.003)
Constant	0.321	(0.014)***	0.105	(0.009)***	0.052	(0.007)***	0.076	(0.008)***
Observations	10102		10102		10102		10102	

*** p<0.01, ** p<0.05, * p<0.1

- Improved household food security measured by food consumption score and household dietary diversity was associated with improved nutrition status.
- Increased household hunger was associated with increased stunting by 0.8% at 1% level confidence and underweight by 0.6% at 10% level of significance.

Determinants of Exclusive Breastfeeding

VARIABLES	(1) Exclusive Breastfeeding coef	(2) se
Household head age	-0.001	(0.002)
Female headed households	-0.083	(0.045)*
Primary level	0.218	(0.089)**
ZJC level	0.197	(0.093)**
O' level	0.296	(0.092)***
A' level	0.220	(0.155)
Diploma/Certificate after primary	0.767	(0.145)***
Diploma/Certificate after secondary	0.010	(0.145)
Graduate/Post-Graduate	-0.028	(0.122)
Protestant	0.060	(0.137)
Pentecostal	0.034	(0.106)
Apostolic Sect	-0.006	(0.102)
Zion	-0.207	(0.113)*
Other Christian	-0.083	(0.150)
Islam	-0.009	(0.141)
Traditional	0.013	(0.149)
Other religion	-0.045	(0.170)
No religion	-0.112	(0.107)
Household size	0.013	(0.015)
Ln monthly income USD	-0.009	(0.011)
Household head disability	-0.101	(0.093)
Household chronic condition	0.011	(0.069)
Asset index	-0.002	(0.007)
Mash Central	-0.211	(0.073)***
Mash East	-0.107	(0.074)
Mash West	-0.209	(0.072)***
Mat North	0.240	(0.081)***
Mat South	-0.003	(0.099)
Midlands	-0.241	(0.080)***
Masvingo	0.031	(0.084)
Constant	0.341	(0.170)**
Observations	713	
R-squared	0.126	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Increase in household head education level was associated with increased likelihood of practicing exclusive breastfeeding.
- Households headed by household heads of the Zion religious sect were less likely to practice exclusive breastfeeding compared to the Catholics religion.

Correlations of Feeding Practices and Household Characteristics

VARIABLES	(1) Minimum Meal Frequency coef	(2) se	(3) Minimum Dietary Diversity coef	(4) se	(5) Minimum Acceptable Diet coef	(6) se
Household head age	-0.001	(0.001)	0.000	(0.001)	-0.001	(0.000)
Female headed households	0.007	(0.018)	-0.012	(0.017)	0.003	(0.012)
Primary level	-0.033	(0.034)	-0.023	(0.030)	-0.054	(0.024)**
ZJC level	-0.050	(0.037)	0.005	(0.033)	-0.067	(0.025)***
O' level	-0.038	(0.035)	0.022	(0.031)	-0.049	(0.025)**
A' level	-0.088	(0.072)	-0.084	(0.064)	-0.108	(0.045)**
Diploma/Certificate after primary	0.097	(0.153)	-0.142	(0.126)	-0.111	(0.077)
Diploma/Certificate after secondary	0.040	(0.092)	0.007	(0.090)	-0.012	(0.078)
Graduate/Post-Graduate	-0.048	(0.135)	0.391	(0.180)**	-0.111	(0.097)
Protestant	-0.003	(0.049)	0.017	(0.045)	0.026	(0.034)
Pentecostal	-0.046	(0.043)	-0.008	(0.040)	0.003	(0.029)
Apostolic Sect	-0.064	(0.039)	-0.050	(0.036)	-0.025	(0.026)
Zion	-0.058	(0.046)	-0.019	(0.042)	-0.005	(0.031)
Other Christian	0.072	(0.053)	0.104	(0.051)**	0.084	(0.039)**
Islam	-0.247	(0.123)**	0.086	(0.168)	-0.145	(0.036)***
Traditional	0.010	(0.068)	-0.023	(0.058)	0.003	(0.043)
Other religion	-0.041	(0.084)	0.153	(0.094)	0.068	(0.067)
No religion	-0.045	(0.042)	-0.080	(0.038)**	-0.028	(0.028)
Household size	0.011	(0.005)**	-0.000	(0.005)	0.009	(0.004)**
Ln monthly income USD	0.020	(0.005)***	0.029	(0.005)***	0.017	(0.004)***
Household head disability	-0.027	(0.036)	0.076	(0.035)**	-0.006	(0.022)
Household chronic condition	0.002	(0.028)	-0.023	(0.025)	-0.023	(0.018)
Asset index	0.013	(0.003)***	0.011	(0.003)***	0.007	(0.002)***
Mash Central	-0.070	(0.032)**	-0.058	(0.029)**	-0.044	(0.022)**
Mash East	-0.011	(0.032)	0.074	(0.031)**	0.037	(0.024)
Mash West	-0.154	(0.032)***	-0.068	(0.031)**	-0.067	(0.023)***
Mat North	-0.124	(0.036)***	-0.202	(0.030)***	-0.112	(0.023)***
Mat South	-0.028	(0.044)	-0.108	(0.040)***	-0.075	(0.028)***
Midlands	-0.055	(0.032)*	-0.101	(0.030)***	-0.057	(0.022)***
Masvingo	-0.094	(0.037)**	-0.049	(0.036)	-0.029	(0.027)
Constant	0.311	(0.068)***	0.169	(0.062)***	0.087	(0.045)*
Observations	3,954		3,954		3,954	
R-squared	0.033		0.066		0.043	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Household head education level being graduate or post graduate was associated with a 3.9% increase in children receiving a minimum dietary diversity hence This was significant at 1%.
- Increase in household head education was associated with reduced likelihood that a child received a minimum acceptable diet.

Correlation of Water, Sanitation and Hygiene and Child Illness

VARIABLES	Diarrhoea		Cough		Fever	
	coef	se	coef	se	coef	se
Access to improved water	-0.019	(0.011)*	-0.016	(0.016)	-0.012	(0.014)
Access to Improved sanitation facilities	-0.027	(0.008)***	-0.022	(0.013)*	-0.013	(0.011)
Presence of a handwashing facility	0.025	(0.019)	-0.005	(0.029)	0.024	(0.026)
Distance from main water source	0.001	(0.008)	0.018	(0.013)	0.014	(0.011)
Minutes taken to fetch water	-0.002	(0.009)	0.013	(0.014)	0.003	(0.013)
Constant	0.203	(0.010)***	0.602	(0.015)***	0.361	(0.013)***
Observations	11073		11073		11073	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Results show that household access improved water and improved sanitation facilities were associated with reduced incidences of diarrhoea amongst children 0-59 months hence this was significant at 10% and 1% respectively.
- Access to improved sanitation by a household was associated with 2% reduced chance of children 0-59 months having a cough 2 weeks prior to survey.

Correlation of Nutrition Status ,Illness And Vaccination Status Children

VARIABLES	Stunting		Underweight		Wasting		Overweight & Obese	
	coef	se	coef	se	coef	se	coef	se
Diarrhoea	0.046	(0.014)***	0.018	(0.008)**	0.008	(0.006)	0.011	(0.007)
Cough	0.057	(0.010)***	0.023	(0.006)***	0.005	(0.004)	-0.003	(0.005)
Fever	0.043	(0.011)***	0.011	(0.006)*	0.005	(0.004)	-0.002	(0.005)
Ever Vaccinated	-0.098	(0.018)***	-0.042	(0.010)***	0.002	(0.006)	-0.012	(0.008)
Constant	0.275	(0.005)***	0.094	(0.003)***	0.048	(0.002)***	0.075	(0.003)***
Observations	10,092		10,092		10,092		10,092	
R-squared	0.001		0.006		0.003		0.006	

*** p<0.01, ** p<0.05, * p<0.1

- Results show that illness amongst children was associated with undernutrition(stunting and underweight) and this was significant at 1%.
- Vaccinated children were less likely to be stunted or underweight hence this was significant at 1%.

Determinants of Illness and Vaccination for Children 0-59 Months

	(1) Diarrhoea	(2)	(3) Cough	(4)	(5) Fever	(6)	(7) Child Ever Vaccinated	(8)
VARIABLES	coef	se	coef	se	coef	se	coef	se
Household head age	-0.001	(0.000)**	-0.002	(0.000)***	-0.001	(0.000)***	-0.002	(0.000)***
Female headed households	-0.026	(0.009)***	-0.020	(0.015)	-0.032	(0.013)**	0.083	(0.014)***
Primary level	-0.024	(0.018)	-0.055	(0.027)**	-0.050	(0.023)**	0.012	(0.025)
ZJC level	-0.043	(0.020)**	-0.063	(0.029)**	-0.080	(0.025)***	-0.004	(0.028)
O' level	-0.056	(0.019)***	-0.081	(0.027)***	-0.076	(0.024)***	0.038	(0.026)
A' level	-0.073	(0.037)**	-0.073	(0.055)	-0.103	(0.048)**	0.026	(0.051)
Diploma/Certificate after primary	-0.117	(0.043)***	-0.133	(0.104)	-0.111	(0.080)	0.055	(0.084)
Diploma/Certificate after secondary	-0.121	(0.036)***	-0.086	(0.066)	-0.151	(0.052)***	-0.036	(0.054)
Graduate/Post-Graduate	-0.067	(0.062)	0.020	(0.130)	-0.100	(0.095)	0.002	(0.110)
Protestant	0.023	(0.021)	0.064	(0.036)*	0.078	(0.031)**	-0.041	(0.032)
Pentecostal	0.020	(0.019)	0.100	(0.033)***	0.078	(0.027)***	0.014	(0.029)
Apostolic Sect	0.054	(0.017)***	0.113	(0.030)***	0.091	(0.024)***	-0.065	(0.026)**
Zion	0.034	(0.021)	0.091	(0.035)**	0.102	(0.029)***	-0.024	(0.031)
Other Christian	0.018	(0.022)	0.080	(0.038)**	0.070	(0.032)**	0.000	(0.033)
Islam	-0.017	(0.058)	0.342	(0.124)***	0.140	(0.113)	0.062	(0.085)
Traditional	0.025	(0.031)	0.102	(0.050)**	0.044	(0.041)	0.009	(0.039)
Other religion	0.015	(0.038)	0.023	(0.071)	-0.031	(0.048)	0.032	(0.058)
No religion	0.028	(0.019)	0.094	(0.032)***	0.085	(0.026)***	0.009	(0.027)
Household size	0.017	(0.003)***	0.053	(0.005)***	0.033	(0.004)***	0.101	(0.006)***
Ln monthly income USD	-0.003	(0.003)	0.001	(0.004)	-0.002	(0.004)	0.007	(0.004)*
Household head disability	0.034	(0.019)*	0.064	(0.027)**	0.114	(0.025)***	0.037	(0.023)
Household chronic condition	0.008	(0.013)	0.070	(0.021)***	0.060	(0.018)***	0.058	(0.018)***
Asset index	-0.007	(0.001)***	-0.006	(0.002)***	-0.008	(0.002)***	-0.002	(0.002)
Mash Central	-0.053	(0.015)***	-0.066	(0.023)***	-0.083	(0.021)***	-0.033	(0.021)
Mash East	-0.029	(0.016)*	-0.091	(0.024)***	-0.065	(0.022)***	0.058	(0.023)**
Mash West	-0.012	(0.017)	0.024	(0.025)	-0.053	(0.023)**	0.003	(0.024)
Mat North	-0.097	(0.016)***	-0.082	(0.026)***	-0.166	(0.022)***	0.032	(0.023)
Mat South	-0.072	(0.020)***	-0.038	(0.035)	-0.078	(0.030)***	0.099	(0.031)***
Midlands	-0.011	(0.016)	0.062	(0.025)**	-0.018	(0.022)	-0.068	(0.023)***
Masvingo	-0.023	(0.019)	0.025	(0.028)	0.057	(0.027)**	0.012	(0.025)
Constant	0.251	(0.035)***	0.461	(0.055)***	0.358	(0.047)***	0.755	(0.050)***
Observations	11,049		11,049		11,049		11,049	
R-squared	0.018		0.031		0.028		0.072	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Results show that female headed households were 2.6% and 3.2% less likely to have diarrhoea and cough compared to their counterparts.
- Female headed households were 8.3% more likely to have vaccinated children compared to male headed households.
- Increase in household head education was associated with reduced incidence of childhood illnesses.

Correlation of Water ,Sanitation and Background Characteristics

	Access to improved water		Access to Improved sanitation		Handwashing facility is available	
VARIABLES	**coef**	**se**	**coef**	**se**	**coef**	**se**
Household head age	0.001	(0.000)***	0.003	(0.000)***	0.000	(0.000)**
Female headed households	0.018	(0.007)***	0.029	(0.008)***	0.004	(0.004)
Primary level	0.017	(0.012)	0.018	(0.014)	-0.003	(0.006)
ZJC level	0.042	(0.013)***	0.067	(0.015)***	0.007	(0.007)
O' level	0.066	(0.013)***	0.130	(0.015)***	0.017	(0.007)**
A' level	0.079	(0.026)***	0.184	(0.031)***	0.040	(0.020)**
Diploma/Certificate after primary	0.136	(0.027)***	0.175	(0.039)***	0.080	(0.035)**
Diploma/Certificate after secondary	0.091	(0.027)***	0.250	(0.029)***	0.089	(0.029)***
Graduate/Post-Graduate	0.091	(0.032)***	0.190	(0.033)***	0.120	(0.040)***
Protestant	0.014	(0.014)	-0.013	(0.016)	-0.006	(0.011)
Pentecostal	-0.013	(0.013)	-0.050	(0.015)***	-0.012	(0.010)
Apostolic Sect	-0.038	(0.012)***	-0.107	(0.013)***	-0.021	(0.008)**
Zion	-0.031	(0.014)**	-0.104	(0.016)***	-0.023	(0.010)**
Other Christian	0.045	(0.015)***	0.008	(0.017)	0.006	(0.012)
Islam	0.030	(0.043)	-0.036	(0.054)	0.001	(0.030)
Traditional	-0.038	(0.022)*	-0.157	(0.026)***	-0.022	(0.013)*
Other religion	-0.002	(0.026)	-0.074	(0.032)**	0.010	(0.021)
No religion	-0.029	(0.013)**	-0.103	(0.015)***	-0.012	(0.009)
Household size	-0.002	(0.002)	-0.009	(0.002)***	-0.004	(0.001)***
Ln monthly income USD	0.015	(0.002)***	0.020	(0.002)***	0.008	(0.001)***
Household head disability	0.024	(0.011)**	0.023	(0.013)*	-0.009	(0.008)
Household chronic condition	0.002	(0.008)	-0.007	(0.010)	0.013	(0.006)**
Asset index	0.004	(0.001)***	0.023	(0.001)***	0.006	(0.001)***
Constant	0.684	(0.024)***	0.407	(0.027)***	0.016	(0.016)
Observations	17,773		17,763		17,773	
R-squared	0.029		0.113		0.034	

Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1

- Increase in household head age was associated with increased likelihood that the household accessed improved water, sanitation and has a handwashing facility.
- Female headed households were 1.8% and 2.9% more likely to use improved water and sanitation, hence this was significant at 1%.
- Increase in household head education level was associated with increased the chances of having a handwashing facility.

Conclusions and Recommendations

Conclusions and Recommendations

Child Health

- The Government is commended for successful reaching national target of 85% for children that had received vaccination since birth. The national effort to ensure every child has access to vaccines remains a developmental priority therefore attention should also be given to districts with low vaccination whose zero dosage was above 15% (Shamva: 29.4%, Kwekwe: 28%, Buhera: 22.6%, Mutare: 16.4%, Mutasa: 16.3% and Mhondoro-Ngezi: 16%). The Ministry of Health and Child Care working with multi-stakeholders needs to develop strategies to improve access to immunisation for religious objectors and vaccine-hesitant households. Interventions that address the emerging drivers of vaccine hesitancy such as spread of misinformation through social media platforms, messaging applications and word-of-mouth communication should be prioritised.

- Vitamin A supplementation to children 6 to 59 months was above the NDS1 target of 90%. The Ministry responsible for Health should continue with the strategies applied, that is task sharing with community health workers, integrating with campaign blitz and child health and nutrition support groups/ care groups. However, there is need for the Ministry responsible for Health to strengthen routine surveillance and documentation of Vitamin A supplementation efforts at community level.

Conclusions and Recommendations

Dietary Intake and Taboos

- Household food taboos and restrictions may contribute to negative health and nutrition outcomes. About 48.1% of households had food taboos that restricted the consumption of certain meat and meat products. Mashonaland Central province had 58.4% of households that were not consuming certain meats and meat products. There are potential links of these social dimensions of food access to the high reported levels of malnutrition and low minimum acceptable diets in some districts (Shamva district of Mashonaland Central). There is need to enhance operationalisation of SBC messages whilst increasing the interface with the community and individuals. The Ministries responsible for Health and Information should make use of available information platforms such as community radio stations, tailor-making messages to address context specific drivers of poor dietary intake.

Infant and Young Child Feeding

- Zimbabwe is a breastfeeding country and is indicated by the ever-breastfed coverage of above 90% and early initiation prevalence of 83.8%. The Ministry responsible for Health is encouraged to continue investments in health and nutrition interventions such as Baby Friendly Hospitals Inititiatives (BFHI) and promotion of the care group model.

Conclusions and Recommendations

Infant and Young Child Feeding

- Continued breastfeeding is a vital life saving practice as it provides about a third of the nutrients required for growth and development for children 12 to 23 months. The findings show that nationally 54% of children aged 12-23 months were being breastfed beyond one year against a target of at least 90%. Continued breastfeeding improves with home and family-based interventions, such as home visits by community health workers and scaling up of infant and young child feeding support groups. The **Ministry of Health and Child Care** through multisectoral collaboration should scale up approaches which provide support to breastfeeding mothers and communities through existing Food and Nutrition Security Committees, care groups and Infant and Young Child Feeding support groups. Overlaying of nutrition activities during planned/ongoing sectorial activities (e.g. during food fairs and food days) should be prioritised.

- Enforcement of policies that support the maternity protection legislation to ensure prolonged maternity leave, as well as the reduction of barriers for working mothers to breastfeed (provision of lactation rooms and breaks to express milk in the workplace) can help increase continued breastfeeding beyond one year. Proper regulation of the breast-milk substitute industry and enforcement of the International Code of Marketing of Breast-milk Substitutes is also an essential element for promoting and protecting continued breastfeeding.

Conclusions and Recommendations

Diet Quality

- The quality of diet practice which is measured by the proportion of children consuming a Minimum Acceptable Diet (MAD) has improved from 2% (2024) to 11.9% in 2025. This however remains below the MFNSS target of 25%. There is compelling evidence that supports the provision of nutritional counseling to caregivers through local multi-sector support group platforms, one-on-one and feeding demonstrations as potential interventions to improve complementary feeding practices and ultimately the nutritional status of children in developing countries. The Ministry responsible for Health should scale up caregiver access to care groups that are linked with other multi-sector interventions.

- WHO guiding principles recommend that children aged 6–23 months be fed a variety of foods to ensure that nutrient needs associated with improved linear growth are met. 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. About 27% of children were reported to be consuming a diverse diet, with an improvement in the proportion that consumed egg and/or flesh from 14% in 2024 to 36.4% in2025. Food-based strategies involving dietary diversification (homestead nutrition gardening, animal husbandry and nutrition education) as the long-term sustainable strategies should be scaled-up. The Ministry responsible for Agriculture should create an enabling environment that supports sustainable agriculture for practising dietary diversification with behavior change communication as an integral segment. These efforts should be augmented by household level messaging and support to address intrahousehold food dynamics like taboos.

Conclusions and Recommendations

Nutrition Status

- Child wasting (Global Acute Malnutrition) was 4.3% at national level with Mbire (9.1%), Mudzi (9%), Bikita (9%) and Shurugwi (9%), having the highest proportions of children above the 5% WHO threshold for emergency response. Child wasting carries a high risk of death if left unmanaged. It is recommended that the Ministry responsible for Health sets up sentinel site surveillance mechanisms in districts 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.

- In the face of high overweight and obesity among adults 18-59 years (33.2%) and adults 60 years and above (39.5%), policies and legislation are needed to promote healthy food environments, both formal and informal to empower consumers to make nutritious food choices. The Ministry responsible for Health needs to scale-up nutrition education and awareness to prevent risk factors for Non-Communicable Diseases (NCDs). Nutrition education can raise awareness about the consequences of poor dietary behaviours. More locally tailor-made nutrition education campaigns and awareness efforts are needed to educate the communities about healthy nutritional behaviours.

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